

MANUAL FOR HEALTH COUNSELORS

THE MANAS PROGRAM



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Introduction

Common mental health problems like Depression are a major public health concern in Goa and in other parts of the world. They affect a large number of people in the community, lead to much distress, prevent those affected from leading a productive life and, in some instances can lead to suicide. However, there are a range of simple and effective treatments that can be provided to patients to help them overcome these problems. These are best delivered in primary health care settings and much of the care can be provided by persons who do not need to have previous experience in mental health treatments.

This manual is a resource for Health Counselors working in **Family Physician Clinics (FPC)** as part of the MANAS program. This program is for common mental disorders like depression and anxiety seen in primary health care facilities like the FPC; since depression is the commonest disorder within this group of stress related mental health problems, in the manual we refer to these problems simply as '**Depression**'. The aim of the MANAS program is to integrate the recognition and treatment of Depression into routine primary health care. In the MANAS program, a range of effective treatments will be provided for patients with Depression. These treatments are matched to the individual requirements of patients to both improve the effectiveness of the treatments and to use the limited resources efficiently.

The **Health Counselor (HC)** is the most crucial person in the MANAS program. The HC is expected to perform a number of different roles in the course of her usual work. These include integrating the overall program within the FPCs, providing clinical services to patients, facilitating follow up and maintaining the required standards of documentation. She will be supported closely in her work through a supervisory system that will encourage continuous improvement in a positive learning atmosphere.

You may wonder why we have chosen you to be trained to perform the unique and important role of the Health Counselor. For example, why did we not choose a mental health professional (such as a clinical psychologist) or even a health professional (such as a nurse)? The reasons are simple: first, because there are far too few mental health professionals in India to meet the needs of the millions of patients in primary care who suffer from Depression; and second, because the skills and methods to treat Depression can be learned and practiced by anyone with the necessary commitment, communication skills and training.

To be effective practitioners, the HC will need to acquire the set of essential theoretical and practical skills which the manual describes. The manual is organized as a series of chapters that will provide these skills in a stepwise manner. Chapter 1 introduces the essential theoretical basis for understanding stress and Depression including its detection and diagnosis and assessment of suicide risk. In Chapter 2, the MANAS program and the various specific

treatments that will be used in the program are described together with their application for treating Depression. Chapter 3 describes the operational details of the program including the structure of the team, supervision, documentation requirements and integration within the clinics. Chapter 4 consists of the Appendices that are relevant to MANAS program. The manual also has a glossary of some technical terms and an appendix of organizations that address social needs in Goa.

This manual has been written for HCs who may not have had any previous exposure to providing care for persons with mental health problems. Accordingly, we have attempted to use non-technical language as much as possible and used common examples to make it interesting and user friendly. However, we know that some words may still be complicated and difficult to understand. Please do not hesitate to ask questions to explain anything which is not clear. We would also welcome any suggestions to make the manual better and more user-friendly.

This version of the manual builds upon the previous drafts and has been shaped by the rich experiences we gained in the course of the program in Primary Health Centres (PHCs) and in piloting the program in FPCs. We hope these experiences will add value to the manual by making it relevant to the challenges and opportunities that exist in the real world while encouraging a problem solving approach by HCs.

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We do hope this manual will be a valued resource for Health Counselors during their training and in the course of work.

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Chapter 1

Stress and Depression

Chapter 1.1

INTRODUCTION TO STRESS RELATED DISORDERS

This chapter includes the following:

- What is Stress
- Common types of stress
- Different reactions to stress
- Understanding stress and its consequences: the Biopsychosocial model.

1.1a What is stress?

Over the last few years, there has been an increasing awareness of stress and stress related problems in everyday life. Changes in lifestyles, the growing reporting of stress on TV and the newspapers, and the pressures of today's work environment are some of the commonly cited reasons why we are more aware of stress related problems in our communities. As a result, the words stress and tension have become part of the common language that we use in our day to day activities.

In general, stress is commonly understood in mechanical terms and is often compared to having an excessive physical load being placed on a person. While some stress is bearable, beyond a certain threshold there is a 'breakdown' of the person's ability to deal with daily issues. The inability to deal with stress becomes obvious as difficulties in various areas of the person's life. For e.g., stress can cause a worsening of health problems, create difficulties in close relationships and have a negative influence on studies or work performance.

For our purpose, **stress can be defined as any event or experience that disturbs the balance or the ability of the person to function smoothly.**

1.1b Common types of stress

Since stress is an unavoidable part of our life experiences, there has been a lot of interest in attempts to classify and study it. Some of the common ways in which stress is classified are:

- Stress as being caused by **changes inside or outside us.**
For example, the diagnosis of serious health problems like heart disease, cancer or mental illness causes a great deal of stress to the person. Again, since we are social creatures, changes in our relationships are frequent causes of stress. Death of a loved one and the break up of a valued relationship are some common examples of these types of stresses.
- Stress can be **sudden (acute) or long term**

Another common way of understanding stress is to classify them according to how they happen i.e. whether the event happened all of a sudden or has been continuing for a longer period of time. Examples of acute stress include death of a family member, serious accidents, or having to face natural or man made disasters. Some common longstanding stresses include social and economic discrimination because of being a woman or belonging to a disadvantaged social class, poverty, marital problems and disabling illnesses that restrict the person's quality of life. As we shall discuss later, the effects of sudden or long standing stress produce different biological, social and psychological effects.

- Stress can be **mild or severe in intensity**

It makes common sense that more serious problems will cause greater stress to the person. Research has also shown consistently that there is an increasing tendency to experience stress related problems as the severity of the stressful experience increases.

1.1c Stress does not cause the same reaction in everyone

It is common knowledge that there are widely varying reactions in the way people deal with stress with some people being more likely to develop problems in their life after experiencing stress. How do we understand this?

As we noted earlier, stress is produced by events in our environment. After the particular event is experienced, all of us react by giving the event some emotional meaning. **Since no two persons are the same in terms of their biological make up, personality or social environment, people will react to the same stressful situation in unique and different ways.** Failing in examinations is a good illustration of the above. While some persons are very seriously affected to the point of contemplating suicide, others are able to deal with the event by taking the failure as a challenge and excelling the next time.

The way individuals deal with difficulties are **different at different points in one's life** as experiences from our own lives will demonstrate. It must be mentioned that **not all stress is bad.** Sometimes, stress can help improve our functioning as we are more alert, focused and oriented to the task when stressed. It can also be an opportunity for seeing things in a different perspective and enhance our personal growth by improving self esteem and the feeling of being able to be in control of one's life.

1.1d Understanding stress in a holistic manner

As we noted earlier, what makes an event stressful is the meaning we attach to it. This process is, in turn, influenced by the social environment, cultural beliefs and attitudes, past experience and personality type of the individual. For example, someone who is naturally anxious will tend to get upset more easily compared to another person who is more relaxed and easy going. The social situation in which a person lives can also influence how a person deals with

stress. For example, after the death of her husband, the wife who does not have supportive family and faces economic difficulties has a much greater chance of feeling stressed. However, there are some consequences of stress that are common across individuals as well. These can be conveniently described under the following headings:

- **The physical consequences of stress**

The human body is designed to react to stress in a particular manner and this has been well studied in the context of **acute stress reactions**. As soon as a stressful situation is experienced, the brain and body go on an alert mode. This is mediated by the release of certain chemicals in the brain which also influence bodily functions. Norepinephrine or adrenaline is released in large quantities at this stage which improves attention, increases the heart and respiration rate and improves blood supply to the muscles (the 'fight or flight' response). For example, if we suddenly see a snake, our heart starts beating quickly, we start breathing faster and our muscles get tense. These are the automatic preparations that the body makes to escape from the situation. Similarly, when we get angry, we experience the same physical changes that help us to fight, if necessary. Another important chemical that is released when we are stressed is cortisol which is a naturally occurring hormone. This also improves the short term functioning of the body by increasing metabolism and making more energy available to deal with the problem.

However, if the **stress continues for some time**, the alert mode of functioning is difficult to maintain as this uses up too much energy. As a consequence, with chronic stress there is a general exhaustion of the brain and body's ability to function at optimum levels. This is when the brain and body 'give up' making the person more vulnerable to developing physical and/or mental difficulties like fatigue, sleeping difficulties and aches and pains. The negative impact of chronic stress has now been demonstrated both in infectious diseases and in survival rates in chronic diseases like heart disease and cancer. For example, patients who are depressed or anxious following a heart attack are more likely to die sooner compared to patients who have a positive mental state. This could be because patients who are depressed are less motivated to continue medicines or exercise, stop smoking and maintain a healthy diet.

- **The emotional consequences of stress**

The mental consequences of acute and chronic stress have a similar profile to the physical responses described above. In the short term, stress has an energizing effect on mental functions like attention span, concentration and memory which are then utilized for solving the problem(s) being encountered. This is usually quite successful in dealing with most daily problems. For example, the heightened/aroused state of readiness helps individuals cope with the strains of work, caring for the family and sorting out interpersonal disputes. However, when the stress is overwhelming (e.g. loss of employment

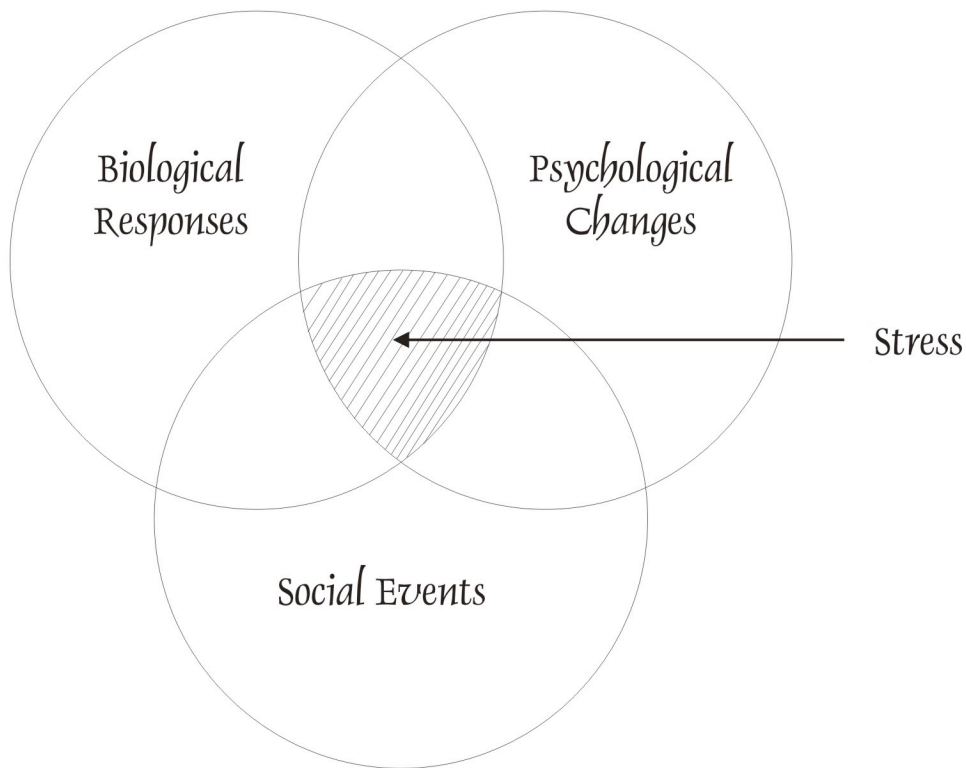
and social status, being physically or sexually assaulted, loss of home during disasters) or when the stresses are ongoing with little possibility of being resolved (e.g. domestic violence, poverty, infection with HIV/AIDS) the psychological resources for coping may be exhausted and individuals experience a lot of distress as shown by depressed or anxious mood, lack of concentration and feelings of hopelessness.

- **The social consequences of stress**

Social networks can have a protective function in dealing with stress and can be thought of as a **safety net**. For example, when we are upset about something, we talk to parents, friends and family members who provide us support and help in resolving the difficulties. On the other hand, **social networks can be a cause of distress** and can make the person feel trapped and humiliated with no escape routes. A good example is the trauma faced by some women after marriage when there is a dispute over dowry for which they are subjected to domestic violence and neglect. The effects of ongoing, unresolved stress can also be seen in the social context (office, family, and friends); for example, the person withdraws from previous social interactions with friends or colleagues.

Though the biological, psychological and social consequences of stress have been described separately for the sake of convenience, it is vital to understand that they are not independent of each other. On the other hand, there is a **continuous interaction** between them in the meaning people give to stress and its effects and outcomes following the experience of stress (see Figure1); **stress is best understood as a biopsychosocial experience.**

Figure 1:
The Biopsychosocial causes of Stress



Summary points:

- Stress is part of everyday life and can be defined as any event that disturbs the biopsychosocial balance of the person.
- Stress can be due to changes in the internal or external environment, can be acute or longstanding and of various intensities.
- Stress has some common physical, emotional and social consequences.
- The consequences of stress vary between individuals because of different ways of perceiving and reacting to the problem.

Chapter 1.2

VULNERABILITY & RESILIENCE

This chapter includes following:

- What is Mental Health
- What is Vulnerability
- What is Resilience
- What are Risk Factors and Protective Factors
- What is the relevance of vulnerability and resilience to the Health Counselor

1.2a What is Mental Health?

WHO defines health as being a complete state of physical, psychological and social well-being. Mental health may be considered to have three aspects.

- First, mental health involves the ability of an individual to fulfill their own potential. This means that the individual can, with effort and hard work, achieve the goals they strive for to their best capacity
- Second, mental health includes a sense of control over the environment. This means that the person learns to overcome obstacles caused by external circumstances by drawing on their inner strength
- Thirdly, positive mental health means having the ability to identify, face and solve problems. This is achieved by adopting positive coping strategies to deal with everyday problems

In our context, harmony with members of one's family and with the community one lives in is also a crucial component of our mental health.

1.2b What is resilience?

All of us face difficulties of some kind or another in our daily lives. The capacity to deal with such difficulties and to avoid health problems differs tremendously among individuals. Even with the most severe stress and most glaring difficulties, many people do not suffer Depression. The concept of resilience refers to the individual's capacity to deal successfully with adversity and to avoid 'breakdown' and health problems when confronted with stressors.

A number of inter-related processes can have an important impact on the development of resilience. For example, we know that losing one's parents early in one's life (for example, during childhood) predisposes to Depression; however, this is mainly true if it leads to inadequate care and to lack of emotional stability in the family. Thus, the presence of a loving relationship from other relatives can build resilience in the child to cope with the loss of parents, and build up resistance to developing Depression in adulthood.

1.2c What are protective factors?

A number of factors have been found to increase a person's resilience, and these are called "protective factors". Protective factors are influences that modify a person's response to a stressor in such a way that they prevent the stressor from resulting in Depression. A number of protective factors exist and these include:

- Strong, trusting relationships with relatives (such as spouse), friends, colleagues at work
- Having a 'positive' view of oneself, for example, that one is good at being a mother
- Past experience of having faced difficulties successfully
- Having experienced a childhood with caring parents and relatives
- Living in a community with strong social networks and which is safe
- Having experienced good physical health

1.2d What is vulnerability?

Vulnerability is the opposite of resilience. Mental health and mental illnesses are determined by multiple and interacting biological, psychological and social factors, just as health and illness in general. Vulnerability increases the chances that a person, when faced with stressors, develops Depression. This is called the **Stress-Vulnerability model of Depression**. Briefly put, the idea is that people become ill when the stress they face becomes more than they can cope with. Also, people's ability to deal with stress – their vulnerability – varies so problems which one person may take in their stride might be enough to cause another person to become depressed.

Genes that we inherit from our parents determine many things about us such as our gender and the color of our eyes and hair. Our genes also determine which illnesses we may be vulnerable to at some point in our lives. Some people have a genetic vulnerability for Depression. This means that if we have close relatives who have clinical depression, we may inherit a tendency to develop the illness.

The clearest evidence for vulnerability relates to the risk of mental illnesses in people who are socially or economically disadvantaged. The greater vulnerability of disadvantaged people in each community to mental illnesses may be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health.

Other examples of vulnerability factors are absence of a strong, affectionate relationship during childhood and being a woman.

1.2e What are risk factors?

Factors which lead to the development a health problem are called 'risk factors'; risk factors typically increase the vulnerability for a person to develop the health problem. In the case of Depression, these include:

- Physical Health Factors
 - Suffering from a chronic physical illness or disability
 - For women-suffering from gynecological complaints
 - Heavy alcohol consumption
 - Tobacco use (smoking or chewed)
 - Caring for a loved person who is severely ill
- Socioeconomic Factors
 - Being in debt
 - Unemployment
 - Heavy work load (e.g. looking after many children)
- Relationship Factors
 - Lack of trusting relationships (e.g. with friends or spouse)
 - Living in a violent relationship
 - Experiencing child abuse
 - Loss of parents in early life
- Difficult life events
 - Bereavement (i.e. losing someone you love through death)
 - Break-up of a relationship
 - Transition of a relationship (for e.g. retiring from work or children leaving home)

1.2f What is the relevance of protective and risk factors to the Health Counselor?

The HC will be providing counseling for people who already suffer from depression. Understanding vulnerability and resilience has a direct influence on what you might do to advice them in the following ways:

- By identifying protective factors, you can build on these to help the person recover and then remain in good mental health. For example, a woman with a supportive family can be encouraged to seek help from her family in times of stress.
- By identifying risk factors, you can encourage the person to reduce these, or reduce their impact and thus help the person recover and then remain in good mental health. For example, a patient who drinks excessively is educated about the harmful effects of alcohol and encouraged to cut down/stop drinking.

Summary points:

- Resilience is an individual's capacity to cope with stressors and is influenced by the presence of protective factors in the person's life
- Vulnerability is the opposite of resilience and increases the chances that stressors result in Depression. Presence of 'risk factors' increase vulnerability and lead to development of health problems
- Increasing protective factors and reducing risk factors are important strategies in counseling patients with Depression.

Chapter 1.3

DEPRESSION: AN OVERVIEW OF SYMPTOMS

This chapter includes the following:

- What is Depression and Anxiety
- How does Depression present in primary care
- Conditions that may mimic Depression or co-exist with Depression

1.3a What is Depression and Anxiety?

Depression means feeling low, sad, fed-up or miserable. It is an emotion which almost everyone suffers from at some time in their life and can be thought of as normal. Some times, however, depression lasts for long periods like more than a month and is associated with disabling symptoms such as tiredness and difficulty in concentrating. The feeling starts to affect daily life making it more difficult to work or look after small children at home. If depression starts to get in the way of life and lasts for a length of time, then we say that the patient is suffering from an illness called Depression.

Anxiety is the experience of feeling fearful and nervous. Like, depression, this is normal in certain situations. For example, a student often feels anxious and tense before examinations. Like depression, Anxiety becomes an illness when it causes severe symptoms like palpitations and fear of having an immediate heart attack, continues for a period of time (generally more than 2 weeks) and starts interfering with the person's daily life.

Even though we talk about depression and anxiety as different emotional states, in reality, they are like the two sides of the same coin. When a person is feeling sad, she may also worry a lot. When a person is feeling tense, she may also lose interest in meeting friends. In fact, in clinical practice, the vast majority of patients with anxiety and depression have mixture of symptoms of both emotional states.

In this manual, when we refer to the term Depression, we mean patients who suffer from either Depression or Anxiety or have a combination of symptoms.

Depression is the most common type of mental disorder in primary health care settings. Research from Goa and other parts of India has shown that Depression is an important health problem because:

- It affects between 10 to 20% of all adults attending Family Physician Clinics
- It is associated with high levels of disability and utilization of medical services
- It worsens the outcomes of any co-existing physical health problem
- In mothers, it can affect the growth and development of children
- *In severe cases, if untreated, it may lead to suicide*

1.3b How does Depression present in Primary Care?

In the primary care setting, patients with depression may not complain of low mood, but rather with physical complaints e.g. headache, stomach upset, dizziness. Unexplained or multiple physical symptoms are strongly associated with presence of depression.

Clinical Features of Depression

Presenting Complaints

- vague aches and pains all over the body
- tiredness, fatigue and weakness
- disturbed sleep (usually worse, but occasionally too much sleep)
- poor appetite (sometimes increased appetite)

Complaints on inquiry

- feeling sad and miserable
- feeling a loss of interest in life, social interactions, work etc
- feeling guilty
- feeling hopeless about the future
- difficulty making decisions
- thoughts that one is not as good as others (low self-esteem)
- thoughts that it would be better if one was not alive
- suicidal ideas and plans
- difficulty in concentrating

Clinical features of Anxiety

Presenting Complaints

- palpitations
- a feeling of suffocation
- chest pain
- dizziness
- trembling, shaking all over
- headaches
- pins and needles (or sensation of ants crawling) on limbs or face
- poor sleep

Complaints on inquiry

- feeling as if something terrible is going to happen
- feeling scared
- worrying too much about one's problems or one's health
- thoughts that one is going to die, lose control or go mad

There are some specific kinds of anxiety symptoms. These are panic attacks and phobias.

Panic attacks are attacks of extreme anxiety and fear. This is the description of a typical panic attack:

- it happens suddenly without any warning.
- it is so extreme with such severe physical symptoms such as palpitations (i.e. feeling one's heart beating fast) or difficulty breathing, that the person is terrified that he may die or collapse or lose control of his mind.
- they last from a few minutes up to half an hour
- they disappear as suddenly as they started

Panic attacks are quite common. Many persons will have one or two panic attacks sometime during their lives. However, sometimes, panic attacks become more frequent. When they occur regularly, for example, once or twice a week, then this is called **Panic Disorder**.

Some persons get scared of specific situations. These fears are not reasonable because the situations are not themselves dangerous. Typically, the person with these fears will avoid the situations in order to prevent getting scared. These fears are called **phobias**. Most of us have one phobia or another, for example, of spiders or snakes. However, some people have phobias of every day situations, such as:

- crowded places such as public buses or markets
- open places such as anywhere out of the house
- social situations such as meeting people or speaking in public.

When a person becomes unreasonably fearful of these situations and starts avoiding them, it affects their life by stopping them from going out of the house alone for work or in going to the market. This is why some phobias become health problems.

Remember! *Most patients with depression and anxiety never complain of psychological or emotional symptoms as their main problem; their main complaints are often physical and behavioral symptoms.*

It is important to remember that Depression can often occur with other conditions. Hence one needs to assess for presence of these in a patient who is depressed:

- Substance-related disorders especially alcohol
- Medical illness especially chronic illness like arthritis, diabetes

- Personality problems i.e. long-standing patterns of behavior that result in poor coping and problem-solving abilities e.g. those who feel inferior to others very easily.

You will learn later that some of these patients will need to be referred to the Clinical Specialist for further management.

Summary points:

- Depression is common in primary care affecting upto 20% of the patients
- In primary care settings, patients with Depression complain of physical problems rather than low mood
- Depression frequently occurs with Anxiety and patients usually complain of a mixture of symptoms
- You should be familiar with the various symptoms that a person with Depression may experience
- Depression often occurs together with other physical health problems

Chapter 1.4

DETECTING DEPRESSION IN THE CLINIC

This chapter includes the following:

- Screening for Depression in the clinic
- Use of the General Health Questionnaire

In the previous sections, you will have learned about the impact of stress on a person's mental health. You will also have learned that some people develop a mental disorder when facing stresses. There are two types of mental disorders which can affect the person, and which are the focus of this training program: depression and anxiety. As mentioned earlier, both typically occur together, and we will refer to them both using just one label: "Depression". You will also have learned that there are a number of symptoms (or complaints) that a person who is suffering from Depression may experience - these symptoms can affect the person's thinking, emotions, physical health or behaviors.

Despite knowing about the symptoms of Depression, in reality, very few patients with Depression are correctly diagnosed in the primary health care clinics. There are many reasons for this, including:

- There is considerable stigma (i.e. shame and embarrassment) about mental illness and few patients will want to be told that they are suffering from a mental illness
- Most primary care health workers have had little training or experience in the detection and treatment of Depression
- Most primary health workers fear that discussion about mental health may be time-consuming, and so avoid it altogether.
- Most patients present with physical complaints such as tiredness and sleep problems - thus, doctors treat them for these physical complaints (for example, by giving tonics or vitamins for tiredness) instead of treating them for Depression
- Unless asked, few patients will openly discuss emotional complaints or complaints about their stressors because they do not expect that the clinic staff will be interested in their personal problems.

The MANAS Program tries to overcome each of these problems in the following ways:

- In MANAS, we use words which do not cause stigma, such as 'tension' and 'stress'
- We provide a Health Counselor as an additional person in the FPC who can provide the time-consuming psychological and social treatments

- We provide a Health Assistant who can ask questions to all patients about their mental health which can then be used to detect Depression. It is this process of asking questions which we call “Screening” and is described in more detail below.

1.4a Screening

Screening is a process in which a group of people are subjected to a specific procedure in order to detect a particular health problem. Here are some common examples of screening in health care:

- Weighing a child regularly to detect malnutrition
- Asking women to self-examine their breasts regularly to detect breast cancer
- Doing blood sugar tests every year after the age of 40 to detect diabetes

For detecting Depression, there is one standard way of screening FPC patients- this is to ask them a set of questions about their mental health, i.e. interviewing them with what is called a “Screening Questionnaire”.

The General Health Questionnaire: In the Manas Program, we will be using the General Health Questionnaire (GHQ), an interview which has 12 questions, as a screening questionnaire. The GHQ was originally developed in the UK and is one of the most widely used screening questionnaires in the world. It has been used all over India and in Goa. Recently, the Manas Program compared five internationally used screening questionnaires and found that the GHQ was the best for detecting Depression. The GHQ has 12 questions; refer to Appendix 4.1.

The questionnaire asks about each of these 12 emotional experiences over the previous two weeks. As you will see, some questions are ‘negative’, i.e. they ask about the presence of symptoms (such as ‘losing sleep over worry’) while others are ‘positive’, i.e. they ask about the absence of symptoms (such as ‘been able to concentrate’). Each question is scored either 0 (which means the symptom is absent) or 1 (which means the symptom is present). In the practical exercise, you will be asked to identify which of the 12 questions are ‘negative’ and which are ‘positive’.

Once the questionnaire is completed, the total score of all 12 questions are added up to give a single score for each patient. This score is then used as a measure of the person’s Depression at this point. In the GHQ, the higher the score, the more severe is the stress related Depression.

Using the GHQ in Manas

The GHQ will be used in two ways in Manas.

1. **To detect Depression:** All adult patients will be screened by the Health Assistant (you will learn more about who the Health Assistant is and their role in Manas); the Health Assistant will carry out the interview as described

above, and then rate the patient as being Depressed (if the score is 6 or more) or Not Depressed (if the score is 5 or less). The GHQ score also provides an indication of the severity of depression: a score of 6 or 7 indicates a **mild** depression while a score of 8 to 12 indicates a **moderate to severe** depression. This classification is important since it determines the choice of treatment. You will learn more about this in Chapter 2.1.

2. **To evaluate how the patient's Depression is progressing with treatment:** In later sessions of the training program, you will learn that Health Counselors must assess how patients are progressing over time. Usually, you can just ask the patient how they are feeling since the previous appointment. Sometimes, the patient may not be sure of whether their mental health has improved or worsened. In this case you can use the GHQ and compare with their score when they were first seen by you. For example, if the patient's score at the time of detection was 9, and when they saw you after two months the score was 7, you would say they had improved 'a little' (i.e. improved by 2 points on a scale of 12). If their score was 4, you might say they had improved 'a lot'. However, if their score was 11, then you would say their health had worsened. This change in mental health (worsening or improvement) is very important for deciding what the next plan for the treatment should be.

Summary points:

- To improve the detection of Depression in the primary health care setting, the MANAS program screens all adult patients who attend the clinic
- The screening instrument used is the General Health Questionnaire which consists of 12 questions exploring different symptoms of Depression
- In addition to the detection of Depression, the GHQ can also be used to assess the effect of treatment in Depressive symptoms over time

Chapter 1.5

THE ASSESSMENT OF SUICIDAL RISK

Suicide is a major public health priority in Goa since it causes large number of deaths that are potentially preventable. As Health Counselors, one of the key tasks would be the identification and assessment of the risk of suicide in the patients you would be seeing in the course of your work. This will help you plan interventions that can minimize the possibility of suicidal acts and save precious lives. In this chapter, we will learn about the method of carefully assessing the risk of suicide.

This chapter includes the following:

- How do we define suicidal acts?
- The global and Indian burden of suicide
- The principles of suicide risk assessment

1.5a How do we define suicidal acts?

Completed suicide is defined as an act of knowingly harming oneself that results in death. The methods employed by people who complete suicide vary widely across the world and are dependent on local factors like the easy availability of guns, pesticides or cooking gas. However, drowning, hanging and ingestion of medicines are common methods seen in most areas of the world. In Goa, jumping into wells and consumption of pesticides are also commonly used methods to commit suicide. **Attempted suicide, in contrast, is an act of harming oneself that is not fatal.** Suicide attempts are 10-20 times more common than completed suicide and are most common in young women. Any suicidal act poses a significantly increased risk of completed suicide during the person's lifetime and should be taken very seriously when assessing risk.

1.5b The global and Indian burden of suicide

It is estimated that suicide claims more than 1 million lives in the world every year. This figure is certainly an underestimation because deaths caused by suicide are under-reported in most parts of the world, including in India, due to the stigma associated with it and because of poorly developed reporting systems in developing countries. Unfortunately, the number of young and elderly persons committing suicide in India has been increasing in recent times. Many experts have linked this to the rapid social changes like urbanization, poverty, the breakdown of traditional family support systems, loss of shared cultural values and the increasing use of drugs.

In India, the available data suggests that Southern India has greater number of deaths due to suicide with Kerala being a particular 'hot spot'. The best data

about the importance of suicide being an important health problem has come from a rural block in Tamil Nadu which has shown the alarming extent of the problem. It is estimated that suicide is responsible for a quarter of all deaths in young men and up to half of all deaths in young females. If this figure is applied to the rest of India, the number of deaths due to suicide would be very large. Suicide is therefore an issue which needs urgent action.

1.5c The principles of Risk Assessment

(A) The importance of detection

As a counselor, you will be working with patients who are depressed and/ or anxious and are seeking help; these disorders are amongst the most important causes of suicide. **The assessment of suicidal risk is an essential part of your work and must be integrated within the first session of psychoeducation.**

The most important thing to remember is to routinely ask for the presence of suicidal ideas. It is a wrong idea that asking for suicidal ideas introduces the idea in the patient's mind. On the contrary, asking whether the patient has experienced suicidal ideas is the only way to identify risk and provide the necessary help to prevent suicidal acts. **Risk may alter over time. Therefore, frequent review may be necessary in the same person.** Since this is a very private experience that the patient may feel guilty or embarrassed about sharing, it is important to ask for the presence of suicidal ideas in a gentle and non-judgmental manner. **A good relationship with the patient makes it easier to assess risk.**

Some of the ways that the question may be framed include:

- *“Have you felt in the last few weeks that it would be better if you did not wake up in the mornings?”*
- *“I can see that you are going through a very difficult period. In your situation, many people feel that carrying on with life is not worth it. Have you ever felt this way in the last few weeks?”*
- *“Have you ever felt that that the problems in your life are too difficult to be solved and that you are better off dead?”*

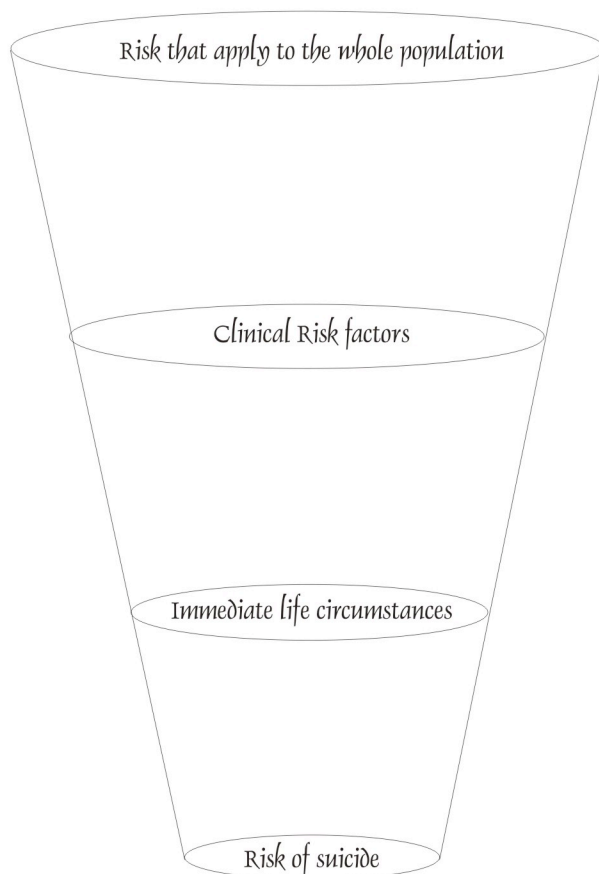
(B) Understanding factors contributing to risk.

Risk factors for suicide can be understood as being multi- layered and in the form of a cone (see Figure 2). The risk factors can be broadly classified as:

- **Socio demographic risk factors:** These are chronic, relatively long-standing factors that apply to the whole of the population rather than just the individual. These factors are also hard to modify easily.
- **Clinical risk factors:** These are the risks that are related to the clinical problems that the patient presents with. Some of these risk factors can be modified and should, therefore, be part of the treatment plans.
- **Immediate risk factors:** These are the risks that are closely linked to the current social and psychological situation of the patient and need immediate attention to reduce the risk of suicidal acts.

Figure 2:

Risk Factors for suicide assessment



Socio demographic risk factors:

- **Age:** The risk of suicide is the greatest in young adults and in old age.
- **Sex:** Suicidal risk is higher in females but men make more violent and lethal attempts.

- Socio-economic status: Lower socio economic status has a strong relationship with suicide.
- Marital status: Single persons, persons who have recently lost their spouse or recently separated persons are at a greater risk of suicide.
- Employment: Being unemployed or recently losing one's job is an very important risk factor
- Social isolation and lack of social support.

Clinical risk factors:

- *Presence of mental illness or chronic, serious physical illness:* Having any current or past mental or physical illness is one of the strongest predictors of suicide. Many people who commit suicide have diagnosable illnesses like Depression. In the MANAS program, all patients who receive treatment are depressed and, by definition, have a higher risk. On the other hand, the treatment of the mental illness is one of the most important ways of reducing risks.
- *Family history of suicide:* This is another important risk factor since having a family member who has committed suicide increases the risk many times.
- *Previous history of suicide attempt:* The risk of completed suicide is 10 times greater in persons who have attempted suicide earlier.
- *Use of alcohol:* The current and past use of alcohol, commoner in men, is a very important predictor of suicidal risk.
- *Unsupportive family:* This is an understandable risk factor which is especially important to consider in young adults, women who have married recently and the elderly.
- *History of past or current abuse:* Physical and sexual abuse are very important risk factors. In our context, ongoing domestic violence from an alcoholic husband is a common and a serious risk factor that warrants immediate attention.

Immediate risks:

- *Ongoing and severe social stresses:* Social stresses where the person feels trapped (large debts), humiliated or loses status (sudden loss of employment, failure in examinations) are often the immediate factor for attempting suicide.
- *Hopelessness:* The experience of hopelessness (*'nothing can be done to change my situation'*) is the final common pathway to suicidal acts and is the single best predictor of risk in the immediate term.
- *Loss of interest:* Another important clue to the risk of immediate suicidal risk is when the person loses interest and withdraws from their usual social interactions with friends or family members or does not feel motivated to work as usual. In these circumstances, biological changes like diminished appetite and sleep are quite common and lead to the person dropping out of treatment as well.

- *Conveying the intention to attempt suicide*: Suicidal acts can be impulsive or planned in advance. In the case of planned suicide, very often, the person would have communicated their intent through clues like suddenly giving away personal possessions and drawing up a legal will
- Making attempts to get *access to means* of suicidal attempt like buying pesticides or stocking large amounts of medicines. This is an extremely serious situation that signals high suicidal risk and needs immediate interventions.

The *Checklist for assessment of suicide risk* (see intervention record card in Appendix 4.2) will help you summarize the degree of risk.

(C) Protective factors

The act of harming oneself is a very difficult decision to make since life is the most precious thing we possess. Most often, persons who attempt suicide are caught in two minds about the act till the last minute. This is partly due to protective factors in the person's life.

Protective factors refer to those reasons that minimize the risk of suicide and are therefore the opposite of risk factors. An understanding of these factors is essential in planning interventions for reducing the suicidal risk. In managing suicidal risk, we must try to increase the protective factors in the person's life.

Some of the more common protective factors are:

- *Social support* from family, friends and other significant relationships like children who offer support.
- *Religious and cultural beliefs* that consider suicide as morally wrong can be a very important factor preventing suicide.
- *Community involvement* and integration through employment and membership of groups can be powerful factors that reduce risks.
- *Access to help* like priests, counselors and telephone hotlines where the person can discuss her problems in a confidential manner.
- *The patient's perception of the consequences* of the suicidal act and the possible repercussions on children and family are frequently important factors that hold the person back from committing suicide.
- *Individual personality differences* like an optimistic view of life, sense of control, positive coping styles and problem solving abilities are personal assets that can reduce the risk of suicide.

1.5d Assessing the degree of risk

Once you identify that the patient has been experiencing suicidal ideas, it is essential to then make an estimate of the degree of the risk. It is possible that some patients may not feel comfortable about disclosing their suicidal ideas in

the first meeting. In both scenarios, you need to be aware of identified risk factors for suicide and make an informed judgment about the possible risk involved that will guide your further interventions.

It is equally important to understand that the prediction of suicide is an imperfect science and that it is better to overestimate the risk rather than ignoring important clues. If the patient does mention that she is experiencing suicidal ideas, it is very important that you are able to manage your personal anxiety (that is normal in these situations) and remain calm but emotionally supportive. Remember, you can always discuss such cases with the Clinical Specialist.

An understanding of the risk and protective factors should enable you to make a judgment about the seriousness and immediacy of the risk (see box below). At this point, if you think the patient you have just seen is at possible risk of attempting suicide, you should ask some specific questions that will confirm the degree of the risk. These include:

- Have you been having thoughts of harming or killing yourself?
- Have you made any plans for harming yourself?
- Have you been having these thoughts repeatedly and cannot distract yourself from them?
- Have you been feeling hopeless and that nothing can help you?
- Have you been thinking about what will happen to your family after you die?

At this point, taking into account your understanding of the balance between risk and protective factors and the frequency and type of suicidal thoughts, you will need to specify the degree of risk for that patient. In MANAS, we have three possible categories of risks and you will need to choose the most appropriate one based on the guidelines given in the box below.

Levels of risk of suicide.

- **No/Low risk:** Absent or very occasional, stray reports of passive suicidal ideas ('I am better off dead') which the patient can forget easily and do other things. There are mild clinical problems, no immediate risks and adequate protective factors.
- **Moderate risk:** Persistent suicidal ideas with no concrete plans, moderate- severe clinical problems, one or more immediate risk factors and limited protective factors.
- **High risk:** Persistent suicidal ideas with definite plans, severe and multiple clinical risks, multiple immediate risks including severe hopelessness and limited protective factors.

The management of patients who you have assessed to be at risk for suicide is discussed in Chapter 2.3

Summary points:

- Assessment of suicide risk is an integral part of your role as Health Counselor and must be addressed in the first psychoeducation session
- A good rapport with the patient makes it easier to assess suicide risk
- It is important to understand the risk factors for suicide which can be classified as socio-demographic, clinical and immediate risk factors.
- Protective factors that reduce the suicide risk must also be identified as they are important in planning risk management strategies
- Degree of suicide risk can be classified as low, moderate or high depending on the balance of risk and protective factors and the frequency and type of suicidal thoughts

Chapter 2

Treatments for Depression

Chapter 2.1

THE COLLABORATIVE STEPPED CARE INTERVENTION OF THE MANAS PROGRAM

This chapter includes the following:

- Principles of the Manas intervention
- The treatments provided as part of the Manas intervention
- The key personnel involved in providing the treatments
- The detailed steps of the Collaborative Stepped Care model

First, let us become familiar with two words which will be used repeatedly. We need to understand how they are different.

- *Treatment*: this word refers to a specific method of treating Depression; for example, using antidepressant medicines is one type of treatment, while using Psychological Treatment is another type of treatment.
- *Intervention*: this word refers to the way a package of treatments is delivered to the patient. In Manas, we are trying out two different intervention packages; Health Counselors are only involved with one package, called the Collaborative Stepped Care Intervention. This is the focus of this section.

2.1a Principles

The principles for the intervention are:

- Use of acceptable labels for mental health problems: Research clearly shows that social factors, such as poverty and domestic violence, are the main causes of Depression. These are also the views of patients themselves. Using terms such as “mental illness” will not be acceptable to many patients. Thus, we use locally acceptable words reflecting social difficulties, stress and tension in daily life. However, we can use terms like Depression when communicating with doctors and primary health workers.
- The ideal location for treatment of Depression is in primary care: This is a WHO recommendation based on four key reasons: first, the high burden of Depression in primary care; second, the severe shortage of specialist mental health providers such as psychiatrists or psychologists; third, the stigma associated with seeing a mental health specialist; and fourth, the relatively simple treatments which are effective for Depression and which the Health Counselor will be providing.
- Chronic (i.e. long standing) disease intervention principles: Most primary care is focused to the management of acute diseases, such as malaria, which

respond to a simple treatment like a single course of medicines. Chronic diseases, on the other hand, typically need a combination of medical, social and psychological treatments (i.e. an intervention), follow up over longer periods of time, and the need for the health care approach to be based on team work. The team you will be part of is the Primary Health Care Team. The four key players of this team are: the *Health Counselor, the Health Assistant, the Family Physician and the Clinical Specialist*. Several other FPC staff may also play important roles (see below).

The principles of chronic disease management are similar for any chronic disease (such as Depression, HIV/AIDS, diabetes or heart disease). The four key principles are:

- **Stepped Care:** Imagine a series of steps. To go to the second step, you must first land on the first step. To go to the third step, you go via the first and second steps; and so on. Unless, of course, you are in a big hurry in which case you may skip a step! In the case of Manas, what this means is that not everyone who suffers from Depression needs the same treatment. Everyone might need a simple, relatively cheap and risk-free treatment (for example, psychoeducation or advice about the symptoms-the first step), and only those who don't get better with this need more intensive treatments (for example, antidepressants and psychological treatments-the second and third steps). Thus, the intervention is tailored to the needs of the individual patient and is delivered in 'steps' of specific treatments, depending on the severity of the illness and the response of the patient to the treatment. See figure 3, below.
- **Collaborative care:** Collaboration is a big word with a simple message - to work as a team. The Clinical Specialist works collaboratively with the primary care team to ensure that the patient gets the maximum benefit of the intervention. In addition, within the primary care team all the team members work collaboratively. For example, the HC and HA work collaboratively in diagnosing and providing the intervention to patients with depression. The HC and FP too work collaboratively, discussing clinical issues around individual patient care.
- **Combination of health promotion and medical treatments:** The intervention combines both health promotion (such as education about diet, lifestyle changes etc) and specific medical treatments (e.g. antidepressants and psychological treatments). All the treatments we use are of proven efficacy in the management of Depression.
- **Adherence management:** A major challenge in the management of chronic diseases that the Manas program seeks to address is ensuring that patients follow up regularly and complete their course of treatments.

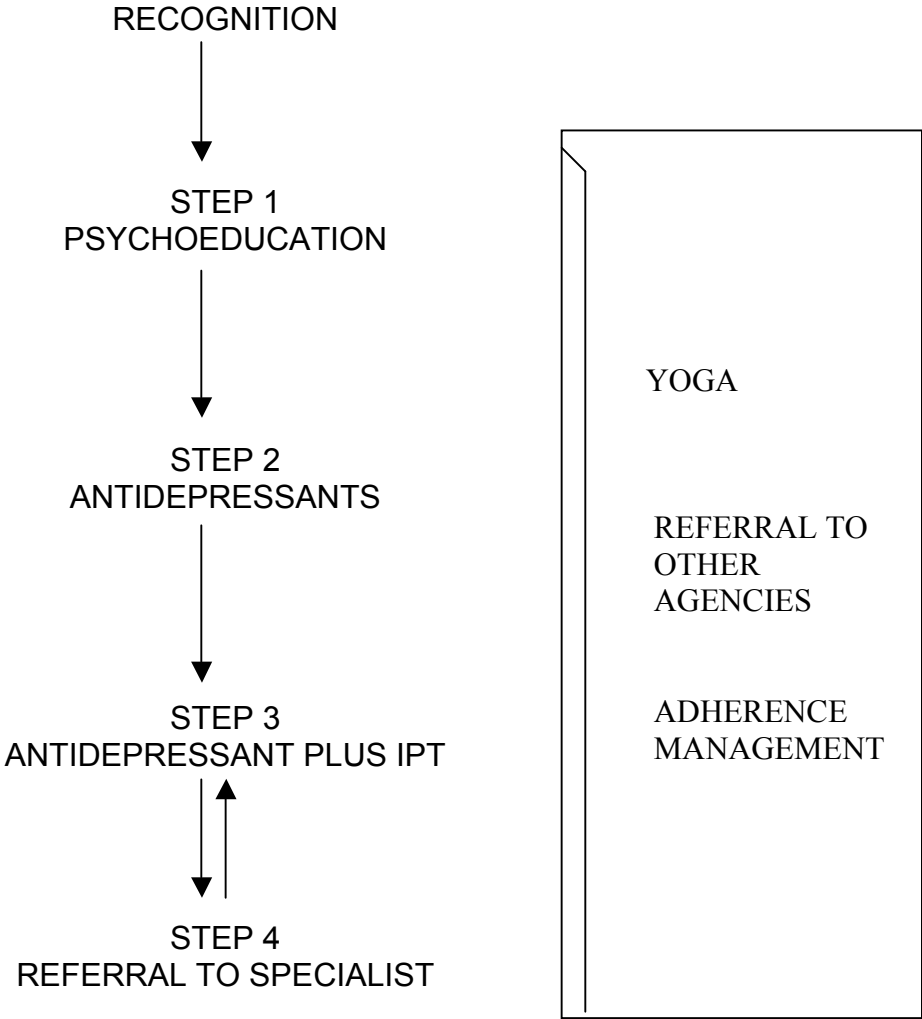
2.1b What treatments will be provided in the intervention?

Let us now consider the specific treatments which are included in the Collaborative Stepped Care Intervention. These treatments have been chosen on the basis of the best scientific evidence available and after careful consultation with national and international experts.

1. **Detection of Depression:** After all, if you don't detect Depression, you can't treat it! This treatment was discussed earlier in the course. This is the only treatment in the Intervention which is the responsibility of the Health Assistant (see below).
2. **Psycho-education:** A treatment which consists of a combination of practical advice for managing symptoms of Depression (such as tiredness and sleep problems), advice on managing tension (such as breathing exercises) and referral to other agencies for problems which can be better handled by them (for e.g. social welfare)
3. **Yoga:** Everyone knows what yoga is! This ancient Indian practice is highly useful for promoting one's physical and mental health.
4. **Interpersonal Psychotherapy (IPT):** This is a specialized type of psychological treatment which requires at least 6 sessions with the patient.
5. **Antidepressants:** These are medicines which are given to treat Depression and will be prescribed by the Family Physician.
6. **Adherence management:** It is a good idea to become very familiar with the word 'adherence'; this is going to be the biggest challenge of delivering the Collaborative Stepped Care Intervention. It literally means 'sticking to'; practically, it means taking steps to make sure that the patient takes the treatments as advised, for example, that he or she continues with the antidepressant medicine or comes for the IPT sessions as required.
7. **Referral to the Clinical Specialist:** Despite your best efforts, there will be a small number of patients with Depression who need to see the Clinical Specialist.

Each of these treatments will be discussed in more detail in the following chapters.

Figure 3: A simple flow chart of the steps of care



The Key Personnel for the Stepped Care Intervention

- **The Family Physician (FP):** the Family Physician is in charge of the entire program in their clinic. They will have two major roles: to encourage patients who have been screened to be suffering from Depression to take the treatment advised; and to prescribe antidepressants.
- **The Health Assistant (HA):** this person will work closely with the clinic Secretary or Assistant (if present) who manages a number of tasks including registering and directing patients in a particular order. The Health Assistant's job is purely to screen (i.e. ask a short questionnaire) adult patients attending the FPC to identify those who are suffering from a Depression. She will report directly to the Family Physician and the HC.
- **The Health Counselor (HC):** this person is trained to provide counseling and a range of other treatments. Her main role is to work with the Family Physician and provide a range of appropriate treatments for patients with Depression. The HC will report, on a day to day basis, to the Family Physician. In addition, she will also report to the Clinical Specialist for supervision.
- **The Clinical Specialist (CS):** this is a visiting psychiatrist who has two key roles: to support the entire FPC team for difficult clinical cases and to monitor the quality of the program.

2.1c Steps in detail

Step	For whom	Timing	Treatment	BY WHOM
1	Adult FPC patients	Before consultation with FP	Screening questionnaire; report for doctor	Health Assistant
2	Patients screened with Depression	At first consultation	Advice regarding screening questionnaire results; advice regarding seeing HC Psychoeducation and follow up appointment as appropriate Information about Yoga sessions	FP HC HC
3	Patients who are severely ill at first consultation or whose symptoms persist at follow-up	At first consultation or at first follow up at 2-4 weeks	Antidepressants Psychoeducation Adherence Management	FP HC HC
4	For patients who remain unwell or are not adherent	Patients who do not respond to Step 2 despite taking the treatment	Antidepressants & IPT Adherence Management	FP HC HC
5	For participants who do not respond despite good adherence	Patients who do not respond to Step 3 despite taking the treatment & Patients who are expressing suicidal ideas at any time	Continue all existing treatments Refer to Clinical Specialist	HC & FP Clinical Specialist

FP- Family Physician
HC- Health Counselor

Summary points:

- The Manas intervention uses the Collaborative Stepped Care that integrates psychological and medical treatments for Depression.
- The treatments are provided in a graded fashion with simpler treatments being provided to all patients and the more sophisticated, resource intensive treatment being reserved for more severe illness
- The FP, HA, HC and CS work collaboratively to ensure the patient receives an optimum level of care

Chapter 2.2

GENERAL PRINCIPLES OF COUNSELING

An essential prerequisite for the Health Counselor to help patients with depression is to establish rapport and build a relationship with the patient. Only then will the patient be willing to confide in the counselor and benefit from the process of counseling. Building a relationship requires certain skills and attributes and this chapter aims to address these.

The general principles of counseling are discussed under the following headings:

- What is counseling?
- Self awareness as a requirement for counseling
- Attributes of a good Counselor
- Basic counseling and interviewing skills

2.2a What is Counseling?

Counseling is a 'talking' treatment that provides assistance and guidance in resolving personal, social or psychological problems and difficulties, by a trained person. It is a two-way process of an interaction between two people - the counselor and the patient. The patient is the person who turns to the counselor for help to deal with a problem (or problems), and the counselor is the one who, through the process of counseling, helps the patient deal with these problems and their health consequences. The counseling process aims at making the person become more aware of him/her self, to accept his/her weaknesses, and to identify his/her strengths. Through counseling, the person gains a clearer picture of the problems facing her and the various options available to change the situation and thus decide upon a suitable course of action. This enables the person to regain some control and mastery over his/her problems and thereby feel less helpless.

Counseling **does not include:**

1. Telling patients what to do
2. Making decisions for patients
3. Judging patients as good or bad people
4. Interrogating patients
5. Blaming patients
6. Preaching or lecturing to patients
7. Making promises that you cannot keep
8. Imposing your own beliefs on patients

2.2b Self awareness as a pre requisite to counseling:

What is self awareness?

Self awareness is being aware of one own attitudes, values and beliefs and how these have an affect on one's interactions with other people.

Why does one need to be self-aware to be a good Counselor?

As a counselor self-awareness is important for a number of reasons:

- Self-awareness helps identify and learn about one's own values, beliefs and attitudes. This process helps one identify any stereotyped way of thinking, prejudices or biases that could influence how one treats certain patients. For e.g. the counselor may have a bias towards homosexuals or people of a particular religion and this could influence the counseling process if she is not aware of the bias.
- A Counselor needs to make a clear distinction between herself and her patients. Self-awareness helps differentiate between one's own thoughts, feelings and problems from those that belong to the patient. Failure to do this can result in the Counselor imposing a way of seeing things, or solutions that would work for her, rather than understanding how the patient sees them and finding solutions that work for the patient. For example, a counselor might think it unacceptable to live with a violent spouse and might impose this view on a woman who is in a violent relationship who may not be thinking along those lines.
- Being sensitive to her own reactions to what is happening in the counseling situation may also make the Counselor more aware of things about herself that were not obvious and open up opportunities for her own growth and development. For example, if the counselor feels uncomfortable when a patient is describing her tendency to pamper her child excessively, it draws the attention of the counselor to her own parenting style.
- Making this separation or boundary between the counselor's thoughts, feelings or problems and those of the patient is also an essential part of the counselor taking care of herself. She needs to make sure that this boundary remains clear. If it becomes blurred – if the counselor finds it difficult to separate the patient's situation from her own, or finds herself preoccupied with a patient's problem – it is a sign that she has taken on the patient's problems as if they were her own. This can lead to emotional fatigue and high stress levels.

2.2c What are the characteristics of a good Counselor?

Counseling is a skill which can be learned by any person who has an interest in the subject and an open mind. Some of the most important requirements are to be:

- **A good listener:**

We are always 'hearing others out'. However, our listening process is selective and we often hear 'what we want to hear'. In counseling, one has to listen very carefully to the feelings being expressed by the patient as well as to the words used to express the feelings with an open mind. .

- **Be empathic:**

Empathy is the ability to put ones own self in the place of the patient and feel what he or she could be feeling at the moment. The counselor then feels the frustration, anger, indifference, and the fears of the patient. The process helps the counselor understand the patient and her situation better. It is different from expressing sympathy or pity where the listener only expresses the fact that she feels bad for the patient. This does not, in any way, make the patient feel that she is being genuinely understood.

Ways to communicate empathy

Some ways to introduce expressions of empathy:

"You seem to feel..." ("you seem to feel discouraged")

"You seem to feel... but you also seem...." (when patient seems to have conflicting feelings)

"It seems to me that you feel..."

"It sounds as if..."

"You seem to be..."

"If I understood you correctly, you are feeling..."

"I wonder if you mean..."

Remember:

- Link feelings to situation, context (*"you seem to feel...because..."*)
- This linkage needs to be initially tentative and provisional - you can never be sure you are right, until you have checked with the patient (*"from what you describe, it appears to me that you have decided to leave your job. Am I right?"*)

Activities that can compromise empathy

- Pretending to understand when you don't – rather ask for clarification.
- Not responding at all or giving a superficial response which gives the impression the patient was not 'heard' or what she expressed was not worth responding to. For example: a lady expresses that she just lost her job and your response is *'how sad'*
- Giving a long response that says more about the counselor than the patient's feelings
- Just repeating word-for-word what the patient said when expressing intense emotion
- Sympathizing e.g. *"I feel so bad for you, you are stuck at home since you have been ill"*

- Asking a question or giving advice instead of responding to a feeling expressed e.g. *“don’t cry, be strong. You have to look after your children now that your husband is no more.”*
- Using words like *“I understand”* in a superficial way
- Sharing a personal experience that the counselor perceives as similar (but may not be)
- Preaching or bringing in her personal moral bias (*“that’s not the way to treat your partner”*)
- Interpretations that suggest personal judgments or blame (*“it seems you tend to lose your temper easily”*)

- **Be non-judgmental:**

Hand in hand with empathy goes the ability to have a non-judgmental attitude. The counselor has to accept the patient for who she is irrespective of her religion, caste, etc. Not only is the patient entitled to her own views and feelings, but, even where these are contrary to those of the counselor, she does not judge the patient negatively. If the counselor finds it difficult to maintain this attitude with a particular patient, she should refer the patient to another counselor. For e.g. a counselor who is uncomfortable in dealing with homosexuality, should be aware of this and discuss this with the Clinical Specialist.

- **Generate trust:**

The counselor has to make sure that she conveys to the patient that whatever is spoken between them is confidential and that she would maintain the trust that the patient has placed in her. If a need arises wherein the counselor feels that she has to reveal something spoken during the counseling session to a third person, for eg. the Clinical Specialist, permission of the patient has to be sought.

- **Be patient:**

Counseling requires patience. The patient may take a lot of time to understand oneself and one's strengths. An impatient counselor will often feel tempted to give advice but this does not serve the purpose of counseling.

- **Be observant:**

The counselor needs to be very observant not just about what the patient says, but also the body language used. The patient speaking with a smile on her face, but with fists clenched, or a lot of finger twisting going on, may indicate a build up of tension, which the counselor needs to observe.

- **Respect and acceptance:**

Always remember that the very basis of counseling is built upon respecting the other individual, the kind of person she is and accepting that people are capable of making their own decisions and managing their lives in general. Showing respect allows the counselor to create an atmosphere of acceptance where the patient feels understood, cared for and respected, without having to meet any

pre-conditions. This means accepting that the patient has a right to think and feel differently from you.

To be an effective counselor you need to be:

1. a good listener
2. empathic
3. non-judgmental
4. able to generate trust
5. patient
6. observant
7. show respect and acceptance

2.3d Basic Counseling and interviewing skills

Encouraging people to talk about their problems without influencing them with one's own views is essential for conducting effective counseling and this calls for some specific skills.

• **Attending Behaviour:**

This is the most basic and yet a very important skill in counseling. The counselor should convey interest in what is being said and yet ensure that the patient sticks to the point and minimises needless talk. There are four critical dimensions to the attending behaviour:

i) Eye contact:

Maintain eye contact with the person all the time.

ii) Attentive Body language:

Make encouraging gestures, show an expression of interest on your face
Sit facing the patient with your arms opened out rather than folded against your chest. Do not keep checking you watch. Focus on listening to what patient is saying.

iii) Vocal qualities:

Keep your tone gentle, speak slowly and clearly

iv) Verbal Tracking:

Keep to the topic initiated by the patient.

If the person keeps on talking without keeping to the topic at hand gently get the person to focus on the problem but do not start talking yourself.

• **Questioning Skills:**

In the course of counseling one finds it necessary to employ questioning as part of getting the person to talk further. If the person is talkative it may not be

necessary to ask many questions. However, if used effectively, questions can help to obtain a lot of relevant information. There are two types of questions:

i) Open ended Questions: These are very useful in getting the person to talk. They are questions that cannot be answered in a few words or sentences. They encourage the person to talk and give maximum information, for e.g., "*could you tell me more about that? / how did you feel when that happened?*".

ii) Closed Questions: These are questions that can be answered in a few words, they help focus an interview and to bring out specifics. e.g., "*Where do you live?*". A general framework for collecting the required information in the first part of counseling would be the following:

- Who is the patient? What are the key personal background factors? Who else is involved in the patient's daily life?
- What is the problem? What are the specific details of the situation?
- When does the problem occur? What happens immediately before or after the situation?
- Where does the problem occur, in what environment and situation?
- Why does the problem occur? What triggers it? What makes it better?
- How does the person react? How does she or he feel about it?

When does questioning become a problem?

- Bombardment/ grilling - Never ask too many questions it can put people on the defensive. Too many questions can confuse a person
- Questions as statements: e.g., '*don't you think it would be helpful if you found a job?*' - putting your own view ahead can put the person off.
- Why Questions - Exercise caution when using "Why" questions - it can cause discomfort and sound threatening and judgemental e.g., "*Why did you not go to work?*"
- Keep the questions short and simple. Long questions can confuse a patient.

• **Observation Skills:**

Another important skill that one needs to be a good counselor is to be observant. Observation needs to focus on patient's non-verbal behaviour in three areas. These are:

i) Patient eye contact patterns: e.g. When a person breaks eye contact or shifts his gaze constantly in it could mean that he is distracted and you have to probe.

ii) Body language: Leaning forward can mean excitement about an idea. Leaning back and crossing arms could mean the person is closing off.

iii) Facial expressions like the furrowing of the brow furrowing, lip tightening or loosening, flushing and tearfulness can indicate tension.

- **Encouragers and Paraphrases:**

These are skills used to let the patient know that the counselor has been listening to what he / she has been saying, has seen their point of view and feels the world to be as they experience it.

Encouragers are just words interspersed in between, like "um", "is it" "really" "ah ha". These also include nodding your head keeping your palms open and other friendly non-verbal gestures. Sometimes just the repetition of a keyword could become an encourager. This usually leads to the person giving further details about the same topic. These words and actions encourage the person to continue talking, while letting him or her know that he is being heard. For example, a patient who says that her life is a mess., the counselor says "..a mess?" this encourages the patient to elaborate what she means.

Paraphrases are the feedback given to the patient by the counselor by shortening and clarifying the patient's comments. Paraphrasing is not just parroting of words. It is done by repeating some of the counselors own words alongside some important words of the patient. Paraphrases help the process of counseling by:

- Clarifying for the patient what he or she has said e.g. *"You appear to be saying..."*, *"You sound like..."*
- Clarifying for the interviewer what the patient has said - by feeding back what you have heard, you can check on the accuracy of your listening e.g. *"Did I get you correct?"*, *"Am I hearing you correctly?"*
- Helping patients to talk in more detail about issues of concern to them.
- Helping a talkative patient stop repeating the same facts or story.

- **Noting and reflecting feelings:**

This is a very useful skill that helps the patient talk and make him feel understood. It helps in identifying and sorting out patients' feelings. The focus is on the emotions of the patient and his/her subjective experiences in coping with the situation. To do this one needs to pay attention both to what is said, and what is not said. For example:

- Emotional words used by the patient e.g. "I was so angry that I felt like hitting him" to which one would respond as *" You must have been really angry"*
- Non-verbally expressed emotional words, e.g. to a person biting her lips - *"you seem very anxious today"*

Emotions can be observed directly or drawn out through questions (*"how do you feel about that? Do you feel angry?"*) and then reflected back through the following steps:

- i) Begin with words such as, *"you feel"* or *"sounds like you feel"* or *"could it be you feel?"* Use the patients name when possible.
- ii) Feeling words may be added (sad, happy, glad, puzzled, uncertain, confused)

- iii) The context may be added through a paraphrase or a repetition of key content (*"Looks like, you feel happy about getting a job"*)
- iv) A present tense reflection is more powerful than a past or future tense. *'You feel happy right now'* rather than *'you felt'*
- v) After identifying a feeling you can confirm this with the patient to make sure you are correct in your understanding (*"am I hearing you correctly?"*)

You can sometimes gather specific information after reflection e.g.: *"you seem angry with your father. Could you give me one example of a specific situation when you feel this anger?"*

- **Clarifying:**

When the patient talks of anything that is not clear or contradictory to what she said earlier the counselor can clarify rather than draw her own conclusions. Sometimes when a patient is anxious he or she can keep talking in an unfocused way or moving from one topic to another. In such circumstances it is better to stop the patient gently and clarify matters that have been left incomplete or unclear.

- **Focusing on positive strengths of the patient:**

In the process of using the other counseling skills one useful technique is to identify the positive assets or strengths of the patient and reflecting them back to the patient. This raises the self esteem of the patient. Ways in which the counselor can use this skill:

- The counselor can begin the session by asking what has happened recently that the patient feels good about.
- The counselor can use it to remind a patient of something positive, for example *"You say you are unhappy about your daughter-in law being rude to you. At the same time you also mentioned how you enjoy playing with your grand son. That must be making you feel happy."*
- If your patient constantly repeats negative statements, these can be paraphrased and then followed by positive feedback. For example: *"Yes, being insulted by your daughter-in-law really hurts. At the same time, I see a number of positive points — you have a good sense of humor, you seem to have very caring neighbours , and your daughter too seems to care for you a lot."*

Basic counseling skills are:

1. Attending behaviors i.e. Eye contact, attentive body language, vocal qualities, verbal tracking
2. Questioning skills
3. Observation skills
4. Encouragers and paraphrasing
5. Noting and reflecting feelings
6. Clarifying
7. Positive asset focus

This case narrative illustrates different counseling skills:

Madhavi: I am fed up. My husband has been beating me everyday. I feel like running away. (Madhavi is biting her lips)

Counselor: You seem to be so anxious and you sound so fed up of the situation that you want to run away from home.

Reflecting feelings and observed non-verbal behaviour

Madhavi: Yes, it is really humiliating. Two years back my husband lost his job, since then he has been drinking.

Counselor: Has your husband been beating you too since then?

Closed question.

Madhavi: He used to shout and use bad words earlier but now, since my daughter has been born, he beats me everyday.

C: Hmm

Encourager.

M: After he lost his job I have been managing the household but since my daughter is born I have to look after her and have not been able to work as much. He used to take money from me for his drinks, now I try to hide the money so he beats me.

C: How do you feel about the situation?

Open ended question and clarification

M: I feel very angry, it is so difficult to manage the household with what I earn. I have to leave my small child with my mother and go to work and then I have to suffer this harassment from him. On top of it his family blames me.

C: It must be very upsetting for you.

Reflecting

M: Yes, I tried to talk to my brothers but they say I have to bear up with the beating. But why should I keep quiet. I am not going to take this beating anymore.

C: You appear to be very upset by your husband and family and don't want to keep quiet and now you feel like doing something about it.

Paraphrasing

2.3e Telephone counseling

Telephone counseling is the use of the telephone to provide counseling to patients. It can include various aspects of clinical care including diagnosis/assessment, intervention and follow up. Some patients may find it difficult to travel to the health centre due to various constraints; eg. Costs involved in reaching the health centre, work hours, care responsibilities at home and their own health factors. In such instances, the telephone provides increased access to these patients and enables the counselor to conduct assessments, provide education, counseling, follow up services and reminders for missed appointments.

Before initiating the call the following important points should be noted:

1. Consent: During face-to-face meetings, assessment must be conducted to determine the patient's willingness to be contacted at home and to participate in a telephone counselling session. This consent should be documented.
2. Privacy and confidentiality: should be assured and maintained at all times. This includes privacy at the patient's location and at the HC's location. For example, if the patient is not available when you call, it may be inappropriate to leave your name or information about yourself. This needs to be discussed with the patient in advance. Also ensure that you are alone and unlikely to be disturbed when making the call.
3. Be prepared with the various points that you need to cover during the call.

Initiating the call:

1. Introduce yourself. Remind the patient of her/his visit to the clinic and your mentioning that you may call. Give the introduction enough time – don't rush.
2. Move smoothly from the introduction to the reason for your call.
3. Remember this is most likely to be a new experience for the patient, so encourage participation and make an effort to reassure hesitant speakers.

During the call:

First review the clinical state of the patient (as in psychoeducation session 2).

Then, depending on stage of intervention, proceed with psychoeducation/IPT.

At all times, remember:

- Be focused, sit up straight in your chair, talk directly into the mouthpiece.
- Be courteous, pleasant and friendly.
- Speak as clearly as possible in a natural conversational manner. Your tone of voice, attentiveness and manner can make all the difference to the patient's comfort during the call.
- Pay close attention to what the patient is saying and how they are saying it. Listen for hesitation or pauses that may indicate uncertainty and may need you to probe or verify.

- Take it slowly: give the patient time to talk without interruption and without having to hurry.
- As a general principle, answer all the patient's questions, complaints and objections politely. Remain respectful and maintain an even tone of voice.

Concluding the call

Summarize all that has been discussed. Ask the patient if she has any questions or wants to add anything to the discussion. Make an appointment for the next call or clinic visit.

Record keeping:

After the call is completed, it is necessary to record/document the interview in detail.

Document the details of the call including the duration, content and your impressions of the patient's current state and future intervention plan.

If the patient is not available when you call, ask when you can call back. Also ask the name of the person who answers the phone and his/her relationship to the patient (if possible). Leave a message and your telephone number. If no one answers the phone, call back at 3 different times of the day.

Be prepared to deal with problem situations which may arise. Example:

- The patient is rushed and "just wants to get this over with." Ask if there is a better time to call when the patient is not busy. You may also convey to the patient that you have set aside time to speak with her and are in no hurry so she can take her time in speaking to you.
- The patient is overly chatty and gives an unduly long account of her problems. Interrupt her and try to get her to focus on important information. Ask direct/closed questions.
- The patient is confused or unable to focus. Try and elicit information about health problems and suggest a visit to the PHC
- The patient is argumentative. Stay calm and do not engage in an argument. Repeat the reason for your call and if you sense the patient continues to be argumentative, terminate the conversation gently.
- The patient is distraught and emotional. Allow the patient time to ventilate her feelings. Do not interrupt. Encourage her to express her feelings and provide a non-judgmental, supportive attitude. Encourage her to make a visit to the PHC
- The patient is suicidal. Assess the risk of suicide, ask her to come to the PHC as soon as possible, elicit help from a family member, make a no-suicide agreement

Summary points:

- Counseling is a two way interaction between the counselor and the patient that provides assistance and guidance in resolving personal, social or psychological problems
- To be a good counselor you should be a good listener, empathic, non judgmental, patient, observant, convey respect and acceptance and able to generate trust in the patient
- Basic counseling skills include attending behaviour, questioning skills, observation skills, use of encouragers and paraphrases, noting and reflecting feelings, clarifying and positive asset focus

References:

Barefoot Counseling. A Manual for Community Workers. Dias Saxena F, Andrew G. Sangath, Goa; 2003

Mental Health and ARV Therapy. Basic Counseling Guidelines, Facilitators Training Guide. WHO, Geneva; 2005

Chapter 2.3:

PSYCHOEDUCATION

2.3a Introduction

As the name suggests, psychoeducation is the process by which the patient is given an explanation about what her illness is and is provided with practical advice to deal with her problems. This educational process is most effective when conducted as an active, two way interaction between the patient and the Health Counselor. Psychoeducation can be a very powerful method for providing positive benefits to a patient with Depression. This is because the patient feels that her troublesome health problems have been identified as being an understandable illness and that there are simple but effective ways of dealing with the problems. The benefits could also be due to the sense of mastery and control over her problems that the psychoeducational process provides which directly addresses core symptoms of depression like helplessness, tiredness and lack of sleep.

This chapter includes the following:

- Detailed procedure for each session of psychoeducation – the assessment, review and termination sessions
- Management of suicide risk
- Advice for patients who are taking antidepressants (ADT)
- Assessing the need to step up care in patients who do not respond to treatment
- Steps involved in ending the intervention
- Protocol for dealing with difficult situations

2.3b Session 1: Assessment Session

Once the patient has been diagnosed to have Depression based on the results of the screening procedure and the doctor's assessment, the patient is referred to the HC.

During this first contact with the patient some important steps to keep in mind are:

- Greeting the patient, introducing oneself, confirming the patient's name, building a rapport with the patient and explaining your role in his treatment.
"My name isI am a health counselor working in this clinic with the doctor."

Building a rapport with the patient becomes easier if you spend some time asking him why he had come to the doctor. Patients will generally speak a lot of about

their somatic complaints and how he or she has been taking medications for the complaints etc. Ask him what the doctor has prescribed, has he been coming to the health centre for long etc.

Check the doctor's notes/prescription and enquire with the patient if antidepressants have been prescribed. (Refer to Appendix 4.3 for information on antidepressant).

Once the patient is comfortable explain your role to him: *"The doctor has asked you to see me because I will be talking to you about your stress-related health problems and giving advice to help you get better. This treatment is being offered in addition to the doctor's treatment which will continue as usual"*.

- Emphasizing confidentiality.

"Whatever we speak about will be entirely between us. If the need arises for me to share any of this with the doctor/someone close to you, I will do so only with your permission".

Then the HC initiates psychoeducation during which basic information is provided about the nature of the complaints, an understanding about their causation and advice on how to promote mental health. This session comprises a number of specific components, all of which must be delivered in about 30 minutes. Thus, fluency is a key asset and this can be best achieved through practice. The key steps in the first session are:

1. Eliciting symptoms, inquiry for suicidal ideas, obtaining a baseline mood rating
2. Eliciting psychosocial stressors in the persons life specially those that are closely related to onset of stress symptoms
3. Reassurance and explanation about the link between patient's stress and complaints.
4. Explaining the diagnosis and giving hope.
5. Giving the sick role
6. Management of suicide risk
7. Breathing exercise
8. Advise on specific symptoms
9. Advice to patients using alcohol or tobacco
10. Advice on ADT
11. Referral to community agencies
12. Describing the interventions and adherence management
13. Concluding the session

As a visual aid, the HC will use the flip charts, turning to the relevant pages during the session (see box below).

How to use the flip charts

The flip charts consist of illustrations and abbreviated text that helps you communicate information to the patient. Using a flip chart ensures that you cover all the important issues. When using the flip chart during the psychoeducation session keep the following points in mind:

- Place the flip chart on the table so that both you and the patient can see the pages
- Maintain eye contact while speaking to the patient - do not read from the chart. (The text that accompanies the charts is provided in the manual. You should be fluent with this)
- Point to the relevant text/pictures from time to time to draw the patient's attention to the contents of the chart
- You might need to use only some of the pages. It will depend on the patient's symptoms
- Pause between subsequent pages and confirm that the patient has understood the information provided. Also, give the patient time to ask questions
- Link the information on the flip charts to the handouts you give the patients later in the session

The key steps of the first psychoeducation session are detailed below:

1. Eliciting the key symptoms

Symptom Checklist

- Sleep difficulties
- Appetite problems
- Tiredness
- Feeling miserable
- Feeling worried all the time
- Aches and pains
- Palpitations
- Irritability
- Loss of interest
- Lack of concentration
- Suicidal thoughts

Refer to the checklist of key symptoms and go over these with the patient in a structured manner.

Some times the patient may have mentioned some of them.

For e.g. if the patient has been complaining of poor sleep and poor appetite,

say: *“You said earlier you have difficulty in falling asleep and difficulties with eating, could you tell me more about it?”*

While recapping, avoid using technical terms for e.g. *“You have a phobia”*

Instead focus on the symptoms, for example saying *“You feel your heart beating when you are in a crowd?”*

Once you go through the check list and elicit the symptoms the patient is suffering from get him to briefly tell you:

- Since when has he been suffering from these symptoms?
- How severe are the symptoms- What is the personal distress caused by the symptoms? What is their impact on the patient’s work and social functioning? For example, the patient may be unable to do her daily household tasks or may withdraw from her friends as a result of her Depression
- Has the patient had these symptoms before?
- Did the patient receive any treatment for these symptoms? If yes what? Enquire what methods the person is employing to cope with the symptoms.
- Does the patient use alcohol, tobacco or sleeping pills?

Key point to remember:

- Allow the person to speak freely in response to the questions; be attentive, show concern and empathy while listening.

Do a **baseline mood rating** using the mood ladder. Show the patient the ladder and ask: *“On this ladder, if the bottom rung, zero, is the worst you have ever felt and the top rung, ten is the best you have ever felt. Where would you currently place yourself?”* Make a note of the mood as rated by the patient. This will be useful in follow up sessions to judge if patients are better or not. It is also useful as a tool to provide feedback to patients about their improvement (or lack of it).

- **Suicidal thoughts:** See that every patient is asked about ideas of self-harm/suicidal ideas. Asking about such ideas does not increase the risk of suicide. This is done by saying *“sometimes, people who have stress in their lives feel hopeless about their future. They may feel life isn’t worth living anymore. Have you felt this way recently?”*

If the person expresses suicidal ideas, carry out a suicide risk assessment (Refer chapter 1.5). On the basis of your assessment, follow the suicide management protocol discussed below.

2. Eliciting psychosocial stressors

The HC now needs to ask for the social difficulties in the patient’s life. These may have a direct relationship to the onset of the symptoms and they may be either sudden or long standing. These can be elicited by asking:

*“When your symptoms of began, was there any stressful event that occurred in your life?” or,
“In your life, is there something that has been causing you considerable worry and tension?”*

Based on the patient’s response to these questions, the HC completes **the social difficulty checklist** (refer Appendix 4.2). This checklist includes most of the common stressors that patients experience, for example, financial difficulties, domestic violence and interpersonal conflicts. Describe, in some detail, the exact nature of the stressor as this is the basis on which you will then refer the patient to the appropriate social agency (described later in this chapter).

3.Reassurance and explanation about the link between patient’s stress and complaints.

- Does the patient have an explanation for her symptoms? For example, some patients may believe that their symptoms are a result of stressful life events while others may attribute them to black magic, ill luck etc. It is important to understand this especially for adherence management since patients who do not believe psychological treatments or medication are necessary for their symptoms, are less likely to adhere to these treatments. See box below.

Patient's perception of their problem

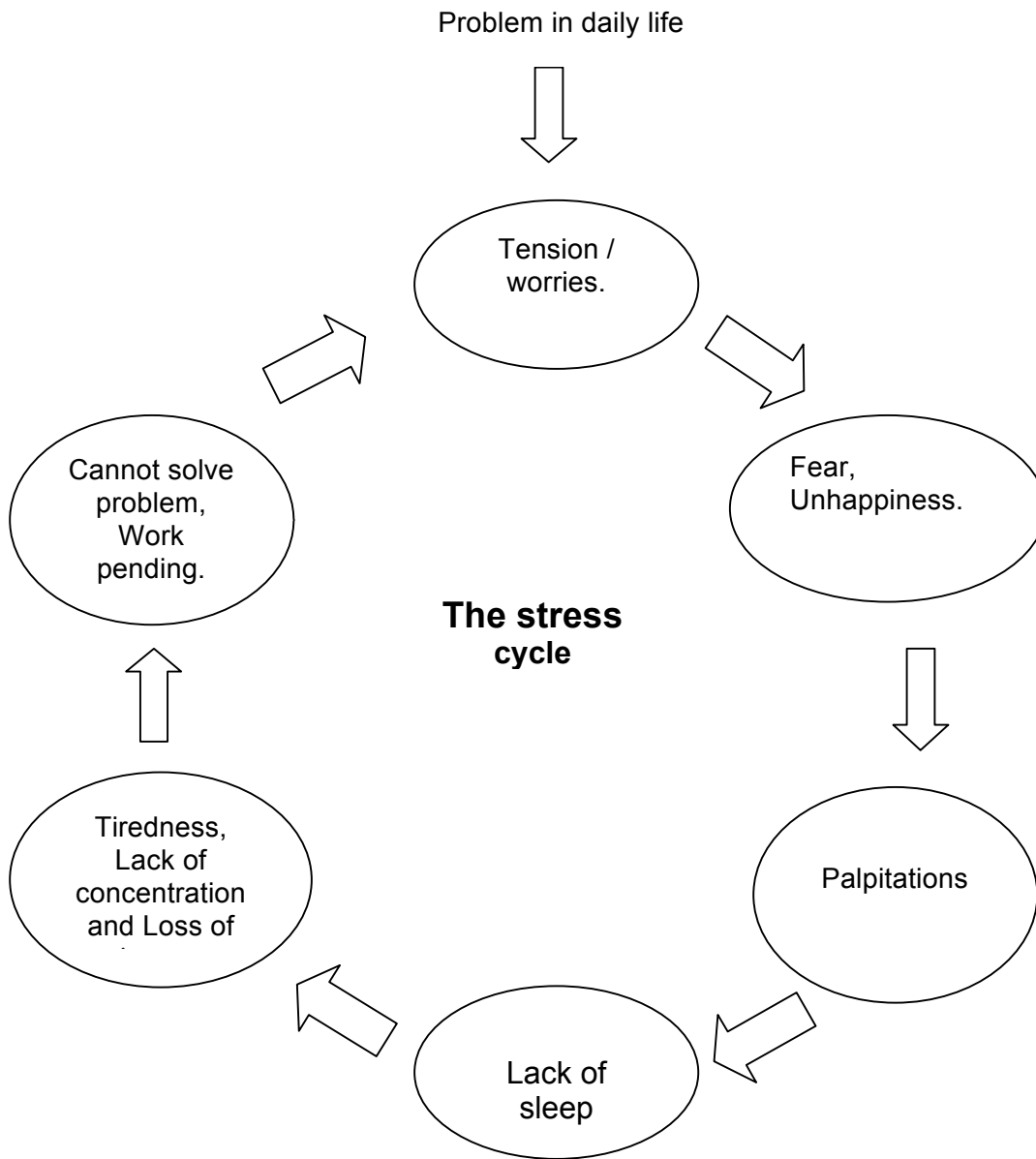
It is important to elicit the reasons patients attribute to their symptoms as this will determine their acceptance of and adherence to ADT and other treatments. It is also important to pay heed to what the patient believes is causing their symptoms and incorporate this into your explanation of the mind body link. Some examples are given below:

1. Patient says that their illness is due to black magic/fate/past bad deeds
 - Without refuting the patient's perception (or agreeing with it), explain to them an important reason for their symptoms is the mind-body link and elaborate upon this.
 - If the patient disagrees with your explanation, without arguing with him, tell him to try out the advice you have given him and see if it is of benefit
2. Patient attributes their symptoms to a physical illness or to a minor accident/menopause/sterilization operation/hysterectomy
 - Agree that while this may be one of the reasons while presenting him another reason i.e. the mind-body link
 - If patient is persistent about physical complaints, ask him to speak to the doctor (for specialized treatment if necessary or to clarify his doubts)
 - Ask the patient to follow the advise given and note the difference
3. Patient attributes the stress in their life as a reason for their symptoms
 - Reinforce this belief and explain the mind body link through the stress cycle
4. Someone else in the family has a similar problem and patient relates his problem to this
 - Same as 1 above

Once the HC has gone through all the complaints the next step would be reassurance and explanation about the body-mind link. This can be explained thus:

"When we are tense/worried, the tension has negative effects on our body because our body and mind are linked. So whenever we are tensed, our body shows the effect of this tension and we experience symptoms like sleep problems, tiredness, palpitations, aches and pains, lack of concentration and interest etc. Many people experience these types of complaints."

Explain the stress cycle:



Reassurance should include the following components:

- Acknowledging that some of the symptoms, particularly those of sleep, tiredness, other physical complaints, and psychological symptoms must be making it very difficult to handle every day activities/work; and that all persons experience symptoms of bodily discomfort at some time or the other.
“All of us feel pain and discomfort now and then. We feel tired, suffer headaches or sleep problems now and then. However, when there is tension or stress in our lives, many people become sad and worry a lot. This often puts more pressure

on our body and the body feels ill. This is why you are feeling tired and having problems sleeping”

- That none of these symptoms would result in a life-threatening or dangerous illness. For example, for patients whose main symptoms are panic and anxiety:

“Your symptoms of difficulty breathing, dizziness, heart beating fast and fear are because of attacks of anxiety. These are common problems and are not signs of a dangerous illness. In fact, they occur because you are tense or worried about something and this makes you breathe faster than normal. When you breathe faster, this produces changes in your body which make your heart beat fast and make you scared that something terrible is about to happen. There are ways by which you could stop your attack by controlling your breathing.”

- After providing an explanation of the symptoms, it is important to give the patient a chance to ask questions. This can be done by asking the patient:

“Do you feel you have understood why you are suffering these symptoms (eg. disturbed sleep, loss of appetite, loss of interest in work, etc.)? If you would like to ask any questions, please do so.”

4. Explaining the diagnosis and giving hope

The diagnosis should be explained in a way which is acceptable to the patient and will not lead to stigma or embarrassment: for example, never say that the patient has a mental illness, and avoid using technical terms such as phobia or panic, unless there are locally acceptable words to describe these conditions. One may say that:

“From what you have told me, you seem to be suffering from an illness resulting from stress. Your complaints/symptoms are the result of this illness. This illness is very common; many people attending this clinic suffer from a similar illness. This illness is treatable and in this clinic, we are providing all the effective treatments for this illness”.

Remember! There is no need to use the label of ‘mental illness’; this often means something quite different to patients and can alienate them from the counseling

5. Giving the sick role

Many patients with depression are unable to carry out their day to day responsibilities as they did before the onset of symptoms. This makes them feel guilty and inadequate. In addition, they are sometimes accused of being lazy or stubborn by their family and friends. Hence, it is important to explain to them that this is an understandable consequence of their depression and will improve as their depression improves. You can do this by giving them the sick role, thus:

“You may not be able to do the things you have to do or want to do in the same way as before your stress symptoms started. For example, if you had a broken leg, you wouldn’t expect yourself to be able to run. The treatment we are offering you will help you get better. When you feel better, you will see that you will be able to do many more things.”

6. The management of suicidal risk

The management of suicidal risk will depend on the estimation of the intensity of the problems. The basic interventions around the management of suicidal risk include some general principles which must be implemented before the patient leaves the session with you. These include:

- **Establishing a trusting relationship with the patient:** This is the most crucial part of the interventions and is the foundation on which everything else is planned. The aims of adequate engagement are to make the patient feel that her problems are being understood in an empathic manner and that you are not critical or judgmental about her disclosure. To achieve this, you must be consciously utilizing your counseling skills of verbal and non verbal communication in an appropriate manner.
- **Encouraging the patient to talk about her problems (ventilation):** The aim of engagement is to facilitate the patient being able to ventilate her concerns and distress with you comfortably. Please remember that suicidal ideas cause a lot of distress to patients because of the associated guilt and interpretation of it being a sign of ‘weakness’. Ventilation can be a very powerful tool in decreasing the intensity of suicidal ideas. Frequently, patients will become emotional and tearful during this time and you need to be supportive without encouraging the idea of self harm.
- **Giving the patient hope:** As mentioned earlier, hopelessness is a commonly associated psychological state with suicidal ideas and is a strong predictor of whether the patient will actually make an attempt. Acknowledging and managing hopelessness is, therefore, a very important part of the initial interview and should be done explicitly. One of the ways to do this is to tell the patient that you have understood her problems and are concerned about her well being but that you do not share her lack of optimism. It may also be useful to point out to the patient that hopelessness is a key symptom of Depression and that treatment will lessen the impact of the hopelessness.
- **Increasing protective factors:** This is another key task to be accomplished during the interview. You would need to understand what are the factors that have stopped the patient from actually carrying out her plans and the list given in Chapter 1.5 may be a useful starting point. The idea is to make these factors explicit during the discussion so that the patient leaves with the feeling

that there are things in her life which make it worth her making an effort to live.

- **Ensuring safety:** This is another essential part of the common interventions that need to be carried out, especially when the risk of suicide is either moderate or severe. The first principle is to involve significant others in the patient's immediate family and inform them of your concerns about her safety so that she can be observed at home. This is best done following a discussion with the patient and obtaining her consent. However, in some circumstances it may be necessary to breach confidentiality as the patient's safety is of paramount concern. Secondly, you would have to discuss with the patient how access to means of suicide (pesticides, medicines, ropes, sharp weapons) can be limited and explain that this is part of your professional obligations. Do not let the patient leave the interview room until you are satisfied that you have taken the necessary precautions around ensuring safety.
- **Asking for advice and directions:** Please remember that you will have continuous access to the Clinical Specialist who is experienced in dealing with the management of suicidal risk. In any situation where you are unsure about what you should be doing, please ask for necessary advice from the Clinical Specialist without any hesitation.
- **Enhancing the frequency of contact:** One of the more important ways to ensure that suicidal patients are engaged adequately and feel that you are making an effort to meet their needs is to increase the frequency of contact. In addition, it would be useful to make telephone calls in between the face to face meetings and enquire about their well being. Finally, in case the risk is perceived to be high, there may be the need to make a home visit and ensure that the plans to ensure safety are being adequately monitored. Make an agreement with the patient that she will call you (or someone else) if she is feeling suicidal.
- **Documentation:** The importance of adequate documentation of the risk assessment procedure, plans and their implementation on an ongoing basis is absolutely vital and an essential part of the process. For example, documenting that you met with family members and consulted appropriately with the Clinical Specialist is important for quality assurance and clinical purposes.

Suggested action for categories of risks:

- **Low:** Continue with intervention steps as usual, encourage patient to follow through with advice, enhance protective factors/ hope and ensure that she attends follow up sessions for monitoring of risk.

- **Moderate:** Provide interventions including the opportunity for ventilation, ensure adherence with ADT if prescribed, enhance protective factors, ensure safety by enlisting the support of family, increase the frequency of contact, share your concerns with the FPC and consult with the Clinical Specialist during supervision visit without exception.
- **High: Immediate referral to Clinical Specialist** for advice and follow through with plans to ensure safety which may include inpatient admission in the short term. In case outpatient management is decided upon, ensure that you are in contact on a daily basis and also increase face to face meetings to at least once every week.

Summary of risk management in MANAS program

	Level of risk		
	Low	Moderate	High
Action to be taken	Encourage to continue with treatment and specific advice. Enhance protective factors. Ensure follow up within 2 weeks.	Provide appropriate step of treatment Provide hope that things will get better. Ensure safety; talk to family with patient's consent. Ensure follow up and contact within 7 days. Enhance protective factors Share concerns with FPC Consult with CS on phone or during supervision.	Contact CS immediately for advice. Ensure safety and observation by enlisting family. Provide support and hope and If OP care continues, contact daily on phone and have face to face meeting within 3 days (home visit) for risk reassessment.

7. Breathing exercise

This is an important part of the psychoeducation session and many patients with depression feel better when they practice this exercise regularly.

- Explain that you would be teaching them a practical and useful technique for relaxing the body and mind by controlling breathing. Explain that this technique is used not only in medical clinics but also in yoga and meditation.
- Demonstrate the exercise after explaining the steps outlined below - show him how to breathe in the manner you are recommending.
- Then, ask the patient to do the exercise. It is helpful, for the first time, to take the patient through the steps your self.
- Let the patient continue the breathing exercise in silence for about 5 minutes.
- Confirm that the patient has learnt the technique correctly and encourage him to practice it regularly at home

Steps in the *breathing exercise*

- There is no special position; any position which the person finds comfortable is the right one. Thus, the patient can sit or lie down (if there is space in your office)
- Give the person a choice of doing the exercise either with eyes open or closed. Generally, the exercise is more rewarding if the eyes are closed but some patients may feel uncomfortable with their eyes closed.
- After about 10 seconds, he should start concentrating his mind on his breathing rhythm
- Now, the patient should concentrate on breathing slow, regular, steady breaths through the nose
- If a person asks how “slow” the rhythm should be, you can suggest that they should breathe in until they can count slowly to 3, then breathe out to the count of 3 and then pause for the count of 3 till he breathes in again. As the exercise progresses, the rhythm can be slowed even further according to the comfort levels of the patient.
- You can suggest that each time the person breathes out, they could say in their minds, the thought “relax” or an equivalent thought in the local language. Patients who are religious can use a word which has some importance to their faith. For example, a Hindu could say “Om” while a Christian may say “Praise The Lord”.
- Continue the breathing until the anxiety has completely ebbed and for at least 10 minutes.
- If a patient complains of palpitations, tingling- numbness in fingers or mouth, chest pain or any other physical discomfort during the exercise, it may mean that he is breathing too fast; slow down the rhythm to one that he finds more comfortable

8. Advice on specific symptoms (refer Chapter 2.4)

9. Advice to patients using alcohol or tobacco (if applicable) (refer Chapter 2.4)

10. Advice on ADT (if applicable)

What to tell the patient who has started antidepressants:

- The medicines are safe and can be taken along with other medicines.
- They are widely used and many people have benefited from these tablets.
- They will help in reducing your symptoms and improve your overall health.
- They are not addictive.
- They may occasionally produce side effects like headache, churning in the stomach, etc. But these are typically uncommon, mild and short-lived.
- They start showing a positive effect on health in a few days
- They must be taken regularly for maximum benefit and on a full stomach, preferably after breakfast.
- They must be taken for at least six months to ensure complete recovery or as prescribed by your doctor.
- It is important to take the medicines even if you feel better, for complete recovery. If you stop the treatment too soon, your symptoms will return.
- If you find the side effects unbearable, inform the health counselor and doctor.
- If you want to discontinue the treatment, consult the health counselor and doctor.
- Remember to come back and take the prescription from your doctor when you need to.
- Remember to carry empty strips of tablets on your next visit (so that the antidepressant is easily identified and the doctor is reminded to prescribe it).

11. Referral to community agencies

Patients attending the clinic often have depression in the context of very difficult social circumstances. Failure to address these and provide practical assistance ,when required, can alienate the patient who will then not be able to benefit from the program. Guiding patients and providing information to them about the various agencies/schemes that exist and which they can approach (with your help), makes them feel that their immediate social concerns are being addressed. This will make them accept the other treatments and advise more readily.

A list of such community agencies and welfare scheme available in Goa is provided in Appendix 4.11. The HC needs to be keep this list handy at all times and familiarize herself with the information provided. Establishing prior contact with the agencies in the locality and providing a referral letter or making a telephone call to the agency when referring a patient will be of immense value in ensuring the patient gets the help she/he needs. It is also important during follow up to ask the patient about the results of the referral, so that further action may be taken if needed. For example, you may help the patient complete a form required to avail of a social welfare benefit.

Examples of community referrals:

- A patient with a drinking problem will benefit with information about the local Alcoholics Anonymous group and a referral letter for the same
- If unemployment is a problem either for the patient or a family member, a letter to an employment agency will be of help
- A woman who seeks help to deal with a violent spouse can be referred to the local women's support group
- An elderly man with financial problems can be referred to the Senior Citizen's scheme
- The widow pension scheme can be used for women who are widowed or separated
- Educational schemes can be availed of to provide scholarships, books, etc for children from backward classes or families with financial problems

Refer Appendix 4.7 for sample referral letter.

12. Describing the intervention

Once the person has been given the explanations and advice, the main aspects of the intervention should be discussed. These are:

- That *“since you want to get better quickly, you need both the doctors’ treatment, and other treatments given by me that will help you handle the stress and tension”*.
- That if the patient also suffers from a physical illness (which is likely), they are receiving treatment for this illness from the doctor, and the treatment of the stress-related illness would help improve the physical illness outcome as well.
- These treatments help the person handle stress and tension more effectively and make them feel better. Many people who have done this have felt better and have had to visit the doctor less often.
- That the patient does not have to pay any additional cost to see the counselor
- That the treatment is most effective if the patient meets the counselor regularly and takes the medication prescribed by the doctor; it is not necessary to specify the exact number of sessions at this stage. Instead, a general statement that most persons will show considerable long-term benefit usually within a few weeks is adequate.
- That a crucial aspect of the treatment is to come for the follow-up appointments with the counselor and that the next appointment will be in about two weeks
- Ideally, follow up appointments should be at a time when the clinic is relatively quiet (which is usually when the doctor's clinic is closed); however, if this is not convenient, the patient can coordinate the counseling appointments with visits to the doctor

- Introduce the availability of yoga in the clinic, the dates when classes will be conducted and explain its benefits. ie:
 - Improved circulation of blood throughout the body
 - Better oxygenation of blood.
 - Reduction in spine and joint pains and body aches.
 - Calming down of mind, good sleep.
 - Feeling of well – being and energy .

Inform the patient about the day, timing and venue of the yoga sessions.

- **Give the relevant hand outs to the patient** specific to his /her symptoms, for example, on Diet, Anger /Irritability, Panic Attack, Phobia, Tiredness/Fatigue, Sleep Problem, Information on Antidepressants including the handouts for psychoeducation and yoga. Inform the patient that the handouts will be helpful since it may be difficult for the patient to remember all that has been explained in the session and as a guide to follow the instructions at home. If they are not able to read the contents of the handouts they can request any of their family members or neighbours to do the same. Also if she/he has any difficulties understanding the same he/she can clarify these with the HC at the next appointment.

13. Concluding the session

- Summarize all that has been covered during the first session, emphasizing once more that the patient is suffering from an illness, and that the patient will get better with the intervention.
- Emphasize that she/he needs to review her/his progress and learn new techniques at the next session. It is important to highlight that there are additional coping strategies that will be taught in future sessions. *“Depending on how you feel, we have other treatments to offer when you come back”.*
- Give an appointment keeping it flexible so that it suits the patient’s convenience and is coordinated with a visit to the doctor, if possible. Give the patient an appointment card after agreeing on a time for the review and also your clinic phone number.
- Ensure you have the postal address of the patient with landmarks and contact phone number.

Tasks to be completed at the end of session 1:

- At the end of the session the HC devises a plan for session 2 based on her understanding of the problem area i.e: grief, interpersonal conflict, role transition. Refer to the IPT module for details of this.
- Complete the patient intervention card
- Enter the patient’s next appointment date in your diary

PROTOCOL FOR DIFFICULT CASE SCENARIOS

There may be difficult case scenarios or circumstances which you may encounter in the clinic. Below, is a description of some of these scenarios with instructions on how to deal with them. While these scenarios are not comprehensive, they are collated from the experiences of the health counsellors who have worked in the program during its earlier phases (in the piloting phase and phase 1 ie the PHC phase).

1. Brief case history:

40 year old lady referred by Doctor is suffering from a psychotic illness (characterized by unusual symptoms such as aggressiveness, suspiciousness and sometimes muttering/gesticulating to self). She was angry, restless and abusive towards the HC. She tried snatching the mobile phone from the HC

Steps to follow:

- The first thing you need to do is seek help from whoever is in the clinic.
- Meanwhile, speak to the patient firmly but gently and try to calm her.
- Inform the doctor about patient's behaviour
- Inform IF about the situation and CS if necessary
- If she is accompanied, speak to relatives of the need to take her to the Psychiatry training hospital, The Institute of Psychology and Human Behaviour (IPHB)/Psychiatrist for treatment and admission if necessary and write a referral note accordingly. If unaccompanied, try and contact a relative or send a letter with the patient for a relative to meet or call you.
- Follow up with the patient/relative about her current status and whether they have followed your advice
- CS will speak to the doctor regarding the need for appropriate referral as treatment of such patients are beyond the scope of Manas

2. Brief case history:

25 year old man visits the clinic in an intoxicated state. He is suffering from mild depression. He was verbally abusive towards his mother who accompanied him. He was also crying and insisted that the HC should listen to him as he thought of her as his sister and she should be aware of his family problems

Steps to follow:

- Take safety precautions when patient is intoxicated (see box, below)
- Speak to the patient in a calm and firm manner
- Do not attempt to interview a patient who is intoxicated. Cut the session short and ask the patient/relative to return when he is not under the influence of alcohol.
- Refer the patient to the doctor and inform him why you cannot provide services at this time

- If the relative is willing, provide information of where the patient can seek help for his drinking problem-alcoholics anonymous, detoxification centre, IPHB
- Follow up with the patient

3. Brief case history:

32 yr old man is accompanied by his mother. The doctor refers him for counseling for mild depression. Before his mother comes into the room, the patient tells you he is HIV +. He is taking treatment from the Medical College for this. His family is not aware of his illness.

Steps to follow:

- Speak to the patient alone – asks his mother to leave the room.
- Give psycho education including symptom advice
- Inform about NGOs associated with AIDS and Care homes
- Take consent to speak to the clinic doctor about his HIV status (if the doctor is unaware of this) and explain the importance of the information for his overall treatment
- Adherence management for psychoeducation as well as for his treatment at the Medical College
- Speak to CS for further management

4. Brief case history

A 20 yr old man was initially reluctant to talk about his problem. On probing, he says that he has frequent night fall (ie. the nocturnal emission of semen). He is worried that this will cause impotence (This is a culture specific belief held by young men you have night fall. They think that it indicates loss of energy and virility and will eventually lead to impotence)

Steps to follow:

- Be comfortable about discussing the problem in a professional manner
- Psycho education. Give simple advice – night fall is normal, does not lead to weakness/impotence
- Talk to the doctor about the symptoms and ask him to provide further advice to the patient
- Discuss with CS about further management, if doctor feels it is important

5. Brief case history:

27 yr old pregnant lady, has 2 daughters. She is worried about her children, and is contemplating an abortion. She has an alcoholic husband who is physically abusive at times. She asks the HC's opinion about whether she should have an abortion

Steps to follow:

- Psycho education
- Give referral to gynecologist
- Provide information about Alcoholic Anonymous and detoxification centre
- Refrain from giving advice to the patient about the abortion –help her make her own decision after considering pros and cons of various options
- If she decides to have an abortion, provide referral to necessary agency for legal and safe, supported abortions.

6. Brief case history:

A 68 yr old woman with mild depression is not interested in psycho education, did not come for follow up visit, She visited the clinic when the symptoms worsened Doctor did not prescribe ADT as patient was already taking a lot of other medicines

Patient refused IPT

Steps to follow:

- Session 2 – psycho education with emphasis on need to take some initiative to get better. Try and identify social supports who might assist in the process
- Adherence management
- If the patient's symptoms now indicate a moderate/severe depression, ask doctor to discuss other ADT options with the CS on the phone or in monthly supervisory meetings at the clinic

7. Brief case history:

32 yr old man with mild depression was given psychoeducation. He was regular at each follow up. He began to call the HC on the telephone at odd hours, sent personal sms and sought personal information about the HC. When asked to follow up after a month, he insisted on meeting the HC sooner. When he was informed about discharge from the program, he refused to accept it

Steps to follow:

- Psycho education, follow the protocol
- Firmly inform the patient that you will not answer calls out of working hours and for anything other than an emergency. Explain to the patient that you are here to help him and other patients deal with stress related problems and will not give any personal information about yourself as it is not relevant to the patients treatment .
- Inform the doctor about the patients attitude and seek advise from IF/CS about how to deal with this problem

8. Brief case history:

A 32 yr old man with moderate to severe depression, alcohol dependence and high suicidal risk was separated from his wife and children due to domestic violence. He is currently living with his mother. He showed a photograph of his children to the HC and started crying, insisting that the HC should inform his wife about his illness and that he is admitted in the hospital. When informed about IPHB, patient asked for financial help to visit IPHB.

Steps to follow:

- Psycho education
- Inform doctor and CS
- Urgent referral to IPHB
- Inform the patient's mother about his condition and need for urgent admission
- Give a follow up appointment after 1 week
- Keep check on patients health – through telephone calls and home visit (accompanied by another person if possible) if you have not been able to establish contact with a family member.
- When any patient requests financial assistance, politely inform them that your role is to help them deal with their stress related problem. Inform them about financial schemes that they can avail of or refer them to employment agencies depending on their problem

9. Brief case history:

A 65 yr old widower living with his 2 sons who are married, is financially stable He has good social support. He has a hearing difficulty. He is suffering from moderate depression and has been prescribed ADT

Steps to follow:

- Inform the doctor about the hearing difficulty
- Repeat each question till the patient has understood, clarify
- If the patient cannot hear your instructions and can read, give him handouts and encourage him to read them at home.
- Instruct accompanying family member about need for regular follow up.

10. Brief case history:

An 18 yr old boy accompanied by mother, has mild depression and expressed worry about future but did not want to disclose any details. Patient refused to follow advice given by the HC, showed disinterest, was inattentive and restless during the psycho education

Steps to follow:

- Firstly, build rapport with the patient and make him feel at ease
- Acknowledge his feelings and emphasize confidentiality
- If he is not interested in psychoeducation, give handouts related to advice on symptoms and encourage him to read them at home

- Give follow up appointment
- If patient is willing, discuss with mother/ closest person
- Discuss with CS regarding further management

11. Brief case history

A 50 year old lady with moderate depression. Her main stressor is her husband's drinking habit. He is verbally abusive and not ready for referrals to detoxification centres. The patient cannot follow advise on sleep which is her main health complaint

Steps to follow:

- Follow protocol of psycho education ,emphasize the the link between her stress symptoms and the stressor (husband's drinking habit)
- Ensure that she receives ADT and emphasise need for adherence
- If both patient and her husband are willing, request him to meet you and explore reasons for refusing help for drinking problem
- If patients husband is willing, give further information about referral agencies and provide information about Alcoholics Anonymous and detoxification centres

12. Brief case history

A 26 year old lady with mild depression has interpersonal problem with her in laws. Patient's husband refuses to send her to the clinic and she seeks your help in speaking to him

Steps to follow:

- Offer to speak to the husband. If he can't come to the clinic, contact him on the telephone after discussing this with the patient.
- Explain to the husband your role in the clinic and the treatment you are offering
- If the stress the woman is experiencing is also due to her relationship with her husband, do not state this explicitly. Instead say that your aim is to help her deal with the effects that stress is having on her health. If the husband insists on knowing more, gently refuse to divulge confidential information.
- If the husband asks for help too, discuss with you supervisor and proceed accordingly.

13. Brief case history

A 45 year old lady with moderate depression. insists on receiving injections for her various aches and pains as she believes that it is the only thing which will help her

Steps to follow:

- Ensure that the doctor has prescribed ADT
- Explain to the patient the benefits of ADT for her stress related symptoms and the lack of benefit as well as additional risks of injections
- If she continues to insist, ask her to take ADT regularly for 4 weeks to see if it helps before she resorts to injections

14. Brief case history

A 50 year old widow with mild depression is preoccupied with financial problems and her son's inability to find a suitable job. She is inattentive to the psychoeducation and instead repeatedly asks for help to deal with her financial difficulties.

Steps to follow:

- First address her financial concerns. Inform her about the government schemes available for widows and for those with financial problems
- Guide her about the procedure involved and provide her with the address of the nearest government office where she will get further information
- Provide her with information about employment agencies and write a referral letter to the official there
- Then, when she has been reassured about your willingness to help her with her social problems, proceed with psychoeducation
- Ask her to let you know the outcome of the referral

Paying attention to your personal safety

At all times, it is important for you take steps to ensure you are safe from any kind of threat. For example, a patient or a relative may be disturbed and may attempt to physically harm you. These simple measures will help you stay safe:

- If you sense any kind of threat, keep the room door ajar, and place your chair closer to the exit
- Always ensure you can call out to someone for help if necessary
- If the patient is agitated, speak in a calm and firm manner. Terminate the session and ask the patient to return with a relative
- Ask for help from the doctor or clinic staff if you find it difficult to calm the patient

2.3c Session 2: Review Session

This session usually lasts for 30 mins and essentially comprises of the following steps:

1. Reviewing the clinical status of the patient.
2. Reinforcement of information provided in session 1.
3. Introduction of specific techniques based on problem area identified
4. Planning further intervention in patients who have not improved or have worsened since previous visit.

1. Review the Clinical Status of the Patient

This is a crucial first step for each session. The clinical status of the patient can be reviewed in the following ways:

1) By inquiring how the patient has been feeling since she/ he came to the clinic the last time, for e.g. *“how have you been since we last met?”* If the patient does not volunteer descriptions of mood or events since the previous meeting, ask a more specific question such as *“previously you were suffering from stress problems like tiredness, difficulty with sleep, etc. How have these problems been in the past few days?”* and *“do you think your conditions/symptoms have improved, are they same, or are you feeling worse since we last met?”*

2) By repeating the mood rating. Show the patient the mood ladder and ask: *“As I had asked you to rate your mood in the last session, if zero is the worst you have ever felt and 10 is the best you have ever felt, can you tell me how you have been feeling since we last met? Where would you place yourself on the ladder now?”*

Note the difference in the rating and provide feedback to the patient.

Always ask about ideas of self-harm to patients who report not feeling any change or feeling they have worsened.

2. Reinforcement of information provided in session 1.

Ask the patient if they were able to follow the advice given by you in the last session and if not, the reasons for this., for e.g. Ask the patient to do the breathing technique once again under guidance.

For patients who are improving:

- Explain the specific techniques of coping with stress based on the problem area you have identified in session 1 – elaborated below
- Emphasize the need to continue practicing the techniques that have been taught and to be optimistic that they are on the road to recovery
- Let the doctor know that there is an improvement in the patient’s condition
- Advise the patient to come back for a review in 4 weeks

- Advise the patient that if the symptoms should worsen again, to come back for a review earlier

3. Introduction of specific techniques based on problem area identified

At the end of session 1, the HC identifies the problem area based of information obtained from the patient about psychosocial stressors. She then introduces specific techniques to the patient to help her deal with problems (The IPT module describes these techniques in detail. In this 2nd session you will provide basic focused advice):

- For Grief (loss of a significant person in the patient's life): facilitate the mourning process by encouraging the patient to talk about events surrounding the death and express his feelings of sadness and loss.
- For interpersonal disputes (ongoing disagreements): Where faulty communication triggers dispute, educate the patient about effective communication strategies and modifying expectations. Where the patient cannot think of possible option available, use decision analysis (see below) to assist patients in making a choice between different possible coping strategies.
- For role transition (life changes): discuss positive and negative aspects of the new role (this will include talking about what he misses of the old role) and identify simple strategies of coping with the new role eg. identify supportive persons, develop new skills.
- Loneliness and social isolation: encourage the patient to form new relationships and draw on already existing ones to reduce loneliness.

4.Planning further intervention in patients who have not improved

- Ask about the worries and stressors which are associated with the complaints. (for example in a patient who is extremely concerned about his health: "are you thinking about your health all the time? Does this affect your work?"). Have they become worse? How is the patient coping with them?
- If the patient has not been able to adhere to the advice given in the first session, review the reasons for this. For example, if the patient had complained of fatigue and was supposed to do one activity every day for 15 minutes like sweeping one room or feeding the cows, but says he couldn't do it, review the reasons and try to get him to come up with another activity which could be easily accomplished. If he/ she found it difficult to do the breathing exercises, review it in the clinic. Let him/her do the exercise once more under guidance.
- If the patient has moderate/high suicidal risk, discuss with the GP and consider referral to the Clinical Specialist
- Inform the doctor about the continuing symptoms; the doctor may initiate antidepressants

- If the doctor gives antidepressants, it is essential that the HC provides information regarding their use as elaborated in Chapter 2.5.
- Review in 2 weeks.

When should you refer patients to the Clinical Specialist?

- Patients with high suicide risk
- Unusual symptoms which indicate that the patient may have a psychiatric illness other than Depression such as hearing imaginary voices, unreasonable suspiciousness, severe behaviour disturbance
- Significant memory problems and confused behaviour especially in the elderly
- Treatment failure- having used an antidepressants in adequate dosage and duration without significant improvement i.e. Optimum dose for 8 weeks.
- Dual diagnoses i.e. Moderate/severe depression with alcohol dependence

2.3d Termination Session

At the third psychoeducation session, you should cover the following steps:

- Review the Clinical State of the Patient (including mood rating) as described above.
- Review the patient's use of specific skills to tackle the problem area
- Link any change in mood to the skills used. This can be done by saying "*the effort you have made to communicate more effectively withhas probably resulted in your feeling better*"
- Reinforce the need to follow the advice for specific symptoms as well as strategies to deal with problem area
- Educate about 'early warning signs' and discuss what steps the patient would take in case symptoms reappear. This is described below.
- Monitor and reinforce ADT if these are being prescribed.
- Follow the discharge protocol to end the intervention when appropriate.

For patients who are improving but not fully recovered:

- Emphasize the need to continue practicing the techniques you have taught them and to be optimistic that they are on the road to recovery
- Let the doctor know that there is an improvement in the patient's condition
- Offer a review appointment in 4 to 8 weeks and advise the patient that if the symptoms should worsen again, to come back for a review earlier

For patients who are not improving/feeling worse:

Consider moving to the next step in the intervention. Prior to this cover the following steps:

- Recap on which symptoms have worsened
- Check regarding adherence with treatments: if not adherent, then reinforce need for the treatment. If adherent, then increase the frequency or intensity of treatments. For example, if the patient is on antidepressant treatment, discuss with the doctor the possibility of increasing the medication dose. If the patient has received adequate dose of ADT for 4 weeks, move to step 3 (i.e. offer IPT).
- If the patient has not been able to adhere to the advice given, review the reasons for the same. (Refer adherence improvement guidelines)
- Ask about the worries and stressors which are associated with the complaints. (Eg. has there been any additional stressful event since the last visit?). Make appropriate referrals to other helping agencies.
- If the patient focuses more on the physical complaints repeat the explanation of the mind and body link and why it is necessary to follow the advice.
- Ask about suicidal thoughts. If these are serious, discuss with the GP and consider referral to the Clinical Specialist.
- Review the strategies for all the relevant specific symptoms and techniques of dealing with problem area which were covered during the previous sessions.
- If patient has new symptoms, record these and give appropriate advice
- Review in 2 to 4 weeks.

For patients who have remained well since the previous session and are not on a treatment such as ADT or IPT or have completed this course:

- they may be discharged from the treatment program. See below.

For patients who are well and on a treatment such as ADT or IPT

- Review as per the requirements of the treatment

Follow up Session for patients on ADT are brief 10-15 min sessions you will conduct each time the patient follows up for ADT. During these sessions you should cover the following:

- Review of symptoms and patients overall mood state
- Advise about ADT (refer Chapter 2.5) including need for adherence and explanation of side effects if any
- Reinforce coping techniques taught depending on problem area

Ending the intervention

The end-point of the treatment is reached under the following circumstances:

- The patient has stayed well for 2 consecutive follow-up sessions of psychoeducation.
- The course of antidepressant treatment is completed and the patient has recovered.

In addition to these situations, a patient in the program may be discharged in accordance with the protocol below:

Discharge protocol for MANAS program.

1. Refusal to start or continue with the program- some patients may refuse the offer for treatments either in the initial session when they are referred to the HC or subsequently due to a number of reasons (cannot attend, do not feel advice is useful, do not want to take ADT due to side effects, do not feel they have any mental health problem etc). The HC in these situations tries to understand the reasons for the refusal and tries to convince the patient about the benefits of the intervention. If, after making these efforts, the patient is still adamant about not continuing with the intervention, discharge from the program and inform the referring doctor about it.
2. Some migrant patients have indicated to the HC their inability to attend for follow up as they would be going elsewhere for work or would return to their original place of residence. If the patient is either on Steps 1 or 2, reinforce the advice to continue with the recommended treatments for an appropriate period of time. In case the patient has started on ADT, discuss the need to continue with the medicine wherever they are for 6 months and, if necessary, provide a brief referral letter to a doctor that they might consult in their new place of residence.
3. Some patients have missed their scheduled follow up appointments and the adherence management protocol has been instituted appropriately. If, in spite of all possible efforts, the patient does not return for follow up within 2 months of the last attempt to contact them, they are considered to have dropped out of the program and are to be discharged.
4. The current protocol states that patients can be discharged from the program if they have improved with the treatment. For example, the patient may have practiced the PE and become better which is confirmed in 2 successive follow up visits; discharge the patient and confirm with your IF. For patients who are receiving IPT and have completed the required IPT sessions discharge the patient after consultation with the concerned IPT supervisor. If the patient has completed 6 months of ADT, remember to consult with the FP who would then make the decision about how and if the ADT needs to be stopped before discharging the patient.
5. Some patients are not suitable for the program because they have other psychiatric problems like psychosis, obsessive compulsive disorder and severe alcohol dependence as their primary problem with depression being a secondary diagnosis. These patients are to be referred to the CS who will determine on an individual case by case basis whether they are to be discharged from the program after reviewing their problems.
6. A small number of patients would have severe suicidal risk where in-patient treatment is necessary to manage their risk (in all such scenarios, contact the CS who will make the judgement); these patients have a

threshold of risk that cannot be safely managed in the program and would be discharged to specialist care either in Sangath or to other psychiatric facilities.

7. Death of the patient.

Important points to remember when discharging the patient:

- Termination of treatment is something to discuss with the patient right from the start. This is best done by being explicit about how much time the intervention will take. This is important in order to prevent dependence on the HC and give hope to the patient of recovery within a reasonable time frame.
- Many of the techniques used in the intervention, for e.g. anger management, breathing exercise, yoga are life skills which the patient should be able to continue using beyond the treatment setting.
- The counselor should focus on the patient's success in coping with her stress symptoms and thus increase her confidence in being able to deal with her problems without the counselor's assistance
- Particularly important is the patient's ability to recognise when she needs help in the future. For this, she should be able to identify the early warning signs of stress-related symptoms (such as insomnia, fatigue, etc).

What are “early warning signs”?

Even when people do their best to avoid it, their symptoms may return and they may have a relapse. Some relapses may occur over short periods of time, such as a few days, with very little or no warning. However, most relapses develop gradually over longer periods of time, such as over several weeks.

There are often changes in the person's inner experience and changes in their behavior when a relapse is starting. For some people, the changes may be so minor at first that they may not be noticeable. For others, the changes are more pronounced and distressing. When people look back after a relapse, they often realize that these early changes, even the minor ones, were signs that they were starting to have a relapse. These changes are called “early warning signs”.

Early warning signs are the minor changes in a person's inner experience and behaviors that signal that a relapse may be starting.

Common early warning signs include:

- Feeling tense or nervous
- Eating less or eating more
- Trouble sleeping too much or too little
- Feeling depressed or low
- Feeling like not being around people
- Losing interest in things that he used to enjoy earlier
- Feeling irritable
- Tiredness and fatigue
- Trouble concentrating

What can a patient do in case her symptoms reappear?

When early warning signs are noted, the patient should consider the following:

- Are her stress levels high? What can she do to reduce it?
- Is she following the treatments/suggestions given to her? i.e. Is she doing her breathing exercises, if prescribed antidepressant medication, is she taking it regularly?
- Visit the clinic to see the HC or doctor or
- Speak to a family member or friend for additional support.

Summary points: Steps of Psychoeducation (at a glance)

Assessment Session

- Begins with greeting the patient and assuring confidentiality.
- Eliciting symptoms.
- Elicit psychosocial stressors
- Inquiry for suicidal ideas
- Reassurance and explanation about the link between patient's stress and complaints.
- Explaining the diagnosis and giving hope
- Giving the sick role
- Breathing exercise,
- Advise on specific symptoms including suicide risk management
- Advice on ADT (if prescribed).
- Advice to patients using alcohol or tobacco
- Describing the interventions.
- Referral to community agencies.

Review Session

- Reviewing the clinical status of the patient
- Confirm adherence to treatments provided in previous session and employ adherence management strategies as applicable
- Link change in mood to efforts made by patient and reinforce information provided in previous sessions
- Information about specific techniques to deal with the problem area of grief/interpersonal dispute/role transition/social isolation
- Planning further intervention in patients who have not improved or have worsened since previous visit
- If patient is on ADT, give advice about adherence

Termination Session

- Review the clinical state of the patient and the use of techniques learnt in previous sessions
- Link recovery with skills used
- Educate about “early warning signs” and discuss with the patient what steps to take in case symptoms reappear

Chapter 2.4

SPECIFIC ADVICE FOR SYMPTOMS

Once you have given the patient all the explanations the next step would be to give prescriptive advice on specific symptoms. Ideally, some of these should be given in the first session, based on the types of symptoms the patient has. The most common ones are covered here:

2.4a Sleep Problems:

These are very common problems and can occur as part of a depression or as a separate problem altogether. The key points to advise patients are:

- keep to regular hours for going to bed and waking, irrespective of how the previous night's sleep was
- avoid daytime naps; if the patient must nap in the afternoon, they should restrict it to no more than 45 minutes
- avoid sleeping tablets or alcohol to fall asleep
- avoid tea or coffee after 5 pm if you have a sleep problem
- try relaxation exercises to help fall asleep
- drink a glass of warm milk before bed
- if they cannot fall asleep within 20 minutes or so, they should get out of bed, try out some activity (e.g. walking, etc) try again later when feeling sleepy

2.4b Tiredness & Fatigue:

These are typical features of depression. The person loses interest in activities and begins to feel tired and weak. This leads to further withdrawal from activities and adds to the feeling of tiredness and low mood. These are some steps to break this vicious cycle:

- Explain to the person how his stress is making him feel tired and weak
- the less he involves himself in activities the more tired he will feel. That is important for him to understand - that it is graded activity (see below) that will make him feel less tired and improve his ability to think and solve his problems
- Encourage the person to start with a simple pleasurable activity, of his choice, for a set amount of time every day for e.g., stitching for 15 minutes every day in the morning. The 15 minutes could then be increased to a half-hour gradually. Ask him/ her to notice the change in him/ her after he does it. Do not advise going back to a full day's activity, immediately. There should be a gradual, increase in physical activity stepped up, very slowly, according to the needs of the individual.

2.4c Worry about physical health:

- Let him talk about his physical complaints, if need be even look at his prescriptions and medications. Do not ignore or dismiss them.
- Emphasise that the FP is dealing with some of his problems, others may be related to worrying or stress problems
- Make him realise the close connection between physical health and stress, let him know that learning to cope with his problems could reduce the intensity of the physical symptoms.
- Reinforce that if there is a need for more investigations such as X-rays, the medical doctor will carry them out; the counseling is not an alternative to the standard medical treatment

2.4d Irritability:

- Explain the link between anger and mood and the effect anger has on a persons mind and body, for example, it raises blood pressure and pulse rate and makes solving problems more difficult
- The first step in anger control is to recognise one's anger by paying attention to signs such as tensed muscles and feelings of irritability and frustration
- To try and identify the cause of the feelings of anger and then to take positive steps to resolve the problem
- To try calm down before feelings of anger exaggerate into verbal or physical aggression. A person can calm down by expressing the reasons for anger to a close friend or relative, or by relaxing alone till anger subsides. Leaving the anger-provoking situation and returning when the anger has reduced helps to diffuse the situation. Breathing exercises may help the person calm down.
- As a rule, never act or make a decision when angry. The person will most often regret their actions or deeds later on.

2.4e. Giddiness:

- Explain to the patient that there are simple methods which can help improve giddiness
- If experiencing giddiness during standing or walking, he should sit down until the feeling passes
- If he experiences giddiness when getting up from from bed, he should rise slowly from the lying down position, sit on the edge of the bed for some time with his legs dangling over the edge of the bed and then stand up slowly
- Missed meals may also be a cause for giddiness. This will improve if he eats something
- Breathing too rapidly (hyperventilation) may also result in giddiness. Explain this to the patient and teach him the breathing exercise

2.4f Panic Attacks:

- Explain to the person the relationship between his feelings of fear and the rapid breathing (as described earlier).
- That she should recognise that when the fears begin, physical symptoms start.

- That as soon as the fearful thought starts or she first notices symptoms, she should start controlling her breathing.
- The best way to do this is to do the breathing exercise reminding oneself that there is nothing to fear, till one gains control over the breath
- Explain that you would be teaching them a practical and useful technique for relaxing the body and mind by controlling breathing (the breathing exercises described earlier). Explain that this technique is used not only in medical clinics but also in yoga and meditation.
- Demonstrate the breathing exercise
- Then, ask the patient to do the exercise. It is helpful, for the first time, to take the patient through the steps yourself.
- Let the patient continue the breathing exercise in silence for about 5 minutes.

2.4g Phobias:

The commonest phobia is agoraphobia where a person fears crowded situations such as markets or public transport, or going out of the house. Such persons often become house-bound. The other common phobia is social phobia where a person fears meeting people in social interactions and thus avoids social meetings. If the person is suffering from a phobia, in the first session it would be helpful to just teach the person the breathing exercises and give advice on any of the other specific symptoms and call the person back for the next session telling him that we will work on the his/ her fears when she/ he comes next.

Getting rid of fears: steps in treating phobias

- Identify that their symptoms are related to a fear of the situation which is irrational.
- Grade these fearful situations in a list from the least fearful to the most fearful
- Explain that the only way of overcoming this fear is by exposing oneself to this situation until the fear subsides. This way, one can “unlearn” that there is something to fear about the situation and can face the situation the next time with confidence.
- Emphasize to the patient that avoidance of the situation only serves to make the fear worse.
- Exposure must be done consistently to build up the patient’s confidence and overcome the phobia. They can be taught to deal with the fear during exposure by breathing exercises (as with Panic attacks) and by reassuring themselves in their minds that the fear is temporary and is because of their phobia (rather than any real fearful feature of the situation).
- Expose the patient in steps starting from the less fearful situations; once the patient has mastered this situation and can face it with no fear, encourage them to move to the next situation on the hierarchy and, in this manner, move on to the most fearful situation. For example, a house-bound person could be first encouraged to take a short walk to the neighbours home as the first step. This step is practiced daily until no more fear is experienced. The patient must not leave the situation under any circumstances. After overcoming this fear, they should move on to the next step up.

2.4h Advice on eating healthy:

This advice should be given to all patients and remember to tailor the advice according to the patient's economic status and current eating patterns.

- Explain to the patient that what we eat has a profound effect on our body as well as on the mind.
- Eat meals at fixed intervals. Ignoring your meal timings can lead to negative effects on your health like stomach problems such as increased acidity.
- Meals should be eaten in a relaxed atmosphere and not in a hurry.
- Your diet should have a large amount of fibre. You can do this by regular consumption of whole grain cereals like chapatis, fruits and green leafy vegetables.
- Limit fat from dairy and meat sources like pork and mutton.
- Avoid overly spicy food and deep fried foods on a regular basis.
- Steamed, boiled, baked and roasted foods are preferred to fried foods.
- Avoid munching in between on snacks or fast foods which gives you a lot of unhealthy calories and are responsible for weight gain.
- Brisk walk every day and yoga will help you to maintain a healthy weight.
- Drink plenty of water, especially in the summer months.

2.4i Drinking problem:

This is the advice you give someone who admits to having a drinking problem:

“The problem with alcohol is that sometimes one drink can easily lead to another. Before you know it, you might have had more to drink than you had planned and then experienced some of these problems.

- When people get drunk they do things which they usually would not do normally. For example, they can become either aggressive or they may drive recklessly
- Alcohol is highly addictive - Some people are often unable to stop drinking even though alcohol is harming them
- Moderate to heavy drinking over many years damages the liver, brain, heart and pancreas, and can cause cancer.
- Children learn about behaviour largely from their parents; it is more likely that children of parents who drink heavily will themselves take up the habit later
- For pregnant women, it is not at all safe to drink
- It is unsafe to drive/ ride a vehicle under the influence of alcohol

Tips on how to be a safe drinker:

If you still feel alcohol is important in your life then we suggest you find out a little more about how to drink safely:

- ✓ When you drink, have a maximum limit of 2 small pegs of alcohol; for example, a maximum of 2 small pegs of feni or spirits or 2 small bottles of beer in a day.
- ✓ Decide how many pegs (bottles of beer) you want to drink in an evening and stick with it.
- ✓ Reduce your pegs by choosing drinks that are not so strong.(e.g. beer instead of whisky)

- ✓ Drink a full glass of water before you start drinking alcohol.
- ✓ Drink either water or a soft drink between each alcoholic drink.
- ✓ Eat before you go out and while you are drinking.
- ✓ Set aside specific days in the week when you do not drink
- ✓ Try not to go out too often with friends who drink heavily

Remember that for most people who are trying to stop drinking, it is hard to do so in one attempt. Most commonly, even in people who are keen on stopping, there are times when they might start drinking again, usually when feeling bored or unhappy or in the company of friends. If this happens, it is important that patients do not feel guilty as they may restart the use of heavy and regular drinking. Instead, it is important to accept that it has happened in spite of their best intention and learn from the experience to think of ways of stopping this from happening again.

Patients who have alcohol dependence and develop severe withdrawal symptoms when they reduce or stop drinking should be advised to seek help from the CS or another specialist.

2.4j Stopping tobacco use:

Smoking or chewing tobacco is a common habit that has been shown to have many negative effects. Tobacco, when smoked or chewed, is highly addictive because of the nicotine it contains and most often, what started as occasional use becomes a habit. Most people continue to use tobacco because they get addicted to tobacco. The adverse health consequences of tobacco use include a high risk of early death due to heart disease, breathing difficulties and many types of cancers. Hence, stopping tobacco use is important to be physically and mentally healthier.

Explain the steps involved in stopping smoking:

STEP 1: FIND REASONS TO STOP

The first step is to think carefully about why you want to stop. Being clear about why you want to stop using tobacco can be a very powerful way to stop.

- Using tobacco through smoking or chewing kills
- Cigarettes and chewing tobacco are full of poisons
- Using tobacco causes disease like cancer, heart attacks, breathing problems and depression
- Using tobacco affects fertility, babies and children
- Using tobacco is expensive

STEP 2: MAKE A PLAN

Planning can help you understand why you use tobacco and identify the most useful strategies for stopping.

- Know why you use tobacco and the situations in which you use tobacco smoke regularly; make a record of the times and situations you have used tobacco in and the reasons for it.

- Plan ways to deal with stopping since tobacco is available everywhere!
- Set a date to stop
- Remind yourself of what you need to do to stop using tobacco.

Having a plan can increase the chance of you stopping successfully. Getting help with your stopping from your Doctor or the Health Counselor will give you a much greater chance of long-term success.

STEP 3: PUT YOUR PLAN INTO ACTION

Now it's time to put all your plan into practice and stop

- Choose an approach that suits you : stopping completely and suddenly, cutting down or gradually reducing
- Understanding that you will have withdrawal symptoms like irritability and anxiety in the first few days after you stop; get your family and friends to understand this and to support you at this time
- Resist the urge to smoke even one cigarette or chew even one pouch of guthka; the urge goes away if you can do deep breathing and distract yourself by getting busy. Remember, the desire goes away within 5 minutes.
- Find ways to relax: the breathing exercise described by the HC, change in your routine, early morning walks, etc
- Avoid drinking alcohol as you might feel like using tobacco with your drink
- More strategies: reward yourself with the money you have saved after stopping, take your family out for a meal or a movie or invest in having your teeth cleaned!
- Review your plan: checking whether your plan is working for you and reminding yourself of why you want to stop in the first place

STEP 4: STAY ON TRACK

- You will feel the urge to use tobacco less and less, but staying off tobacco takes a long term effort.
- The next stage is learning to enjoy and value your new tobacco free lifestyle.
- Remember, it is normal to get the craving to smoke or chew tobacco in situations where you used to. Resisting the craving to use tobacco is a necessary step in your effort to stop smoking.
- Don't let other people talk you into having a cigarette or chew tobacco. It's your decision - don't let others pressure you. Tell them 'No' and that you mean it.

While some people are able to stop in their first attempt, most of those who stop will need to make several attempts before they are finally successful. In other words, even with the best intentions, most people go back to using tobacco due to reasons like craving or boredom. If this happens to you, do not feel guilty and disheartened as this will make you continue using tobacco. Instead, accept that this is most often the case, refocus on the reasons on why you want to stop and go through the steps again using your experience usefully.

Summary points:

- Giving advice for specific symptoms that the patient experiences is an important component of the first psychoeducation session
- Following this advice frequently leads to relief in symptoms for those with mild Depression

Chapter 2.5

ANTIDEPRESSANTS (ADT) AND OTHER DRUG TREATMENTS FOR DEPRESSION USED IN PRIMARY CARE

2.5a Introduction

The term antidepressant refers to a group of medicines that are used in the treatment of Depression that is of a moderate – severe nature. The first antidepressant medicines were discovered by chance about 50 years ago and, since then, these have been used extensively worldwide. Though referred to as antidepressants, these medicines have been found to be effective for a number of other disorders like anxiety and for chronic pain.

As the name suggests, antidepressant medicines are the specific and effective drug treatment for Depression. However, most patients with Depression in primary care clinics like the FPC are not treated with these specific treatments. Instead, they are prescribed a number of non specific treatments like vitamins, tonics, pain killers and sedatives (medicines which make a person sleepy) which are both costly and do not provide lasting relief from the symptoms; as a group, it is convenient to refer to these as 'symptomatic drug treatments'.

One of the key objectives of the MANAS program is to encourage doctors to prescribe antidepressants for severe Depression rather than the 'symptomatic treatments'. Treatment with antidepressants is both more effective in reducing the symptoms of Depression and the overall costs of treatment are lower for the patient. In this chapter you will be given an introduction to the various antidepressant medicines that are likely to be used in the MANAS program by the FPs, your specific role in ensuring that patients get the maximum benefit of the treatment and a brief outline of the common 'symptomatic' treatments that you will encounter during your work in FPCs.

This chapter includes the following:

- How do antidepressants work?
- Common antidepressants used in the clinic
- Role of the HC when a patient is on antidepressant treatment
- Symptomatic treatments that are sometimes used in the clinic

2.5b How do antidepressants work?

Though the precise way that antidepressants work is not yet clear, there is enough evidence to suggest that they work by altering the chemical profile of the brain. As you will recall, we had discussed the role of specific chemical messengers in the brain like adrenaline in causing stress and Depression. Antidepressant medicines are carried in the blood to the brain where they attach

themselves to particular parts of the nerve cells. Once attached (like a key fitting a lock), these medicines generally increase the available levels chemicals like adrenaline and serotonin which in turn gradually improve the symptoms of Depression in a manner that is not clear.

For you as a HC, understanding broadly how the antidepressants work is important for 2 reasons.

Firstly, it takes a few days- 2 weeks for the patient to start feeling better as the chemical changes in the brain linked to symptom improvement take time to occur. Thus, there is a 'lag period' before the antidepressants produce benefits for the patient. Secondly, the chemicals that are altered by antidepressants are also present in other areas of the body and those get affected in the same way (increased levels) as the brain. The levels of important chemicals like serotonin and acetylcholine in the body happen very soon after the medicines are started leading to side effects like headache, nausea, diarrhea and other stomach complaints, dry mouth and blurred vision . To put it simply, patients on antidepressants will experience side effects before they start getting better. As we will see later, both the delay in starting to feel better and experiencing side effects initially are important points to communicate to the patient to help her continue with the treatment.

2.5c Common antidepressants used by Family Physicians

There are several different antidepressant drugs available in Goa which Family Physicians would be using during the MANAS program. These medicines can be conveniently categorized into three broad groups based on their chemical structure and mechanism of action. Broadly, antidepressants can be classified as Tricyclic Antidepressants (TCAs), Selective Serotonin Reuptake Inhibitors (SSRIs), and newer medications with mixed actions (see Appendix 4.3).

Family Physicians will have a choice of using one antidepressant or the other in treating patients with moderate-severe Depression. However, it is important to understand that no one antidepressant is clearly superior; in other words, they are all of equivalent effectiveness. Therefore, the most important factors that we will be encouraging Family Physicians to consider before starting antidepressants are the side effect profile, the convenience of a single dosage and the cost to the patient; all of these are to ensure that patients adhere to the medicine long enough to experience full benefits. While choosing and prescribing the particular antidepressant is the FP's responsibility, you will also have a very important and unique role to play for patients on ADT. Appendix 4.3 summarizes the commonly used antidepressants with their doses and side effects

Key messages on antidepressant use in treating Depression:

- Antidepressants are used to treat moderate- severe Depression
- Although called antidepressants, these medicines are equally effective for the management of anxiety disorders
- All antidepressants are of equal overall effectiveness
- Antidepressants have different side effects and a range of costs
- Antidepressants are not addictive
- Antidepressants are most effective if they are taken regularly at the right dose and for an appropriate time- usually for 6 months

2.5d When will the FP start antidepressants?

In the MANAS program in the Family Physician Clinics, we will be recommending that Family Physicians use ADT for patients who have moderate- severe Depression and therefore need more intensive, Step 2 treatment. The decision to start the medicine is, of course, one that the FP will make based on the screening score and his clinical judgment. Once the FP has started treatment with ADT, he will indicate the same to you on the Patient Card (refer Appendix 4.12). Patients can be started on ADT at the initial visit when they score above the threshold for moderate- severe Depression on the GHQ or at subsequent visits when Step 1 treatments are not effective.

2.5e What is your role when a patient is taking antidepressant medication?

Your role as a HC when a patient is on ADT is crucial. As we have learnt earlier, the successful treatment of Depression involves the principles of chronic disease management wherein patients have to be encouraged to continue with the recommended treatments for an adequate time. Discontinuation of treatment or non adherence is the single biggest barrier to obtaining the best outcomes. Your central role when ADT has been started will be to use all possible strategies to encourage adherence with the medicine.

The treatment of Depression with ADT can be conveniently divided into 3 phases. In the initial, acute phase of about 4-6 weeks, the aim of treatment is to reduce the symptoms and enable the patient to continue with her life as before the illness. Since Depression is a relapsing condition, patients need to continue the medicine for a period of time even when they are feeling well to prevent a relapse of the problems. This is the second or the continuation phase of treatment which lasts usually for 6 months. Finally after a period of about 6 months of continuing with the treatment when the patient has recovered, a decision needs to be made about stopping the medicine- the planned

discontinuation of treatment. These stages are important to remember since your inputs will vary depending on the stage of treatment.

Starting ADT: (Initial, Acute phase)

Your role to encourage and monitor the use of antidepressant treatment starts from the first session when the FP prescribes the medicine. At this point, you will be expected to provide information emphasizing the need for the medicine and the benefits that are likely to be experienced by starting and continuing with the medicine. During this session, you will also be expected to inform the patient about the time lag between starting and the health benefits becoming evident and possible side effects which may occur earlier but which are usually temporary. This message should be phrased in a manner to encourage the patient to understand that the initial side effects are to be expected and can be managed easily and is not a reason to discontinue the medicine. Finally, all possible measures, including contact details, need to be recorded to ensure that the patient returns for a follow up visit.

What to tell the patient who has started antidepressants:

- The medicines are safe and can be taken along with other medicines.
- They are widely used and many people have benefited from these tablets. They will help in reducing your symptoms and improve your overall health.
- They are not addictive.
- They may occasionally produce side effects like headache, churning in the stomach, dryness of mouth, etc. Since these are typically uncommon, mild and short-lived, do not over emphasize them to the patient.
- They start showing a positive effect on health in a few days- 2 weeks.
- They must be taken regularly for maximum benefit and on a full stomach, preferably after breakfast.
- They must be taken for at least six months to ensure complete recovery or as prescribed by your doctor.
- It is important to take the medicines even if you feel better, for complete recovery. If you stop the treatment too soon, your symptoms may return.
- If you find the side effects unbearable, inform the health counselor and doctor.
- If you want to discontinue the treatment, consult the health counselor and doctor.
- Remember to come back and meet your doctor regularly while you continue with ADT.

Reviewing ADT treatment: (maintenance phase)

When the patient returns for the first time after being prescribed ADT, you should compliment the patient for having come back as planned. A review of the symptoms and the presence of side effects should be conducted which then needs to be fed back to the FP. At this point, the FP may increase the dose of the medicine and ask the patient to come back after a month. You will need to

encourage the patient to take the medicine as prescribed and discuss the possibility of contacting her before her planned review at 4 weeks to enquire about her progress and adherence.

At the third review, most patients would be expected to have improved and you will need to do a brief review of 5-10 minutes where you enquire and reinforce taking of the medicine, discuss the benefits of treatment and inform her about the danger of a relapse if medicines are stopped prematurely. From here on, the treatment enters the continuation phase where the doctor may review her once every 2 months when she can also meet you. This can be supplemented by telephone counseling to encourage adherence. If, during this review, you find that the patient is not better then discuss this with the FP who can increase the dose or, if necessary, consult the CS.

Stopping ADT:

Finally, at the end of 6 months of treatment, you will need to alert the doctor about the need to make a decision to either continue or stop the medicine. If the decision is to stop the treatment, you must follow the discharge protocol described in Appendix 4.6.

2.5f Symptomatic treatments for Depression commonly used in primary care

Patients with Depression in primary care clinics are frequently prescribed 'symptomatic treatments' like vitamins, tonics, sleeping pills, painkillers, food supplements and injections which are both unnecessary and costly. In some cases, the use of medicines like sleeping tablets for long periods can lead to the patient getting addicted to the medicine. Doctors prescribe these treatments for a number of reasons. Many patients with mild Depression do respond to these treatments and improve. This commonly observed fact of the patient improving even without specific treatment is known as the 'placebo effect' and occurs for reasons that are not clear. The placebo response of some patients reinforces the doctor's belief that the particular symptomatic treatment is indeed effective and he may decide to use it for all patients with suspected Depression. However, the more important reasons for the use of these treatments include the non detection of Depression, the lack of time to provide even brief counseling and the fact that most doctors are not trained in the principles of counseling. Finally, there is the pressure to prescribe something for the patient even when the doctor is aware that this is not necessary as patients expect to be given something after the consultation. There is also the widespread perception in doctors that 'talking treatments' are not accepted by patients who will shop around for another doctor who does prescribe vitamins or tonics. This dilemma is particularly significant for FP since they may be worried about losing their patients to other doctors who succumb to the patients' demands.

One of the key aims of the MANAS program is to reduce the inappropriate use of symptomatic treatments by creating the necessary conditions for providing treatments that are both effective and matched to the needs of the patient. A number of key strategies will be used to improve the prescribing behavior of FP's which will include improved detection of Depression through screening, encouragement and support of the CS to enhance the confidence of the FP to use antidepressants appropriately, reduce the use of symptomatic treatments and in ensuring that only patients who are moderate –severely depressed are prescribed ADT.

It is not unusual for patients to demand injections or vitamins/sleeping pills and to feel dissatisfied if the doctor does not prescribe these. At such times, it is important to explain to the patient that:

- Their symptoms of fatigue/insomnia are a part of their stress related illness and will get better if they follow the advice given by you (or take the antidepressants prescribed by the doctor)
- Unnecessary injections can be harmful as they can increase the chances of infection. Likewise, vitamins are costly and sleeping pills can cause dependence and be difficult to discontinue when they are no longer required. Further, none of these medications are useful for stress related problems
- If patients still insist on receiving these medications, urge them to try out your advice/the antidepressant medication for a while and see how they feel.

Summary points:

- Antidepressants are used in the Manas trial for all patients with a moderate/severe Depression or those with mild Depression who fail to improve with psychoeducation
- The choice of antidepressant is governed by the FP's familiarity with the use of a particular ADT, the side effect profile and the cost of treatment
- Your role as HC is to explain the benefits of ADT to all patients who are prescribed these and to encourage them to adhere to the full course of treatment
- While we encourage the use of ADT for patients who need it, we also recommend that the FP reduces the use of symptomatic treatments such as vitamins, tonics, sleeping pills and injections which have no benefit in depression and in fact may prove harmful.
- ADT are not recommended for mild Depression.

Chapter 2.6

INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSION

2.6a. Overview

What is IPT?

IPT (Interpersonal Psychotherapy) was initially developed for use by mental health professionals to treat adults with moderate-severe depression. It has been adapted for different disorders and ages (from adolescents to the elderly) and its effectiveness has been demonstrated in numerous scientific trials.

Depression, most often, occurs in a social and interpersonal context. In IPT, depressive symptoms are closely linked to events in one's life. These events fit within one or more of the following categories; **role dispute, role transition, grief, or interpersonal deficits**. In IPT the patient learns to understand the relationship between his symptoms and interpersonal triggers, and to reduce depressive symptoms by finding better ways of dealing with the interpersonal problems that have been contributing to his depression.

The key features of IPT are:

- Depression is understood as a medical disorder.
- The patient is given the 'sick role.'
- It is a time-limited, focused, "here and now" treatment for depression
- Makes explicit the diagnosis of Depression and the treatment plan
- It considers Depression as not being anyone's fault and looks at what was happening in person's life when the current depression began (trigger for the depression)
- It looks at current rather than past interpersonal relationships
- It focuses on helping the patient decide what he wants and what skills he will need to develop to achieve what he wants.
- The therapist plays an active role, but is not an 'advice giver' or guru.
- IPT categorizes interpersonal problems under four broad problem areas and considers that the onset of depression is associated with one or more of these problem areas (but the focus of the treatment is never on more than two problem areas):

Grief - death of a loved one

Role Disputes – serious disagreement with someone important

Role Transitions – any life change, bad or good

Interpersonal Deficits - *loneliness and social isolation* that results in feeling lonely, bored and/or cut off from the others

FACTS ABOUT DEPRESSION THAT FORM THE BASES OF IPT:

- Depression is common.
- Depression is a medical condition
- Depression may run in families.
- Depression may occur when there are major life changes, serious disagreements with others, death of a loved one or when life is lonely
- Depression makes usual work and family life difficult.
- Depression is treatable.

2.6b. Detailed process

The strategies used in IPT occur in three phases of treatment:

- Initial
- Middle phase
- Termination phase

Each of these phases is described below.

Who would require IPT in the Manas program?

Patients with moderate or severe Depression who do not improve or worsen despite receiving adequate treatment with ADT, are offered IPT in addition to ADT as a step 3 treatment.

Introduction to IPT

Most of the initial phase of IPT has been incorporated into the psychoeducation sessions. For example, session 1 of psychoeducation includes giving the patient the sick role and giving hope. Session 2 of psychoeducation includes identifying the most likely problem area and instituting basic coping skills based on this. Most patients with Depression will improve with these measures. Some patients who receive step 1 (psychoeducation) and step 2 (antidepressant) treatment may not improve or may, in fact, worsen. In such circumstances, it is necessary to move to step 3 which is the addition of IPT to ongoing treatment with antidepressants. For these patients, IPT is introduced as follows:

“As I told you previously that there is going to be another treatment to help you manage your problem. For this treatment you will be required to come to the clinic to meet me for 6 sessions over 2-3 months or longer depending on your improvement. Each session will be for approximately 45 minutes each. This treatment will help you deal with the issues that are related to your tension, we will talk about the problems that are causing you stress in greater detail and see how you can cope better.”

For patients who ask if it is necessary- the HC needs to emphasize that it is for their benefit and because their response to ADT has been inadequate. The HC can inform the patient that it is a free treatment; they do not have to pay. You may need to emphasize that many patients have shown improvement with this form of 'talking treatment', but this is not essential. Refusal to consent to the treatment will NOT interfere with any other form of help/treatment they receive from the clinic. Also allow them to think about it and revert at ANY stage if they change their mind.

IF AT THIS POINT THE PATIENT AGREES TO ACCEPT IPT, FOLLOW THE STEPS GIVEN BELOW

Initial Phase (Session 1-2)

Tasks

- A. Start and end this and each subsequent session on time. Session should last about 45 minutes.
- B. Welcome the patient.
- C. Repeat how sessions work, emphasizing confidentiality, regular attendance; dropping out ("if you feel that you would like to stop coming, it's important to come and discuss this, maybe we can find what the problem is and deal with it")
- D. Review stress symptoms.
- E. Rate stress symptoms using the "mood ladder"
- F. Give hope. These patients will probably feel especially hopeless since their treatment with ADT has not worked. Tell the patients that *"Not every treatment works for everybody. It takes time and the right treatment. We are not going to try a new treatment that has been shown to help a lot of people who have stress related illness. It is called Interpersonal Psychotherapy (you may call this "a counseling treatment" in the local language), and it has been used around the world to help people who have similar problems to those that you have. We are going to spend time today looking at the situations in your life that trigger and keep your stress going. We want to spend time today looking at the people in your life that are connected to your stress and who are affected by it."*
- G. Conduct the Interpersonal (IP) Inventory the tasks of which include:
 - 1. Get a better insight into the triggers of the patient's stress.
 - 2. Remember to have the patient describe when he first noticed the symptoms and see if you can determine with him what was happening or not happening in his life at that time.
 - 3. Get a better sense of the intervening triggers and current interpersonal stressors--what sustains the patient's stress.
 - 4. Since you already know the patient, you probably have some hypothesis about the relevant problem area(s). When conducting the inventory,

remember to ask only about the important people in the patient's life that are associated with the already identified stressors. For example you might start the inventory in this way: *"I am want to spend some time today understanding a little further how some of the important people in your life may be contributing to your stress related illness. Let's start with....."*(Fill in the name of the person you know from the patient's life who seems to be at the center of the stress.) Remember to keep the focus of the Interpersonal Inventory on the problem area that you've already identified. This should not be a time for the patient to ramble. Keep a tight focus. Begin by explaining to the patient: *"In order to help you deal with your stress further, I need to understand about the relationships in your life that may be contributing to your stress."*

Ask questions such as (These are only suggestions. You don't need to ask all of these. Choose those which seem relevant. Add questions that you think are important.):

- a. *Do you have any problems with*?
- b. *Has anything changed in your relationship with? When did this happen?*
- c. *What would you like to change about this relationship?*
- d. *How often do you see*?
- e. *What do you like about*?
- f. *How often do you argue with? Describe a typical argument.*
- g. *How do you get along with friends? Do you have friendships from long ago?*
- h. *Has anyone important to you died? When? How has this affected your depression?*

Note: the IP inventory is also useful to identify supportive figures in the patient's life

H. Identify major problem area(s). The therapist outlines his understanding of the patient's interpersonal problem. This is called the Interpersonal Formulation. An example of such a formulation is: *"Based on what you have told me, it seems that your health problems are related to what has been going on in your life, in particular, the grief you are experiencing following the death of your mother. What I suggest is that over the next few weeks we focus on this problem and identify ways you can cope with it better. As we do this, you will find your health problems improving".* Or *"Your health problems seem to be related to the stress you are experiencing due to the frequent quarrels with your husband over your wanting to find a job. We will, over the next few weeks, discuss how you can deal with this better so that the situation improves and you feel better."* Thus based on the information gathered, the therapist determines the problem area(s) related to the current stress and chooses 1 - 2 of the following:

Grief
Interpersonal Disputes
Role Transition
Interpersonal Deficits

- I. Get agreement from patient that this is the problem area(s) that he/she believes is causing stress and that he/she would like to change.
- J. Find out how the patient would like the situation to be different.
- K. If patient disagrees with the chosen problem area –does not think that this is the important issue- focus on the one he chooses and during the middle phase, try to link it to the one you have in mind, if possible. For example, if a patient developed depression after the death of her aunt who was like a parent to her, but chose to work on her problematic relationship with her boyfriend (dispute), you can agree to this in the initial sessions. During the middle phase, you can say things like “*how does it feel not to have your aunt around during this difficult time*”? This may be effective in getting the patient to focus on the grief she is experiencing.

Middle Phase (Sessions 2-5)

Tasks for every session

- A. Start and end sessions on time.
- B. Welcome the patient.
- C. Check patient’s stress by using the “mood ladder”
- D. Link stress to events from previous week and events from previous week to stress. For example, if patient says “I had a lot of headaches and stress during the week”, find out what happened in the interpersonal events linked to his problem area. If patient says “I had a lot of fights with my mother in law” find out how this affected his stress symptoms before exploring what happened.
- E. Focus on identified problem area(s).
- F. Encourage patient to practice outside the office some of the skills that have been learned in sessions.
- G. Continue educating about symptoms of stress.
- H. Continue making links, and encourage patient to make links between stress symptoms and what is or not happening in the patient’s life.
- I. Remind patient about how many sessions remain

Tasks for each problem area:

Grief—loss of an important person in the patient’s life

Example: A 55year old woman whose husband died suddenly of a stroke was unable to mourn his death substantially as she was inundated with the responsibility of providing for their 3 children and running the family business.

One year later she presents with loss of sleep and appetite, irritability and disinterest in work suggesting Depression.

Goals:

1. Facilitate the mourning process.
2. Help the patient reestablish interest and develop new relationships to help manage the loss of the deceased.

Strategies—What to do in sessions:

1. Review stress symptoms.
2. Relate the beginning of symptoms to the death of a person important to the patient (worsening of symptoms at anniversaries).
3. Encourage patient to talk and express his sadness about the loss.
4. Describe the events just prior to, during, and after the death. Talk about the death scene.
5. Discuss the patient's relationship with the deceased (reconstruct the relationship).
6. Discuss the patient's positive and negative feelings about the deceased (*"Every relationship has rough times. What was your rough time"?*)
7. Discuss how the future feels without the deceased, including the unrealized plans and the change in patient's social/family status after the death).
8. Encourage relationships old and new and encourage the development of interests.

Interpersonal Disputes—ongoing disagreements

Example: a women presents with depression, the onset of which coincides with her discovering her husband's extra marital relationship. This has led to frequent, bitter quarrels over several months between her and her husband. She feels overwhelmed and does not know how to handle this situation.

Goals:

1. Identify the dispute, including the stage of the dispute---renegotiation, impasse, dissolution (see below).
2. Choose a plan of action.
3. Modify expectations or faulty communication so that the difference of opinion is resolved.

Strategies—What to do in sessions:

1. Review stress symptoms.
2. Relate symptom onset to the interpersonal dispute.

3. Identify stage of dispute:
 - a. Renegotiation: A renegotiation exists when the parties are in active contact about their differences as in the example above. If the dispute is in the renegotiation stage, plan on helping patient develop better communication skills.
 - b. Impasse: An impasse exists when discussions have stopped about the disputed issue, both parties want to continue the relationship but feel hopeless and stuck. If the dispute is in the impasse stage, review with patient what he has already tried to resolve the dispute, and try to help him with other approaches. Get him talking and experimenting.
 - c. Dissolution: When one or both parties want to end the relationship, assist mourning and help person to move on. Make sure that this is not really an impasse: ask the person if she is willing to try one last time.
4. Encourage patient to talk about his/her feelings.
5. Help the patient understand the dispute as a difference in expectations of the people involved.
6. Help the patient understand his/her expectations.
7. Help the patient understand, but not necessarily accept, the other's expectations.

TECHNIQUE USED: COMMUNICATION ANALYSIS* (Have the patient describe what happened as if he/she had a video camera; focus on a specific incident; also have him/her describe thoughts and feelings).

8. Find out what the patient wants and choose a plan of action.

TECHNIQUE USED: DECISION ANALYSIS* (With patients who have trouble finding options, start by making suggestions, then ask the patient to think of some)

9. Help the patient change communication patterns to improve the situation.

TECHNIQUE USED: ROLE-PLAY *(Rehearse what the patient plans to communicate. Switch roles so that the patient has the opportunity to play him/herself and the other person in the dispute. The therapist should not make the role-play too easy. It should be a realistic example of what may happen in real life.)

10. Help the patient develop improved communication
 - a. Find a good time to talk when the other person will be receptive to the conversation (strike while the iron is cold!!!).
 - b. Focus on the current dispute (don't talk about all the mistakes the other person made in the past).
 - c. Separate the person from his behavior ("you hurt my feelings" leads to more constructive discussion than "you are horrible and disrespectful").
 - d. Acknowledge the other party's expectations ("I know you feel like I am not paying attention to you").
 - e. Use "I" statements about how you feel and what you want.
 - f. Avoid using words such as "always" and "never."
 - g. Find advocates to help if you cannot directly communicate with the other party.

*Techniques are discussed in detail below.

Role Transitions—life changes

Example: a middle aged man sustained a hip fracture following a road traffic accident. Since then, he walks with a limp and has frequent radiating pain down one leg. This has led to his having to stop working (he was a farm labourer), frequent visits to the doctor and increasing dependence on his wife and sons. His depressive symptoms coincide with these life changes.

Goals:

1. Mourn the loss of the old role.
2. See the positive aspects of the new role.
3. Develop any new skills necessary to gain mastery of the new role.

Strategies--What to do in sessions:

1. Review stress symptoms
2. Relate stress symptoms to difficulty in coping with new life situation.
3. Discuss positive and negative aspects of the old role. Patients may exaggerate the positive aspects of the old role and minimize the unpleasant aspects. It is important to draw their attention to both.
4. Mourn the loss of the old role – express guilt, anger, fears at the loss
5. Discuss the positive and negative aspects of the new role.
6. Explore opportunities in the new role.
7. If no positive aspects exist help the patient determine what is within his/her control. Even in the most negative circumstances, patients will be able to identify something that they can do to feel better, for example, learning to make the most of their time when faced with a serious medical illness
8. Encourage the patient to talk about feelings.
9. Help the patient develop new skills that he/she will need in the new role. For example, it may mean helping the patient to manage the transition effectively by finding a new job, finding a new home, meeting new people, etc.
10. Help the person find advocates/supportive figures to help him manage the new role. In the example above, the patient can be helped to identify a reliable doctor who can provide advice about pain relief and guide the patient about further treatment

Interpersonal Deficits—loneliness and social isolation

Example: A 35 year old depressed man lives alone, has very few friends and would like to get married. He is unable to make friends with women as he feels

socially awkward and does not know how to sustain a conversation with them. He has low self esteem and believes that women find him uninteresting.

Goals:

1. Reduce the patient's social isolation.
2. Encourage the patient to form new relationships and to look for new opportunities for socialization.

Strategies-- What to do in sessions:

1. Review stress symptoms.
2. Relate stress symptoms to isolation.
3. Explore current social interactions by asking about family and friends. For example, *"how often do you see them?" "what do you enjoy about seeing them?"*
4. Find out the problems in the social interactions. Does the patient have trouble starting and/or maintaining relationships? *"what are the problems that come up in your interactions with....?"*
5. Use extensive role-play and feedback.
6. Encourage social interaction outside the therapy, and have the patient talk during the sessions about how the experiments from the previous week went. *"This is a good time to try and work on your relationships. We can talk about what goes right or wrong when we meet for our next session".* If the patient contacted an old friend and arranged to see that person, you can ask: *"describe how it went. How did you feel? What did you say?"*

Each such description provides an opportunity for you to reinforce the positive steps the patient has taken , provide encouragement and use role play for interactions that have not gone well.

Remember: Regardless of the problem area, complete the middle phase tasks for every session.

TERMINATION PHASE (Session 6)

Tasks

- A. Termination is explicitly discussed through out the therapy.
- B. Welcome the patient and remind him/her that there are two sessions remaining after this one.
- C. Check on the patients' stress symptoms.
- D. Review changes in the symptoms and interpersonal problem area(s).
- E. Explore the patient's feelings about termination—fear, excitement, pride, sadness.
- F. Discuss possible sources of problems in the future, and skills the patient might use to prevent stress based on what she has learnt in her sessions with you.

G. Ask the patient to describe how he/she would know that the stress is coming back, i.e. what symptoms will he/she notice.

H. Make an action plan (for e.g. when to contact the doctor or HC In the future)

I. Deal with non-response or partial response, and discuss possibility of continuation or maintenance treatment.

Some patients who have long standing interpersonal problems and lingering symptoms, may need additional booster sessions to reinforce the skills learnt during therapy. These sessions are spaced at intervals of one month and the tasks are the same as that of middle phase sessions described above. These sessions are continued until necessary with discussion with your supervisor.

Treatment Techniques Used in the Middle Phase of IPT

Communication analysis

Goals:

1. Help the patient understand the feelings he/she conveys with verbal and nonverbal communications.
2. Help the patient understand the impact of these communications on others.
3. Help the patient understand the impact of others' communications on him/her.
4. Help the patient understand that he/she has the ability to change these interactions and that as a result experience a change in his/her feelings associated with the relationship.

Guidelines:

1. Identify an interpersonal communication to examine in detail (*"let's talk about the worst fight of the week"*, *"tell me how was the visit to your sister's house"*)
2. Encourage the patient to explain what was said in the communication. Ask questions such as: *What did you say? What did she say? How did it make you feel? Is that the message you wanted to send? What else could you have said? How could you have said it differently? How did you feel when she said ___ back to you? What do you think she meant?*
3. Illustrate the cyclical nature of the communication.

Decision analysis (finding options)

Following exploration of the situation through communication analysis, action is encouraged: *"What are you going to do about the situation?"*

1. Select an interpersonal situation that is causing a problem.
2. Encourage the patient to generate possible solutions to the conflict. Brain storm, don't evaluate any of the ideas yet.
3. Evaluate the pros and cons of each solution.
4. Select one solution or a combination of a number of them to try first.
5. Rehearse the interaction for the first solution.

6. Encourage the patient to try the solution out of the office during the week. Remember to reinforce that this is an experiment and that it may or not work, but that it is important to come back the next week to discuss the outcome.
7. Start with smaller problems first to help patient build confidence.
8. Review the interaction the following week examining either its success or where it didn't work and possible reasons why.

Role-play

Goals:

1. To give the patient a SAFE place to practice new interpersonal skills (e.g. expression of affect)
2. To give the patient the opportunity for rehearsal and to receive feedback on skills and strategies prior to trying to apply them outside the therapy.
3. To improve the persons social confidence.

Guidelines:

1. Role-playing is an active technique (act it out).
2. Be prepared to initially gently push some patients to do it. They may feel self-conscious.
3. Do not make the role-play too easy (remember that in reality the other person may be rough or confrontational).
4. You have the option to play the patient role first so that the patient gives you a flavor for how the other person really is. You can also start by being the other person, it's up to you and the patient. You can then switch roles.
5. At the end of the role-play, ask the patient how he/she felt was she comfortable with any part of the role-play, does he/she feel ready to try this at home.
6. For anxious patients—lead them to it gently.
7. Talk through the role-play first.
8. Structure it for them.

Work at home

Remind the patient frequently about termination, but not every week: *"We have X more meeting until we end."* This encourages the therapist and patient to keep the momentum going.

1. Explain to the patient that he/she will be experimenting with new skills from what has developed from communication analysis, decision analysis, and role-play.
2. Work at home is developed as a result of work within a particular problem area.
3. Work at home is tailored to the individual patient and is not strictly prescribed.

Maintaining clinical records: HC will keep records in the prescribed form below for each session.

**Individual IPT clinical record
Individual Sessions**

Patient Name _____ Patient ID: _____

Session no ____ Date: _____ Health Counsellor : _____

Symptoms: (Tick ones applicable)

symptoms	tick	Improved	same	Worst
Sleep problems				
Aches and pains/ worry about physical health				
Poor concentration/ Memory				
Fatigue/ lack of interest				
Panic attacks/ Phobias				
Suicidal ideas				

List Problem area(s) identified;

Interpersonal inventory:
(notes on relationships)

Goals

Brief description on what was covered during session

Plan for next session:

Chapter 2.7

ADHERENCE MANAGEMENT

2.7a Introduction

Chronic diseases, whether infectious (such as HIV/AIDS) or non-infectious (such as Depression) in origin, need long-term treatments to get the best outcomes. This applies both to medicines that need to be taken on a daily basis, even when there are no obvious symptoms, as well as specific lifestyle changes that the patient needs to commit to and continue with. For example, the treatment of heart diseases involves regular exercise, stopping smoking and excessive alcohol use, modifications of diet to decrease fat and salt intake as well as medicines that need to be taken 2-3 times per day. In chronic infectious diseases like HIV/AIDS, it is similarly vital that patients take a complex treatment regime at least 95% of the time for the rest of their lives, along with substantial lifestyle and sexual behavior changes to achieve the best effects of the treatments. As discussed earlier, Depression is often a chronic disease and the treatments that produce the greatest benefits (antidepressants, lifestyle changes, IPT) need to be continued for a certain period of time (like 6 months of treatment with antidepressant) for the patient to recover and maintain their improvement.

While there are effective treatments available for most chronic diseases, **the single, greatest challenge facing health providers worldwide is to get patients to continue with their recommended treatments for the required periods of time.** If you consider that taking treatment is a challenge even when it needs to be taken only for a few days, (like antibiotics for chest infections) where many patients start to miss the doses of medicines once the acute symptoms start to improve, then you can imagine how great a challenge this is for chronic diseases. It is obvious that even the best interventions will be of limited benefit if the patient is not following through with the necessary requirements and is, in technical terms, non-adherent with treatments.

This chapter includes the following:

- How do we define adherence?
- The extent and health consequences of nonadherence
- Understanding the reasons that influence adherence
- General principles of improving adherence in chronic diseases
- Adherence management strategies in the Manas program
- Summary table

2.7b How do we define adherence?

Adherence can be understood as ‘the act or quality of sticking (adhering) to something’. Adherence is an aspect of treatment which can be defined as a

patient's ability to follow a treatment plan, take medications at prescribed times and frequencies, and sustain positive lifestyle changes.

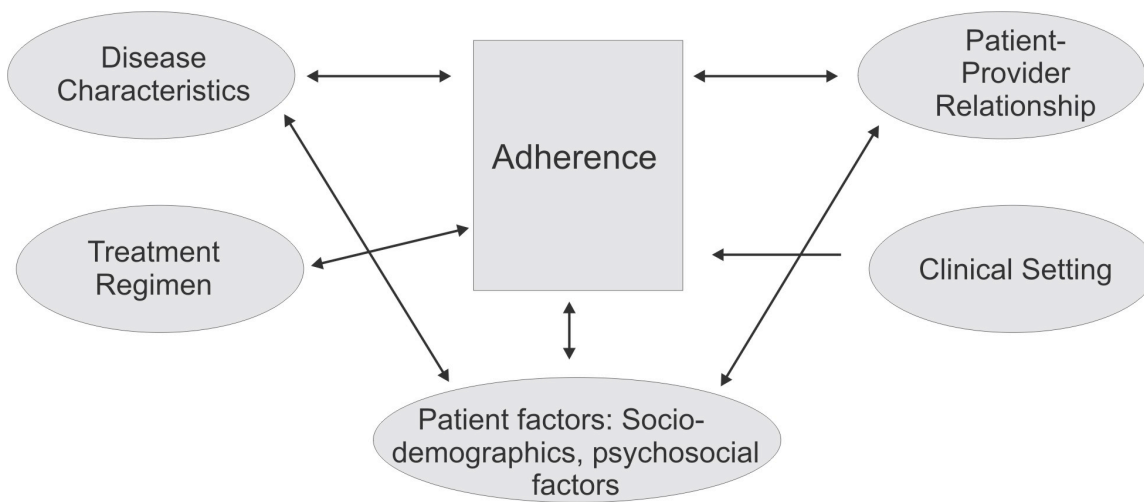
2.7c The extent and health consequences of non- adherence

As we noted earlier, the problem of non adherence is a huge public health problem globally and is of particular relevance in countries like India where resources for healthcare are limited. Non adherence with treatments can cause a relapse of the original illness, can contribute to the emergence of drug resistance making subsequent treatments more difficult, and place a high health and economic cost (loss of productivity due to continued sickness) on the individual and society. In the case of Depression, we know that this is one of the disorders where patients are most likely to drop out of treatment with a reduced chance of recovery, greater chance of relapse of symptoms, failure to attend to work and increased risk of suicide. In a previous study done in Goa, though antidepressants produced significant clinical benefits in the first couple of months, the effects of treatment were lost at 12 months because most patients had discontinued their medications. During Phase 1 of MANAS, only about 30% of patients prescribed antidepressants were adherent with the medicine and very few completed the suggested number of IPT sessions.

2.7d Understanding the reasons that influence adherence

There are a number of factors that influence adherence and are represented in the figure below:

Figure 4. The interaction of factors that influence adherence



Patient factors:

Patient factors which may influence adherence are socio-demographic factors such as gender, ethnicity, age, employment, income, education and literacy. In general, socio-demographic factors do not seem to influence adherence too much, although some studies have found that male sex, older age, higher income levels, higher education and literacy correlate with better adherence.

On the other hand, a number of psychosocial factors have been found to strongly influence adherence. It is important to identify these factors since most of them are modifiable. These factors include:

- Having good social supports like an understanding family who encourage the patient to adhere with treatment recommendations.
- A patient's knowledge and understanding of her medication regimen and a good understanding of the relationship between non-adherence and poor outcomes
- A patient's belief and confidence in treatments being provided and her self-efficacy (confidence in oneself to be able to adhere) also influence adherence.
- Finally, adherence is better in situations where the patient and the health provider's understanding of the illness match reasonably well.

Treatment related factors:

In chronic diseases, frequently the treatment regimen involves use of multiple drugs several times a day. For example, in the treatment of Depression, sometimes doctors can prescribe many pills per day which need to be taken at different times in a day. These are often difficult to follow for patients and contribute to poor adherence. In general, the more complex the treatment requirements become, the lower is the adherence.

Another very important reason for non adherence is the experience of side effects of the treatment. For example, in the treatment of Depression, antidepressant medications may have unpleasant immediate and longer term side effects. It is obvious that if patients experience these side effects, they tend to stop treatment or take it irregularly; in both scenarios, the outcomes are poor. However, patient education about side-effects and how to manage them often helps overcome this challenge.

The patient –health care provider relationship:

As you might expect, the quality of the patient and health care provider (the FP and HC in MANAS) relationship plays an important role in determining adherence. Trust and confidence in care providers has been found to influence adherence positively in all settings. The importance of a positive therapeutic relationship cannot be exaggerated as this is possibly the single most important factor that predicts long term adherence.

Disease characteristics:

Sometimes the disease itself can be a risk factor for non adherence. In the context of the MANAS program, it is very important to remember that Depression itself is a commonly observed reason that predicts poor adherence. In particular, experiencing symptoms like lack of motivation, helplessness and hopelessness can reduce the motivation of the patient to continue with treatments. Also, the poor concentration and memory problems that many depressed patients experience can lead to forgetting to take medicines or keep appointments to see the counselor. Similarly, ongoing use of alcohol and drugs generally predict poor adherence to treatments for reasons that are obvious.

Clinical setting related factors:

It is important to remember that the setting in which treatments are being delivered are important in determining adherence. For example, if patients go to the treatment facility and feel that the staff is rude or uncaring, it is more likely that they would not return for continuing their treatment. On the other hand, sympathetic staff, provision of basic physical amenities like clean toilets, drinking water and privacy during physical examinations or counseling sessions, provides incentives for the patient to follow through on a regular basis.

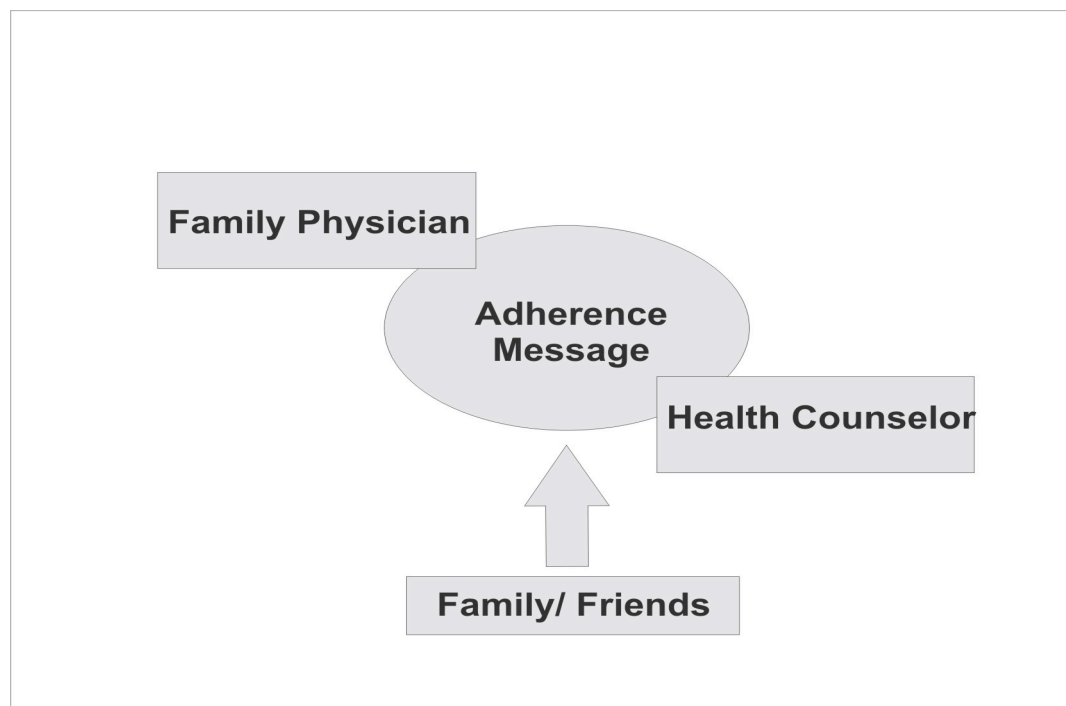
Another factor that can influence adherence is the assured availability of the treatment and staff. For example, if patients attend the health centre to find that the doctor or their medicines are not regularly available, they are likely to stop treatment.

Finally, if treatment facilities are easily accessible (i.e. patients do not have to travel long distances to reach them), then this is strongly associated with better adherence.

2.7e What are the general principles of improving adherence in chronic diseases?

Figure 5 below provides an understanding of the methods that can be employed in health programs to improve the adherence of patients to their treatments.

Figure 5: The multiple players involved in improving adherence



There is no single method of improving adherence in MANAS. Methods like patient education, reminders or incentives when provided in isolation do not have a lasting impact on adherence rates in any chronic disease treatment program. The most important message is that a number of interventions which address the problem of non adherence at multiple levels are most likely to be successful. The general principles of a good adherence management program are broadly based on the following principles which then need to be applied at multiple levels of the program in question:

- Providing **accessible care**; in MANAS, if patients live very far from the clinic, they are likely not to return. Telephone consultations may be the best way to continue counseling treatments.
- Ensuring that the care provided is **equitable** i.e. does not systematically exclude any part of the population (for e.g. migrant workers).
- Treatments are **simple** and **acceptable** i.e. patients feel that the treatments are easy to follow and meet their expectations.
- The treatment is **affordable**; in MANAS, the additional psychosocial interventions provided in the FPC by the MANAS team do not cost the patient any additional amount. As happens in real life, patients must pay for the cost of the antidepressant and any other medicines that the FP prescribes, the travel cost, and take time off work, to return to the clinic regularly to receive treatment. This is also a cost of treatment. We address the first issue by recommending the use of cheap antidepressants and the second one by coordinating follow-up sessions with the patient's convenience (for e.g. when

he has an appointment to see the doctor, or is coming to the area of the clinic for some other reason)

- Finally, the treatments that are being provided need to be based on good scientific evidence i.e. are **effective**. We use the stepped care model to deliver a **range of treatments that match the different needs of the patient**.

2.7f The adherence management strategies of the MANAS program

The MANAS program has already been conducted in some Primary Health Centres in Goa. During this time, it has become very clear that treatments for Depression can be delivered best only if the challenge of non-adherence is dealt with systematically. We have made an intensive effort to understand the possible reasons as to why patients do not follow through with treatment recommendations and modified the delivery of the program accordingly.

Some of the major problems with adherence and their potential solutions are detailed below:

- **Lack of information in the FPCs about the program:** It is important that everybody who is part of the FPC is able to provide information about the program being available in the clinic. For this phase of MANAS, it is especially important that the clinic assistants are co-opted and briefed about the program and the role that they are expected to play.
- **Patients are working as daily wage earners and do not have the time to come back to meet with the HC:** In the PHCs one of the most common reason for patients not coming back for scheduled follow up visits was that they were engaged in daily wage jobs and could not afford to miss work. Thus it is very important to find out about the employment status of the patient during the first visit so that you can judge whether the patient is likely to have difficulties in coming to the clinic. Then, the HC would need to explain to the patient that she is available for consultation in the afternoon as well and that the patient can drop in at a convenient time later in the day before the FPC closes or come in on Saturday mornings. Plan follow-up sessions with the patient's convenience (for e.g. when he has an appointment to see the doctor, or is coming to the area of the clinic for some other reason). If telephones are available, then this is another way in which counseling treatments can be provided. Home visits may be used very rarely for selected patients who have unique risks after consultation with the CS.
- **Patients forget about the date when they are supposed to come back for the next appointment:** Though the HC writes down the date for the follow up visit, only a small number of patients actually meet the HC on the designated date. The majority of patients come back a week or even later for the appointment. In addition, when we asked patients who had dropped out the reasons for not coming back, some of them mentioned that they felt

uncomfortable about going back after having missed the date. The HC should clearly say to the patient that although a date may be suggested for the follow-up, if for some reason they cannot make it on that date, they are still welcome to drop in for the appointment on some other date that is convenient for them.

- **The Family Physicians sometimes forget to remind patients that regular treatments over a period of time is essential for their recovery:** Doctors have a very important role in motivating patients to come back for follow up appointments and both the HC and the CS who will interact with the doctors in the clinic should regularly remind them about their role in ensuring adherence. Also, doctors are encouraged to use once a day dosing regimens which are more convenient than multiple daily doses.
- **Patients drop out of treatment when they start feeling better:** During the initial psychoeducation session, the HC should clearly explain the chronic and recurring nature of Depression and the importance of following through with treatments even after the patient starts feeling better for the best results. It is important to say that if the patient does not complete the 'course', they will relapse. You may give an example that the patients understand, for e.g. the example of malaria-although the course of tablets may be for a week, most patients find that their fever recovers in just two days. However, if the patient stops the course at that time, the malarial fever will come back, and it may no longer respond to the same treatment again.
- **Patients are uncomfortable about some of the psychoeducation techniques for the management of Depression:** Some patients reported feeling uncomfortable with the breathing techniques in particular during the psychoeducation sessions as it increased their anxiety. HCs should always ask patients specifically about their comfort level during this exercise. If patients feel uncomfortable, ask them to try the exercise with their eyes open or slow the breathing rate. If patients do not want to carry out this technique, tell them that this is perfectly all right and proceed with the rest of the session.
- **Patients do not feel they have a 'mental health problem':** Some patients deny that they have any 'mental health' problem and will insist that their problems are related to physical health problems like lack of sleep or tiredness. In MANAS, we have anticipated this situation and we avoid using the term 'mental' under all circumstances while explaining the nature of the problem to patients. Instead, as we have learned, it is best to use the term 'stress or tension related' when explaining the nature of the problem to patients as this is something that patients identify with easily and do not feel a sense of personal stigma about.
- **Patients have important social problems that maintain the Depression:** The HC would need to explore if there are social reasons (poverty, domestic

violence etc) for the Depression during the health education session by using a checklist (see Appendix 4.2). If any social problem is identified, she would need to consider possible solutions collaboratively with the patient. The resource list of agencies that can provide services for people in need of social assistance is provided to facilitate referrals. It is preferable that the HC writes a small note to the agency or make a telephone call and introduce the patient to a particular person in the agency. Showing concern for social difficulties can enhance trust in the HC and improve adherence.

- **Patients were not reminded about meeting with the HC after having missed their planned appointment:** HCs need to follow the protocol for the necessary actions once the patient has missed her scheduled appointment (see below). Generally, sending reminder letters and telephone calls to enquire how they were feeling and to reschedule the appointment at a time that was mutually convenient are useful strategies to remind the patient to come back for necessary follow up sessions.

To ensure that possible risk factors that can compromise adherence are identified in the initial session, HCs will be required to complete the checklist for adherence risk (Appendix 4.2). This will summarize the risk factors for the individual patient and will help guide specific strategies to minimize the risk factors to the extent possible.

2.7g Summary table of adherence management in the MANAS program:

The table below incorporates the roles that each member of the intervention team has in improving the adherence of patients with Depression who present to the FPC. It also details the important practices which have been found to be useful during the course of the program and is intended as a guide for HCs to follow during their work. This list is a guideline and each practice will have its own problems and local solutions that HC’s need to be aware of in improving rates of adherence.

Table 1. Adherence management arrangements for the MANAS program

1. Human resource management

Contact Person	Inputs Provided	Expected Outcomes
A. Clinic Assistant (Point of first contact for patients in FPC)	<ul style="list-style-type: none"> • Health Assistant to meet regularly prior to starting registration and orient to the necessity of screening after registration. • Clinic Assistant and Health Assistant have established system to ensure all registered clients are referred and screened for Depression, whenever appropriate. 	Minimizing (<5% of registered clients) loss of potential subjects due to non – detection
B. Health	<ul style="list-style-type: none"> • Meet Clinic Assistant prior to starting work 	<ul style="list-style-type: none"> • Improve adequacy

Assistant	<p>and meet briefly after registration closes to ensure any problems that have arisen are solved.</p> <ul style="list-style-type: none"> • Screen clients using GHQ using empathic questioning style. • For clients who screen positive, remind them to meet the HC after seeing the doctor before leaving the FPC. 	<p>of screening.</p> <ul style="list-style-type: none"> • Reduce dropouts between screening and meeting HC.
C. Family Physician	<ul style="list-style-type: none"> • Educate client briefly about nature of problems emphasizing stress as causal. • Encourage clients to meet HC after consultation. • Emphasize need for regular follow-up, depending on the treatment, for best outcomes. • If prescribing antidepressants, explain need for continuation and brief advice re: side effect profile • Meet HC and CS to discuss any ideas re: improving follow up rates 	<ul style="list-style-type: none"> • Improve number of persons attending HC appointment • Improve adherence with overall treatment package
D. Health Counselor	<ul style="list-style-type: none"> • Important message of psycho education being need for adherence for optimum benefits • Complete adherence checklist in initial session and plan solutions appropriately. • Flexible follow-up dates and timings negotiated with patient to maximize chances of follow-up • Follow-up dates whenever possible, to match with doctor's appointment for the convenience of patient • Meet the FP regularly to provide feedback about patients, especially those who have missed appointment. At monthly intervals, it may be a good idea to provide a list of those who have missed follow up to the Clinic Assistant and the FP so that they can actively refer those patients to the HC. • Adhering closely to the protocol for contacting patients who have not attended scheduled meetings. • Provide mobile phone number to patients who can contact for new appointments, if necessary. • Ensure that the postal address and other crucial contact details in the Intervention 	<ul style="list-style-type: none"> • Patient understands nature of problems and need to adhere to suggested treatments for best outcomes • Integrate adherence management as a key component of the overall intervention at every level and opportunity.

	<p>Record Card are filled out completely.</p> <ul style="list-style-type: none"> • Record contact telephone number whenever possible; also clarify if the telephone is in the home or if patient has to be called to a different location. • Brief contact and basic counseling on the phone whenever possible. • Record all steps taken to improve adherence in the process indicator document • Discuss new strategies for improving adherence with CS and other HCs during supervision meetings • For patients who come for yoga sessions, take the opportunity to carry out brief counseling and reminding about antidepressants • Be familiar with all the other treatments and physical health problems the patient is suffering from-this will help the patient feel that the HC is concerned about all health aspects • Be sensitive to patient's social problems-listening to these problems, advising patients about what to do and writing referral letters to relevant community agencies and following this up will help improve the HCs credibility • Monitor the use of antidepressants closely-this is a key treatment for patients with more serious problems who are on Step 2 treatment. It is very important that these patients with the more serious problems are given more than usual inputs to continue with treatments. 	
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2. Environmental and procedural interventions

1. HC should make concerted efforts in the 'running in' period to interact with the FP and Clinic Assistant and establish an excellent rapport with them. For all practical purposes, you are a member of the FPC with a clear line of accountability to the FP.

2. Make sure you update your community resources directory to include all local agencies in the area. Once you have this information, it is useful to contact them and introduce yourself, explain your role in the clinic and that you might be making referrals to the agency, if the need arises.
3. Make sure you have a good idea of the socio demographic profile of patients who come to the clinic in discussion with the FP and the Health Assistant. This information can be very helpful in improving the acceptability of the intervention in that clinic.
4. Ensuring minimum standards of space allocation and privacy are met prior to starting intervention; the ideal location for the Health Assistant would be in close proximity to the Clinic Assistant and for the HC in close proximity to doctor's consulting room.
5. The CS will ensure that there is adequate training of doctors, and then during ongoing supervision, will focus on the appropriate use of adherence management strategies in the clinic.
6. Improving the knowledge of the availability of the program for all patients who attend the clinic through well located posters and other creative methods that can be implemented in the clinic.
7. Enhancing visibility of boards, signs and room where HC can be met.
8. Handouts for patients that emphasize need for adherence to be given to all patients during the first psychoeducation session; also ensure that your contact phone number is made available in the handout.
9. Yoga programs with staff of facilities, patients and general community to improve program visibility and reduce any stigma about consultation with the HC; these can also be a forum to encourage patients to attend subsequent sessions.

Protocol for HCs for patients who have missed scheduled appointment:

For patients on Step 1

1. Wait for 1 week after the scheduled date of follow up for the patient on Step 1 to return for appointment.
2. Contact patient through phone whenever possible and ask her to return for the new appointment on a convenient date.
3. If no phone is available, send a reminder letter after one week asking the patient to attend on a new date and timings.
4. If no response to the first reminder letter in the next 3 weeks, send second reminder letter with another date for follow up.
5. If no response to the second reminder letter for the next 12 weeks (3 months), send final letter before instituting discharge procedures as per the discharge protocol.

For patients on Step 2 and above:

1. Send a letter to the patient one week before his scheduled appointment to remind him to visit the clinic. This is important since you want to ensure that the patient does not interrupt his course of ADT.
2. If the patient misses his appointment, wait for 2 days after the patient was scheduled to follow up and if phone number is available, contact immediately and remind the patient to continue with the prescribed treatment and arrange a nearby date for making a visit to the clinic.
3. If there is no convenient phone number, send first reminder letter with a specific mention of the need to continue with the antidepressant and to return for a follow up visit with the FP and the HC.
4. If no response to the reminder letter within the next 6 weeks, send second reminder letter.
5. If no response to the second reminder letter for the next 12 weeks, send final letter before instituting discharge procedures.

Summary points:

- A major challenge in the management of Depression is to ensure that patients adhere to their recommended treatment
- Factors that influence adherence should be understood as they help identify barriers to adherence which then can be overcome by using effective adherence management strategies
- Effective adherence management is based on the principle of providing care that is accessible, equitable, acceptable, affordable and effective
- Then MANAS program has used these principles to formulate an adherence management protocol which you will follow in the clinic to ensure that most patients complete the full course of treatment

CHAPTER 2.8

YOGA FOR DEPRESSION

This chapter is covered under the following sections:

- What is yoga?
- What are the types of yoga?
- Understanding stress-a yogic perspective
- Concept of disease in yoga
- Basis and application of yoga as therapy
- Yoga therapy module for anxiety and depression
- Basic instructions to practice yoga
- Important points for yoga teachers
- Essential requirements for practicing yoga

2.8a What is yoga?

Yoga is an ancient Indian science and a way of life. Yoga is one of the six philosophies of India which is regarded as a secular spiritual discipline. Classically, the word Yoga is derived from the Sanskrit root 'Yuj' which means union. Hence, yoga is considered as the path to unite the individual being with that of the cosmic one. In recent times, the term has been used in the context of union of the mind with the body [soma].

Three classical yoga texts define yoga as:

'Yogah citta vritti nirodhaha', [Patanjali Yoga Sutras]

Yoga is a path to reach a mental state devoid of very strong positive or negative feelings, without sudden flashes of memory, this very difficult to reach state is described as a 'mental state devoid of modifications' which leads to a state of equilibrium and enlightenment.

Considering that a 'no thought state' as a reference state, there are five mental modifications viz., right knowledge [*pramana*], wrong knowledge [*viparyaya*], illusion [*vikalpa*], sleep [*nidra*] and memory [*smriti*].

'Samatvam Yoga Uchayate'....

From yoga one attains equilibrium, balance and harmony within and around.

'Manah prashmana upayaha yogah ityabidiyathe'

Yoga is a skill to calm the mind [the agitated-stressed mind].

Patanjali's Yoga Sutras (circa 900 B.C.)-the most respected yoga text, recommends eight practices to attain the state of equilibrium called '*ashtanga yoga*'. The eight practices are:

- *Yama*-Recommended code of conduct- five personal observances viz., *ahimsa* [non-violence], *satya* [truthfulness], *asthaya* [abstinence from

stealing and misappropriation], *bramacharya* [celibacy] and *aparigraha* [non-possessiveness]

- *Niyama*-Recommended code of conduct- five social observances viz., *soucha* [purity (external & internal)], *santhosa* [contentment], *tapa* [the practice of austerity], *svadyaya* [the self study of spiritual literature] and *iswarapranidana* [living in tune with cosmic consciousness]
- *Asanas*-Physical postures
- *Pranayama*-Voluntarily regulated yoga breathing
- *Prathyhara*- Sensory withdrawal
- *Dharana*-Meditative focusing
- *Dhyana*-Meditative defocussing
- *Samadhi*-Experience of transcendence

2.8b What are the types of yoga?

Classically there are four types of yoga viz., (i) *Jnana yoga*-the path of knowledge, (ii) *Bhakthi yoga*-the path of surrender/devotion, (iii) *Karma yoga*-the path of selfless work and (iv) *Raja yoga*-the path of self control. In the present day context, it is the *raja yoga* which is referred to as yoga.

In recent times, *raja yoga* –the king of yoga - is practiced in a number of styles based on the founding teacher, i.e., the *yoga guru*. These styles emphasize at least one of the three most popular practices of yoga, i.e., *asanas*-physical postures, *pranayamas*-voluntarily regulated yoga breathing and *dhyana*-meditation. Some of the well known styles are:

- Styles which focus on *asanas* or physical postures
 - *Sivananada yoga* – based on the teachings of Swami Sivananda
 - *Iyengar yoga* – based on the teachings of Sri BKS Iyengar
 - Yoga as taught by Swami Dharendra Brahmachari
 - *Vinyasa yoga* – of Sri Patabhi Jois
 - *The yoga* - of Sri Deshikachar
 - *Bikram yoga* – of Bikram Chowdhary
- Styles which focus on *pranayama*-voluntarily regulated yoga breathing
 - *Patanjali yoga – as taught by Swami Ramdev*
 - *Sudarshan Kriya yoga* [SKY] – of Sri Sri Ravishankar, The art of living foundation
- Styles which focus on *dhyana*-meditation
 - Transcendental meditation [TM] – as taught by Maharishi Mahesh Yogi
 - Self realization meditation- of Paramahansa Sri Yogananda
 - *Vipassana meditation* – as taught by Sri Goenka
 - Meditation as taught by Osho

- *Brahmakumari raja yoga meditation* – of Brahmakumari Raja Yoga University
 - Life bliss program of Swami Sukhabodananda
 - *Nityananda yoga* – of Swami Nityananda
- Apart from these specific yoga styles which are practiced as taught by popular yoga gurus there are well established institutions which teaches yoga based on the original teachings of *Patanjali (circa 900 B.C.)*. These schools have evolved yoga programs which gives equal importance to all the eight steps of *Patanjalis yoga sutras viz., (i) Yama*-Recommended code of conduct- five personal observances, (ii) *Niyama*-Recommended code of conduct- five social observances, (iii) *Asanas*-Physical postures, (iv) *Pranayama*-Voluntarily regulated yoga breathing (v) *Prathyhara*-Sensory withdrawal, (vi) *Dharana*-Meditative focusing, (vii) *Dhyana*-Meditative defocusing and (viii) *Samadhi*-Experience of transcendence
These are:
 - Integrated Approach of Yoga Therapy [IAYT] rarely called as *Vivekananda yoga* – of Swami Vivekananda Yoga Research Foundation [a Yoga University], Bengaluru
 - Yoga of Bihar School of Yoga, Munger, Bihar
 - Integral yoga of Sri Aurobindo, Pondicherry
 - Yoga as taught by Swami Kuvalyananda of Kaivalydam, Lonavla

2.8c Understanding stress - a yogic perspective

Yoga texts consider everything that disturbs the inner balance and causes mental distractions as sources of stress. Patanjali's *yoga sutras* describe specific factors that are identified as stress producing factors and *astanga yoga* as its remedy. These are called '*kleshas*' viz.,

- *Avidya* [Ignorance] – lack of knowledge to distinguish mortal & immortal; auspicious & inauspicious and freedom & bondage
- *Asmita* [Strong sense of 'self'] – a sense of glorified self identity and self centered living
- *Raga* [intense liking] – strong affinity, liking and attachment
- *Dvesha* [intense hatred] - strong repulsion, dislike, and hatred, and
- *Abhinivesha* [fear of death] – fear ranging from known phobias to fear of losing self identity and ultimately of death

It is prescribed that one has to resort to practicing yoga [*abhyasa*] and have a holistic outlook of life [*vairagya*] to attain mental stability and equilibrium.

2.8d Concept of disease in yoga

Yoga Vasista one of the comprehensive classical yoga texts classifies disease [*vyadhi*] as (i) *adhija vyadhi* [inherited disease] and (ii) *anadhija vyadhi* [acquired disease]. *Anadhija vyadhi* are those diseases which are caused by infections and trauma. Everything else is regarded as *adhija vyadhi* i.e., inherited. Stress

related/lifestyle related or psychosomatic diseases are classified as inherited. This is in the context of personality, vulnerability and lifestyle. Hence, *Yoga Vasista* recommends yoga as an ancient and potent mind-body intervention to treat *adhija vyadhi*, in the context of stress related diseases, viz., anxiety and depression.

2.8e Basis and application of yoga as therapy

Yoga is an ancient Indian science which includes the practice of loosening exercises (*sithilikarana vyayama*), purifying practices (*shatkriyas*), specific postures (*asanas*), cleansing practices (*kriyas*), voluntarily regulated breathing (*pranayamas*), yoga-based guided relaxation and meditation (*dhyana*). Yoga training has been reported to decrease heart rate and breath rate which are signs of increased arousal in normal volunteers. For example, significant reductions were shown for depression, anger, anxiety, neurotic symptoms and low frequency heart rate variability in 17 patients with depression following training in *Iyengar yoga*.

The classical yoga therapy is an integrated yoga program combining practices intended to act at physical, emotional, intellectual and even at spiritual levels. This yoga program is derived from principles in ancient texts (*Patanjali's Yoga Sutras and the Taittreya Upanisad*) which emphasize that yoga should promote health at all levels. Another ancient Indian text (*the Mandukya Upanisad*) considers the 'body' as three parts namely, the physical part (*sthula sharira*), a subtle or inner part (*sukshma sharira*) and the causal body (*kaarana sarira*). These three parts are represented as five levels of existence (*pancha koshas*).

These are the physical level (*annamaya kosha*), the level of subtle life energy (*pranayama kosha*), the level of emotional thinking (*manomaya kosha*), the level of rational thinking and judgment (*vijnanamaya kosha*) and the level of complete health and happiness (*anandamaya kosha*). In this description the physical level and physical part (of the body) (*sthula sharira*) are the same. The levels of subtle energy, emotional and rational thinking form the 'subtle inner part' (*sukshma sharira*) and the level of complete health and happiness is the causal body (*kaarana sharira*). A balance between these three parts (*shariras*) is believed to be necessary for complete health.

The 'eight limbed yoga' (*astanga yoga*) of Sage *Patanjali* acts at different levels of existence i.e., (i) *yama and niyama [rules for social conduct]* act at the level of rational thinking and judgment; (ii) *asanas* [physical postures] at the physical level; (iii) *pranayama* [voluntarily regulated yoga breathing] at the level of subtle life energy; (iv) *prathyahara and dharana* at the level of emotional and rational thinking (vii) *dhyana and samadhi* at the level of complete health and happiness. This traditional style of yoga has come to be known as an 'Integrated approach of yoga therapy [IAYT]' also popularly referred to as '*Patanjala Yoga or Vivekananda Yoga*'.

2.8f Yoga therapy module for anxiety and depression

The need for the disease-specific yoga module:

With a large number of yoga techniques to choose from it is important to select the most suitable techniques to treat a specific disease. This selection is based on (i) the traditional prescription [based on the described effect of each practice], (ii) research evidence on physiological effects of yoga, and (iii) unpublished clinical observations.

About the Manas yoga therapy module:

Yoga is introduced in three sessions and practiced with a weekly review session. The practices are listed and described separately for each session with illustrations wherever possible. Although a common yoga therapy program is adopted for anxiety and depression, after the completion of the three sessions the yoga instructor would emphasize the importance of focusing on specific techniques separately for anxiety and depression.

A general rule of thumb is that patients with symptoms of anxiety are instructed to focus on slow breathing techniques, relaxing yoga postures, *pranayama*, guided relaxation and meditation. Patients with signs of depression would be asked to focus on repeated rounds of breathing exercises practiced briskly, all *asanas* [physical postures], repeated rounds of a high-frequency breathing *kriya* [cleansing techniques] called *kapalabhathi* & balancing *pranayama* i.e., *nadisudhi pranayama* also popularly known as *anuloma-viloma pranayama* – alternate nostril breathing.

General description of the session and the prescribed techniques:

The yoga sessions should be conducted in small groups with one teacher for a maximum of ten participants. The yoga teacher should have adequate training and experience in dealing with patients suffering from common mental disorders. Typically each session would be for 60 min and this would include: loosening exercises (*shithilikarana vyayama*, 10 min), physical postures (*asanas*, 20 min), voluntarily regulated breathing (*pranayama*, 15 min), and yoga-based guided relaxation (15 min).

Loosening exercises (*Sithilikarana Vyayama*, in Sanskrit) are a set of practices intended to increase mobility of joints and to prepare for the practice of yoga

postures. The techniques involve repetitive movements of all the joints from the toes up to the neck (the detailed list of *sithilikarana vyayama* is given in the 'Manas module' below]. For example, complex joints such as the shoulder could have movements such as rotation, flexion, extension, abduction and adduction.

For the practice of yoga postures (*asanas*) participants were asked to be in a posture as long as they could with comfort and with normal breathing. The following yoga postures will be taught as part of this module: mountain posture (*tadasana*), lateral arc posture (*ardha-kati-chakrasana*), comfortable posture while seated on the floor [*sukhasana*] or half lotus posture (*ardha-padmasana*), cobra posture (*bhujangasana*), crocodile posture (*makarasana*), leg lock posture (*pavanamuktasana*), diamond posture (*vajrasana*), butterfly posture/bound angle posture/cobbler's posture and movement (*badha konasana*) and corpse posture (*shavasana*). These postures are shown in Fig. 1 given below.

While seated with eyes closed keeping the neck and back as straight as possible, voluntarily regulated breathing techniques (*pranayamas*) will be practiced where the nostrils are manipulated by adopting a specific hand gesture (*mudra*) where the index finger and middle fingers will be flexed against the palm keeping the thumb and other fingers extended. This *mudra* is illustrated in the figure 1. The ring and little finger will be used to regulate the breathing through the left nostril while the thumb was similarly used for the right nostril.

The practice of alternate nostril breathing (*nadishudhi* or *anuloma-viloma pranyama*) would begin with exhalation through the left nostril, inhalation through the same side followed by exhalation and then inhalation on the right side. This will be considered as one round and practiced for nine rounds. Bumble bee practice (*brahmari*) involves exhalation with a humming sound with the mouth closed and the index fingers on either side in the ears. This practice will be performed for five rounds.

Guided relaxation involves lying in the corpse posture (*shavasana*) and relaxing parts of the body beginning with the toes and moving upwards according to instructions.

Sessions

The yoga course consists of three sessions – 1 ½ hr. each on consecutive days followed by an open session once a week. Each session consists of: Theory + Practical + Revision + New Techniques.

SESSION 1

This session begins with an introduction to yoga and the theory behind this ancient practice. This is followed by general instructions to participants (see section 2.8g) and then demonstration of the specific yoga techniques. The introduction and theory should include the following points:

- **Symptoms of stress are a result of today's life style**
(Contents may vary for rural / urban areas)
 - A sedentary existence
 - Over eating
 - An unbalanced diet – “Nutritionally deficient” / “junk food”
 - Over - work

Yoga is an age-old Indian science which could be a useful adjunct, a complimentary science to medicines.

- **Principles of Yoga which address these lifestyle issues**
 - Relaxation and movements of all groups of muscles.
 - Full movement of all joints and spine
 - Deep, slow breathing

All of these results in several benefits like:

- Improved circulation of blood throughout the body
 - Better oxygenation of blood.
 - Reduction in joints pains & body aches.
 - Calming down of mind, good sleep.
 - Feeling of well – being and energetic in work and otherwise.
- **Types of yoga – different classifications**
 - **Definition of yoga**

SESSION 1:

Technique	Description
Training single syllable chanting in <i>Tadasana</i>	Single syllable chants which are known to facilitate deep breathing, enhance awareness and induce mental calmness viz., A [pronounced as aa-produces resonance in the abdomen region], U [pronounced as vu-produces resonance in the chest region], M [pronounced as mm-produces resonance in the head region] while in <i>tadasana</i> [is a starting pose for standing series of yoga postures]. These chants are done with eyes closed to enhance internalization of one's awareness.
Breathing techniques [these are preparatory breathing practices to sensitize the practitioner about breathing and movement]	<p>HANDS IN AND OUT BREATHING STARTING POSITION [Sthiti]: Tadasana PRACTICE:</p> <ul style="list-style-type: none"> • Stretch out your arms in front, in level with your shoulders & bring the palms together. While inhaling spread your arms sideways in the horizontal plane. • While exhaling bring the arms forward with palms touching each other. • Repeat five times, making your arm movements continuous, breath flowing in and out rhythmically. Synchronize breathing with arm movements. • Relax in <i>Tadasana</i>. Feel the changes in the breath and the body, especially the arms, shoulders and the back of the neck.
Loosening techniques	<p>PADA SANCALANA [CYCLING [] IN STANDING POSTURE WITH FORWARD-BACKWARD MOVEMENT] STARTING POSITION [Sthiti] in Tadasana. PRACTICE:</p> <ul style="list-style-type: none"> ○ Bring the right leg upwards and forwards and at the same time stretch the foot forward. Then move the leg backwards, now stretching the foot backward. Eventually making a circular movement as done while cycling. ○ This makes it one round. Practice ten such rounds. ○ Repeat the same practice with the left leg. <p>NOTE:</p> <ul style="list-style-type: none"> • Do not bend the knee at any stage of the practice. • You can keep your hands on the waist, or can have wall support for proper balance. • The leg movement should be continuous. • Gradually increase the speed and mobility, within your limit • Raise the leg forward / backward as much as you can.

	<p>Specific precaution: Patients with neck & back pain, spondylitis, prolapsed intervertebral disc, high blood pressure, heart disease, glaucoma [increased pressure in the eyes] and retinal detachment should practice this technique with care and learn the comforting pace under the supervision of a trained yoga instructor</p>
<p>Asanas physical postures</p>	<p>- 1. ARDA-KATI-CHAKRASANA [LATERAL ARC POSTURE]: practiced separately from right and left side STARTING POSITION: <i>Tadasana</i>. PRACTICE:</p> <ul style="list-style-type: none"> • While inhaling, slowly raise the right arm side ways up above the head until the biceps touch the ear, palm facing left. • Bend slowly on the left side; slide the left palm down as far as possible along the left leg. • Exhale as you bend. Raised hand should not bend at the elbow. Knees straight. Breathe normally. Maintain the position for about a minute. • Inhaling completely slowly stretch up the trunk and the arm to vertical position. • Bring the hand down to <i>Sthiti</i> position on exhale. • Repeat on the left side, by bending towards the right. <p>2. SUKHASANA [COMFORTABLE POSTURE WHILE SEATED ON THE FLOOR]: This is a posture where one sits on the floor in a cross legged position with the palms placed on the knees. If required, in the initial stages one can sit with support by placing the palms on the ground on either side.</p> <p>3. BADDHA-KONASANA [BUTTERFLY POSTURE AND MOVEMENT]: <i>Sthiti: Dandasana</i> [leg stretched position while seated on the floor-this is a starting posture for sitting series].</p> <ul style="list-style-type: none"> • Bend the knees and bring the soles of the feet together. • Then pull them as close to the body as possible. The heels may touch the perineum, • If possible, completely relax the inner thigh muscles. <p>PRACTICEING BUTTERFLY MOVEMENT: STAGE-I (Clasping the feet with both hands).</p> <ul style="list-style-type: none"> • Clasp the feet with both hands.

	<ul style="list-style-type: none"> • Now gently bounce the knees up and down, if required, using the elbows as levers to press the legs down. • Try to touch the knees to the ground on the downward stroke. • Practice 30 to 50 up and down movements. <p>STAGE-II (Hands on the knees).</p> <ul style="list-style-type: none"> • Place the hands on the knees. • Using the palms, gently push the knees down towards the floor, allowing them to spring up again. • Repeat 20 to 30 times. • Straighten the legs and relax in <i>dandasana</i>. <p>NOTE:</p> <ul style="list-style-type: none"> • Do not force the movements. • Try to keep the back, neck and head straight. • Also keep the trunk still during the practice. <p>4. VAJRASANA [DIAMOND POSTURE]: <i>Sthiti: Dandasana [leg stretched position]</i></p> <ul style="list-style-type: none"> • By placing the left palm by the left side of the body, gently fold the right leg and place the right foot under the right buttocks. • Similarly, gently fold the leg and place the left foot under the left buttocks. • Now, firmly be seated on the ankles and feet fanning backwards. • Place the palms on the knees and sit straight looking forward and then close the eyes. • Maintain this posture with normal breath for a while. • Then slowly release the right foot and the right leg and then the left leg and the left foot. <ul style="list-style-type: none"> • Relax in the leg stretched position.
<p>A preparatory kriya [internal cleansing and activating breathing practice]</p>	<p>Kapalabhathi kriya [HIGH FREQUENCY YOGA BREATHING]:</p> <p>STARTING POSITION: Sit in any meditative posture. Keep your spine, neck erect and perfectly vertical to the ground and keeping your eyes closed, shoulders collapsed and sit with the sense of complete relaxation</p> <p>PRACTICE:</p> <ul style="list-style-type: none"> • In this practice, exhalations will be very active and forceful whereas the inhalations will be totally passive and happening on its own. • In fact, it is done by blasting out the air and is accomplished by vigorous flapping movement of the

	<p>abdomen in quick succession.</p> <ul style="list-style-type: none"> • Inhale passively by relaxing the abdominal muscles at the end of each expulsion. • Repeat the expulsion as quickly as possible starting with 60 strokes or expulsions per minute and increasing with practice up to 120 expulsions per minute. • At the end of one minute, stop the practice. • Now you will observe an automatic suspension of breath. In fact, there will be no urge for breathing. • Simultaneously the mind achieves a state of silence. Enjoy this state of silence. • Then gradually, breathing resumes when you start breathing in and out slowly and then after few rounds breathing becomes normal. <p>NOTE:</p> <ul style="list-style-type: none"> • Throughout the entire practice the spine must be kept erect. Otherwise, there is a possibility of hurting the spine because of the vigorous flapping of the abdomen. • In the beginning it may not be possible for one to do the practice continuously for one minute and for so many expulsions or strokes. Therefore, one can start with 10 to 20 strokes or expulsions in one round without bothering for the time it takes and do it for 2 to 3 rounds. Once you get the technique of doing it properly, you can do it rapidly meeting the prescribed number of strokes. • People with High BP, IHD, vertigo, epilepsy, Hernia, Gastric Ulcer, Slipped disc, Spondylosis should practice this with not more than 20 strokes. Also it is advised that women during menstruation and in pregnancy avoid this practice.
<p>Pranayama Voluntarily regulated breathing practices</p>	<p>–</p> <ol style="list-style-type: none"> 1. Demonstration of hand gestures [<i>mudras</i>] used in the <i>pranayama</i> practice: While practicing pranayama the nostrils are manipulated by adopting a specific hand gesture called <i>mudra</i> where the index finger and middle fingers will be flexed against the palm keeping the thumb and other fingers extended. This <i>mudra</i> is illustrated in the figure 1. The ring and little finger will be used to regulate the breathing through the left nostril while the thumb was similarly used for the right nostril. 2. SUKHA PRANAYAMA [FULL YOGIC BREATHING]

STARTING POSITION: Sit in any meditative posture viz., *sukhasana*, *padmasana* [lotus posture] or *vajrasana* [diamond posture].

PRACTICE:

- There are three parts to the full yogic breathing viz., abdominal [where, lower portion of the lungs are filled with air-this is evident by bulging the abdomen forward]; thoracic [where the middle portion of the lungs are filled-this is evident by complete chest expansion] and clavicular [in this case the upper lobes are filled with the air-this is evident by the gentle elevation of the shoulder blades and collar bones].

ABDOMINAL BREATHING OR DIAPHRAGMATIC BREATHING

STARTING POSITION: Sit in any meditative posture.

PRACTICE:

- Inhale deeply, slowly and continuously. This is called *puraka*, the abdomen is made to bulge continuously with the air entering specially in the lower section of the lungs.
- Before exhaling stop the breath (*antarya kumbhaka*) for a second.
- While exhaling (*recaka*) the abdomen is drawn inwards continuously and slowly.
- Before the breath is reversed, stop the breath (*bahya kumbhaka*) for a second and then inhale.
- Repeat the breathing cycle. There should be no jerks in the whole process. It should be smooth, continuous and relaxing.
- The diaphragm separating the thorax from the abdomen descends during inhalation with the bulging of the abdomen. This increases the airflow into the lower sections of the lungs. The rhythmic movement of the diaphragm massages the contents of the abdomen gently, and helps the organs to function normally.

THORACIC (CHEST) BREATHING OR INTERCOSTAL BREATHING)

STARTING: Sit in any meditative posture.

PRACTICE:

- In this practice perform inhalation and exhalation by expanding and contracting the chest.
- The middle portion of the lungs is opened up fully by this

	<p>type of breathing.</p> <p>CLAVICULAR BREATHING STARTING POSITION: Sit in any meditative posture. PRACTICE:</p> <ul style="list-style-type: none"> • Raise the collarbones while inhaling. Keep the abdominal muscles contracted. • The air is forced into the upper most regions of the lungs thus ventilating the upper lobes. The sparingly used upper lobes of the lungs will be properly aerated by this breathing. • In full yogic breathing technique all the three types will be combined. • During inhalation, and exhalation the breathing sequence is combined i.e., abdominal thoracic and clavicular. • The whole process should be relaxing and comfortable with deep, slow and rhythmic breathing. <p>3. NADI SHUDHI/ANULOMA-VILOMA PRNAYAMA [ALTERNATE NOSTRIL BREATHING] STARTING POSITION: Sit in any meditative posture. PRACTICE:</p> <ul style="list-style-type: none"> • Close the right nostril with the right thumb by adopting <i>Nasika mudra</i> and exhale completely through the left nostril, then inhale deeply through the same left nostril. • Close the left nostril with your ring & small fingers of the right hand, then open the right nostril and exhale through the right nostril, again inhale through the right nostril. • Then close the right nostril and exhale through the left nostril. This is one round of <i>Nadisuddhi pranayama</i>. • Repeat the practice for nine rounds. This practice also helps to maintain balance between <i>nadis</i>-the energy channels where the subtle energy [<i>prana</i>] flows and has shown to bring about autonomic balance. <p>4. BHRAMARI PRANAYAMA [HUMMING BEE PRACTICE]</p> <ul style="list-style-type: none"> • Understand the M-kara [a sanskrit syllable known to produce resonance in the head region] and chant 'M kara [pronounced as mmm...]' a few times with closed lips, jaws gently open. • Place the index finger on the tragus-a pointed eminence of the external ear and press.
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	<ul style="list-style-type: none"> • Then, take a deep breath and while exhaling start chanting 'M – kara'. • Longer the exhalation-longer the chanting. • Listen to the resonance after every chant and then repeat the 'M-kara' chanting. • Repeat this for 5-10 times.
<p>Guided relaxation in Shavasana [CORPSE POSTURE]</p>	<p>1. Instant relaxation technique: STARTING POSITION: <i>Sthiti: Shavasana.</i></p> <p>2.</p> <ul style="list-style-type: none"> • This is one of the guided relaxation techniques in which systematic stimulation and relaxation of each and every group of muscles of the body results in deeper relaxation to that part. <p>PRACTICE:</p> <ul style="list-style-type: none"> ○ Lie flat on your back keeping the heels and toes together, palms by the sides of your thighs, head and neck in one line with the spine. ○ Inhale and tighten your toes, ankles, feet and calves one after the other. Pull up the kneecaps, tighten thighs & squeeze the buttocks. ○ Exhale and the suck in the abdomen. Make a fist of your hands and tighten the arms. ○ Inhaling, expand your chest. Tighten your shoulders, neck and face. Tighten your whole body. Tighten ... Tighten ... Tighten. Release your breath and relax. <p>Note: The above instruction should be completed within a minute</p> <hr/> <p>3. DEEP RELAXATION TECHNIQUE: STARTING POSITION: <i>Sthiti: Shavasana.</i></p> <p>PRACTICE: Following instruction should be given-</p> <p>Phase-I</p> <ul style="list-style-type: none"> • Bring your awareness to the tip of the toes, gently move your toes and relax. Sensitize [awareness through visualization] the soles of your feet, loosen the ankle joints, relax the calf muscles, pull up the knee caps, relax your thigh muscles, buttock muscles, loosen hip joints, relax pelvic region and the waist region. Totally relax your lower part of the body. R...e...l...a...x. Chant 'A' kara and feel the vibration in your lower parts of the body. <p>Phase-II</p>

- Gently bring your awareness to the abdominal region and observe the abdominal movement for a while, relax your abdominal muscles, relax the chest muscles. Gently bring your awareness on your lower back, relax your lower back, loosen all the vertebral joints one by one. Relax the muscles and nerves around the back bones. Relax your middle back, shoulder blades and upper back muscles...totally relax.

Shift your awareness to the tip of the fingers, gently move them a little and sensitize. Relax your fingers one by one. Relax your palms, loosen the wrist joints, relax the forearms, loosen the elbow joints, relax the hind arms-triceps, biceps and relax your shoulders. Shift your awareness to your neck, slowly turn your head to the right and left, again bring back to the center. Relax the muscles and nerves of the neck. Relax your middle part of the body totally relax. R...e...l...a...x. Chant 'U' kara and feel the vibration in your lower parts of the body.

Phase-III

Gently bring your awareness to your head region. Relax your lower jaw and upper jaw, lower and upper gums, lower and upper teeth and relax your tongue. Relax your palates-hard and soft, relax your throat and vocal chords. Gently shift your awareness to your lips, relax your lower and upper lips. Shift your awareness to your nose, observe your nostrils, and feel the warm air touching the walls of the nostrils as you exhale and feel the cool air touching the walls of the nostrils as you inhale. Observe for a few seconds and relax your nostrils. Relax your cheek muscles, feel the heaviness of the cheeks and have a beautiful smile on your cheeks. Relax your eye balls muscles, feel the heaviness of eye balls, relax your eye lids, eye brows and in between the eye brows. Relax your forehead, temple muscles, ears the sides of the head, back of the head and crown of the head. Relax your head region totally relax.

R...e...l...a...x. Chant 'M' kara and feel the vibration in your lower parts of the body.

Phase-IV

- Observe your whole body from toes to head and relax, chant A-U-M-kara together. Feel the resonance throughout the body.

Phase-V

- Slowly come out of the body consciousness and

	<p>visualize your body lying on the ground completely collapsed.</p> <p>Phase-VI</p> <ul style="list-style-type: none"> Imagine the vast beautiful blue sky. The limitless blue sky. Expand your awareness as vast as the blue sky. Merge yourself into the blue sky. You are becoming the blue sky. You are the blue sky. Enjoy the infinite bliss. E .. N .. J .. O .. Y ... the blissful state of silence and all pervasive awareness. <p>Phase-VII</p> <ul style="list-style-type: none"> Slowly come back to body consciousness. Inhale deeply. Chant 'A-U-M-kara". Feel the resonance throughout the body. The soothing and massaging effect from toes to head. <p>Phase-VIII</p> <ul style="list-style-type: none"> Gently move your whole body a little. Feel the lightness, alertness and energy throughout the body. Slowly bring your legs together and the hands by the side of the body. Turn over to the left or the right side and come up when your are ready. <p style="text-align: center;">Note: Shorter periods for patients with depression</p>
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Session 1 ends by addressing the participants' queries and instructions to them to return the next day when new techniques will be taught.

SESSION 2:

Note: Practice one round of each of the techniques learnt in the first session and then move on to learn new techniques for the session

Technique	Description
Asanas physical postures -	<p>1. MAKARASANA [CROCODILE POSTURE]: STARTING POSITION: Lie down on the abdomen with the legs apart and toes pointing outwards. Arms stretched over the head and chin touching the floor.</p> <p>PRACTICE:</p> <ul style="list-style-type: none"> Bend the right arm and place the right palm on the

	<p>shoulder.</p> <ul style="list-style-type: none"> • Then, bend the left arm and place the left palm on the right shoulder. • Now allow the head to relax on to the folded arms so that the neck is supported at the point where the two arms cross. • Lie down and relax in this position for sometime.
	<p>2. BHUJANGASANA [COBRA POSTURE]: STARTING POSITION: <i>Sthiti: Makarasana -</i></p> <p>PRACTICE:</p> <ul style="list-style-type: none"> • Bring the palms to the level of the last rib bone and place them on the ground. Keep the hands bent at elbows; least pressure to be exerted on the hands. Maintain the elbows touching the body and let it not spread out. • Raise the head first and then the upper portion of the trunk slowly, till the navel portion, just as the cobra raises its hood. Arch the dorsal spine well. Keep the body below the navel straight and in touch with the ground. Maintain this position for a minute. • Come back to <i>Sthiti</i> position & relax in <i>Makarasana</i>. •
	<p>3. PAVANAMUKTASANA [LEG LOCK POSTURE]: STARTING POSITION [<i>Sthiti</i>]: <i>shavasana</i>.</p> <p>PRACTICE:</p> <ul style="list-style-type: none"> • Raise the right leg keeping it straight about 45° from the ground. Keep the left leg firmly on the ground. Inhale partially. • Place the right leg perpendicular to the ground with inhalation. • Bend the right leg and press the knees over the chest by holding the legs by interlocked fingers of the hand. Exhale and bring the knee to touch the chin. • Maintain this position for one minute with normal breathing • Return to <i>Sthiti</i> position. • Repeat with the left leg.
<p>A preparatory kriya [internal cleansing and activating breathing</p>	<p><i>Kapalabhathi kriya</i> [HIGH FREQUENCY YOGA BREATHING]: As described in the session 1.</p>

practice]		
Pranayama Voluntarily regulated breathing practices	–	1. <i>Sukha pranayama</i> [FULL YOGIC BREATHING] : As described in the session 1.
		2. <i>Nadi shudhi/Anuloma-viloma prnayama</i> [ALTERNATE NOSTRIL BREATHING]
		3. <i>Bhramari pranayama</i> [HUMMING BEE PRACTICE]
Guided relaxation <i>Shavasana</i>	in	1. Instant relaxation technique:
		2. Deep relaxation technique:
		Note: Shorter periods for patients with depression

At the end of session 2, participants' queries are addressed and they are asked to return the next day.

SESSION 3:

In this session patients would practice techniques learnt in the first two sessions. Hence this session is a complete session of yoga therapy program for anxiety and depression. In this session the focus would be to check the accuracy of practice, understanding the sequence and the completing the session within the time allotted for the session.

Technique	Description
<i>Tadasana</i>	
Breathing techniques	HANDS IN AND OUT [SIDEWAYS]: As described in session 1.
Loosening techniques	PADA SANCALANA []
Asanas - physical postures	1. <i>Arda-kati-chakrasana</i> : Practiced separately from right and left side
	2. <i>Bhujangasana</i>
	3. <i>Makarasana</i>
	4. <i>Pavanamuktasana</i>
	5. <i>Sukhasana</i>
	6. <i>Baddha-konasana</i>
	7. <i>Vajrasana</i>
Kriya-Internal cleansing technique	<i>Kapalabhathi kriya</i>
Pranayama-Voluntarily regulated breathing yoga	1. <i>Sukha pranayama/:</i>
	2. <i>Nadi shudhi/Anuloma-viloma prnayama</i> [alternate nostril breathing]
	3. <i>Bhramari pranayama</i> [humming bee practice]
	1. Instant relaxation technique

Guided relaxation in <i>Shavasana</i>	1. Instant relaxation technique
	2. Deep relaxation technique Note: Shorter periods for patients with depression

At the end of session 3, the importance of regular practice is emphasised and patients are offered weekly review sessions if they wish to avail of these.

Weekly review session

Weekly review session is meant to monitor the quality of practice, provide clarifications [if required], discuss the compliance [preferably through daily diary], deal with the difficulties encountered, and provide solutions for any side effects [if any].

List of common difficulties while practicing yoga and recommended solutions

Sl. No.	Common difficulties	Recommended solutions
1	First day syndrome: painful muscles	Giving a break here aggravates the pain. Hence low intensity session is recommended
2	Forgetting the name of the practice	Working with the chart helps
3	Forgetting the sequence of practice	Sequence is important as it gives the session a smooth flow viz., standing series; prone series; supine series; sitting series; <i>pranayama</i> practice in sitting position and finally <i>shavasana</i> in the supine position. This sequence ensures complementary postures are practiced which is essential in preventing injuries.
4	Forgetting the final posture	All the postures are taught by counts. This helps to keep track of the posture.
5	Breathing pattern while practicing the postures	Inhalation is done while bending backwards and exhalation while bending forward. In the final posture normal breathing is maintained. This has to be ensured during the review session.
6	Flexibility	On a given day, the practitioner should listen to body signals and skip those practices which hurt.
7	Practicing pranayama	While practicing <i>pranayama</i> one has maintained 1:2 ratios for inhalation and exhalation. This should be ensured and at no point the practitioner should hold the breath unless it is part of the practice

8	Guided relaxation	The sequence and the instructions decide the quality of the relaxation. Hence in the review session the familiarity to the instructions has to be checked.
9	Flexibility in the time of the practice	Patients should be encouraged to be flexible with the time of the practice rather than missing a session for the day. The basic rule of practicing 2 hours after the last meal should be followed.
10	Guidelines during the menstrual period	During this period the emphasis should be to practice breathing exercise, <i>pranayama</i> [except <i>kapalbhati kriya</i>] and guided relaxation

2.8g Basic instructions to practice yoga

- Yoga is best practiced on empty stomach (*except Sukhasana /Vajrasana*) i.e., 90 min to 120 min after a meal
- Yoga to be practiced regularly, preferably once daily
- Early hours of the day are the recommended time for yoga.
- Immediate beneficial results should not be expected. With regular practice one can experience the proven health benefits. Ladies are instructed to not to practice certain techniques during menstrual period / pregnancy. These include: generally those practices which compress abdominal cavity viz., *kapalbhati kriya*, forward bending postures, *bhujangasana*, *pavanamuktasana* and *badha konasana*. Yoga should be practiced with utmost relaxation with a sense of self awareness.
- Do not force yourself to carry out any technique; note body signals such as pain which tells you not to continue or complete the technique
- Avoid comparing yourself with others since each person is different considering various factors like age, body flexibility, medical history, pain – threshold etc.
- It is described that yoga when practiced properly results in health benefits and can produce side effects when practiced wrongly. Hence yoga should be learnt in two phases i.e., learning phase and self-observation phase. This ensures the quality of the practice and prevents the harmful effects [if any].

2.8h Important points for yoga teachers

- Follow the prescribed style, school and the method
- Use an elevated space for demonstration
- Use charts showing body structure (anatomy) to explain the techniques.
- Use a white / black board and yoga charts and illustrations of techniques.
- Follow the same dress code as for participants
- Practice yoga regularly to experience health benefits. Then, you can confidently motivate patients to comply with the yoga intervention.
- Study / prepare well before each session. Avoid looking into notes / the manual while conducting sessions.

- Practice giving lessons / instructions.
- Contact the consultant for any clarifications.

2.8i Essential requirements for practicing yoga

- A well ventilated space
- Preferably quiet
- People should not walk through the hall during a session, i.e., it cannot be a thoroughfare
- The temperature should be comfortable
- Soft mats made of cotton or professional yoga mats
- Loose clothing to practice at ease
- Course materials viz., posters, illustrations and books

Figure 1: Photos/illustration of the yoga techniques:



Summary points

- Yoga is an ancient Indian science and a way of life
- Practicing yoga is shown to have stress reducing effects
- There is evidence supporting the use of yoga in the management of anxiety and depression
- Of all the styles, an integrated approach where a combination of *asanas*, *kriyas*, *pranayamas*, relaxation and meditation are used, was found to produce best results
- Regular practice and attendance at review sessions is necessary to ensure maximum benefit
- Yoga can be one of the best adjunct therapies in the management of common mental disorders

Chapter 3

The Delivery of the MANAS Program

Chapter 3.1

STRUCTURE OF THE MANAS TEAM AND FUNCTIONS OF INDIVIDUAL MEMBERS

This chapter includes the following:

- Introduction and prerequisites for a good team
- Structure of the Manas team
- Roles and responsibilities of Manas team members

3.1a Introduction

All health care interventions are delivered by people who are the most important part of the program. Having a team of people who are well trained, confident about their work and satisfied with their specific roles helps the program to be successful. A good example would be to consider a car which, to run smoothly, needs all the individual parts to perform at their best. Similarly, for the MANAS program to be effective, the team needs to function as a whole in a harmonious manner. This section describes the overall structure of the program and the specific roles of HC's and other staff members. This will help you understand the way in which you should be working and interacting with the rest of the team.

What makes a good team?

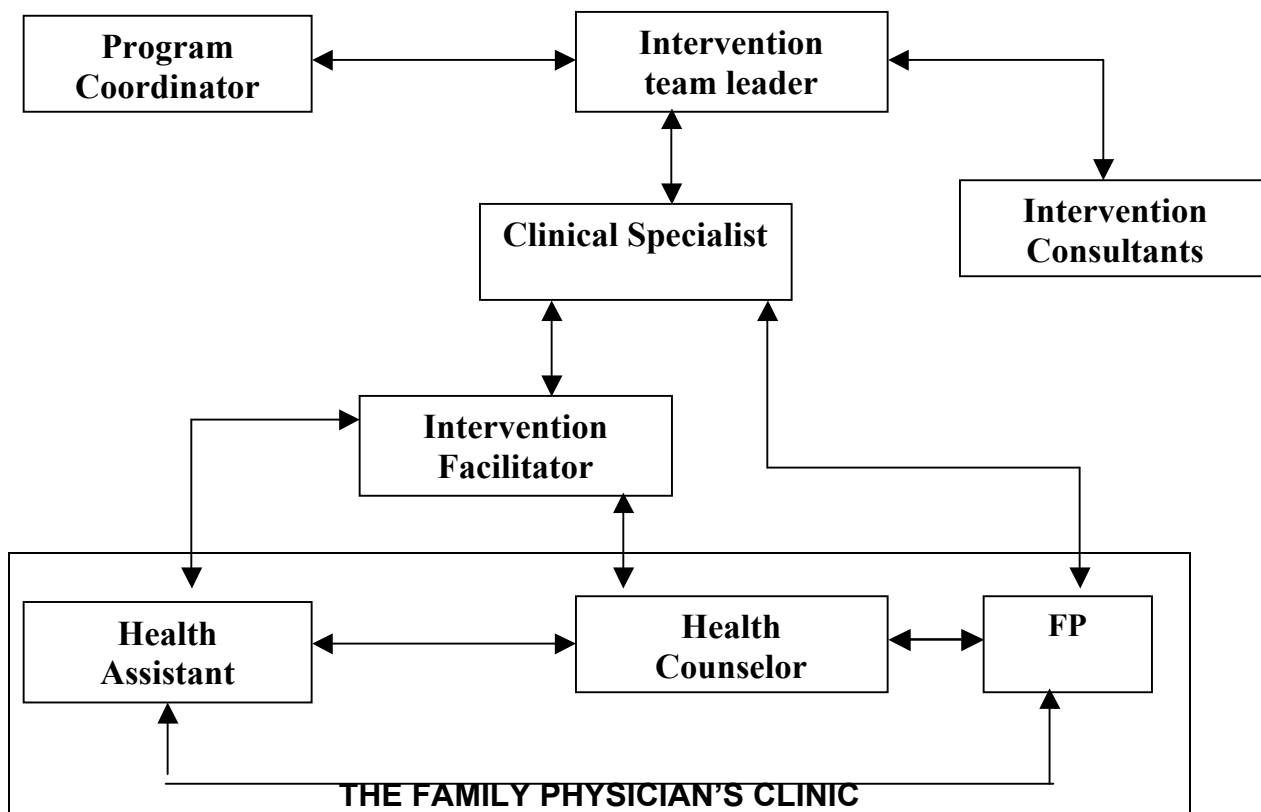
- The whole **team having shared goals and values**: In the context of MANAS, this means that we all agree that our primary focus will be on providing the best treatments to the patients we will be seeing in the clinics. In addition, we will be treating all our patients with dignity and help them reach their maximum potential.
- Having **respect for all team members** and valuing the work they do.
- Every member of the **team has ownership** of the program and is responsible for maintaining the quality of their individual work.
- Having free and open **communication between team members** and to learn from each other.
- Focus on ways to **improve the quality** of the program continuously so that the team delivers the best care possible to patients.
- Having agreed **management procedures, lines of clinical responsibility** and clear ideas about the boundaries of each other's roles to reduce the possibility of disagreements.
- There is a **supportive atmosphere** within the team which helps us learn from and support each other.
- **Decisions** that affect the team are made **through consultations** and in an open manner.

3.2b Structure of the team

The MANAS team consists of a number of members performing different roles in the clinics. During the earlier phase of the work, we have learnt about the importance of having a clear team structure and have tried a number of things to improve the functioning of the team. Figure 6 below shows the planned structure of the team that will deliver the intervention during the program. This may need some modifications to match individual clinic requirements and any changes would be guided by your experiences.

Please note that the Family Physician (FP) in whose clinic we are based is the designated head of the clinic. Since you will be expected to integrate your work within the FPC structure, the FP will be the person that you will be reporting to on a frequent basis. The other members of the MANAS team will be giving you supervisory support and would not be expected to involve themselves in the day to day functioning of the program.

Fig 6: Structure of the MANAS team



From the figure, you will notice that the HC and the Health Assistant (HA) work closely in each clinic as a team and will report to the Family Physician for any immediate issues that need attention. For each clinic, there will be an Intervention Facilitator (IF) who will be visiting your clinic at regular intervals and can also be contacted at any time on the phone. She will be the person you can contact first for any clinical issues or other matters that you need additional guidance with. The IF will have the responsibility of liaising with the CS who can then provide any additional advice, as required. Each clinic will also have a designated Psychiatrist as the Clinical Specialist who will also be making visits to the clinic for supervision and can be contacted on the phone as required. The Clinical Specialist will have the overall responsibility for the smooth implementation of the program in the FPC. The Program Coordinator will be responsible for all logistical and managerial support necessary for the team to function smoothly. Finally, the Intervention Team Leader will be the person who has overall responsibility for the program. The roles and responsibilities of the team members are described below.

3.2c: Roles & Responsibilities of MANAS team members

Program Management Team

The roles and responsibilities listed below include all members of the Manas team, including those who are concerned with the overall management of the randomized controlled trial which is evaluating the Manas program.

Program Coordinator:

- To be responsible for overall managerial aspects of the program including logistical requirements of various team members / clinics. Specifically this includes the setting up of clinic space, providing stock of materials to teams, managing leave and transport arrangements, when needed.
- Be responsible for all human resource needs of the program in consultation with intervention team leader.
- Contribute to regular appraisal process for team members.
- Be responsible for overall financial accounting of the program.
- To report directly to the Principal Investigator (PI).

Program Secretary:

- Provide secretarial support to Program Coordinator and maintain necessary records.
- Be responsible to receive addresses from HC and pass on to VHAG (thee organization contracted to carry out the outcome evaluations)
- Be responsible for coordinating trainings and making logistic arrangements.
- To provide secretarial support to the Principal Investigator/ PC and intervention team leader
- To report directly to the Program Coordinator

FPC Communication Officer:

- Responsible for setting up clinics as per agreed protocols by FPC staff and Coordinator
- Responsible for arranging and conducting briefing meetings along with intervention team leader.
- To report directly to the Program Coordinator

The Intervention Team:**Health Assistants:**

- Undertake necessary training for carrying out assigned tasks at primary care practices.
- Assist in setting up clinics during running in phase.
- Conduct screening of patients in assigned clinics.
- Maintain records of day to day activities and provide update about screening details.
- Inform patients about the program and about seeing the HC (in CSC clinics)
- Take part in supervision for quality assurance purposes.
- To participate in appraisal process for maintaining necessary skills.
- Provide necessary feedback on measures to facilitate screening process.
- Work as part of the FPC team and reports directly to the IF

Health Counselors:

- You will be placed in a family physician clinic (FPC) and will be expected to implement the interventions necessary for the program.
- You will be primarily affiliated with the FPC; you are required to fulfill the supervisory requirements of the program including attendance and participation in monthly group meetings at the centre (see below).
- To meet the quality and safety standards of the program.
- To ensure that data collection and management process is completed on time.
- To maintain clinical and recording standards as set out by program team.
- Will report to the doctor and the Clinical Specialist and Intervention Facilitator allocated to your clinic

Reserve HC:

- You will be expected to spend a proportion of your time in the clinic with the rest of the intervention team on a regular basis.
- In the absence of an HC in the clinic allotted to you, you will be expected to fulfill all the roles and responsibilities of the HC in that clinic
- You will be expected to meet other clinical requirements that your supervisors design for you and, through this process, ensure that your skills are improved.
- You will need to meet the quality and safety standards of the program.
- You will need to provide other logistical or skill resources for the program and for Sangath as requested by your supervisor.

- In case of serious adverse events reported from EC clinics, you may need to make home visits following discussion with your supervisor
- HCs will report to the Clinical Specialist

Intervention Facilitators:

These were originally HCs themselves who have now been promoted to a supervisory role

- Undertake necessary training for implementing interventions in family physician clinics (FPC) as outlined in the program.
- Ensure adequate standards of clinical care being provided by HCs and HAs through structured supervision in clinics allotted to them.
- Ensure adequacy of data recording methods and reporting of process indicators by HCs.
- Build capacities of HCs in various identified areas.
- To be the first contact person for HC in clinical scenarios and to facilitate necessary networking.
- To consult with Intervention Consultants/Clinical Specialists whenever necessary.
- To step in for the other IF in her absence
- Report directly to intervention team leader.

The Family Physician:

- To provide antidepressant treatment for patients who need it
- To fill details of treatment provided in the patient card
- To encourage patients to meet the HC and follow up regularly
- To discuss clinical problems with the CS when the need arises
- To discuss clinical cases with the HC and

Yoga Consultant

- Provide training for IFs & HCs in various techniques of yoga that have been identified as part of the yoga package of MANAS.
- Maintain standards of these interventions through on – site supervision and participation in monthly group meetings.
- Develop training material
- Report directly to Intervention Team Leader.

Clinical Specialist

- To provide on-site supervision for HCs and IFs at designated FPCs and liaise with the team for solving any operational issues identified.
- To provide specialist support for FP's and members of the intervention team, when necessary through phone contact and clinic visits.
- To take lead role in maintaining quality standards and safe practices of interventions being delivered.
- Report directly to Intervention Team Leader.

- Ensuring that quality assured clinical services are provided in an appropriate, accessible and equitable manner to all patients recruited into the program.
- Training of doctors, HC's and other program staff as relevant
- Ensuring that standards of documentation are adequate and meet the needs of the program.
- Responsible to the Intervention team leader and will provide regular updates on the working of intervention team in assigned clinics.
- Coordinate leaves with Intervention Team Leader
- Report to Intervention Team Leader

Intervention Team Leader:

- Coordinating the overall planning and implementation of the MANAS program intervention, including overall responsibility for ensuring delivery of interventions in primary care settings including quality assurance, safety standards and adequate data recording as per agreed protocols.
- Ensuring that clinical services are provided in an appropriate, accessible and equitable manner to all patients recruited into the program.
- Putting in place a clinical governance framework to promote innovation, excellence, safety and quality assurance of services offered.
- Leading the capacity building of staff and doctors involved in the trial through training and supervision on an ongoing basis.
- Ensuring that standards of documentation are adequate and meet the needs of the program and to manage the collection of process indicator data.
- Providing clinical services to the local community and clinical capacity building of staff within Sangath.
- Provide expertise as clinical specialist for GPs and other members of the intervention team.
- Provide leadership around intervention related human resource issues including appraisal of all CSC intervention team members. .
- Responsible to provide regular updates to the Principal Investigator (PI) on the working of intervention team, particularly to anticipate and resolve difficulties faced in the clinic.
- Coordinate leaves with clinical specialist
- To report directly to the PI

Summary points:

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| <ul style="list-style-type: none"> • The MANAS team consists of individual members working in unison to ensure that the program runs in a smooth and efficient manner • The roles and responsibilities of each team member are clearly defined |
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Chapter 3.2

SUPERVISION AND DOCUMENTATION

This chapter includes the following:

- What is supervision?
- Why is supervision important?
- How is supervision arranged in the Manas program?
- What do you need to do to make supervision useful?
- Documentation in the Manas program

3.2a What is supervision?

Supervision is a process through which the HC is guided by an expert to ensure that the skills of the HC are continuously refreshed and improved. This process of learning allows the HC to discharge her expected duties at a level of competence that meets the quality standards of the program. During the supervision sessions, the supervisor will provide support, technical inputs and guide the HC in her clinical work. In the MANAS program, you would have been trained initially to provide a range of treatments for patients presenting with symptoms of Depression in FPCs. The supervision process will allow you to practice the treatments in a confident manner so that you can become effective in your work as a HC.

The supervision process has 2 important functions:

- Professional support: The supervisor will discuss with you the patients you have seen, the quality of the assessments with the clinical records and the management plans that have been made. The supervision process will make suggestions about additional strategies you can use for the assessment and treatments of the particular patient who you might need help for. The short term and long term goals of management of the patient will also be discussed and recorded for further review.
- Personal support: Working with patients with Depression, suicidal risk and multiple social problems on an ongoing basis can sometimes become a stressful experience. This can be manifested in various ways like the health worker losing motivation to work, feeling anxious or depressed and becoming easily irritable with patients or friends; this problem is called 'burnout'. An important part of supervision is to identify any personal problems related to work or issues in your personal life that are affecting your personal well being. The supervision process allows you to deal with them in a confidential, supportive and enabling manner and overcome them. In addition, during supervision, you might wish to discuss any personal goals you have set for yourself and get the supervisor's support to make them happen so that the quality of your life improves.

In short, supervision is a positive learning experience for the supervisor and the HC. Through the process of supervision, you should feel supported personally and continuously gain technical skills to help you provide the best possible quality of services.

3.2b Why is supervision important?

Any health program like MANAS is delivered by staff who would have had some training before actually seeing patients in real life. While the training provides them with the necessary theoretical and practical skills to start working, no training can capture entirely the variety of problems that the person will face in real life settings. Supervision allows the HC to practice and implement what they have learnt in the most appropriate manner and provide the maximum benefits to their patients. Some of the more important reasons why supervision is essential for you are:

- It allows the HC to discuss patients who present with problems that are complex or difficult and helps you to manage them in the best possible manner by taking the advice of an experienced supervisor who would have dealt with similar problems in the past.
- Since you will be working with patients who have significant life problems, it is very important that the treatment you are offering is effective and appropriate. Supervision allows you to maintain the standards of care that the MANAS program wants to achieve by ensuring that the intervention is rational and well thought out.
- At times, you will be seeing patients who have significant risk factors that increase their chances of self harm. In these situations, it is essential that the best possible interventions are provided to minimize the risks involved and that the safety issues are addressed in the appropriate manner. Supervision then becomes an essential element of the way in which safety standards of the program are met and to ensure that you feel supported in the situation.
- Supervision also allows you to have a continuous learning focus while you are working and should facilitate your personal and professional growth. This experience should make you a competent practitioner and also help you identify professional and personal development goals that your supervisor can help you plan for.
- Research has identified that supervision is an essential element of any successful health program and is especially important when Depression is being treated in primary care settings. Previously, it was thought that training alone would be enough to make program staff into effective practitioners but this has repeatedly been shown to be false. Without ongoing supervision, staff gradually tends to lose the skills that were taught and go back to practicing in a manner similar to before the training program. Supervision, therefore, provides staff with the opportunity to upgrade and refresh their new skills in an ongoing manner and makes the investment in training worthwhile.

- As HCs you will be working in a FPC which has an established system of working. Since the MANAS program will change the previous way of functioning in the clinic, some staff may be resistant to changing for reasons which may be beyond your control. In such situations where there are problems in your work environment, discussing the problem(s) with your supervisor can be a very useful way of getting fresh ideas of how to resolve any problems that may be preventing you from working in the most effective manner.

3.2c How will supervision be arranged in the MANAS program?

There will be 2 forms of supervision available to you in the program:

- Planned supervision in clinics: This will happen at the FPC on a weekly basis initially (while you are getting settled) and then be spaced out to once a month basis when you feel confident in your role as an HC. The supervision will be provided by the Intervention Facilitators, Consultants and the Clinical Specialist assigned to your clinic (see Table 1). This team of supervisors will work with you to design a schedule for supervision that is both convenient and feasible and will be guided by your requirements for support. This form of supervision will happen between you and the supervisor on a one to one basis. During the initial phase of the program, supervisors would be sitting with you during some sessions with patients and would provide you with advice regarding how you could improve your counseling skills and the delivery of treatment.
- Group supervision: Once a month, we will be asking all the HC's in the program to meet together for supervisory sessions where psychological interventions like psychoeducation would be discussed. It is planned that HC's would be presenting the cases of patients (based on the case notes) who they would have seen for psychoeducation or IPT and discuss the process and other issues with supervisors who are certified as IPT trainers. These group sessions would also provide an opportunity for all the HC's to share their experiences (peer review) about the problems they have faced in their individual work and the solutions that were useful in overcoming them, including any innovations in practice. In addition, we hope that this monthly meeting would be good time to catch up with your friends and colleagues and exchange notes on life in general!

3.2d What will you need to do to make the supervision most useful?

Supervision is an active and dynamic process which is most useful if you take an active role in planning the sessions. This means that you would have to record and document the details of the interventions with your patients and identify any difficulties that you faced. You need to make a list of these problem cases or other difficulties you might have faced, detail the strategies that you used to overcome these problems and record why you thought these did not

work in the way you had hoped for. This will help both you and the supervisor to focus on the problem and generate possible ways to overcome them within the limited time available. Another vital part of supervision is to record the discussions you had in the case record of the patient so that the suggestions that were made in the session are followed up as suggested. It is important to remember that supervision is not a mechanism to only monitor the supervisee. It is a 2 way process and the supervisor also benefits from the process through learning from you about difficult situations and trying to solve problems in an orderly manner.

In Appendix 4.10, you can find the form which describes how individual supervisors will rate your work. This will enable you to understand clearly the parameters on which you will be supervised and rated.

3.2e Documentation in the MANAS program:

As the name suggests, documentation refers to the recording of information related to the contacts you had with individual patients. This captures the essential details of what occurred during the meeting i.e. the clinical and social problems that the patient presented with and the advice that you provided based on the collaborative stepped care model that the MANAS program follows. The nature of the documentation is different depending on whether the patient is coming for the first time or following up and the intervention record card (see Appendix 4.2) will enable you to record the relevant information accordingly. It is important for you to understand the importance of adequate documentation in the MANAS program; some of the more important reasons are given below:

- It is a clinical record that is useful for you to refer to when the patient returns for follow up. When the records are maintained properly, it enables you and the patient to focus on the relevant details and make the best use of your limited time.
- Since you will be seeing a large number of patients, it is impossible for you to remember their individual problems and personal details. A good quality clinical record will tell you what were the symptoms that the patient had presented with, what was the nature of interventions that you had carried out and the tasks that both had agreed on during subsequent sessions. This baseline information allows you to monitor the progress of the patient accurately and will also make the patient feel that her concerns are being addressed in a systematic manner.
- As we noted earlier, the quality of the clinical record has a direct relationship with the quality and agenda of the supervision process by making it very focused.
- The intervention record card is also an indicator of the process of treatment i.e. it provides a summary of the type and details of the interventions provided. This is a special focus of the MANAS program since we would like to ensure that the we can evaluate whether the program goals are being met.

- Correct documentation would also be important in ensuring that the stepped care treatments are being followed in a systematic and rational manner. For example, if a patient is being ‘stepped up’ to receive antidepressants, the reasons for that decision need to be detailed so that your supervisor can judge whether the decision is appropriate.
- Clinical records are a very useful way of monitoring the quality of any health intervention and we intend to use it for ensuring that the quality of the intervention are being maintained to an expected standard.
- Finally, clinical records will provide the intervention team the details of the intervention that you would have completed with the patient who has experienced an adverse effect related to the intervention like side effects from antidepressant medicine. As part of the quality and safety standards that we are following in MANAS, we have to report all such events to an independent monitoring and ethics committee. The report will be based on the details available from the clinical records and to answer any further questions that this committee might have. It is obvious that all of us will benefit from having the documentation completed to the expected standard for our purpose and for committee members who would like to verify the standards independently.

Table: Documentation to be completed by the HC

No.	Type of document/ record	Purpose
1.	Intervention record form	Clinical details, process indicators
2.	Daily register	Daily record of patients’ visits
3.	Appointment diary	To record patients’ appointments for adherence management
4.	Yog assessment and physical evaluation forms	To assess performance of participants during the yoga sessions and record information about their health
5.	Individual IPT clinical record	To record details of patient’s symptoms, problem area and plan for the next session For IPT patients only
6.	Weekly and monthly process indicator reports	To record weekly and monthly process indicator information

Summary points:

- | |
|--|
| <ul style="list-style-type: none"> • You are provided individual regular structured supervision by the IF and CS in the clinic and through group meetings with other HCs every month at the centre • This will help to monitor the quality of your work, provide assistance with difficult cases and provide you with personal support if needed. • Meticulous documentation is very important both for providing patient care and monitoring quality of the intervention |
|--|

Chapter 3.3

INTEGRATING SERVICES IN FAMILY PHYSICIAN CLINICS

3.3a Introduction

As we have described before, the MANAS program is located in the FPC. As a HC you will be expected to be an integral part of the FPC and will work with the FP and other staff members who are already a part of the FPC. This can be a challenge both for you and the existing FPC staff since both parties would need to develop a close working arrangement that is unique to the Manas program. . In addition, the structure and functioning of FPCs can be quite varied and you will need to orient yourself properly and identify any challenges to the implementation of the program. For this purpose, we will have an initial period which we refer to as the 'running in' phase where you will be expected to complete a set of tasks that will test the program's implementation in a systematic manner. During and at the end of this period, you will need to discuss with your supervisors about problems and possible solutions that need to be addressed collaboratively and fine tune the intervention accordingly.

This chapter includes the following:

- The tasks of the HC during the running in period
- The mapping tool for the FPC

3.3b The tasks of the HC in the 'running in' period

1. In the initial phase, you, the HA, the FP and the CS and any other staff in the clinic will need to meet to review the arrangements and the process of conducting the program smoothly. As the HC, you will be expected to make the presentation using audio- visual aids where you will explain the purpose and the specific workings of the various staff in the MANAS program and how others in the FPC need to contribute to the process to make it work best for patients with Depression. This presentation will also serve the purpose of formally introducing you and the team to all clinic members. (Appendix 4.10)
2. Over the next couple of days, you will be expected to undertake the mapping exercise of the FPC that you are assigned to with the help of the tool designed for the purpose (see below). This will help you get to know the other members of the FPC and develop the terms of your work relationship while giving you a detailed understanding of the facility.
3. In the following few days, you will need to sit with the FP and other staff of the FPC and observe the process that a patient goes through when she visits the FPC. This would include observing the registration, observing the order in which patients are asked see the doctor and sitting in with the doctor while

he/ she conducts the interview. This period of observation would help you to work out the exact manner in which you will locate the MANAS program within the FPC and identify any problems that might come in the way of your work. This will also help you build rapport and trust with the FP staff.

4. In this phase, you will also need to set up your work area. You need to check if the room and the chairs are comfortable, whether the arrangements give you adequate privacy, the placement of the cupboard for the records and the physical environment of the room and make it as pleasant as possible. Another important part of this exercise is to ensure that you and your patients have access to safe drinking water, a place to store your lunch and (very importantly) you must obtain a set of keys to the toilet.
5. Take some time to set up the MANAS posters, the signs to your room, arranging all your materials such as the intervention record cards and psychoeducational materials (flip-chart, handouts).
6. Try out the actual process of the intervention including screening, the use of the patient card, the referral from the FP to you for the first session of psychoeducation, conducting the initial session and the relevant documentation with a small number of patients. This will identify any potential problems and will be an opportunity to resolve those in consultation with the team.
7. At the end of this phase, you will need to provide a brief report to the IF regarding the activities that you undertook and the key learnings of the period.

3.3c The mapping tool for Family Physician Clinics

FPC DETAIL SHEET FOR MANAS

1. FPC Details:

FP Name: _____ Tel No: _____

FPC Address: _____

2. Staff in the FPC (if any) and their roles:

3. Other Details:

- No. of patients attending the FPC per month : _____
- No. of adult patients attending FPC per month: _____
- No. of new patients registered per month: _____
- Register maintenance: _____
- Transport facility available to reach FPC: Bus Taxi Pilot
Bus routes and timings: _____

- Holidays: _____

- Facilities available at FPC:
 - * Electricity _____
 - * Fan _____
 - * Toilet _____
 - * Drinking water _____
 - * Availability of furniture's _____

- * Food/canteen _____
- Availability of space: THIS SECTION SHOULD ALSO BE SHOWN ON A MAP OF THE FPC WHICH SHOWS ALL THE SPACES AND WHERE EACH OF THESE WILL BE PLACED
 - * For storing files _____
 - * For displaying posters _____
 - * For Yoga sessions (FPC/ Panchayat Hall / temple) _____
 - * For screener _____
 - * For Health Counselor _____
- Availability of mobile network specify which network: _____
- If no – availability of telephone facility/Using FPC phone _____
- Nearest post office details: _____

4. Registration Procedure:

- Case papers are given to patients or kept in clinic: _____
- When new case paper is made, after how long: _____
- Incase of key person's absence, who is responsible his duty? _____

5. Physical Map of FPC:

Summary points:

- The initial running in phase will help you understand how the clinic functions and what the roles of various members in the clinic are.
- During this time you will also explain the program to other staff members set up your work area and make preparations to deliver the intervention

Chapter 4

APPENDIX

Appendix 4.1: General Health Questionnaire (GHQ) with examples

This consists of the 12 item questionnaire used for the purpose of screening. There are some questions that patient's may not understand easily and for these we have provided examples that you can use to illustrate the meaning of the questions to the patients.

Screening Questionnaire (GHQ 12)

Start time:

We would like to know if you have had any medical complaints and how your health has been in general over the past two weeks.

- आमका कळुंक जाय, तुमका कसलेच भलायकीची तक्रार आसा जाल्यार आनी तुमची भलायकी फाटल्या दोन सुमानानी कशी आसली ती. उपकार करून सगळ्या प्रश्नाच्यो जापो दियात .
- मी तुम्हाला काही प्रश्न विचारणार आहे ते तुमच्या शारिरीक तक्रारीबद्दल आहे . गेल्या दोन आठवड्यात तुमचे आरोग्य कसे आहे त्याबद्दल मी तुम्हाला प्रश्न विचारणार आहे .
- मैं आपको आपके शारिरीक तकलीफों के बारे में पूछूंगी/ पीछले दो हफ्तों में आपका स्वास्थ्य कैसा रहा है इसके बारेमें जानना चाहती हूँ/

Instructions :

Shaded Questions if answered as No code 1 and If yes code 0

Unshaded questions if answered as Yes code 1 and if No code 0

HAVE YOU RECENTLY:- / गेल्या दौन सुमानांनी / गेल्या दौन आठवड्यात / इन दो हफ्तों में आप :-

GHQ 1	been able to concentrate on whatever you're doing? /तु किते करता ताचेर तुजें लक्ष/मन लागता?तुम्ही जे काही करता त्यावर तुमचं लक्ष/ मन लागतं का ? /जो कुछ करते है उसमें आपका ध्यान लगता है ?	
GHQ 2	lost much sleep over worry? कसलोय हुस्को आसा म्हण तुजी न्हीद उणी / कमी जाल्या? काळजी /चिंते मुळे तुमची झोप कमी झाली आहे का? /ज्यादा चींता के कारण क्या आपकी नींद कम हुई है?	
GHQ 3	felt that you are playing a useful part in things? /तुका दिसता तु उपयोगाचे /गरजेचे काम करता म्हण?तुम्ही काही उपयोगाचं /गरजेचं काम करतात असं तुम्हाला वाटतं का?/क्या आपको लगता है की आप कोई भी उपयोगी /फायदेमंद काम कर सकते है ?	
GHQ 4	felt capable of making decisions about things? /तु कसल्याय गोष्टीचो निर्णय / ठराव घेवुंक शकता? /तुम्ही कोणतेही निर्णय स्वतः घेऊ शकता का? /क्या आप कोई भी फैसला ले सकते है ?	
GHQ 5	felt constantly under strain ? /तुज्या मनाचेर सदाच पेज /टेंशन आसता? / तुमच्या मनावर सतत ताण /दडपण असल्यासारखं वाटतं का? /क्या आप हमेशा किसी दबाव में रहते है?	
GHQ 6	felt you could overcome your difficulties? /तु तुज्यो अडचणी सोडोवपाक शकता? / तुम्ही तुमच्या त्रासातून /अडचणीतून बाहेर येऊ शकता का? /क्या आपको लगता है की आप अपनी तकलीफों से बाहर आ सकते है ?	
GHQ 7	been able to enjoy your normal day-to-day activities? /तु तुज्ये सदाचे काम आवडीन करता?रोजचे काम तुम्ही आनंदाने /आवडीने करता का? क्या आपको हररोज / हरदीन / रोज का काम करने में खुशी मीलती है ?	
GHQ 8	been able to face up to your problems ? /तु तुज्या अडचणीक तोंड दिवक / सामोरे वचपाक शकता? / तुमच्या अडचणीना तुम्ही तोंड देऊ शकता का? /क्या आप अपनी मुश्कीलो का सामना कर सकते है ?	
GHQ 9	been feeling unhappy and depressed? /तु दुःखी आनी निराश आसा असे तुका दिसता? तुम्हाला दुःखी आणि उदास वाटतं का? /क्या आपको लगता है की आप दुःखी और निराश है?	

GHQ 10	been losing confidence in yourself? / तुका दिसता तुजो आत्मविश्वास कमी जाला? तुम्हाला वाटतं कि तुमचा आत्मविश्वास कमी झाला आहे? / आपका लगता है की आपका आत्मविश्वास कम हुआ है?	
GHQ 11	been thinking of yourself as a worthless person? / तु अशें चितता कि तुका वालोर / किंमत ना? तुम्हाला काहीच किंमत नाही असा तुम्ही विचार करता का? / क्या आप ऐसा सोचते है की आपकी कोई किंमत नहीं है?	
GHQ 12	been feeling reasonably happy, all things considered ? हया सगळ्या गोष्टीचो / गजालीचो / बाबतीचो विचार केल्यार तुका दिसता कि तु खोशी / खुशाल / सुखी आसा? या सगळ्या गोष्टीचा विचार केला तर तुम्ही साधारणतः/ पुरेसे सुखी आहात असं तुम्हाला वाटतं का? इन सब बातों को ध्यान में रखते हुये क्या आपको लगता है की आप सुखी है?	
Total Score		

End time:

If score is 6 & above write Intervention ID

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GHQ Examples

Q 1.

Example 1

While watching a TV Program are you able to concentrate?

तु टी .वी . पळयतना तुजे लक्ष लागता?

तुम्ही टी .वी . वघताना तुमचं लक्ष लागतं का?

आप टी .वी . देखते वक्त आपका ध्यान लगता है क्या?

Example 2

While cooking, do you remember to put salt in the food?

रांधताना मिठ घालपाच्ये तुमच्या लक्षान उरता?

जेवण करताना मिठ घालायचं तुमच्या लक्षात राहतं का?

खाना पकाते वक्त नमक डालना आपके ध्यान मे रहता है क्या?

While studying, are you able to concentrate on what you are reading?

शिकताना, तु वाचता तेजेर तुजे लक्ष लागता?

शिकत असताना, तुम्ही वाचतात त्यावर तुमचं लक्ष लागतं का?

पढाई करते वक्त पढने मे आपका ध्यान लगता है क्या?

Q3

Whatever work you do (for eg. Housework, fieldwork, job), do you feel it is useful?

तु जे काम करता घरातले वा घराभायले तुका दिसता ते उपयोगाचे काम आसा म्हूण?

तुम्ही जे काही काम करता घरातलं किंवा घराबाहेरचं तुम्हाला वाटतं ते उपयोगाचे काम आहे म्हणून?

आप जो कुछ काम करते है घरमें या बाहर आपको लगता है वो उपयोगी काम है?

Q4

If you have to go somewhere, for example, visit the doctor, are you able to make a decision about this?

तुका जर खयचंरूय वचपाक जाय उदा . डॉक्टराक मेळपाक जाल्या तू हो निर्णय /ठराव घेवुक शकता ?

तुम्हाला जर कुठंही जायचं आहे . उदा . डॉक्टरला भेटायला तर तुम्ही हा निर्णय स्वतः घेउ शकता का ?

अगर आपको कही भी जाना हो उदा . डॉक्टर के पास तो ये फैसला क्या आप खुद ले सकते हो?

Q6

If you have visitors at home and have run out of ingredients to make tea, will you be able to deal with this?

जर तुमच्या घरा सोयरी येयली आनी चांव करपाच्ये सामान सोपला जाल्यार तुम्ही ही अडचण सोडोवपाक शकता?

जर तुमच्याघरी पाहुणे आले आणि चहा करायचं सामान संपलेलं आहे तर तुम्ही या अडचणीतून वाहेर येउ शकता का?

अगर आपके घर मेहमान आये हो और चाय करने का सामान खतम हुवा हो तो क्या आप इस तकलीफ से वाहर आ सकते हो?

Q7

Whatever you do, example housework, job, are you able to enjoy these activities?

तू कितेंय करता, उदा . घरचे काम वा वायर कामांक वता ते तुजें सदाचे काम तु आवडीन करता?

तुम्ही काहीही करता उदा . घरचं काम किंवा वाहेर कामाला जाणं ही तुमची दररोजची कामं तुम्ही आवडीन करतात का?

आप जो कुछ करते हो जैसे की घर का काम या बाहर कामपर जाना क्या ये काम करने में आपको खुशी मिलती है?

Q8

Whatever problems you have for eg. illness in family, are you able to face this?

तुका कितेंय अडचणी येतात जशें घरान कोणीय दुयेंत आसा वा बरो ना जाल्यार तुजें हे अडचणीक तुं तोंड दिवक शकता?

तुम्हाला काहिही अडचण आली जसं कि घरात कुणी आजारी पडलं. तर तुम्ही या अडचणीला तोंड देउ शकता का?

अगर आपको कोई मुश्कील आई जैसे कि घर में कोई बिमार पडा हो तो क्या आप अपनी इस मुश्कील का सामना कर सकते हो?

If patients respond with somatic complaints, then say “ these are physical symptoms you are describing”. I am asking you about your emotional problems?

जर पेशंटान शारीरिक तक्रारी सांगल्यो जाल्यार तांका सांगचे की “ ह्यो ज्यो तक्रारी तुम्ही सांगल्यात त्यो शारीरिक पुण आमका मानसिक तक्रारी कळूंक जाय .

जर रूग्णांनी शारीरिक तक्रारीवद्दल सांगितलं तर त्याला सांगायचं “ह्या ज्या तक्रारी तुम्ही सांगितल्यात त्या शारीरिक आहेत पण आम्हाला मानसिक तक्रारीवद्दल कळायला पाहिजे .

अगर मरिज ने कहा उसे शारीरिक तकलिफ है तो उसे कहना कि “ ये जो तकलिफ आपने बताया है वो शारीरिक है और हमें मानसिक तकलिफों के बारे में जानना है/

After all that you have told me, do you still remain reasonably happy.

हया सगळ्या गोष्टीचो, गजालीचो, बावतीचो विचार केल्यार तुका दिसता कि तु खोशी / खुशाल, सुखी आसा?

या सगळ्या गोष्टी ज्या तुम्ही सांगल्या त्यांचा विचार केला तर तुम्ही साधारणतः पुरेसे सुखी आहात असं तुम्हाला वाटतं का?

ये सव बातें जो आपने बताया है उनको ध्यान में रखते हुये क्या आपको लगता है की आप सुखी है?

Can you write the name of the antidepressant you have prescribed? _____

What dose of the antidepressant have you prescribed?

When have you asked the patient to return for a follow-up

Please describe the primary medical diagnosis in this patient in the box below:

Appendix 4.3: The Intervention record form

This is the form used in the clinic to record the details of each patient who receives the Manas intervention

Intervention Record Form

Intervention ID:

--	--	--	--	--

Date of Registration: _____

Name : _____

Age: _____ **Sex :** _____

Marital Status: _____

Detail Address:

House No / Flat No: _____

Vaddo: _____

Village: _____

Taluka : _____

Landmark: _____

Consent for:

Letter Yes No

Telephone call Yes No

Home visit Yes No Day/ Time : _____

Spouse / Closest person's name: _____

Patient's occupation: _____

Telephone No/Mobile: _____

(If neighbor's contact) Neighbor's Name: _____

Doctor's Name: _____ **Clinic location:** _____

Data checked by _____ Date: _____

Data entered by _____ Date: _____

Intervention ID

--	--	--	--	--

FIRST CONSULTATION

Date : _____ Screening Q score: _____ Attended alone/accompanied _____ Medical diagnosis: _____	
Main Health Complaints	1 2 3 4 5
Mood rating	<input type="text"/>
Risk Assessment	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High
Social Difficulties	
Substance abuse	<input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> None
Possible barriers to adherence	
Adherence Management	
Antidepressant (drug, dose, duration)	
Other medication (apart from vitamins and sleeping pills)	
Advice given	
Follow up appointment (date/time)	
Remarks	
Plan for session 2	Problem area identified _____ Technique/s planned _____

Intervention ID:

--	--	--	--	--

Checklist for Suicide Risk Assessment

Demographic risks:

- Poverty
- Unemployed
- Separated, widowed

Clinical risks:

- Moderate or severe depression
- Previous suicide attempt
- Family history of suicide
- Misuse of alcohol or other drinks
- Physical illness and disability

Immediate risks:

- Ongoing severe social stress
- Lack of social support
- Hopelessness
- Loss of interest
- Frequent suicidal ideas
- Plan to commit suicide and access to means

Summary risk:

- No risk / Low risk
- Moderate risk
- High risk

Additional comments:

Intervention/ action taken:

Intervention ID:

--	--	--	--	--

Checklist for Social Difficulties

Social Difficulties	Brief description	Action taken
<input type="checkbox"/> Financial difficulties		
<input type="checkbox"/> Domestic violence		
<input type="checkbox"/> Unemployment		
<input type="checkbox"/> Legal disputes		
<input type="checkbox"/> Interpersonal conflicts		
<input type="checkbox"/> Problems at work		
<input type="checkbox"/> Health problems in self		

Social Difficulties	Brief description	Action taken
<input type="checkbox"/> Illness/disability in family		
<input type="checkbox"/> Substance abuse in family		
<input type="checkbox"/> Problem with parenting		
<input type="checkbox"/> Bereavement		
<input type="checkbox"/> Lack of support/isolation		
<input type="checkbox"/> Childlessness		
<input type="checkbox"/> Family member leaving home		
<input type="checkbox"/> Others, describe		

Intervention ID:

SUBSEQUENT CONSULTATIONS

Date:		Attended alone/ accompanied	
Type of contact:		<input type="checkbox"/> face-to-face	<input type="checkbox"/> telephone
Change in Main Health Complaints	1 2 3 4 5		
Overall status	<input type="checkbox"/> Better <input type="checkbox"/> No change <input type="checkbox"/> Worse Mood rating <input type="text"/>		
Risk Assessment	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High		
Social Difficulties			
Antidepressant (drug, dose, duration)			
Other medication			
PT Session No.			
Yoga			
Adherence management			
Advice given			
Consultation with Clinical Specialist			
Follow up appt			
Remarks			

Intervention ID:

--	--	--	--	--

MEDICATION RECORD

	Name	Dose	When started
Sleeping pills: Eg. Benzodiazepines Alprazolam/ diazepam		X	
Vitamins, Nutritional supplement		X	
Injections		X	
Antidepressant			

Reasons for starting Antidepressants: Tick the box (only one).

- Severity of depression
- Patient not better with PE
- Other reason. Specify: _____

Reasons for stopping Antidepressants: Tick the box.

PLANNED STOPPAGE – specify reason

- On completion of treatment
- Improved with treatment but course incomplete (doctor stops med or patient refuses)
- Referred out of the program ie. CS, other treatment centre
- Patient already on Psychiatric treatment, hence referred back to treating Psychiatrist
- Patient from another town/village
- Other reason, specify _____

UNPLANNED STOPPAGE – specify reason

- Refuses to continue despite no improvement
- Medication side-effects
- Not convinced medication will help/ are needed
- Failure to keep appointments.
- Other reason. Specify _____

Intervention ID:

--	--	--	--	--

Adherence Management

Barriers to adherence	Action taken to improve adherence
<input type="checkbox"/> Time constraints <input type="checkbox"/> Travel distance <input type="checkbox"/> Travel expense <input type="checkbox"/> Health problem <input type="checkbox"/> Dependent family member <input type="checkbox"/> Uncooperative spouse/relatives <input type="checkbox"/> Unconvinced about need or appropriateness of treatment <input type="checkbox"/> Pressing social difficulties <input type="checkbox"/> Other, specify	<input type="checkbox"/> Give flexible appointment <input type="checkbox"/> Address and telephone number carefully recorded so that patient can be reached by phone call, letter or home visit. <input type="checkbox"/> Offer telephone consultation <input type="checkbox"/> Brief counseling when yoga session attended <input type="checkbox"/> Offer to speak to relative to explain about the treatment <input type="checkbox"/> Reinforce mind body link <input type="checkbox"/> Referral letter to community agency / information about welfare schemes, etc <input type="checkbox"/> Telephone call to remind patient of missed appointment <input type="checkbox"/> Letter sent to remind patient about need to visit the clinic <input type="checkbox"/> Home visit for counseling <input type="checkbox"/> Other, specify:

Intervention ID:

--	--	--	--	--

Details of Discharge from the program

Date of Discharge: _____

Reason for discharge:

Planned discharge:

- improved with treatment and completed course of treatment
- improved with treatment but course incomplete (either doctor stops meds or patient refuses)
- referred out of the program ie. CS, other treatment centre
- patient already on Psychiatric treatment, hence referred back to treating Psychiatrist
- patient from another town/village

Unplanned discharge:

- refusal to start treatment
- refusal to continue treatment despite no improvement
- failure to return for appointment despite all efforts to contact him/her
- change in residence
- no/wrong address
- death of patient
- other, specify _____

Appendix 4.4: Antidepressant table

This consists of a list of commonly used antidepressant medication in primary care with their recommended doses and common side effects

Guidelines for Antidepressant use

Name of antidepressant	Commonly available brand names and strengths	Monthly cost of maintenance dose	Starting dose	Maintenance dose (usually in 2 weeks)	Maximum recommended dose if no response at 4 weeks	Common side effects	Specific clinical indications/ relative contra indications
<u>Serotonin specific reuptake inhibitor (SSRI)</u>							
Fluoxetine	Depzac Fludac Flunat Available as 10, 20 and 40mg capsules	Rs. 72 Rs. 96 Rs. 84 (20 mg daily)	10-20 mg in the morning on full stomach	20 mg	40 mg	GI disturbances Headache Sweating Sexual problems	Convenient once daily dose Generally tend to increase the availability of concurrent medications like warfarin
Sertraline	Zosert Setalin Inosert Serenata Available as 25, 50 and 100 mg tablets	Rs. 189 Rs. 165 Rs. 150 Rs. 195 (100 mg daily)	50 mg in the morning on full stomach	100 mg	200 mg		Non sedating and generally well tolerated Use in lower doses for patients with hepatic or renal problems Taper and withdraw

Citalopram	Celica Citadep Citara Available as 10, 20 30 and 40 mg tablets	Rs. 186 Rs. 132 Rs. 165 (20 mg daily)	10 mg in the morning on full stomach	20 mg	30 mg		
<u>Tricyclic antidepressant (TCA)</u>							
Dothiepin (TCA)	Prothiaden Dothin Exodep (Available as 25, 50, 100 and 150 mg tablets)	Rs. 150 Rs. 170 Rs. 150 (100mg daily)	50 mg at night	100mgs	150 mg	Dryness of mouth Constipation Postural hypotension Sedation Tachycardia	Useful when sedation is requir Weight gain Avoid in patients with cardiac problems and elderly Avoid in patients with high suicida risk Taper and withdr
Imipramine (TCA)	Antidep Depsonil- PM Depranil Available as 25 and 75 mg tablets	Rs. 120 Rs. 80 Rs. 66 (100 mg daily)	50 mg at night	100 mgs	150 mg		
Amitryptiline	Tryptomer Sarotena Relidep	Rs. 108 Rs. 48 Rs. 34	50 mg at night	100 mgs	150 mg		

	Available as 10, 25, 50 and 75 mg tablets	(100 mg daily)					
<u>Other antidepressants with mixed profile of action</u>							
Venlafaxine (SNRI)	Flavix Venla XR Venlor Available as 37.5, 75 and 150 mg tablets and XR capsules	Rs. 165 Rs. 225 Rs. 210 (150 mg daily)	75 mg in the morning on full stomach	150 mg (2 divided doses)	225 mg	Nausea Constipation Headache Sweating Postural hypotension Insomnia	Avoid in pregnant and during breast feeding Taper by 37.5 mg every 2 weeks while stopping; sudden stoppage causes unpleasant withdrawal symptoms
Mirtazapine	Mirtaz Mirzest Mirnite Available in 7.5, 15, 30 and 45 mg tablets	Rs. 345 Rs. 255 Rs. 315 (30 mg daily)	15 mg at night	30 mg	45 mg	Sedation Weight gain GI disturbances Swelling of joints	Useful when insomnia and lowered appetite are prominent symptoms

Appendix 4.5 Letters for adherence management and community referral

These are formats for the letters that are sent to patients to ensure adherence to treatment. In addition, there is also the outline of a letter used to refer patients to social/community organisations for assistance for social problems.

Appendix4.5a: Letter for patients who failed to meet the HC at first visit

Date: _____

To

Hello,

When you visited _____ Clinic on _____, you were asked some questions and asked to meet the Health Counselor for your health problems. Unfortunately, I noticed that you could not meet me. I would like to ask you to meet me as soon as possible at the Clinic.

I am available in the clinic from _____ to _____ days at _____ to _____ time.

My contact no. _____

Thanking you,

HEALTH COUNSELOR
(_____)

Appendix 4.5b: Letter to remind patients of their appointment for ADT follow up

Date: _____

To _____

Hello,

When you visited Dr _____'s clinic you were given an appointment to return on _____ for your medicine prescription and to meet me.

I am writing to remind you of your appointment. Please do visit the clinic or call me if you wish to change the date or time of your visit. I am interested to know if the treatment and advice given to you has helped you and discuss with you if any further treatment might be helpful.

I am available from _____ to _____ days from _____ to _____ time.

Please do not miss this visit to the clinic or call me on _____

Thanking you,

Health Counselor

_____ Clinic

Appendix 4.5c: Letter for patients who have missed their follow up appointment

Date: _____

To

Hello,

I am writing to remind you to see me at _____ clinic for your health.

Can you meet me at the clinic any time in the week

from _____ to _____ between _____ to _____ hours. I am especially interested to know if the treatment and advice given to you has helped you and discussing with you if any further treatment might be helpful.

I hope there is improvement in your health but it is important for your health that you need to visit the clinic to see the health counselor for further advice / for the continuation of medication..

Please do not miss this appointment. If you need to change the appointment date / time, you can telephone me on _____.

HEALTH COUNSELOR

Appendix 4.5d: Final reminder letter

Date: _____

To

Hello,

When you had visited _____ clinic you were asked some questions about your health and were asked to visit me, the Health Counselor. I then gave you an appointment to meet me again but you have been unable to do so.

It has now been a while since we last met, and I am writing to make sure you are in good health. Please do call me or visit me in the clinic to let me know how you are keeping. I am especially interested to know if the treatment and advice given to you has helped you , and discussing with you if any further treatment might be helpful .

I am available from _____ to _____ days at _____ to _____ time.

Please do not miss this visit to the Health Counselor or you can call me on

_____.

Thanking you,

HEALTH COUNSELOR

(_____)

Appendix 4.5e: Reminder letter for Yoga course

Date: _____

To

Hello,

During your visit to _____ Clinic on _____ you were informed by the Health Counselor about Yog course and its advantages.

This is to remind you that we are starting the Yog course from

_____ to _____ at _____ to _____

time at _____ clinic.

Yog can help you to relax your body and mind which lead to improved health and wellbeing. We hope that this course would benefit you.

For further information you can telephone me on _____.

HEALTH COUNSELOR

(_____)

Appendix 4.5f: Letter for referral to community agency
REFERRAL FORM

Date: _____

From: _____

Health Counsellor (Clinic Name) _____

Patient name: _____

Age: _____

Address: _____

Phone no: _____

To,

Dear Madam / Sir,

Reason for referral:

Background information:

I can be contacted on _____ and would be happy to discuss queries and developments with you to ensure best outcome for _____.

Thanking you,

Appendix 4.6 : Format for reporting of process indicators

These are the formats in which the process indicators should be reported to the IF on a weekly and monthly basis.

Format for reporting weekly and monthly process indicator data

WEEKLY REPORT

Clinic	Week days	No. of cases with Interv. ID	Received 1st PE		No with mod/sev depression	Mod/Sev cases on ADT		All patients on ADT		Completed 3 months of ADT		On IPT	Referral to CS
			No.	%		No.	%	No.	%	No.	%	No.	No.
			A	B		C		D	E		F		G

MONTHLY REPORT

Clinic	Month	No. of cases with Int ID	Psychoeducation		Step 2 (ADT)						Yoga		In follow up		Missd follow up		Discharge d		Reason discha	
			Session 1		Total No on step 2	Planned stoppage	On maintenance	Move d to step 3	Misse d FU	Lost to FU	No. att. yoga	No pt att. Yog	No	%	No	%	No.	%	planne d	
			No.	%																

Appendix 4.7: Yog assessment forms

These forms are used during each yoga session to evaluate the physical health of the patients and their performance during the session.

Appendix 4.7a:

Evaluation form for patient

(From a point of view of knowing diseases / conditions for which Yog Techniques are to be practiced with caution or contra - indicated)

Full Name: Mr. /Mrs./Ms. _____

Date of Birth: _____

Full Address (Residence):

_____ Tel / Mob:

_____ (Office):

_____ Tel / Mob:

Education / Qualification: _____

Profession: _____

Languages known (Just ✓): Konkani / Marathi / Hindi / English

Medical History

- | | Yes | No |
|--|------------|-----------|
| A. Circulatory System | | |
| - High blood pressure | | |
| - Chest pain | | |
| - Heart attack | | |
| B. Digestive System | | |
| - Peptic Ulcer | | |
| - Irritable Bowel Syndrome
(Diarrhea with colic – off & on) | | |
| C. Respiratory System | | |
| - Asthma | | |
| D. Eyes | | |
| - Glaucoma (increased eye pressure) | | |
| - Retinal detachment | | |
| E. Musculo-skeletal system | | |
| - Spinal pain | | |
| • Neck | | |
| • Mid – chest | | |
| • Lower back | | |
| - Spondylitis | | |

- Prolapsed Intervertebral disc (If yes → level → upper/mid/lower)
 - Fractures (If yes → write where / which bone)
- D. Nervous System
- Epilepsy
 - Anxiety
 - Depression
- E. Operation (if any)
- Name of disease / operation date

For Ladies
(Only when relevant)

- Menstrual History
- Pregnancy (Are you pregnant)
If yes, how many months.

Appendix 4.7b

YOG ASSESSMENT FORM FOR PARTICIPANTS

Name of Clinic: _____

Name of Health Counselor: _____

Date : _____ to _____

Course No:

Sr. No.	Name of participant	ID. No.	Training Sessions			Follow up – open sessions					Remarks (about home practice)		
			1	2	3	1	2	3	4	5	regular	irregular	

Give the following grades for each participant depending on the over all performance of the participants during the session.

Grades: (For training and follow-up sessions)

- A- Very Good,
- B- Good,
- C- Average,
- D - Satisfactory,
- E- Unsatisfactory.

Tick mark : (✓) Regular / irregular (for home practice).

Appendix 4.8: HC Supervision forms

These are forms used by the IF and the CS to record their observations during supervisory visits. They include quality assessment forms of all the interventions including yoga

Appendix 4.10a: Contact sheet

Contact Sheet for CS and IF

Date : _____

Clinic: _____

Contact made by : CS / IF / other, specify _____

Type of Contact: Visit / telephone / other
Planned / unplanned

Contact Person: HC / HA / Doctor / other, specify _____

Duration of contact: _____

Group meeting: Y / N

Parameter Assessed	No review ed	Quality 0 – poor 1—fair 2—good	Problems	Recommendations
Record Keeping by HC				
1.Patient dairy				
2.Daily reg. of patient contact				
3. Contact summary form				
Intervention delivery Psychoeducation				
IPT				
Antidepressants				

Yoga				
Parameter Assessed	No. review ed	Quality 0 – poor 1—fair 2—good	Problems	Recommendations
Following model of stepped care				
Referral to social agencies				
Adherence management				
a. Psychoeducation follow up				
b. ADT Follow up				
c. Missed patients				
d. IPT follow up				
Screening				
Record keeping by HA 1. Register 2. ADT records 3. Patient cards				

Other issues around collaborative care: Case discussion with the doctor, seen patients referred for Step 4 treatment, etc:

Appendix 4.8b:

Psychoeducation Supervision Checklist Session 1

Intervention ID: _____ **Date** _____

HC : _____ **Clinic:** _____ **Supervisor:** _____

() Audiotape () Live Supervision () Verbal Report Only

Scale : 1 to 5: 5: superior; 4: very good; 3: meets basic skill; 2: doesn't meet basic skill; 1: Poor.

TASKS	Score	Failed to Attempt/ NA	REMARKS
Greeting			
Explaining confidentiality			
Eliciting symptoms			
Mood rating			
Inquiry on suicidal ideas			
Inquiry on alcohol /smoking /drug use			
Eliciting stressors			
Asking for patient's perception of problem and explaining mind-body link			
Giving the sick role Giving hope			
Breathing exercise			
Advice on specific symptoms			
Advice on ADT			
Advice on Alcohol / Smoking			
Describing interventions			
Introducing availability of Yoga			
Referral to community agency			
Concluding the session			

Effective use of flip chart			
Giving handouts			

**Psychoeducation supervision Checklist
Session 2**

Intervention ID: _____

Date: _____

HC: _____

Clinic: _____

Supervisor: _____

Audiotape Live Supervision Verbal Report Only

Scale : 1 to 5:

5: superior; 4: very good 3: meets basic skill 2: doesn't meet basic skill 1: Poor

TASKS	Score	Failed to Attempt/ NA	REMARKS
1. Review of clinical status including suicidal ideas. Mood rating			
2. Review Social difficulties			
3. Reinforcement of information provided in Psycho education 1			
4. Advice on ADT			
5. Discussing specific strategies to deal with identified problem area			
6. Planning further intervention in persons who have not improved			
7. Concluding the session			

**Psycho education supervision Checklist
Session 3**

Intervention ID: _____ Session _____ Date: _____

HC: _____ Clinic: _____ Supervisor: _____

Audiotape Live Supervision Verbal Report Only

Scale : 1 to 5:

5: superior; 4: very good 3: meets basic skill 2: doesn't meet basic skill 1: Poor

TASKS	Score	Failed to Attempt/ NA	REMARKS
1. Review of clinical status			
2. Review Social difficulties			
3. Reinforcement of information provided in previous session			
4. Planning further intervention if necessary for those not better			
5. Ending the intervention (when applicable)			
a. Early warning signs			
b. Steps to take incase symptoms reappears			
6. Concluding the session			

Appendix 4.8c: IPT supervision form

Individual IPT Consultation Checklist
Initial Phase (Session 1)

Patient ID: _____

Session # and Date: _____

Therapist (Th) : _____

Supervisor: _____

Audiotape Live Supervision Verbal/written Report Only

1 = Poor

2 = Fair

3 = Average

4 = Very Good

5 = Excellent

Competency (take into consideration the level of experience, i.e., 1 st , 2 nd , 3 rd case	Use 1 – 5 Rating	Failed to Attempt	Not Applicable to Session	REMARKS
1. Introduces IPT and Reviews patient's stress symptoms for past week				
2. Obtains stress rating ("ladder scale")				
3. Reinforces the link between stress and symptoms –				
4. Conducts interpersonal inventory				
5. Evaluates impact of relationships on stress and stress on relationships				
6. formulates the problem area				
7. Agrees with the patient on 1 or 2 IPT problem area.(s).				
8. Uses counseling skills where appropriate				
9. Concludes the session				

10. Outlines structure of sessions and contract (# of sessions, attendance, patient's role in treatment)				
11. Demonstrates knowledge of IPT model				
12. Works at establishing rapport				
13. Demonstrates accurate understanding of patient's problem and its context				
14. Has a collaborative style				

**IPT-I Consultation Checklist
Middle Phase (Sessions 2-5)**

Patient ID: _____

Session # and Date: _____

Therapist (Th) : _____

Supervisor: _____

Audiotape Live Supervision Verbal/written Report Only

1 = Poor 2 = Fair 3 = Average 4 = Very Good 5 = Excellent

Competency (take into consideration the level of experience, i.e., 1st, 2nd, 3rd case	Use 1 – 5 Rating	Failed to Attempt	Not Applicable to Session	Remarks
1. Reviews stress symptoms for past week				
2. Obtains stress rating ("ladder scale")				
3. Connects previous week's mood to interpersonal events				
4. Elicits details from week which connect mood to events and events to mood				
4. Provides psychoeducation about stress-related illness when appropriate, including normalizing it				
5. Focuses on identified problem area				
6. encourages patient to talk about his feelings				

Grief				
6. Relates stress symptoms to death of important person				

7. encourages the patient to talk about the time just prior to , during and immediately after the death				
8. Reconstructs the relationship with deceased				
9. Elicits positive and negative feelings about deceased				
10. Explores feelings about future without the deceased				
11 Explores new interests, relationships				
12. uses specific techniques as appropriate				
Disputes				
13. Relates symptom onset to dispute				
14. Identifies stage of dispute				
15. Helps patient see differences in expectations				
16. Helps patient see the other's perspective				
17. Uses Communication Analysis				
18. Uses Decision Analysis to set a plan of action				
19. Uses Role Play				
20. Uses Work at Home				

Role Transition				
21. Relates stress symptoms to coping with new role				
22. Helps patient mourn the loss of old role				
23. Discusses positive and negative aspects of old role				
24. Explores positive and negative aspects of new role				
25. Helps patient look at new opportunities and develop new skills				
26. When new role does not have positive side, helps patient look at what he can control in his new role				

Interpersonal Deficits				
27. Relates stress symptoms to loneliness and isolation				
28. Explores current and past social interactions				
29. identifies if the problem is in initiating and /or maintaining relationships				
30. Helps patient engage in social interactions				
30. Uses Communication Analysis				
31. Uses Decision Analysis				
32. Uses Role Play				

33. Give feedback to patient about how he comes across in office to educate how he might be coming across to others				
---	--	--	--	--

34. Demonstrates knowledge of IPT model				
35. Works at establishing rapport				
36. Encourages expression of affect				
37. Keeps patient focused				

**Individual IPT-I Consultation Checklist
Termination Phase**

Patient ID: _____

Session # and Date: _____

Therapist (Th) : _____

Supervisor: _____

Audiotape Live Supervision Verbal/written Report Only

1 = Poor

2 = Fair

3 = Average

4 = Very Good

5 = Excellent

Competency (take into consideration the level of experience, i.e., 1 st , 2 nd , 3 rd case	Use 1 – 5 Rating	Failed to Attempt	Not Applicable to Session	REMARKS
1. Reviews stress symptoms from previous week				
2. Obtains stress rating “ladder scale”				
2. Discusses warning symptoms of stress related illness (How would you know that you are getting stressed again?)				
3. reviews changes in symptoms and interpersonal problem area				
4. Identifies successful strategies used in treatment				
4. Reviews interpersonal goals, successes and efforts to change				
5. Discusses generalization				

of strategies to future situations				
6. Discusses feelings about ending treatment				
7. Assesses need for further treatment				
8. Discusses possibility of recurrence and plan for managing recurrence				
9. Demonstrates knowledge of IPT- model				
10. Works at maintaining rapport				
11. Encourages expression of affect				
12. Keeps patient focused				

YOG ASSESSMENT FORM FOR HEALTH COUNSELOR

Name of Clinic: _____

Name of Health Counselor: _____

Date : _____ to _____

Course No:

Sr. No	Parameter Assessed	Quality 0 - Poor 1- Fair 2 - Good	Problems	Recommendations
1.	Explanations (Theory)			
2.	Demonstration (Practical)			
3.	Evaluation of Participant's Performance			

Assessed by:

DR. S. GHANEKAR
(Yog Consultant)

Intervention Facilitator

Appendix 4.9: Community Referral Agencies

The table below lists various social agencies in Goa along with their contact details to which you should refer patients for their social problems.

REFERRAL AGENCIES

Sr. No	NGO	TEL	Contact person	Services offered
HIV/AIDS				
1.	ASRO, Near Holy Cross church, Cavelossim, Salcete	2871745	Sr. Virita Joseph	Care and support centre, educational support for children, nutrition, OPD, hospital referrals, prevention.
2.	CHART Foundation, R.A Apts, 2nd floor, opp KTC, Madel, Margao	2702031 time: 9.00am to 5.00pm	Sanjay Naik	Sessions for street children, migrant, tourists, distribution of condoms, counseling.
3.	FRB, Vasco	9822155029, 2791677, 2647700	Shakeel Sheikh	
4.	Hope Foundation 1st floor, flat 1, Aguiar apts, opp. Hotel Welcome, Birla rd, Zuarinagar.	5650929	Ashok Magheri	OutReach information, referrals to GMC.
6.	Freedom Foundation, Opp Green Park hotel, 105, A-2, Sorvem, Guirim.	2264262	Karl Pinto	Counseling, women support groups, testing, vocational advice, Dots TB centre, Counseling.
7.	Humsafar Trust- A male sexual health agency, 1st floor, Uma Shankar bldg, near MPT ground, patrong, Baina, Vasco	2500144	Vishant Chodankar	Health care and support, counseling, telephone counseling, referrals to VCCTC, free condom distribution, drop in centre.

8.	Rishta,2nd floor, Zeibreina Complex, Naikavaddo, Calangute.	2275843	Sophia	Information, education,counseling, home based care,support for affected people
9.	Lifeline Foundation,Shop 3,above Anvir stationary, Despamond bldg,St Inez, Panaji.	2421303	Ashfaque Sheikh	Targeted intervention- truckers,tourist related workers,street children, CSW,migrant, counseling,referral to hospital.
10.	Sai Life Care, PDA market, Tisk, Usgao.	9823117295,98904 61027	Ashok Magheri	Awareness,youth development centre,referrals,conde nsed crash course to SSC failures.
11.	Destro E mahila Mandal (DEMM),21, Sapna Tarrace,Swatantra Path, Vasco	2500483,5650407	Celesa Antao	Awareness, Family counseling,creche units,slum schools
12.	Population Service International,1st floor,flat1,ShriKrish na Bldg, opp.Chase International,Vasco.	2514894	Anu Raju	Testing and counseling, Doctor Services.
13.	Arz, Baina Vasco	2519951	Arun Pandey	Counseling, vocational training,referral.
14.	Kripa Foundation Casa Albuquerque,1710 SorantoAnjuna Vagator rd ,Anjuna	2256142	Toshi Malik Pramilla _ (counsellor)	Visit Hospicio Hospital- Margao(Tuesday)
15.	Jaan Ugahi, Margao	2737167	Bernie D'Costa	
16.	Saad A la shira,(refer to Bailancho Saad) Porvorim	2410864	Anjela	Counseling, awareness,prevention.

- | | | | | |
|-----|---|---|---------------|--|
| 17. | GSACS,1st floor,
Dayanand Smruti
bldg,Swami
Vivekanand road,
Panaji | 2427286, 1097
GOASACS@sacharnet.in
Also at
Azilo,Hospico,GMC | Asha Verekar | Confidential
counseling,testing
centre at GMC, blood
bankSTD related
services,free
medicines. |
| 18. | Zindagi flat no:C-3,
Penguine apts, Pixem
Dongri, Vasco | 2512938 | Azad Sheikh | Nutrition,Traveling
expenses,medication,
VCCT,referrals to
GMC, cothing,
entertainment. |
| 19. | Positive
People,Maithili Bldg,
St Inez, Panaji | 2424396 | John Pinheiro | Counseling,awareness
programs. |

DRUG AND ALCOHOL PROBLEMS

- | | | | | |
|----|---------------------------------------|---|-------------------------|------------------------------------|
| 1. | Kripa
Foundation,Arpora,
Bardez | 2256142/2274350 | Toshi Malik | Drug and alcohol
detoxification |
| 2. | Alcoholics
Anonymous | Panaji 2224140,
Saligao 2278268
Assagao
9822181678 | Kemal Barros
2224709 | Alcohol detoxification |

-
- | | | | | |
|----|--|-----------------------|--|------------------|
| 1. | Alcoholics
Anonymou.
Sour & Soria Apptm
sh.no. 89 grd flr
Bh.Gelin Chinese rst
Margao | 9860559909
2702872 | | Francisco Aguior |
|----|--|-----------------------|--|------------------|

- | | | | | |
|----|---|--|--------------------|----------------------------------|
| 4. | Drug and Alcohol
Detoxification at
Khorlim Mapusa and
IPHB | | Dr.Rajesh
Dhume | Drug n Alcohol
detoxification |
|----|---|--|--------------------|----------------------------------|

SHORT STAY SHELTER HOMES FOR WOMEN AND CHILDREN

- | | | | | |
|----|---|---------|--------------------------------|---|
| 1. | Casa de la
Esperanca, House
no.763/2, | 2273921 | Sonia Bona,
Caroline Colaco | Short stay home
3months,8 women,
counseling, medical aid, |
|----|---|---------|--------------------------------|---|

	Gaonkarwado, Anjuna 403509			legal aid.
2.	Asha Niketan, Villa Moraes,Hno.25,Bello y, Nuvem	2738712	-	Short stay home for women and children
3.	Asha Mahal, Taliegao	2451133	Ms. Joshi	Short stay for women 6months-2 yrs.
4.	Home for Destitute women and children, sisters Adorers, Palacio de Deao, Quepem	2662425	-	Short stay facility for women and children
5.	Eshkrupa Foundation for women in distress Porto wado-siolim	2272157	Sis Isabel	Short stay for child below 7yrs of age and women below 50yrs of age.

SHELTER FOR THE ELDERLY

1.	Provedoria , Neugi nagar, Rue de Orem, Panaji.(contact address for details)	2223356	Ms. Hira	Homes for aged and neglected adults in different parts of Goa.
2	Old Aged Home: Dr, Alfredo Antao Memorial, Cotto chandor-goa			
3	St.Joseph Home for Aged. Portowado-Siolim Bardez Goa	2272246	Sis Babora Superior sis crescentia	Homes for aged: only for christian Fee: Rs.2000/- per mnth

RESOURCES FOR SEVERE MENTAL ILLNESSES

- | | | | | |
|----|--|--|--|--|
| 1. | COOJ (Cause of our Joy),6/32, Casa Trinidad, Sonarbhat, Arradi, Saligao, Bardez(branch at Vasco) | 2278543
2253450 9.30am to 4.30pm
fees:1000/- per month | -Dr.Peter Castellino
-Mrs. Nair
-Ms. Janette (mapusa branch) | Caritage Trust providing mental health services like day care and a vocational centre for the severely mentally ill. |
| 2. | Institute of Psyciatry and Human Behavior,opp Fulacho Khuris, Bambolim | 2458687 | Dr. Melvin Chagas Silva | Outpatient and inpatient care for persons with severe mental disorders |

COUNSELING

- | | | | | |
|----|--|--------------------------|---|--|
| 1. | Redemptorist House, Near Ashwin Garage, Porvorim | 2417586 | Fr. Desmond D'souza | Counseling |
| 2. | All India Women's Conference - Family Counseling Centre, Junta House, 3rd lift, 1 st floor, Panaji. | 2235425 | Ms. Madhuri Rao | Counseling, socio legal assistance. |
| 3. | Diocesan Family Service Centre,opp Streamer jetty, D.Bandodkar Marg, Panaji | 2224140 | Fr. Simon | AA, counseling, marriage formation course. |
| 4. | Sangath Centre for Child development and family guidance,841/1, Alto Porvorim Sunning dale appts,Near child care school, | 2414916,2417914, 2711912 | Prachi Khandeparkar, Kalpana Joshi,vandana Kakodkar,Dr. Gauri,Gracy Andrew. | Counseling,child, adloscent and family mental health intervention. |

Pajifond.

CHILDREN WITH PROBLEMS

1.	Apna Ghar, Mercedes.	2434321	, Pramila Fernandes	Remand and observation home for neglected children and in conflict with law, CWC, JJB
2.	Childline c/o Don Bosco's, Panaji	1098,2221986	Fr. Francis	Help offered to children in distress medical, educational.
3.	Childline Nodal Agency c/o Nirmala Institute, Altinho	1098,2231996	Sr. Philomena Serrao	Help given to children in need medical.
4.	CRG, 1st floor, Meera bldg,near Gomantak Office,near St. Inez church.	2426518	Ms. Nishta Dessai	Rights of children, informal school form children, resource room for children at Nagoa
5.	Sethu Child Development and Family Guidance, 1st floor, Fredrica Apts, Caculo Colony, Miramar.	5613749	Dr. Nandita D'Souza	Assessments for developmental problems, speech therapy.
6.	Jan Ugahi,V/14, Vikrant, malbhat	2737167	Bernie D'Souza	Porgrams for street working children,remedial education, non formal education, women's issues

LEGAL AID

1.	Free Legal Aid at High Court of Bobay at Goa, Altinho, Panaji		Advt. Norma Alvares (every Tuesday afternoons)	Free legal aid to women, children and others for cases in court of law.
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ORPHANAGES

1.	Matruchaya Trust, Dhaval, Ponda	2312152,2314507	-	Orphanage for girl child.
2.	Preet Mandir,	2289560	Ms. Lalita	Shelter home for

3.	Khursawado, Carona, Bardez Missionaires of Charity,Near Don Bosco, Panaji	2225321	Fernandes Sr. Aquila	destitute children, adoption centre. Adoption, Orphanage,shelter home for unwed mothers.
SPECIAL SCHOOLS				
1.	Lokvishwas Pratishthan, Shantadurga Krupa Ashram,opp. Matruchaya, Dhavali, Ponda	2314894	Chairperson Suresh Kudchadkar	School for blind, deaf and mentally challenged, conducts RCI recognised 90 days foundation course in special education.
2.	Daddy's Home, Opp Vidhyadhiraj mutt sankul, near Chowgule college, Vidhyanagar,margao.	2759825	Fr. Valmiki Dias	Hostel and school for mentally challenged children.
3.	Gujrati Samaj School,Near Maruti Mandir,Aquem,Margoa	2759825	Mrs.Bhakre	Schoolfor special children
4.	Keshav Seva Trust ,Bicholim Goa.	5631664	Ms.Khanolkar	Special School for mentally challenged children
5.	Peace Haven,Franciscan Hospitals of the immaculate conception,caranzalem	2464870	_sis linette	Hostel and school for mentally challenged Both boys n girls upto age 9 to 13 yrs.
6.	National Association for the Blind,Santa Cruz Tiswadi,Goa	2237236	Ms.Prabu	Boarding and Schooling for the Blind Children
7.	St.xavier's Academy(A program of Caritas,Goa),Kadamba Rd.Old Goa	2286343	Sr.Monica	School for mentally Challenged and other physical handicaps.

8.	District disability Rehabilitation Centre,G.M.C complex,Bambolim.	—	Lourdes Pinto	Hearing assessments,speech and language assesment,physiotherapy.
9.	Sanjay school for the disabled,Near Police station,Porvorim	2412880	Principal A.Viegas	Education and vocational assistance to slow learners,mentally handicapped,Hearing impaired and children with specific physical disailities.
10	Atma vishwas centre	9819317108	Liane D,Gama	Hostel for mentally challenged children above 14yrs age
11	Bailancho Ekvott H.no: 172, Rua Padre Miranda Rd. Margao	2736589 9225902163	Auda Viegas (president)	Consolidate wome power Deals with women victims of divorce n domestic violence.

Appendix 4.10 Introduction to the Manas Program

This is the power point presentation that is made in the clinics during the running in period to introduce the Manas program to the clinic staff

1.

The MANAS Project

Managing stress related health problems in primary care

Directorate of Health Services, Goa

Sangath, Goa

Voluntary Health Association of Goa

London School of Hygiene & Tropical Medicine, UK

2.

What are stress related health problems and how do they present in the clinic?

Most common complaints seen in family physician clinics

- Sleep problems
- Tiredness
- HEADACHE
- OTHER Aches and Pains
- Palpitations
- DIZZINESS

Often these don't improve even with medicines

3.

Stress related health problems present with Medically Unexplained Symptoms

These are symptoms or complaints which

- do not fit into any known medical diagnosis.
- which do not relate to any findings on laboratory or other investigations.
- which do not seem to get better on “usual” medical treatments.
- THEY ARE TYPICALLY CAUSED BY STRESS

4.

Stress and health

- We ALL experience stress in our life, which affects our health in different ways.
- We ALL experience stress in our life, which affects our health in different ways.
- Stress affects our physical health.

- STRESS AFFECTS OUR MENTAL HEALTH
- FOR EXAMPLE: loss of interest, Sadness/Low mood, WORRYING A LOT, LOSING CONCENTRATION, FEELING TENSE, WANTING TO END ONE'S LIFE
- Sometimes, THE PROBLEM BECOMES SEVERE AND LONG-LASTING AND BECOMES AN ILLNESS

5.

Why are these important?

- 15% attenders in FPC have these problems.
- OFTEN Long lasting large sums of money spent.
- Life problems – economic problems, family disputes –high risk for stress.
- Women are at 2-3 times greater risk than men.

6.

What happens to patients with these problems?

- Majority only consult primary health care doctors.
- Most are not recognized as having stress related problem.
- Treated with SLEEPING PILLS, tonics and vitamins.
- Multiple consultations and investigations
- SOME REMAIN ILL FOR LONG PERIODS
- FEW MAY TRY TO END THEIR LIVES

7.

What are the challenges to treating these problems in primary care?

- Potentially large numbers of patients and lack of time.
- Lack of trained mental health manpower, particularly for psychosocial treatments.
- Low levels of recognition of stress problems due to physical presentations and lack of time.
- Low adherence with treatments.
- Use of symptomatic treatments, e.g.long term use of sleeping medicine (e.g. Calmpose), tonics and vitamins.
- Lack of follow up as required for a chronic condition.

8.

What treatments work?

- Giving simple advice about the cause of the complaints, lifestyle changes (such as exercising regularly), advice about sleep, diet etc.

- Medicines, especially antidepressant medicines which are cheap but must be taken for at least 6 months.
- Counseling.
- Yoga.

9.

Where should treatment be given?

- WHO recommends that the best place for treatment is in primary care because:
 1. Most patients do not wish to see mental health specialists because of stigma.
 2. Most patients prefer to be treated close to their homes by their own doctors.
 3. Stress related problems are too common and mental health specialists are too few.
 4. The treatments are simple and can easily be given in primary care settings.

10.

We know what treatments work...

how can these be integrated into routine primary care in a manner that is feasible, effective, and affordable?

The MANAS program

(MANAshanti sudhar Shodh)

- Collaboration between the family physician and additional team trained by Sangath to overcome the problems of treating patients with stress related problems.
- Study whether this program is effective and affordable.

11.

The MANAS Intervention Model

Two models of care

1. Enhanced usual care
2. Collaborative stepped care

12.

Who will deliver the intervention?

THE Health Assistant

- Screen all ADULT patients for presence of stress related illness with SHORT questionnaire WHICH TAKES 2 TO 3 MINUTES
- If a patient is detected to have stress related illness, HA confirms this by administering a longer questionnaire WHICH TAKES 20

MINUTES

- REPORTS THE RESULTS OF SCREENING to doctor with results on patient card.

13.

Role of doctor

- Sees patients and asks about stress symptoms.
- Decides about Antidepressants.
- Sends patients to Health Counselor (only in CSC clinics).

14.

In addition, in CSC clinics.....

HEALTH COUNSELOR

- Works as a part of the clinic team.
- Offers COUNSELING TREATMENT to all patients referred by the doctor.
- Gives explanation regarding nature of symptoms and relationship with stress.
- Reports to the doctor.
- Conducts YOG classes.
- Monitors adherence, follow up and referral to community agencies.

15.

In addition, in CSC clinics.....

The Clinical Specialist

- TRAINING OF DOCTOR
- Support for primary care team.
- Supervision of HA and HC
- Consultation for complex/difficult cases.

16.

What has been our previous experience with the program

- we have worked in 12 PHCs for a period of one year and tested the program for it's feasibility and acceptability in FPCs for 4 months
- There have been many useful learning experiences which have been incorporated in the program to make it more effective.

17.

Previous experience

- It is very important to work together with all clinic staff as

everyone has an important contribution to make.

- E.g. some patients do not meet the HC after being seen by the doctor; the doctor and the doorman can help by telling patients that they need to meet the HC as well.
- Patients, staff and doctors have told us that the intervention is useful but adherence is the major obstacle.

18.

Research evaluation

- Key questions: is the package
 - Feasible
 - Affordable
 - Effective
- ⇔ 3500 PATIENTS Will be interviewed by team from VHAG who will meet patients at their residence.
- your feedback will also be taken.

19.

Implications of the study

- We will analyze the results of the program after completing 12 months in FPCs.
- If results indicate that this program is useful, we will discuss with the government about making it available in all primary care facilities.
- Together, we can make a big contribution to meeting the needs of patients with STRESS RELATED MENTAL HEALTH PROBLEMS.