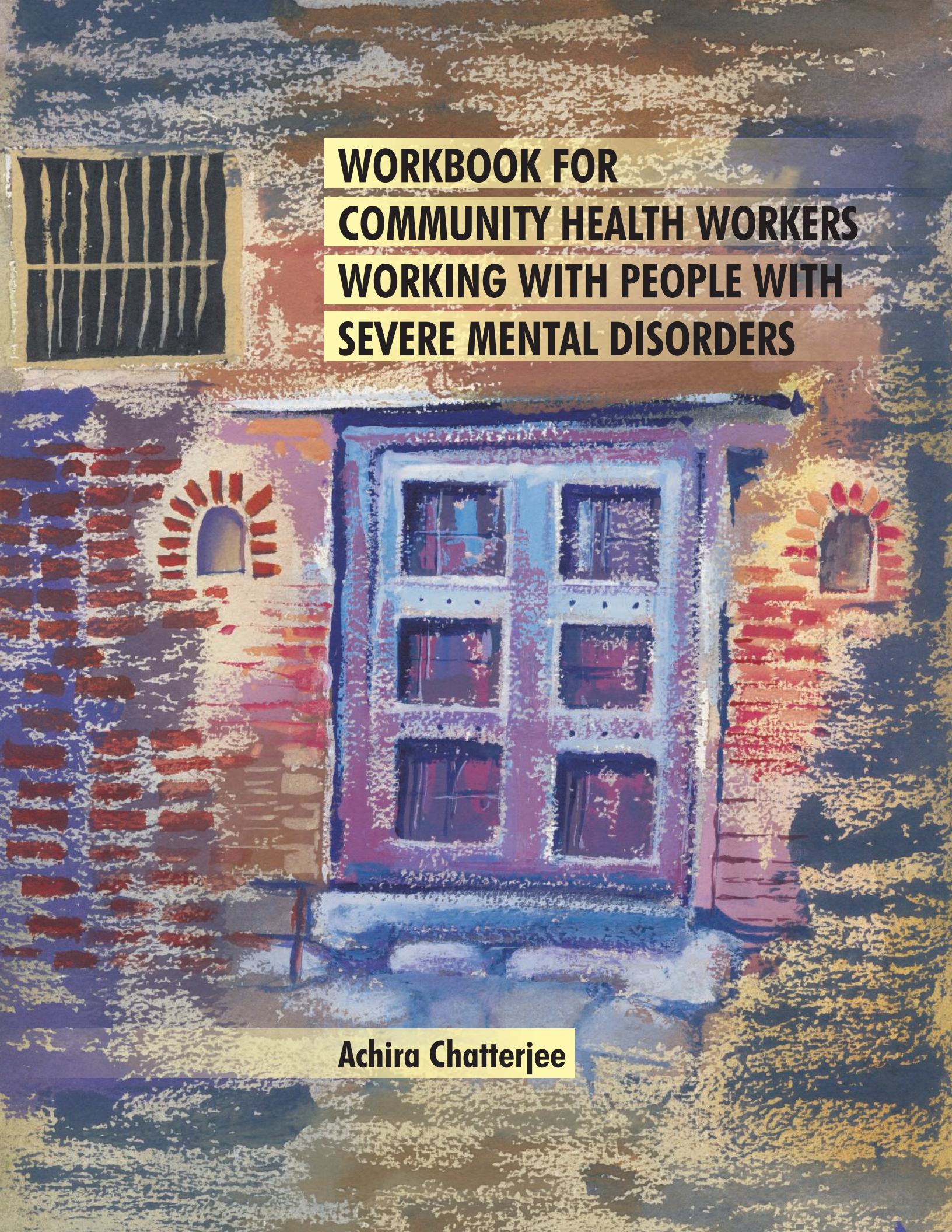

WORKBOOK FOR COMMUNITY HEALTH WORKERS WORKING WITH PEOPLE WITH SEVERE MENTAL DISORDERS

Achira Chatterjee

Workbook for Community Health Workers working with people with Severe Mental Disorders

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Achira Chatterjee

Parivartan

Preface

The idea for the workbook primarily came from discussions with Case Managers, Community Health Workers and trainers to develop training modules that were more user-friendly and interactive. The COPSI manual on schizophrenia and the audio-visual manual created by the Parivartan team are the reference points for this workbook in addition to case studies provided by the community health workers working in the INCENSE and Jan Man Swasthya programs that are being led by the Parivartan Trust. These programs were funded by the Dorabji Tata Trust.

The workbook provides a structured framework by defining the objectives, the method and the assessment framework for the skills required for each module. The first module on 'Self- awareness' provides an opportunity for community workers to reflect on why they want to work in the area of mental health. The remaining modules provide an understanding of how they need to work with the patients with schizophrenia, family members and the community. The last module of 'Self-care" provides strategies for community health workers to deal with their own stress and a support system to address their needs and concerns.

The format of the workbook is attached as an easy reckoner for trainers. I would like to thank the fantastic teams of community health workers from Pune and Tezpur for contributing to the making of this workbook through suggestions and sharing of ideas. Thank you Hamid, Sudipto, Amit and Dharav for receiving the draft of the workbook so favourably and for contributing to this through the COPSI manual, training modules, case studies, audio visual manual and assessment tools. I would like to acknowledge the contributions of Stifa, Jai, Shamika and Dilip for contributing to the case studies and helping me pilot some modules of the workbook. I am grateful to Julian Silverman for reviewing the workbook and for his unconditional support and optimism. Most importantly, thank you Suma for painstakingly formatting this workbook and making it so presentable.

I do hope this workbook will be a valuable resource for those who are training community health workers to engage in community based services for those with schizophrenia in other programs as well.

Achira Chatterjee
Consultant Psychologist
Parivartan Trust, 2017

CONTENTS

FORMAT OF WORKBOOK

S.NO	MODULE	FLOW OF ACTIVITY/FORMAT	LEARNING OUTCOMES/SKILLS	RESOURCES	ASSESSMENT TOOLS
1	***SELF AWARENESS***	• Self-reflective questions and discussion that offers insights. • Responding to an article in the newspaper about the mentally ill. • Audio visual clip (Module 1) • Overview of stigma and discrimination in the context ofschizophrenia (Module 2.5) of Resource manual.	The CHW's can gain insights into their own attitudes and concepts relating to mental illness	• Stigma and Discrimination:Graham Thornicroft • Audio visual clip: • COPSI Manual	• Point of view expressed during discussion • Attitude towards mentally ill expressed as responses to the self-reflective questions
2	***DEVELOPING A WORKING ALLIANCE***	• Skills of counselling video shown to the participants. • Role playing situations first enacted by the counsellor and then by the CHWs. • The counselling relationship manual shared with the CHWs • Training Case Manager's to fill the Initial contactform.(Appendix 1) and Home Assessment Form (Appendix 2)	The CHW's will be able to develop the basic counselling skills of building rapport and demonstrating empathy.	• Basic skills in counselling video: Sangath • The Premium counselling relationship manual. • Role playing situations. • Initial contact form • Home assessment form	• Role playing situations assessed on the following skills: expression of warmth, empathy, listening,reflecting, questioning, providing affirmation, summarizing and asking for feedback.

3	***IDENTIFICATION-SIGNS AND SYMPTOMS OF SCHIZOPHRENIA***	• The CHWs will then be asked to read the COPSI manual Module 1 on Introduction to schizophrenia. • The CHW's will be shown the audio visual presentation of on the signs and symptoms of schizophrenia. • Questions will be asked based on the case studies to assess their understanding. • CHWs will be trained to fill the Symptom Profile checklist (Appendix 3)	The CHWswill understand what schizophrenia is and how the disorder manifests and what the causes of the illness are.	• COPSI manual • JMSP Audio visual manual : Module 1 • Case studies • Questions	• Answers to questions regarding schizophrenia: identification of symptoms • Case studies for identification of symptoms • Quality of information in the Symptom Profile checklist

4	***UNDERSTANDING THE SOCIAL &ECONOMIC IMPACT OF SCHIZOPHRENIA***	• The CHWs will be asked to read the chapter on the "impact on schizophrenia in the family". • CHWs will be trained to fill the Social Difficulties checklist (Appendix 4)	The CHW will understand how schizophrenia effects the person's interpersonal relationships.	• COPSI manual • JMSP Audio Visual Manual: Module 2 • Questions • Role play situation • Testimonies from caregivers on economic impact	• Questions related to the impact on social functioning • Responses to the Social difficulties checklist based on a role play situation and the case studies in the audio visual recording
5	***PRINCIPLES AND METHODS OF PROVIDING CARE***	• Audio visual module 3 on Assessment • COPSI manual Module 2 on Individual treatments, effective problem solving, family treatment and benefits of community linkages • Interviewing techniques.	The CHWs will get an overview of the gamut of treatments for schizophrenia and the importance of psychosocial interventions	• COPSI manual • Audio visual clip: Module 3 • Role play situations	• Role play situations to enact interviews with patients and family members • Discussion on the use of drugs and their side effects • Providing case studies which assess problem solving skills of the CHWs • Role play of different family situations and assessment of the CHWs ability to deal with these scenarios.
6	***SUICIDE RISK ASSESSMENT AND MANAGEMENT***	• Audio visual Module 4 on Risk assessment • COPSI manual Chapter 3.3 on assessment and management of suicide risk • MANAS Health counsellor manual (Chapter 2.4) on the Assessment of Suicidal risk • CHW's will be trained to fill the checklist for Suicide risk assessment (Appendix7)	CHW's will be able to conduct an evidence based risk assessment and respond appropriately	• COPSI Manual • JMSPAudio-Visual manual: Module 4 • MANAS Health counsellor manual	• Role play situations with structured assessment

INTERVENTION					
7.1	***PROVIDING INFORMATION ABOUT ILLNESS, MEDICATION AND THEIR SIDE EFFECTS***	• COPSI Manual chapter 3.4 on providing information about the nature of illness, causes, course and outcome, the medication and their side effects • COPSI flip charts and health information booklets to be used as Psycho-education material • Audio visual Module 6.1 A on Psycho-education • CHW's will practice filling up the Medication Side Effects Checklist (Appendix 8)	CHWs will develop skills required for Psycho-education and be able to deal with a range of questions that may be asked by the patient or family	• COPSI Manual • Audio-visual clip: Module 6.1 A • COPSI Flip chart • Case studies with side effects of medication	• The CHWs will come up with a list of 20 FAQ's and answer these • CHWs will be asked to provide Psycho-education based on the Flip chart and be assessed on accuracy of information, communication skills and ability to answer questions posed by others • CHWswill identify the side effects of medication and fill the Side effects checklist with accuracy

7.2	***RELAPSE PREVENTION***	• COPSI Manual chapter 3.4 on what is relapse, recognizing early signs, effective ways of dealing with early warning signs • Audio visual Module 6 on Relapse Prevention • CHWs will practice filling up the Early warning signs of Relapse checklist(Appendix 9)	CHWs will develop a systematic method of enabling the patient and family members recognize the early signs of relapse and put in place a plan to deal with the situation	• COPSI Manual • Audio-visual clip: Module 6 • Case studies with early warning signs relapse	• The CHWs will fill up the Early warning checklist based on a case study • CHWswill be asked to formulate strategies to deal with the early warning signs of relapse and be assessed on whether they have followed the protocol of information exchange with the family, adherence review, clinical review and formulating a relapse management plan
7.3	***FAMILY INTERVENTIONS***	• COPSI manual chapter 3.5 on sequence, content, assessment of family needs, knowledge about illness, burden of caring, psycho-education and basic interventions. • Audio visual Module 6 on Psycho-education, disabilities in person with schizophrenia. CHWs will revisit the Checklist for Social difficulties(Appendix 4)and Needs Assessment Form (Appendix 5) and fill in details that they may have missed	CHWs will be able to identify the needs of the family and develop a specific management plan tailored to their needs	• COPSI Manual • COPSI DVDs • JMSPAudio-visual clip: Module 6 • Case studies with different family scenarios • COPSI Flip chart	• The CHWs will draft family intervention plans based on case studies with different family needs/scenarios.

7.4	***ADHERENCE MANAGEMENT***	• COPSI Manual chapter 3.6 on defining adherence, non-adherence, understanding reasons for non-adherence and adherence management strategies. • Audio visual Module 5 on Adherence management. • CHWs will practice filling up the Checklist for Assessing Non-adherence (Appendix 10) • The Follow-up Form (Appendix 11) and discharge forms (Appendix 12) will be introduced to the CHWs.	CHWs will be able to draft an adherence management plan based on Individual and family factors, treatment factors, therapeutic relationship factors and environmental and social factors	• COPSI Manual • Audio-visual clip: Module 5 • Case studies with non-adherence • Case studies with follow-up sessions	• The CHWs will draft an adherence management plan based on a case study • The Checklist for assessing non-adherence will be filled by the CHWs • CHWs will fill up the Follow up form and these will be reviewed to assess that the information provided is adequate and accurate
7.5	***HEALTH PROMOTION IN PEOPLE WITH SCHIZOPHRENIA***	• COPSI manual chapter 3.7 on common health problems (weight gain, cardiovascular disease, Type II diabetes, substance abuse, sexual dysfunction, osteoporosis), dietary recommendations and stress management. • Audio visual Module 5 on Physical Health of schizophrenics	CHWs will be able to able to identify physical health problems. substance abuse and diet related problems and provide strategies for health promotion CHWs will be able to help the patient develop effective coping strategies for dealing with stress provoking situations	• COPSI Manual • Audio-visual clip: Module 5 • Case studies	• The CHWs will draft a health promotion plan for two of the cases • The plan will be assessed on the basis of whether they cover all the different areas, whether they are practical and feasible and the strategies that will be used to put these plans into place.

8	***REHABILITATIONAND PROTECTING HUMAN RIGHTS OF PEOPLE WITH SCHIZOPHRENIA***	• COPSI manual chapter 3.8 on principles of rehabilitation, the process, social skills training and vocational skills training and job placement. • Audio visual Module 6 on Recovery in schizophrenia • COPSI manual chapter 3.9 on addressing stigma, forming self-help groups. • Audio visual Module 6 on Stigma Reduction. • Mental Health Care Bill 2011to know about citizenship rights, disability benefits. • UNCRPD agreement signed by India	CHWswill understand the process of rehabilitation, learn how social skills training is practiced, be able to match vocational skills training with possible employment opportunities CHWs will understand the stigma and discrimination faced by people with mental illness CHWs will be aware of the citizenship rights that need to be given to patients with mental illness (Aadhar card, access to disability pensions and schemes, vocational training opportunities, employment options) CHWs will learn skills to advocate on behalf the client to a range of stakeholders including health professionals	• COPSI Manual • Lapata Zindagi • INCENSE employment guide • Audio-visual clip: Module 6 • Module3.9, COPSI Manual • JMSP Audio-Visual Manual, Module • Mental Health Care Bill 2011 • UNCRPD agreement	• CHWswill develop a checklist for rehabilitation under different domains • CHWs will develop plans for rehabilitation under the different domains • The checklist will be assessed for its comprehensiveness and the plans will be evaluated for their feasibility and effectiveness • CHWs will identify instances of stigma and discrimination in the case studies that they have come across, in the audio visual presentations and write them down • CHWs will write down strategies for stigma reduction by working with the families/communities and SHGs • The ways of dealing with stigma and plans of providing citizenship rights will be reviewed for their feasibility

9	***SELF CARE OF CHWS***	• Strategies provided for CHWs to ask for help and deal with their stress and burnout • Positive workplace needs and requirements to promote well being • Problem solving skills to deal with conflicts with colleagues, families and caregivers and people with mental health issues. • Supervision records maintained by supervisors	CHWswill learn to recognize their need to seek help and ask for support CHW's will learn effective problem solving skills	• JMSP AV manual • Testimonies from staff	• Role play situations with different issues that the CHWs will use to display problem solving skills • Supervisors will draft a recording form for supervision sessions that will include domains of both personal and professional issues that will be discussed and dealt with

MODULE 1: SELF AWARENESS

OBJECTIVE/SKILLS:

- *CHWs become aware and gain insights into their own attitudes towards people with mental illness through reflective exercises.*
- *CHWs will understand the concept of mental illness Vis-a- Vis schizophrenia.*

ASSESSMENT TOOLS:

- Point of view expressed during discussions (positive, negative, neutral)
- Attitude towards mentally ill expressed as responses to the self-reflective questions

METHODOLOGY

Section 1: Questionnaire

The following statements relate to how you look at people with mental illness. Please answer these questions as honestly as possible.

1. I feel/felt apprehensive about working with people with mental illness because I was not sure what to expect from them. ☐ **Yes /** ☐ **No**
2. I would not have anyone in my family marry someone with mental illness. . ☐ **Yes /** ☐ **No**
3. I used to think/think that the mentally ill can be violent and dangerous so I am/was scared of them. . ☐ **Yes /** ☐ **No**
4. I think working with the mentally ill will help me learn more about their illness and help me learn how they can be cured. . ☐ **Yes /** ☐ **No**
5. I believe that the mentally illness is a stigma in society and I can help people understand the illness better. . ☐ **Yes /** ☐ **No**
6. I think people with mental illness cannot do work even after they have recovered from their illness. . ☐ **Yes /** ☐ **No**
7. I feel people with mental illness are always a burden on their family. . ☐ **Yes /** ☐ **No**
8. I think people who have recovered from mentally illness cannot be independent. ☐ **Yes /** ☐ **No**

Section 2: Lapati Zindagi screening, Questionnaire and Discussion 30 minute screening +1 hour discussion.

The CHWs will be shown "Lapata Zindagi". Thereafter, they will be asked to answer the questions.

Instructions: The following statements relate to the way our society looks at people with mental illness. The participants are to read each question carefully and then answer them. The discussions will be initiated by the facilitator and the main points will be written on the whiteboard.

1. Most people in my community would feel pity and/or look down on families who have a mentally ill member. . ☐ **Yes /** ☐ **No** ***Discussion point: If yes, what are the possible reasons for this?***
2. Parents who have a family member with mental illness often find it hard to talk about it and ask for help. . ☐ **Yes /** ☐ **No** ***Discussion point: If yes, why is this so?***
3. Mental illness is looked at being a "curse" that has been fallen upon the family for their sins in their past life. Do you think this happens? . ☐ **Yes /** ☐ **No** ***Discussion point: What do you think of this explanation?***
4. Mental illness can be treated and patients can lead normal lives. . ☐ **Yes /** ☐ **No** **Discussion point: Give examples that you know of.**
5. People with mental illness are deprived of their rights and often abused. . ☐ **Yes /** ☐ **No** ***Discussion point: Why are they treated with disrespect and neglected? Can you give examples of how they are treated?***
6. If there is a mentally ill family member, the relatives will hide this fact. Do you think this happens? . ☐ **Yes /** ☐ **No** ***Discussion point: Give examples of how this happens and the reasons behind it.***
7. Once you have mental illness, it is difficult for that person to go back to being "normal". . ☐ **Yes /** ☐ **No** ***Discussion point: Can you share why you think so and relate this to people you know or have heard of?***
8. People with mentally ill are sometimes regarded to have "special powers" and they are given an elevated status. Do you think this is true? . ☐ **Yes /** ☐ **No** ***Discussion point Why are they sometimes given this superior status?***
9. The mentally ill are possessed by evil spirits and these sprits need to be banished by traditional healers. Do you think this is true? . ☐ **Yes /** ☐ **No** ***Discussion point: Why is mental illness looked at like this?***

Section 3: Newspaper Article

Here is a newspaper article that appeared in the "Times of India" on August 19, 2016.Please read the article carefully and then give your answers to the questions that follow.

"Mental patients stripped of dignity, live naked"

-Subhro Niyogi

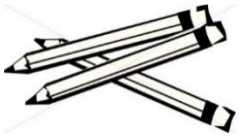
Kolkata/ Murshidabad: *More than 50 inmates of a mental asylum in Behrampore, West Bengal are forced to remain naked, without a shed of fibre to protect their dignity, because of alleged callousness by the authorities. Twenty of them are women. They say that their clothes are so badly infested with bugs that they prefer to go nude. One of the inmates, Kajal Mehta said patients had to sleep on dirty floors and use toilets that were filthy." There is so much filth and waterlogging in the bathrooms that patients slip on the moss and fall, leading to injury. Most inmates have not bathed for months. Since there is no barber, the men can't shave or have a haircut"….*

1. What is your first reaction when you read this article?

2. Have you come across some of these scenarios? If yes, why do you think it is so? In what ways is your set-up better than this?

3. If you could change the above scenario, what are the three things that you would do?

SECTION 4: ASSIGNMENT



The CHWs will watch the audio visual clip on "Stigma and Discrimination" and read the overview of stigma and discrimination in the context of schizophrenia *(Module 2.5)* in the Resource manual. Any questions or doubts will be cleared.

MODULE 2: DEVELOPING A WORKING ALLIANCE/THERAPEUTIC RELATIONSHIP

OBJECTIVE/SKILLS:

- *The Community Health Worker will be able to develop the basic counselling skills of building rapport, demonstrating empathy and building a therapeutic relationship.*

ASSESSMENT TOOLS:

- Role playing situations assessed on the following skills: expression of warmth, empathy, listening, reflecting, questioning, providing affirmation, summarizing and asking for feedback.

METHODOLOGY

Section 1:

1. The ***PREMIUM Counselling Relationship Manual*** is shared with the CHW's. The facilitator asks the CHWs to read through the chapter on "***An Introduction to counselling"****(Chapter 1).*
2. At the end of Chapter 1, the CHWs are asked to summarize the difference between counselling and a friendly chat. The facilitator "*demystifies"* counselling to say that it is a set of skills that one can acquire through practice. The CHW's are asked to brainstorm what they think are these skills. These are written on the whiteboard.
3. The CHWs then read the chapter on ***"An Effective counselling relationship***" (Chapter 2). Two facilitators will display each skill (warmth, empathy, genuineness, listening, reflecting, providing affirmation, summarizing and asking for feedback) by using the examples given in the Manual.
4. The CHWs then read Chapter 3 on "***Creating the Right conditions for getting started"*** and the facilitators demonstrate the skills of Introductions, confidentiality, recording sessions, guidelines for home visits, use of the telephone for counselling.
5. Skills of counselling video-***SANGATH*** is shown to the participants.

Section 2:

1. Role playing situations are provided to the CHWs, for them to develop a working alliance.

Case Study 1:

Shweta is a 21- year old lady who has recently had to have an abortion after she had a physical relationship with her sister's brother-in-law. She is feeling very guilty about engaging in a sexual relationship before marriage and also about having to abort the pregnancy. She is worried that the news will spread to all the villagers and they will say bad things about her and her family. Shweta lives with her father (who drinks alcohol regularly) and brother who is older than her. Her mother died when she was young due to a physical illness. She has an elder sister who is married and lives in the same village. Shweta is accompanied by her friend Anjali who has come along to support Shweta at the appointment. Shweta is in distress and does not know what to do. Her main concerns are stigma to her family name, that she will never get married and will have problems.

Competencies Assessed:

- *Counselling skills of building rapport, demonstrating empathy.*
- *Building a therapeutic relationship with the patient.*
- *Communications skills while dealing with a very sensitive issue for the patient.*

Case Study 2:

You are meeting Anita, a young college going girl of 18-years, who was recently brought to your attention by the village leader. She had been having "fits" for the last 3 years. These seizures happen about twice a week and she is scared that they will come on suddenly. Anita has stopped going to college in the past few months because the fits have been occurring on an average of 3-4 times every week. Her parents believe that Anita has some problem in her brain due to a high fever that she had when she was 6 years old. Her family tried many religious healing practices but they had no effect. Her parents are very worried about her and Anita is wondering whether she will ever be able to complete her graduation.

Competencies Assessed:

- *Counselling skills of building rapport, demonstrating empathy with the patient.*
- *Building a therapeutic relationship.*
- *Counselling skills of listening, reflecting, questioning, providing affirmation and support for the anxious parents.*

Case Study 3:

Harish is a 28-year old man who was working in an IT company. He had a lot of friends whom he would go out with over the weekend. Harish was expecting a promotion at work 3 months ago, but didn't get promoted because his boss told him that his performance was not good enough. Since then, Harish has started withdrawing from his friends and spends a lot of time alone on social networking sites. He doesn't want to go out for movies or parties anymore. Harish is also slacking off at work and tells his colleagues that he is not as good as the rest of them. He gets angry when his colleagues crack a joke and think that they are all laughing at him. Harish was brought to the clinic by his friends who are concerned about him.

Competencies Assessed:

- *Counselling skills of building rapport, demonstrating empathy.*
- *Building a therapeutic relationship with the patient*

Case Study 4:

Mr Nataraj is a 45-year old widower. He started drinking after his wife died two years ago. At first, it was once or twice a week by going to the neighbouring bar. Over the past eight months, his drinking has increased and he needs to go to the bar every night. He wakes up the following morning not remembering what had happened the night before. Mr Nataraj has started going for work late because he is unable to get up in the mornings. His hands have started trembling when he is working on the computer in the office and the only thing he looks forward to is going back to the bar every evening. He has sold his wife's jewellery to be able to support his drinking habit. Mr Nataraj realises that his financial situation is getting worse wants help to stop drinking.

Competencies Assessed:

- *Counselling skills of building rapport, demonstrating empathy.*
- *Building a therapeutic relationship with the patient.*

Section 3:

The CHWs are given instructions on how to fill the Initial contact Form (Appendix 1) and the Home and supported community facility assessment form (Appendix 2).

MODULE 3: IDENTIFICATION-SIGNS AND SYMPTOMS OF SCHIZOPHRENIA

OBJECTIVE/SKILLS:

- *CHWs will understand the relationship between human brain and behaviour*
- *They will be able to define the symptoms of schizophrenia, its predisposing factors, the course and outcome and*
- *CHWs will understand the impact of having a schizophrenic patient on its family members*

ASSESSMENT TOOLS:

- Answers to questions regarding schizophrenia: identification of symptoms
- Case studies for identification of symptoms
- Quality of information in the Symptom Profile checklist (Appendix 3)

METHODOLOGY

Section 1: Pre-knowledge assessment with questionnaire On signs and symptoms of schizophrenia.

1.	Schizophrenia affects 1% of people: ☐ **True /** ☐ **False**
2.	One of the symptoms of schizophrenia is that the person is not in touch with reality: ☐ **True /** ☐ **False**
3.	Schizophrenia affects only people from the lower socio economic group. ☐ **True /** ☐ **False**
4.	People most often develop schizophrenia 'all of a sudden". ☐ **True /** ☐ **False**
5.	People with schizophrenia have unusual sensory experiences in the absence of an actual event in the real world. ☐ **True /** ☐ **False**
6.	Schizophrenics are very dangerous as they may harm themselves or people around them. ☐ **True /** ☐ **False**

7. Schizophrenia is diagnosed by taking a history of the symptoms and by examining the mental functions such as thinking, emotions, attention and cognition. ☐ **True /** ☐ **False**
8. People with schizophrenia tend to die earlier. ☐ **True /** ☐ **False**
9. People with schizophrenia never recover. ☐ **True /** ☐ **False**
10. Schizophrenia is caused when people are possessed by evil spirits. ☐ **True /** ☐ **False**
11. Schizophrenia runs in families. ☐ **True /** ☐ **False**
12. Traditional healers can cure schizophrenics. ☐ **True /** ☐ **False**
13. The treatment of schizophrenia involves the use of medicines, psychological counselling and social and occupational rehabilitation. ☐ **True /** ☐ **False**
14. The treatment of schizophrenia involves the use of medicines, psychological counselling and social and occupational rehabilitation. ☐ **True /** ☐ **False**
15. People who have too much of stress develop schizophrenia. ☐ **True /** ☐ **False**
16. People with schizophrenia often speaks in a manner that is hard to understand. ☐ **True /** ☐ **False**
17. People with schizophrenia are lazy and don't want to work. ☐ **True /** ☐ **False**
18. Patients with schizophrenia can discontinue taking medicines on their own once they get better. ☐ **True /** ☐ **False**
19. Most often in India, families do not want to reveal that they have a person with mental illness because of the stigma and fear of being socially isolated. ☐ **True /** ☐ **False**
20. People with schizophrenia cannot be treated in the community but need to be admitted to mental hospitals. ☐ **True /** ☐ **False**

Section 2: Information sharing on schizophrenia

1. The Community Health Workers will then be asked to read the **COPSI manual** Module 1 on Introduction to schizophrenia
2. The Community Health Workers will be shown the **audio-visual manual (module 12.B.)** on the signs and symptoms of schizophrenia.
3. Post knowledge assessment with questionnaire on signs and symptoms of schizophrenia.

Section 3: Case studies:

Case Study 1:

A 24-year old young man, Ajay, has stopped having a bath, brushing his teeth and changing his clothes. His illness started about 3 months back. Around this time, the family noticed changes in his behaviour. He became very suspicious that villagers were trying to kill him and his family. He started hearing voices of the villagers while he was in the fields. Ajay's sleep decreased and he would be awake at night looking out for his "murderers". He was anxious and fearful most of the time even during the day. This led his family to seek help-initially from a faith healer and later from a psychiatrist. He was admitted to a local hospital for a few days and given treatment.

Case Study 2:

Vijay is a 27-year old man who graduated from high school and got a job working in a video store. After working for about 6 months, Vijay began to hear voices that told him that he was no good. He also began to believe that his boss was planting small video cameras in the returned tapes to catch him making mistakes. Vijay became increasingly agitated at work, particularly during busy times and began "talking strangely" to customers. He got angry if a customer asked him to reserve videos for them. For example, one customer asked for a tape to be reserved and Vijay indicated that, that tape may not be available because it had surveillance photos of him being reviewed by the Police.

After about a year, Vijay quit his job one night, yelling at his boss that he couldn't take the constant abuse of being watched by all the TV screens in the store and even the one in his own home. Vijay lived with his parents at that time. He became increasingly confused and agitated. He slept most of the time and felt hopeless and worthless. Often, Vijay mentioned to his mother that he would be "better off dead".

Case Study 3:

Shanti is a 21-year old business major at a large university. Over the last few weeks, her family and friends have noticed increasingly bizarre. On many occasions they overheard her whispering in an agitated voice, even though there is no one nearby. She wanders off on her own and has been picked up from the streets by the police on several occasions. Lately she has refused to answer or make any calls on her mobile, claiming that if she does it will activate the deadly chip that was implanted in her brain by the evil aliens.

Her parents have tried to get her to go with them to a psychiatrist for an evaluation but she refuses. She has accused them on several occasions of conspiring with aliens to have her killed so they can remove her brain and put it inside one of their own. She has stopped attending classes altogether. She is now so far behind on course work that she will fail if something doesn't change very soon.

Although Shanti occasionally has a few beers with her friends, she's never been known to abuse alcohol or use drugs. She does, however have an estranged aunt who has been in and out of psychiatric hospitals over the years due to erratic and bizarre behaviour.

Instructions to CHWs:

Read the case studies and identify the following:

1. Positive symptoms, negative symptoms and problems with processing information (difficulties, in attention, concentration)

2. The impact of these symptom on their personal, social and occupational functioning.

Section 4: Symptom Profile Checklist:

CHWs will be trained to fill the **Symptom Profile checklist** (Appendix 3) on the basis of the case studies 1-3.

MODULE 4: UNDERSTANDING THE SOCIAL&ECONOMIC IMPACT OF SCHIZOPHRENIA

OBJECTIVE/SKILLS:

- *CHWs will understand how schizophrenia effects the person's interpersonal relationships.*

ASSESSMENT TOOLS:

- Questions related to the impact on social functioning.
- Responses to the Social difficulties checklist (Appendix 4) based on a role play situation and the case studies.

METHODOLOGY

SECTION 1: Informing the case mangers about the impact of schizophrenia on families.

1. TheCHWs will be asked to read chapter 1.7 on "The "impact on schizophrenia in the family"

2. Audio visual presentation on Impact on Family (Module 2.2) and Society (Module 2.4).

SECTION 2: Role play situations for impact of the illness & needs assessment for Community Health Workers

	Situation- Instructions to the Community Health Worker	Instructions to the actors
1.	A 24-year old, young man has been diagnosed with schizophrenia by a psychiatrist. His illness started about 3 months ago. Around this time, his family noticed changes in his behaviour. He has become very suspicious that the villagers were trying to kill him and his family. He started hearing voices of the villagers which were very threatening to him. He had once becoming aggressive towards them when working in the fields. This led his family to seek help, initially from a faith healer and later from a psychiatrist. He was admitted to a local hospital for a few days and given treatment. Since his discharge a few weeks ago, his family have been giving him his medications. Now his symptoms are under control. You are meeting his family for the first time. You need to speak to the patient and the family about what has happened to him.	***Patient:*** You are anxious to know more about what happened to you; you are very engaging and cooperative with the Community Health Worker. Previously you were feeling very suspicious, fearful of your family and could hear the voices of the villagers threatening you and your family. You are feeling much better now. You do not hear voices or feel suspicious any longer. You do not remember many details about what happened but recognize that you were getting angry. You feel very sleepy with medications now and your appetite has increased a lot. You want to know what had happened to you. You are worried about taking medications as they make you sleep a lot and you feel they are addictive. You are worried because you are the only son in the family and have to provide for parents and sisters and do not feel well enough to work. ***Family(Father and eldest uncle)*** Father and uncle do most of the talking. Eldest uncle, as head of the family, is very dominant in discussions. The father is interested to know what the future holds for his son. They are keen to get him married. They want to know specifically about marriage, children and the 'addictive nature' of the tablets. The family engages well with the Community Health Worker. They think this is caused by a curse for their past sins. They don't believe that this is a mental illness and want to perform religious rituals to 'cure' their only son.

Tasks:

1. Give information about the illness to the patient and his family in a way that they will understand.
2. Explain the treatment to the family.
3. Give information about the prognosis of the illness in a way that is realistic and communicates hope.

Competencies Assessed:

1. Psycho-education (Covers giving information about the illness, treatment and prognosis to the family)

Time: 15 minutes

	Situation- Instructions to the Master Trainers	Instructions to the actors
2.	You are meeting a family of 3 members- a windowed mother of 45 years and 2 sons (Dharma, 22 years old and Satish 24 years old) Family Situation: The mother does farming and Satish holds a low income job. Dharma has a severe mental disorder (SMD), because of which the family's life is difficult. 4 years ago, Dharma had undergone all kinds of treatment such as- He was taken to a tantric, pooja and fasts were held for him. They even went to a mosque, but he showed no signs of recovery. They spent lakhs on his treatment but for the last 2 years, he has seen no doctor. The family is facing a crisis of debt. The mother wishes that Satish gets married but because of Dharma's illness, they are not finding a suitable relationship. Dharma used to meet his friends often, but now due to his illness, his friends do not come to see him. Even if his mother and Satish wish to go out somewhere, they need to lock him up in the house and then leave. Otherwise, people around make fun of Dharma and he gets into fights with them.	***Patient:*** You are Dhrama's mother and brother (Satish). Satish has a job and the mother is a farmer. Introduction: There is a family of 3- 45 year old windowed mother and her two sons- Dharma (24) and Satish (22) ***Symptoms of the illness:*** Dharma gets angry very frequently. He is often seen mumbling to himself. He always seems to be afraid and fearful and does not take care of himself. He goes many days without bathing as well. ***Past History:*** Dharma was a good student and went to college regularly. A while ago, because of a girl, he got into a fight with some boys and they proceeded to beat him up. He was seriously injured and was even admitted in the hospital for many days. Since then, every time he sees a girl, he becomes agitated and angry and this has been his state ever since. Someone from the JMSP team has come to visit you. They are going to talk to you about Dharma's illness. You have to give them as much information as possible. They will ask you about your own problems. You have to ask them about Dharma's treatment and tell them all the troubles you face taking care of him and ask them for help in this regard.

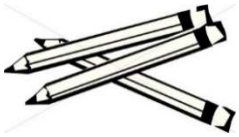
Tasks:

1. You are a community health worker and are going to Dharma's house for ahome visit. When you get to his house, you notice that Dharma is not home but you still speak to his mother and brother. You need to conduct a Needs Assessment (Appendix 5) of Dharma and his family.
2. You need to give Dharma's family realistic hopes about his future and empathetically explain their troubles to them.
3. Before the visit ends, you need to explain to the family of what work you plan to do in the future.

Competencies Assessed:

1. Needs Assessment for SMD.
2. Being able to address any immediate needs that come up during the interview and develop simple plans for addressing these needs.
3. Engaging with families empathetically, providing support and realistic hope to them.

SECTION 3: Identifying the social & economic impact of having a family member with schizophrenia.



The CHWs will be asked to list the Social and economic impact for the two role plays in Section 2.

SECTION 4: Social Difficulties Checklist:

CHWs will fill the Social Difficulties Checklist (Appendix 4) based on the two case studies that have been role played in Section 2.

MODULE 5: PRINCIPLES AND METHODS OF PROVIDING CARE FOR PEOPLE WITH SCHIZOPHRENIA

OBJECTIVE/SKILLS:

- *The CHWs will get an overview of the principles and methods of treatments for schizophrenia and be able to apply them.*

ASSESSMENT TOOLS:

- Role play situations to enact interviews with patients and family members
- Discussion on the use of drugs and their side effects
- Providing case studies which assess problem solving skills of the CHWs
- Role play of different family situations and assessment of the CHWs ability to deal with these scenarios.

METHODOLOGY

Section 1: Information regarding Individual and family treatments for schizophrenia and need for and benefits of community linkages.

1. The Community Health Workers will then be asked to read the **COPSI manual Module 2** on individual treatments, effective problem solving, family treatment and benefits of community linkages.
2. The Community Health Workers will be shown the **audio-visual presentation** on treatments for schizophrenia (Module 5.1 A.).

Section 2: Role play situations to enact interviews with patients and family members.

Case Study 1:

A 24-year old young man, Ajay, has stopped having a bath, brushing his teeth and changing his clothes. His illness started about 3 months back. Around this time, the family noticed changes in his behaviour. He became very suspicious that villagers were trying to kill him and his family. He started hearing voices of the villagers while he was in the fields. Ajay's sleep decreased and he would be awake at night looking out for his "murderers". He was anxious and fearful most of the time even during the day.

This led his family to seek help-initially from a faith healer and later from a psychiatrist. He was admitted to a local hospital for a few days and given treatment.

Case Study 2:

Vijay is a 27-year old man who graduated from high school and got a job working in a video store. After working for about 6 months, Vijay began to hear voices that told him that he was no good. He also began to believe that his boss was planting small video cameras in the returned tapes to catch him making mistakes. Vijay became increasingly agitated at work, particularly during busy times and began "talking strangely" to customers. He got angry if a customer asked him to reserve videos for them. For example, one customer asked for a tape to be reserved and Vijay indicated that, that tape may not be available because it had surveillance photos of him being reviewed by the Police.

After about a year, Vijay quit his job one night, yelling at his boss that he couldn't take the constant abuse of being watched by all the TV screens in the store and even the one in his own home. Vijay lived with his parents at that time. He became increasingly confused and agitated. He slept most of the time and felt hopeless and worthless. Often, Vijay mentioned to his mother that he would be "better off dead".

Case Study 3:

Shanti is a 21-year old business major at a large university. Over the last few weeks, her family and friends have noticed increasingly bizarre. On many occasions they overheard her whispering in an agitated voice, even though there is no one nearby. She wanders off on her own and has been picked up from the streets by the police on several occasions. Lately she has refused to answer or make any calls on her mobile, claiming that if she does it will activate the deadly chip that was implanted in her brain by the evil aliens. Her parents have tried to get her to go with them to a psychiatrist for an evaluation but she refuses. She has accused them on several occasions of conspiring with aliens to have her killed so they can remove her brain and put it inside one of their own. She has stopped attending classes altogether. She is now so far behind on course work that she will fail if something doesn't change very soon.

Although Shanti occasionally has a few beers with her friends, she's never been known to abuse alcohol or use drugs. She does, however have an estranged aunt who has been in and out of psychiatric hospitals over the years due to erratic and bizarre behaviour.

Case Study 4:

A 30-year old woman was found wandering on the streets. She refused to talk when approached. Her clothes were dirty, hair unkempt, nails-dirty and long. Her strong body odour and dishevelled appearance made it difficult to even stand beside her.

When enquiring in nearby shops, hotels etc., the Case Managers learnt that she used to wander throughout the day asking people for food/tea and used to go back home after receiving this. Her mother was jobless, poor and was staying in an area nearby. When Case Managers went home to meet her mother, they found that the house was in a bad shape-with a broken roof, windows and doors. There were hardly any belongings or furniture. The hose seemed to be the ideal characterization of poverty.

Seema was lying down on the floor, without a single cloth on her body. When called by her name, she did not reply. When her mother came, she informed them that Seema wanders on the road to get food, tobacco and then comes home only to sleep every day. Her mother was poor and had no support from any other family member. Later, Case managers found out that Seema was married and had a daughter. Her husband left her 2-3 years ago and since then she started behaving "differently". She also tried to end her life by setting herself on fire. Her mother said that some community members felt that Seema is mentally ill and they should seek psychiatric help from government hospitals (in order to get free treatment), but her mother was not able to take her daughter to the mental hospital as Seema was very non-cooperative, aggressive and sometimes violent towards her mother as well

Case Study 5:

A 32-year old unmarried man, was admitted into regional Mental Hospital, Yerawada, (RMHY) for 2 years with complaints of poor hygiene, muttering to self, hearing voices, aggressive abusive behaviour, fearfulness, paranoia and the diagnosis of Paranoid Schizophrenia. His family included-one sister and one brother. He lived with his brother and his family back home. Though his brother was willing to look after him, he was extremely uncertain that he would be able to manage his symptoms if discharged. He also expressed his financial difficulties which was another reason for not discharging him.

Instructions to CHWs:

Read the case studies and include the following in your role plays:

1. *Enact interviews with patients and family members.*

SECTION 3: ASSESSMENT OF CHW'S:

Role play of different family situations and assessment of the Community Health Worker's ability to deal with these scenarios.

ASSESSMENT FRAMEWORK

1.INTERPERSONAL & COMMUNICATION SKILLS	Did not perform	Needs Improvement	Satisfactory	Good	Excellent
Greets patient respectfully and introduces self.					
Uses an open, inviting posture					
Initially uses open ended questions to allow patient to tell story					
Checks for patient's understanding					
Solicits patient questions and addresses concerns					
Shows interest, empathy and concern throughout					
Paraphrases patient story to show interest and understanding					
Is non-confrontational during visit					

Addresses and is respectful to the patient throughout the visit, for e.g., does not talk down to or belittle the patient						
Has fluent, understandable speech that flows						
2.PROFESSIONALISM	**Did not perform**	**Needs improvement**	**Satisfactory**	**Good**	**Excellent**	
Presents self professionally through posture and patient interaction						
Sensitive to beliefs of the patient						
Tells the patient he or she does not know the answer to his question and that he or she will find the answer to their questions						
Is able to gauge the stress of the family member/s and respond appropriately.						
Is able to explain the causes of the illness in a manner that is understandable for the family						
Is able give hope to the family members about the patient's recovery						
Does not appear impatient during interaction						

MODULE 6: SUICIDE RISK ASSESSMENT AND MANAGEMENT

OBJECTIVE/SKILLS:

- *The CHWs will be able to conduct an evidence based risk assessment and respond appropriately.*

ASSESSMENT TOOLS:

- Role play situations with structured assessment

METHODOLOGY

Section 1: Information on suicide risk assessment and management

1. The CHWs will then be asked to read the ***COPSI manual Module 3.3*** on "The assessment and management of suicide risk' and the ***MANAS Health Counsellor manual (Chapter 2.4)*** on the Assessment of Suicidal risk.

2. ***JMSP Audio-visual manual: Module 4.2 A. and 4.2 B.*** will be shown.

3. CHWs will fill the checklist for ***Suicide risk assessment***(Appendix 7) based on the two cases.

Section 2:

The case studies will be given to the CHWs for role playing.

Case Study 1:

Vijay is a 27-year old man who graduated from high school and got a job working in a video store. After working for about 6 months, Vijay began to hear voices that told him that he was no good. He also began to believe that his boss was planting small video cameras in the returned tapes to catch him making mistakes. Vijay became increasingly agitated at work, particularly during busy times and began "talking strangely" to customers. He got angry if a customer asked him to reserve videos for them. For example, one customer asked for a tape to be reserved and Vijay indicated that, that tape may not be available because it had surveillance photos of him being reviewed by the Police.

After about a year, Vijay quit his job one night, yelling at his boss that he couldn't take the constant abuse of being watched by all the TV screens in the store and even the one in his own home. Vijay lived with his parents at that time. He became increasingly confused and agitated. He slept most of the time and felt hopeless and worthless. Often, Vijay mentioned to his mother that he would be "better off dead".

Case Study 2:

A 30-year old woman was found wandering on the streets. She refused to talk when approached. Her clothes were dirty, hair unkempt, nails-dirty and long. Her strong body odour and dishevelled appearance made it difficult to even stand beside her. When enquiring in nearby shops, hotels etc., the Case Managers learnt that she used to wander throughout the day asking people for food/tea and used to go back home after receiving this, Her mother was jobless, poor and was staying in an area nearby.

When Case Managers went home to meet her mother, they found that the house was in a bad shape-with a broken roof, windows and doors. There were hardly any belongings or furniture. The hose seemed to be the ideal characterization of poverty.

Seema was lying down on the floor, without a single cloth on her body. When called by her name, she did not reply. When her mother came, she informed them that Seema wanders on the road to get food, tobacco and then comes home only to sleep every day. Her mother was poor and had no support from any other family member. Later, Case managers found out that Seema was married and had a daughter. Her husband left her 2-3 years ago and since then she started behaving "differently". She also tried to end her life by setting herself on fire.

Her mother said that some community members felt that Seema is mentally ill and they should seek psychiatric help from government hospitals (in order to get free treatment), but her mother was not able to take her daughter to the mental hospital as Seema was very non-cooperative, aggressive and sometimes violent towards her mother as well.

INTERVENTION

MODULE 7.1: PROVIDING INFORMATION ABOUT ILLNESS, MEDICATION AND THEIR SIDE EFFECTS

OBJECTIVE/SKILLS:

- *CHWs will develop skills required for psycho-education and be able to deal with a range of questions that may be asked by the patient or family.*

ASSESSMENT TOOLS:

- The CHW will come up with a list of 20 FAQ's that families may ask and answer these.
- CHWs will be asked to provide psycho-education based on the Flip chart and be assessed on accuracy of information, communication skills and ability to answer questions posed by others.
- CHWs will identify the side effects of medication and fill the Side effects Checklist (Appendix 8) with accuracy

METHODOLOGY

Section 1: Information about the nature of illness, causes, course and outcome of schizophrenia for the patient and his family members

1. ***COPSI Manual chapter 3.4*** on "*Individual treatments for people with schizophrenia*" about the nature of illness, causes, course and outcome, the medication and their side effects.

Section 2: Assessment

Assessment through FAQ's on why providing information about schizophrenia is important, strategies to provide information, strategies to promote adaptive behaviours, organizing the structure of sessions, introducing the stress vulnerability model, providing information on medicines and their side effects, relapse prevention, common stressors and dealing with distressing symptoms

1. The CHWs will be divided into 2 groups. Each group will develop a set of 20 Frequently Asked Questions along with the answers and ask the other group the question.
2. The group which gets more answers correct, will win.

Section 3: Psycho-education

1. ***Audio visual clip Module 6.1 A.*** on psycho-education will be shown.
2. CHW's will be asked to provide psycho-education based on the Flip chart to the rest of the group who will play the role of the family members

Case Study 1:

A 24-year old young man has been diagnosed as having schizophrenia by psychiatrist. His illness started about 3 months back. Around this time, the family noticed changes in his behaviour. He became very suspicious that the villagers were trying to kill him and his family. He started hearing voices of the villagers which were very threatening to him. He had become aggressive to some villagers while he was in the fields. This led his family to seek help, initially from a faith healer and later from a psychiatrist. He was admitted to a local hospital for a few days ad given treatment. Since his discharge a few weeks ago, his family have been giving him medications. Now, his symptoms are under control.

You are meeting the family for the first time. You need to speak to the patient and his family about what has happened to him.

1. Give information about the illness to the patient and his family in a way that they will understand.
2. Explain the treatment to the family.
3. Give information about prognosis of the illness in a way that is realistic and communicates hope.

Assessment framework:

Assessment of the CHW's by their peers' ability to provide psycho-education based on the following competencies:

SKILLS	Excellent	Competent at the CHW Level	Needs Minor Improvement	Needs Significant Improvement
Allowed patients family to ask questions				
Encouraged family members to voice disagreements with the information provided				
Discussed and clarified information				
Listened to family's view of the illness				
Used common lay man terms that the families could understand				
Was sensitive to the distress experience of family members				
Was able to explain the diagnosis of schizophrenia				

SKILLS	Excellent	Competent at the CHW Level	Needs Minor Improvement	Needs Significant Improvement
Was able to educate the family about the symptoms				
Was able to discuss the causes of schizophrenia				
Discussion on issues related to medication				
Explained the course and prognosis				
Could motivate the family to comply with the medication prescribed				
Reassured the family that the patient would get better				

Section 4: Side Effects of Medication

1. CHWs will practice filling up the ***Medication Side Effects Checklist*** *(Appendix 8)* based on the following case study:

Case Study 1:

You are seeing Rajesh, aged 34-aged, at his home. Rajesh suffers from SMD and had been taking treatment from JMSP for more than a year now. His illness is under control now but he often stops his meditations because of the following reasons:

Cost of medicines are too high.
He feels sleepy.
He has put on too much weight.
He feels very hot when he works in the sun
he feels he will become addicted to the mediations if he takes them for a long time.
He gets tremors
Stops taking the medicines once he feels better.

MODULE 7.2: RELAPSE PREVENTION

OBJECTIVE/SKILLS:

- *CHWs will develop a systematic method of enabling the patient and family members to recognize the early signs of relapse and put in place a plan to deal with the situation.*

ASSESSMENT TOOLS:

- The CHWs will fill up the **Early Warning Checklist** (Appendix 9) based on a case study.
- CHWs will be asked to formulate strategies to deal with the early warning signs of relapse and be assessed on whether they have followed the protocol of information exchange with the family, adherence review, clinical review and formulating a relapse management plan.

METHODOLOGY

SECTION 1: Information on Relapse Prevention

1. ***COPSI Manual chapter 3.4*** on what is relapse, recognizing early signs, effective ways of dealing with early warning signs.
2. **Audio-Visual Module 6.6** on Relapse Prevention.

SECTION 2:

Using a case study to formulate strategies to deal with the early warning signs of relapse and be assessed on whether they have followed the protocol of information exchange with the family, adherence review, clinical review and formulating a relapse management plan.

Case Study 1:

Rajesh has stopped his medicines because of the side effects. He has started showing the early signs of relapse which includes:

Tense and anxious about small things
Has difficulty in sleeping
Has started talking less, hardly smiles and is often tearful
Has started spending a lot of time inside the room, avoids meeting people.
Is finding it difficult to concentrate and pay attentions for a period of time so has started losing track of what he is saying and forgetting things like putting off the tap after washing his hands.
Has started denying that he has an illness and does not want to take medicines and refuses to meet the doctor.
Has started getting suspicious that other people are talking about him.

ASSESSMENT:

1. The CHW will practice filling up the ***Early Warning Signs of Relapse checklist*** *(Appendix 9)*
2. The CHW will be assessed on the following skills.

Skills	Excellent	Competent at the CHW levels	Needs Minor Improvement	Needs Significant Improvement
Was able to formulate strategies to deal with the early warning signs of relapse				
Followed the protocol of information exchange with the family				
Adherence review conducted				
Organized a family meeting to discuss concerns and draw up a plan of action				
Was able to identify the stressors and suggested ways of managing them				
Organized a clinical review meeting to discuss concerns of the family				
Formulated a relapse management plan that was practical and effective				

MODULE 7.3: FAMILY INTERVENTION

OBJECTIVE/SKILLS:

- *CHWs will be able to identify the needs of the family and develop a specific management plan tailored to their needs.*

ASSESSMENT TOOLS:

- The CHWs will draft family intervention plans based on case studies with different family needs/scenarios.

METHODOLOGY

Section 1: Information on Family treatment

1. ***COPSI manual chapter 3.5*** on sequence, content, assessment of family needs, knowledge about illness, burden of caring, psycho-education and basic interventions.
2. ***Audio visual Module 6.1 A*** on Psycho-education and module 6.2 on disabilities in person with schizophrenia.

SECTION 2: Case studies on different family situations

***Case Study 1*:**

You are meeting Rahul's father/mother at the clinic. Rahul is a young and very intelligent young man of 19 years. He always topped his school/college until now. He is a 2nd year engineering student. He was recently diagnosed with schizophrenia. He is taking medications and is better but does not do much at college. He has stopped going to college and stays on his own. He does not study at all and has failed his annual exams. He will have to repeat this year at college.

His father/mother is very concerned about what has happened to him. They know he has an SMD but does not have any more details on this. They have asked to see you so that they can ask you more about his illness.

You have been asked the following questions:

1. *What has happened to Rahul?*

2. *Why does he behave this way?*

3. *Are we responsible for his illness? Did we do something wrong?*

4. *Will he become an engineer?*

5. *Will he have to take medications life long?*

6. *Will he be able to marry? If he marries will his problem go away?*

7. *What can we do as parents to help our son?*

8. *We are old and cannot deal with Rahul's illness so we get angry with him and hit him sometimes. Does that make us bad parents?*

9. *We do not have money to treat Rahul because all our money went into paying fees for Rahul's engineering college. How will we manage?*

10. *Who will look after Rahul after we die?*

Case Study 2:

Ajay, a 24- year old man has been diagnosed with paranoid schizophrenia. He lives with his parents, his wife and a 4-year old daughter. Ajay believes that his wife is having an affair with another man in the village and has beaten his wife on a few occasions when she comes back late. Ajay used to work in a shop till about 8 months ago when his symptoms developed. Ajay's wife Rani feels sad and depressed most of the time and has stopped looking after their daughter. Ajay started on medication about 2 months ago but does not want to take them because he things that his wife is trying to poison him.

Ajay's parents and his wife come to you with the following questions:

1. Why does Ajay have this illness?

2. What can they do if he refuses to take his medicines?

3. How do they deal with Rani who seems sad most of the time?

4. How will they manage the finances now that Ajay has stopped working?

5. Is Ajay ill because of their wrong doing in their past life?

6. Does Ajay need to be taken to a traditional healer?

7. What would happen if Rani left them and went back to her mother's house?

8. Since Rani does not look after her daughter, how long do they have to continue looking after her?

9. When can Ajay go back to work again?

10. Does Rani also need to get treated?

ASSESSMENT:

CHWs will revisit the **Checklist for Social difficulties** (Appendix 4) and **Needs Assessment Form**(Appendix 5) and fill in details based on the role playing of the two case studies.

The CHW will be assessed on the following skills

Skills	Excellent	Competent at the CHW Level	Needs Minor Improvement	Needs Significant Improvement
Was able to engage with the family through empathy and understanding				
Provided opportunities for the family members to express their worries and concerns				
Was able to discuss issues in a systematic and thorough manner				
Looked for positive assets and strengths of the family				
Was able to convey the expectations of the session in terms of family participation and engagement				

Skills	Excellent	Competent at the CHW Level	Needs Minor Improvement	Needs Significant Improvement
Was flexible in his approach with the family				
Displayed skills of active listening				
Reflected content to ensure that the family members are clear about what is being discussed				
Was able to acknowledge and reflect family members feelings				
Was able to form a working relationship with the family				
Was able to ensure that the family would continue with the intervention				
Was able to assess the family's attitudes and beliefs about the illness				
Was able to assess the family's knowledge about schizophrenia				

Skills	Excellent	Competent at the CHW Level	Needs Minor Improvement	Needs Significant Improvement
Was able to understand the burden of caring on the caregivers in terms of their well-being				
Was able to understand and respond to the needs of the family				
Was able to identify social supports				
Used the stress vulnerability model to reduce stress				
Was able to normalize the family routine				
Helped the family have appropriate expectations				
Was able to help the family set limits on unacceptable behaviour				
Was able to simplify communication by asking them to wait for the patient to respond, by appreciating his positive behaviour and avoiding generalized negative comments about him				

Skills	Excellent	Competent at the CHW Level	Needs Minor Improvement	Needs Significant Improvement
Was able to identify unhelpful coping strategies used by the family				
Was able to provide advice to the family on their role in preventing future episodes				

MODULE 7.4: ADHERENCE MANAGEMENT

OBJECTIVE/SKILLS:

- *CHWs will be able to draft an adherence management plan based on individual and family factors, treatment factors and therapeutic relationship factors, environmental and social factors.*

ASSESSMENT TOOLS:

- The CHWs will draft an adherence management plan based on a case study
- The Checklist for assessing non-adherence will be filled by the CHWs
- CHWs will fill up the discharge forms for the two case studies after they have recovered.
- CHWs will fill up the Follow up form and these will be reviewed to assess that the information provided is adequate and accurate.

METHODOLOGY

SECTION 1: Information on Adherence Management

1. ***COPSI Manual chapter 3.6*** on defining adherence, non-adherence, understanding reasons for non-adherence and adherence management strategies.
2. ***Audio visual Module 6.3*** on Adherence management.
3. ***The discharge form*** *(Appendix 12)will be introduced to the CHWs.*
4. ***The Follow-up Form*** *(Appendix 11)*will be introduced to the CHWs.

SECTION 2: Case studies: Using case studies on non-adherence to plan adherence management.

Case Study1:

You are seeing Rajesh, aged 34-aged, at his home. Rajesh suffers from SMD and had been taking treatment from JMSP for more than a year now. His illness is under control now but he often stops his meditations because of the following reasons:

Cost of medicines are too high.
He feels sleepy.
He has put on too much weight.
He feels very hot when he works in the sun
Medication causes stiffness and interferes in his work as a carpenter.
Thinks he will get addicted to medication if he takes them for a long time.

Rajesh stops medications whenever it interferes with his work as a carpenter and takes it only on days that he does not go to work.

Case Study 2:

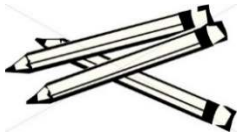
A 30-year old woman was found wandering on the streets. She refused to talk when approached. Her clothes were dirty, hair unkempt, nails-dirty and long. Her strong body odour and dishevelled appearance made it difficult to even stand beside her.

When enquiring in nearby shops, hotels etc., the Case Managers learnt that she used to wander throughout the day asking people for food/tea and used to go back home after receiving this, Her mother was jobless, poor and was staying in an area nearby.

When Case Managers went home to meet her mother, they found that the house was in a bad shape-with a broken roof, windows and doors. There were hardly any belongings or furniture. The hose seemed to be the ideal characterization of poverty.

Seema was lying down on the floor, without a single cloth on her body. When called by her name, she did not reply. When her mother came, she informed them that Seema wanders on the road to get food, tobacco and then comes home only to sleep every day. Her mother was poor and had no support from any other family member. Later, Case managers found out that Seema was married and had a daughter. Her husband left her 2-3 years ago and since then she started behaving "differently". She also tried to end her life by setting herself on fire. Her mother said that some community members felt that Seema is mentally ill and they should seek psychiatric help from government hospitals (in order to get free treatment), but her mother was not able to take her daughter to the mental hospital as Seema was very non-cooperative, aggressive and sometimes violent towards her mother as well.

CHW's will practice filling up the **Checklist for Assessing Non-adherence** (Appendix 10)



1. CHW's will draw up an Adherence management plan. They will be assessed based on the following competencies:

Skills	Excellent	Competent at the CHW level	Needs Minor Improvement	Needs Significant Improvement
Was able to understand the psychosocial factors for non-adherence				
Was able to understand the illness factors of non-adherence like lack of insight, poor memory and concentration and negative symptoms				
Was able to review the treatment related factors				
Was able to address social barriers to adherence and make treatment acceptable				
Was able to address concerns to make treatment accessible				
Was able to address issues to provide equitable treatment				
Was able to strategies to make treatment affordable				

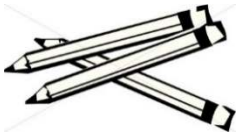
Skills	Excellent	Competent at the CHW level	Needs Minor Improvement	Needs Significant Improvement
Was able to formulate effective treatment plans				
Was able to use specific adherence management procedures (e.g. building medication into the daily routine, use of incentives, using adherence aids, keeping medicine schedules simple, use of injections/syrups)				
Had a strong therapeutic alliance with the patient				
Was able to garner the support of the family for adherence based on a strong relationship with them of trust and support				
Was able to mobilize community resources to promote adherence (disability benefits, loans, support from significant community member)				

SECTION 3: The CHW's will fill up the **Discharge form** (Appendix 12) based on this case study.

Case Study 1:

A 24-year old young man has been diagnosed as having schizophrenia by the psychiatrist. His illness started about 3 months back. Around this time, the family noticed changes in his behaviour. He became very suspicious that the villagers were trying to kill him and his family. He started hearing voices of the villagers which were very threatening to him. He became aggressive to some villagers while he was in the fields. This led his family to seek help, initially from a faith healer and later a psychiatrist. He was admitted to a local hospital for a few days and given treatment. Since his discharge a few weeks ago, his family have been giving him medications. Now, his symptoms are under control.

Section 4: The CHW's will fill up the ***Follow-Up form*** (Appendix 11) based on enactment of the two case studies as role plays.



Case Study 1:

Rajesh has been taking medicines for schizophrenia for over 6 months and has improved in his personal and occupational functioning as a carpenter. Last month, his wife was diagnosed with a terminal illness. Rajesh is finding it very difficult to cope with this and has started showing early warning signs of relapse.

Case Study 2:

Seema was admitted to a hospital and discharged a month later. Once she returned home, she was able to look after herself, cook and take care of her daughter. Her husband came back when he heard Seema had recovered, but Seema is very angry and does not want him back. Seema's mother has reported that her daughter has stopped taking her medication for the last month and fears that she has taken this drastic step to ensure her husband does not come back.

MODULE 7.5: HEALTH PROMOTION IN PEOPLE WITH SCHIZOPHRENIA

OBJECTIVE/SKILLS:

- *The CHWs will be able to identify physical health problems, substance abuse and die related problems and provide strategies for health promotion.*
- *CHWs will be able to help the patient develop effective coping strategies for dealing with stress provoking situations.*

ASSESSMENT TOOLS:

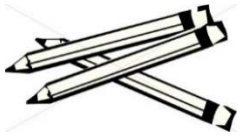
- The CHWs will draft a health promotion plan for two of the cases.
- The plan will be assessed on the basis of whether they cover all the different areas, whether they are practical and feasible and the strategies that will be used to put these plans into place.

METHODOLOGY

Section 1: Information regarding improving physical health of people with schizophrenia

1. ***COPSI manual chapter 3.7*** on common health problems (weight gain, cardiovascular disease, Type II diabetes, substance abuse, sexual dysfunction, osteoporosis), dietary recommendations and stress management
2. ***Audio visual Module 5.3*** on promoting physical health in people with SMD.

Section 2: The CHW's will draft health promotion plans for any two of the following physical health problems:



1. Weight gain and obesity
2. Cardiovascular disease
3. Diabetes
4. Smoking
5. Substance Abuse
6. Reproductive Health complications
7. Osteoporosis

The plans must include:

Health problem	Reasons	Recommended actions	Challenges to making the changes	Solutions

The plans will be assessed on whether are practical, feasible and realistic and whether the information provided is accurate.

Section 3: Stress Management

The CHWs will be asked to provide stress management strategies

(Cognitive, behavioural and social support recruitment) for a number of scenarios of people with schizophrenia:

1. *The man who could not deal with the expectations of a new job.*
2. *The woman who found it difficult to cope with the pressure of not being able to bear a child.*
3. *The girl who started using alcohol because she could not cope with college.*
4. *The woman who gets beaten by her husband because she thinks she is having an affair.*
5. *The family that is finding it difficult to meet the cost of medicines.*
6. *The family that is finding it difficult to get their daughter married because the son has schizophrenia.*

MODULE 8: REHABILITATION AND PROTECTING HUMAN RIGHTS OF PEOPLE WITH SCHIZOPHRENIA

OBJECTIVE/SKILLS:

- *The CHWs will be able to understand the process of rehabilitation, learn how social skills training is practiced, be able to match vocational skills training with possible employment opportunities*
- *CHWs will understand the stigma and discrimination faced by people with mental illness.*
- *CHWs will be aware of the citizenship rights that need to be given to patients with mental illnesses (Aadhar card, access to disability pensions and schemes, vocational training opportunities, employment options)*

ASSESSMENT TOOLS:

- CHWs will develop a checklist for rehabilitation under different domains
- CHWs will develop plans for rehabilitation under the different domains
- The checklist will be assessed for its comprehensiveness and the plans will be evaluated for their feasibility and effectiveness.
- CHWs will identify instances of stigma and discrimination in the case studies that they have come across, in the audio-visual presentations and write them down
- CHWs will write down strategies for stigma reduction by working with the families/communities and SHGs
- The ways of dealing with stigma and plans of providing citizenship rights will be reviewed for their feasibility

METHODOLOGY

Section 1: Information regarding rehabilitation

1. Screening of ***"Lapata Zindagi"***
2. ***COPSI manual chapter 3.8*** on principles of rehabilitation, the process, social skills training and vocational skills training and job placement.
3. ***Audio visual Module 6.7*** on Recovery in schizophrenia

ASSESSMENT:

The CHW's will be asked to list out which areas of functioning have each of the patients shown in "Lapata Zindagi" have improved:

Patients Name	
Area of functioning	**Improvement (describe)**
Self-care	
Skills for independent living	
Social skills	
Work related	

SECTION 2: Rehabilitation related to work:

The CHWs will plan out the work-related rehabilitation for the following case studies:

Case Study 1:

A 48-year old divorced male, was admitted in Regional Mental Hospital, Yerawada (RMHY) for the last three years. His diagnosis was Schizophrenia. At the time of admission, the complaints were aggressiveness, assaultive and wandering behaviour, irritability, over-talkativeness and grandiose thoughts. He recovered from all these symptoms in 6-8 months and was declared fit for discharge by Visitors Committee (VC). His family consisted of his mother, three brother and three sisters and their respective spouses and children. His family members appeared very supportive whenever contacted over phone calls but were sceptical about discharging him. They repetitively mentioned his behavioural issues back home and denied his discharge.

After detailed assessments, the patient was shifted to Devrai ward as he had good functioning and was clinically stable. He did not require basic intervention like personal hygiene or symptom management. He had a fair amount of information about his illness and also had a good understanding of importance of medication. He himself had good experience of working as a pharmacist in the past. He was engaged in social and living skills sessions and livelihood activities in Devrai facility.

In a few days, it was observed that he had good organization and leadership skills. He would take care of small things even absence of INCENSE team in the ward. Initially, some small responsibilities were delegated which he would do well. To lessen his burden these responsibilities were re-distributed among others. He was asked to supervise them and get the things done. Simultaneously, the efforts for discharge started as he was declared fit for discharge by VC.

Psychiatric Social Worker (PSW) and INCENSE team, both took efforts for the patient's discharge. As a routine part of the job, the PSW frequently asked the relatives for permission to discharge but they were not willing to discharge the patient due to his behavioural and adjustment problems back home. As a result, the PSW presented his case in front of the VC. He was declared fit to be discharged by the VC. Thereafter, the INCENSE team started efforts to discharge him. The INCENSE team spoke to the family over the phone and assured them support in dealing with the patients behavioural and adjustment issues. The INCENSE team had a number of telephonic sessions with his two brothers and one sister to persuade them for the discharge. As a result, his family collectively decided to discharge him, with assurance from the team of their continued support and intervention, post discharge. The INCENSE team also encouraged his family to find the patient a suitable job so as to keep him engaged, to avoid clashes with other family members and other behavioural issues. With lots of consistent follow-ups with his family, the patient's brothers discharged him.

As expected, the family started complaining about the patient's behavioural issues such as dominating the family, interference in his brother's family and their responsibilities, being irritable frequently- a few days after discharge. INCENSE team provided some practical solutions to the family and patient. This support was need based. Main input from the INCENSE team was to engage patient's in structured everyday routine, from morning exercise to livelihood alternative. In order to get back to his job as a pharmacist, the patient has to retrieve all his important documents like his work license as a pharmacist, voter ID, bank passbook etc., which were misplaced over a period of time. The INCENSE team provided support, guidance and motivation to reacquire the documents such as his Aadhar Card, bank passbook, ATM and work license.

Presently, the INCENSE team provides intervention to the patient and family to identify the different manifestations of behaviour due to mental illness and personality traits, nature of illness and importance of treatment, dealing with behavioural issues, need for family's unconditional acceptance and support. The INCENSE team has also been providing remote guidance to the patient and his family for relapse prevention and exploring employment opportunities.

Case Study 2:

A 25-30-year old woman was found wandering on the street. She refused to talk when approached. Her clothes were dirty, hair unkempt, nails long and dirty, her strong body odour and dishevelled appearance made it difficult to even stand beside her. After enquiring in nearby shops, hostels etc., the Case Managers learnt that she used to wander throughout the day, asking people for food/ tea and used to go back home after receiving the same. Her mother was unemployed, poor and was staying in an area nearby.

When the Case Manager went home to meet her mother, they found that the house was in a very bad state- with broken roofs, windows and doors. There were hardly any belongings or furniture. The state of the house seemed to be an ideal characterization of poverty. Seema was lying down on the floor, without a single stitch of cloth on her body. When called, she did not reply. When her mother came, she informed them that Seema wander on the street to get food, tobacco and then comes home only to sleep almost every day. Later, the Case Manager found out that Seema was married and had a daughter. Her husband left her 2-3 years ago and since then she has been behaving "differently". She also tried to end her life by burning. Her mother said that some community members felt that Seema was mentally ill and that they should seek psychiatric help from the government hospital (in order to get free treatment) but her mother was unable to take her daughter to the hospital as Seema was very non-cooperative, aggressive and sometimes violent towards her own mother as well.

INCENSE Intervention-:

The need for admission to a psychiatric hospital was discussed in detail with Seema's mother, to which she agreed. She had no money for admission and Seema was getting violent whenever anybody approached her to talk. On request from the INCENSE team, the local corporator sent his men along with the team to take her to the hospital for admission. When Seema was inside the hospital, her poor, unemployed mother started feeling depressed. She had no food to eat. Neighbours reported that her mother was talking to herself, showing signs of restlessness, having some hallucinations etc. Therefore, she too was taken to the OPD and was prescribed psychiatric medication. She was also given help to find a job and earn her bread and butter.

The INCENSE team followed up with her inside hospital, provided support, unconditional acceptance, conducted some sessions on hygiene, psycho-education, life skills etc. Through Seema was not fully recovered symptomatically, after a year since admission, hospital authorities forcefully discharged her. When she came back home, her symptoms were still present. She reported that someone (voices) were asking her to commit suicide, there were many such individuals flying in the air who were continuously asking her to commit suicide. She mentioned that those were the individual who made her burn herself a few years ago. She further said that if she does not commit suicide, these individuals will kill her anyway. She also had a strong wish to die.

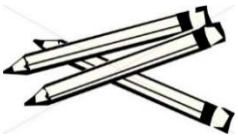
She also used to say that due to these commanding hallucinations, she used to feel that her body does not belong to her and hence she wanted to leave her body and die. The desire for death was so strong that the suffering (that she had gone through while burning herself) was perceived as very less against the wish to free herself from her body.

The INCENSE team, provided intervention to her even after discharge. She was helped by the team to even get surgery on her burnt hand. After this surgery, she is now able to work using that same hand.

Section 3: Information regarding social barriers, stigma and strategies for overcoming them

1. ***COPSI manual chapter 3.9*** on addressing stigma, forming self-help groups.
2. ***Audio visual Module 6.5*** on Stigma Reduction.
3. ***Mental Health Care Bill*** 2011to know about citizenship rights, disability benefits.
4. ***UNCRPD agreement*** signed by India.

Section 4: Assessment of strategies to address stigma:



1. The following table with the particular aspect of stigma experience and narratives from formative IDI's will be provided.
2. CHWs will think of strategies to address the stigma experience:

Table 1: the experience of Stigma and strategies to address them.

Particular aspect of Stigma Experience	**Narratives from formative IDI's**	**Recommended *strategies*** ***(THIS COLUMN IS NOT TO BE GIVEN)***
Negative views of outcome and lack of belief in the possibility of recovery.	"I am mad and I will remain like this in the future" ***(Person with schizophrenia)***	*Psycho-education with the person with schizophrenia and Caregivers:* • Provide accurate information and hope about course of illness, recovery and about what persons with schizophrenia can do themselves to ensure optimal outcomes • Emphasize the possibility of positive outcomes • Provide examples/ case stories of people with positive outcomes • Emphasize the positive effects treatment can have
Negative views of illness	"I feel this way because condition was, was very silly and, was some psychiatric condition was there so […] that is why I was referred to psychiatric doctor. May be because of that, they feel that I went for something, that is why I'm not able to tell them" ***(Person with schizophrenia)***	*In psycho-education with the person with schizophrenia and Caregivers:* • Provide accurate information on nature of Illness • Address myths about the illness- that it is due to past misdeeds or 'karma' • Emphasize concepts of 'illness like any other', 'it's nobody's fault' and 'illness that anyone can get'

Low self-esteem and self confidence	"My self-esteem has gone low. I feel I don't have any good qualities and all."***(Person with schizophrenia)***	• Address low self-esteem after identifying qualities and strengths and building them up further • Rehabilitation to improve and networking on things the person with schizophrenia wants to focus on
Sense of Embarrassment	"I feel he is not normal like other children he doesn't socialize doesn't speak well that is what I feel embarrassed about. "***(Caregiver)***	• Psycho-education for Caregivers (understanding and accepting some difficulties as part of the illness) • Support groups for Caregivers and Person with schizophrenias (sharing of experiences and mutual support) • Social Skills Training for Person with schizophrenia
Concealing the Illness • Not knowing what to say	"I didn't tell them, I just told them that my … like I had bad fever and all so I didn't tell them the thing which actually happened […] because I myself don't know properly what happened to me." ***(Person with schizophrenia)***	• Psycho-education (understanding of condition, possible causes and triggers) • *Role plays:* practice what and how to explain to others about the illness

Concealing the Illness • Anticipated Discrimination	"If they come to know they will just laughing at me may be, may be, start having a different behaviours with me, and may be." **(Person with schizophrenia)**	• Explore (where appropriate) what is likely to happen if illness is disclosed to selected people. • Explore advantages and disadvantages of disclosing (aspects of) illness to specific persons (e.g. distinguish between cohabiting family (helpful if they understand) and family living elsewhere (who the close family may not want to tell). • Role plays of disclosing to persons the person with schizophrenia/caregiver would like to disclose to.
Concealing the Illness • Impact on Marital Prospects	"Because it affects badly afterwards…now if you ask me why… it is because when the time comes for marriage people inquire…how is the girl…so that time it affects" ***(Caregiver)***	
Concealing the Illness • Fear of Disclosure to People at Work	"I never did reimbursement because […] when we forward the bills they go to our office…so those who are interested can find out what's wrong with her...So because of that I never claimed the bills." ***(Caregiver)***	

Concealing the Illness • Trying to Conceal despite most people knowing	"Actually we don't want anybody to know about my son's illness but at the same time we can't hide because in village everything is closely connected" ***(Caregiver)***	• Explore advantages and disadvantages of concealing the illness (as above) • Work towards acceptance of illness within the family (as above, distinguishing between cohabiting family and other family as appropriate)
Concealing the Illness • Avoiding social contact for fear of disclosure	Examples brought up by case managers/ CHW in the Chennai.	• Support initiatives for persons with schizophrenias and families • Explore advantages and disadvantages of concealing the illness (as above)
Fear of Disclosure through home visits by CHW's or researchers	"When you come and somebody finds you there on the road and you ask "Where is advocate V's house?" and if they say "Who are you?' say I am "X", if they say "Why are you going there?" […] just keep it a secret. If anybody asks say "I have some work with him he is a lawyer" ***(Caregiver)***	• Offer to hold sessions in a neutral place nearby if the person with schizophrenia or family wishes this. • Reach an agreement with the family at the first visit about how to deal with neighbours asking; ensure this is dealt with consistently by different team members visiting the home

Negative treatment and discrimination from people outside the family • verbal abuse, mocking, not being let in the house, being treated differently at college/ school or at work	[About the neighbours] "They don't even allow me to enter their house." ***(Person with schizophrenia)***	• Discuss stigma and discrimination as something that happens to many people with similar problems • Discuss ways of coping with discrimination from others; give feedback on useful strategies that have been reported by other person with schizophrenia or families. • Think through and practice ways of responding to negative comments from others. • Motivate person and family to join support groups
Negative Treatment and Discrimination from People within the home	People with schizophrenia reported not getting basic amenities or not being let into their own house.	• In psycho-education with caregivers, provide realistic information about potential for improvement with adequate treatment • Work towards acceptance within the family • Encourage resumption of some household work at the earliest to convince caregivers about the utility of the person • In a sensitive way, explore reasons for negative behaviour from within the family/household and discuss practical solutions

MODULE 9: LOOKING AFTER YOURSELF

OBJECTIVE/SKILLS:

- *CHWs will learn to recognize their need to seek help and ask for support.*
- *CHWs will learn effective problem solving skills to deal with conflicts with colleagues, families and caregivers and people with mental health issues.*
- *Positive workplace needs and requirements to promote well-being.*

ASSESSMENT TOOLS:

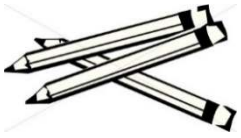
- Role play situations with different issues that the CHWs will use to display problem solving skills.
- Supervisors will draft a recording form for supervision sessions that will include domains of both personal and professional issues that will be discussed and dealt with.

METHODOLOGY

Section 1: Why looking after yourself is important. Information from-

1. JMSP AV manual module 6.8.
2. Testimonies from staff

Section 2: Positive workplace needs and requirements to promote well-being.



The 'H' Assessment is a simple monitoring and evaluation tool to explore the strengths (or successes) and weaknesses (or challenges) of any initiative/ group/ process and to suggest action ideas to improve the same.

Key Objectives:

1. To explore the strengths of the roles that he will play
2. To explore the weaknesses or challenges of the roles
3. To share action ideas to improve his functioning as an effective case manager

Time Needed: 60 minutes

Key Steps:

- Make an "H" shape on large flipchart paper.
- In the left hand column draw a happy face, in the right hand column a sad face and below the middle "H" bar draw a light bulb (to represent 'bright ideas').
- The CHWs will write down the following as a reflective exercise:

 **POSITIVES**		 **CHALLENGES**
	ACTION IDEAS TO IMPROVE THE ORGANISATION	

➢ **Facilitators Notes:**

- *What are the key benefits of your role as a Community Health Worker?*
- *What are the challenges of being a Community Health Worker?*
- *What are the key action ideas to improve this organization?* □
- *How can these action ideas be put into practice?*

- **Materials Needed:**
- Flipchart paper,
- flipchart pens,
- post-its

Section 3: Using the 3-2-1 tool for reviewing their work as CHW's

1. **3-2-1 Bridge:** Activating prior knowledge and making connections
2. The participants will be divided into four groups will be asked to look at the training and their experiences use this technique:

AFTER THE TRAINING	AFTER MY EXPERIENCE IN THE COMMUNITY
3 Thoughts/Ideas *2 Questions* *1 Analogy*	*3 Thoughts/Ideas* *2 Questions* *1 Analogy*

Bridge: *Explain how your new responses connect to your initial responses?*

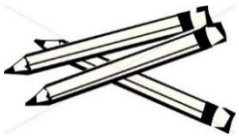
Purpose:*What kind of thinking does this routine encourage?*

This routine asks participants to uncover their initial thoughts, ideas, questions and understandings about a topic and then to connect these to new thinking about the topic after they have had experienced working in the community. This routine can be used when participants are developing understanding of a concept over time. It may be a concept that they know a lot about in one context but instruction will focus their learning in a new direction. Whenever new information is gained, bridges can be built between new ideas and prior understanding. The focus is on understanding and connecting one's thinking, rather than pushing it toward a specific outcome.

The participants share their initial and new thinking, explaining to their partners how and why their thinking shifted. Make it clear to participants that their initial thinking is not right or wrong, it is just a starting point. New experiences take our thinking in new directions.

- **Materials Needed:**
- Flipchart paper
- flipchart pens
- post-its

Section 4: Problem solving skills to deal with conflicts with colleagues, families and care givers of people with mental health issues



- The CHW's will be asked to work in pairs and write out one situation which could cause a conflict with colleagues, families, carers and people with mental illness.
- Each pair will present the conflict situation and the other participants will brainstorm all the different ways of dealing with the conflict situation.

Section 5: Supervision

What is supervision?

Supervision is a process through which the Community Health Worker is guided by an expert to ensure that the skills you have learnt are continuously refreshed and improved during the time you are actually using them in your work. This process of continuous learning allows the CHW to discharge his/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 you in your clinical work. You would have been trained initially to provide a range of treatments for persons with schizophrenia and their families. The supervision process will allow you to practice the treatments in a confident and effective manner.

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, the clinical records and the management plans that you have made. The supervision process will generate additional strategies you can use for the treatments of the particular person with schizophrenia or their families who you are

experiencing some difficulty with. For example, sometimes family members may be uncooperative or disinterested in the intervention which you feel is compromising the overall effectiveness of the treatments. In this scenario, your supervisor will discuss the situation in detail and (through problem solving) identify possible ways of improving the engagement of the family. 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 people with schizophrenia and their families with psychotic symptoms, suicidal risk and multiple social problems on an ongoing basis can sometimes become a stressful experience. This can be manifested in various ways like 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 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.

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

Why is supervision important?

Prior to being selected to work as Community Health Workers, you have had some training before providing services in real life. While the training provides you 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 you to practice and implement what you have learnt in the most appropriate manner and provide the maximum benefits to people you will be working with. Some of the more important reasons why supervision is essential for you are:

- It allows you to discuss persons with schizophrenia 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 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.
- Scientific research has identified that supervision is an essential element of any successful health program working with people in the long term. Previously, it was thought that training alone would be enough to make program staff delivering new treatments 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 CHWs you will be working in a team that has people with a range of expertise. Sometimes, you might find that there are certain situations in the team environment which are affecting your confidence and morale. 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.

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

Supervision is a dynamic process which is most productive 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 clients 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.

Supervision Routine

- The CHWs will be supervised every week by the Case manager (on site) and be provided an opportunity to discuss their personal and professional concerns.
- The CHW's will form a peer support group to help each other deal with issues/concerns/stressors.
- The CHWs will have a community team meeting along with the Psychiatrists, Case managers and Intervention Coordinators every week/fortnight to review and update intervention plans and for crises management or management of complex scenarios.

RESOURCES:

Module	Resources
Module 1: ***Self awareness***	Stigma and discrimination: Graham Thornicroft COPSI Manual, Module: 2.5 JMSP Audio-Visual Manual module 2.5.
Module 2***: Developing a working alliance/ therapeutic alliance***	Basic skills in counselling video: Sangath The Premium Counselling relationship manual Role playing situations Initial contact form Home assessment form
Module 3: Identification- ***Signs and symptoms of Schizophrenia***	COPSI Manual Module: 1 JMSP Audio-visual manual, Module 1.2 B Case Studies Pre and post assessment questions Symptom profile checklist http://www.psyweb.com/Casestudies/CaseStudies.jsp
Module 4***: Understanding the social and economic impact of people with Schizophrenia***.	COPSI Manual JMSP Audio-Visual Manual, Module 2.2 and 2.4. Questions related to impact Role play situations
Module 5: ***Principles and methods of providing care.***	Module 2, COPSI Manual JMSP Audio-Visual Manual Module 5.1 A Role Play situations
Module 6: ***Suicide risk assessment and management***	COPSI Manual, Module 3.3 MANAS health counsellors manual, Module 3.4 JMSP Audio- Visual Manual, Module 4.2 A and 4.2 B Suicide risk assessment form Case Studies for Individual Care plans.

Module 7.1***Providing information about illness, mediation and side effects***	COPSI Manual, Module JMSP Audio-Visual Manual, Module 6.1 A COPSI flip chart Case Studies with medication side effects
Module 7.2: ***Relapse Prevention***	COPSI Manual JMSP Audio Visual Manual, Module 6.6 Case Studies with early warning signs of relapse
Module 7.3: ***Family Intervention***	COPSI Manual, Module 3.5 JMSP Audio- Visual Manual, Module 6.1 A and 6.2 Case Studies on different family situations Checklist for social difficulties Needs assessment forms
Module 7.4: ***Adherence Management***	COPSI Manual, Module 3.6 JMSP Audio-Visual Manual, Module 6.3 Checklist for assessing non-adherence Follow up form
Module 7.5: ***Health promotion in people with schizophrenia***	COPSI Manual, Module 3.7 JMSP Audio-Visual Manual, Module 5.3
Module 8: ***Rehabilitation and protection of human rights of people with Schizophrenia.***	COPSI Manual, Module 3.8 and 3.9 JMSP Audio-Visual Manual, Module 6.7 and 6.5 Lapata Zindagi (movie) (https://www.youtube.com/watch?v=ahOVl7fXRSo&t=22s) Mental health care bill-2011 UNCRPD agreement
Module 9: ***Looking after yourself***.	JMSP Audio-Visual manual 6.8 Testimonies from staff

APPENDIX

Initial Contact Form

Date (dd/mm/yy): _____

1. Introduction to patient and caregivers	Yes ☐ No ☐
2. Convenient day and time for CHW's subsequent visits	
3. Who is/are the primary caregiver(s) and relationship to patient	
4. Any immediate family need	
5. Person/s present during the visit	
6.Next follow up visit	Date: Time:
Any other remarks	

Home and supported community facility assessment Form

Date (dd/mm/yy): _____

	Description
1. Persons living at home Who are living at home? What is their relationship to the patient? Please describe using family tree	
2. Type of home and privacy: Please describe the home including the number of rooms. Does the patient have a private room?	**Please describe the home including the number of rooms.** ☐No exclusive rooms ☐One room ☐Two rooms ☐Three Rooms ☐Four Rooms ☐ Five Rooms ☐Six Rooms and above **Condition of houses:** ☐Good ☐ Livable ☐Dilapidated
3. Environment at home (calm, peaceful, noisy etc.)	
4. Where is the most suitable place to hold the intervention sessions? Inside the house (which room?), outside the house (where?)	

5. If in Supported Community facility, describe:

a) How long is the patient staying in Supported Community Housing?

b) How many patients live in one room?

c) What if the patient needs (extra) privacy?

d) Is the environment safe /secured?

e) Who provides support and how?

f) State of hygiene in facility:

g) Nutrition status?

Symptom Profile Checklist

☐ Baseline ☐ 6 months ☐ 12 months

Date (dd/mm/yy): _____

Symptom (tick as appropriate)	**Comments** (provide details for symptoms identified)	**Strategies for Symptom Management** (complete after discussion with intervention coordinator)
Behavioural changes: ☐Lack of personal care ☐Wandering ☐Anger and aggression ☐Excessive/ very reduced activity ☐Other (Please specify): _____		
Changes in biological functions: ☐Sleep- reduced or excessive ☐Appetite-reduced or excessive ☐Menstrual cycle- regular or Irregular ☐Sexual functions- lack of desire, Erectile problems, painful sex etc.		

Changes in mood: ☐ Sad and unhappy most of the time ☐Angry and irritable most of the time ☐Very happy and cheerful most of the time without obvious reason ☐Dull and not interested ☐Anxious and fearful most of the time		
Abnormal Thinking: ☐Talking about plans or conspiracy to harm him/her ☐People talking about him/her behind his back ☐Convinced about his superior abilities ☐Feeling hopeless and worthless ☐Worried excessively about something going wrong ☐Other_____ _____		

Having unusual experiences: ☐Seeing things others cannot ☐Hearing things others cannot ☐Smelling/ tasting something others cannot		
☐**Suicidal thoughts or plans**		
What does the patient think is the problem: ☐Does not have any problem ☐Thinks he/she has a problem but does not know what it is ☐Thinks that there is a supernatural cause of the illness		

☐Thinks that there is something wrong with the brain/ mind ☐Not sure		

Any other comments:

Caregiver Assessment of Social Difficulties Checklist

☐ Baseline ☐ 6 months ☐ 12 months

Date: (dd/mm/yy):_____

Social Difficulties	☐**Baseline**	☐ **6 months**	☐**12 months**
Financial difficulties	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Domestic Violence	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Unemployment	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Legal disputes	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Interpersonal conflicts	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Illness in family/ Disability	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Substance abuse	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Parenting issues	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Bereavement	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Social isolation	☐Yes☐No☐N/A	☐Yes☐No☐N/A	☐Yes☐No☐N/A
Others	☐Yes☐No	☐Yes☐No	☐Yes☐No

Describe Social Difficulties identified in the table below

Social Difficulty	Brief Description	Action taken	What happened?

Needs Assessment Form

☐ Baseline ☐ 6 months ☐ 12 months

Date (dd/mm/yy): _____

Description of needs	**Met need** (Tick)	**Unmet need** (Tick)	**Partially met need** (Tick)	**Brief description/ Comments**
1. Managing Symptoms				
Positive symptoms				
Negative symptoms				
Cognitive symptoms				
2. Emotional Well-Being				
Meaningful activities				
Managing negative emotions (depression, anxiety & anger)				
3. Social needs				
Appropriate Housing				
Citizenship proof				
Access to disability benefits				
4. Role Functioning				
Work at home				
Paid employment				
Parenting				
Spouse				
Home related activities				
5. Social Relationships				
Friends				
Family members				
Co-workers				
Marital relationship				
6. Leisure Activities				
Hobbies				
Sports				

Playing music or watching TV				
Listening to music				
7. Self-Care and Other LivingSkills				
Grooming / hygiene				
Money management				
Use of transportation				
Shopping / food prep				
Cleaning & caring for clothes				
Personal safety				
8. PhysicalHealth				
Health check-up				
Regular dental care				
Eating nutritiously				
Stopping tobacco use				
Avoiding alcohol use				
Managing other diseases				
9. Spiritual Needs				
Involvement in religious Activities				
Experiencing nature				
Meditation / yoga				
10. Stigma and discrimination				
Concern about disclosure				
Discrimination from others				
Low self- esteem/ Shame				
11. Any other Needs				

Individual Service Plan Form for person with SMD

☐ Baseline ☐ 6 months ☐ 12 months Date (dd/mm/yy) _____

Identified unmet need	Tick if yes	What are the necessary inputs	How will the input be delivered
Managing Symptoms	☐		
Suicide Risk:	☐		

Medication Adherence:	☐		
Medication Side Effects	☐		
Emotional Well-Being	☐		

Role Functioning	☐		
Social Relationships	☐		
Relapse Prevention	☐		

Leisure Activities	☐		
Self-Care and Other Living Skills	☐		
Physical Health	☐		

Spiritual Needs	☐		
Dealing with Stigma	☐		
Self-help group	☐		
Any Other	☐		

Suicide Risk Assessment Checklist

☐ Baseline ☐ 6 months ☐ 12 months

Date (dd/mm/yy): _____

Demographic risks

- Male
- Young adult
- Poverty
- Lack of social support
- Unemployed
- Separated from family
- Single or separated

Clinical risks:

- Persistent, 'commanding' hallucinations
- Depression
- Previous suicide attempt
- Family history of suicide
- Misuse of alcohol or other intoxicating substances
- Physical illness and disability
- Long duration of symptoms
- Clear awareness of personal loss due to illness
- Side effects of medicines
- Not taking medicines/ not wanting to engage
- Immediately before or after admission

Immediate risks:

- Persistent, 'commanding' hallucinations
- Ongoing severe social difficulty/ problems seem unsolvable to patient
- Hopelessness
- Loss of interest
- Communication of desire to end life
- Active plan to commit suicide and access to means

Summary risk: (remember immediate risks> clinical risk> demographic risk)

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

Action Taken: (Describe)

Degree of risk

- Absent / Low – Very occasional thoughts / passive ideas prevailing, no concrete plans, social support, stable life circumstances.

- Moderate – Persistent ideas, moderate – severe clinical problems, limited protective factors, 1 or more immediate risks.

- Severe / High – active plan, severe / multiple clinical risks, multiple current problems, severe hopelessness, limited protective factors.

1. Protocol if moderate risk rating:

- Discuss and agree on safety plans with patient and family (means, observation)
- Discuss with supervisor and organize clinical review
- Enhance protective factors
- Meet immediate social problems in a planned manner
- Ensure adequate treatment and adherence
- Ensure follow up and increase frequency of contact
- Reassess risk during every visit

2. Protocol if high risk rating:

- Discuss with Intervention Coordinator and treating Psychiatrist immediately and follow suggested management plans
- Inpatient treatment maybe required in the short term for safety- provide family with details and referral
- Discuss with family and ensure safety; ensure continuous observation
- Assertive and frequent follow up and ongoing risk reassessment

Medication Side-Effects Checklist

☐ Baseline ☐ 3 month ☐ 6 month ☐ end point

Date: _____

(For HL, fill for those on medication)

**If present, needs to be addressed with Treating Psychiatrists*

 # Applicable to women only

Side effect	**Not Present** (Please tick)	**Occasionally present** (Please tick)	**Definitely present most of the time**(Please tick)
* Sedation			
* Muscular stiffness			
* Tremor			
* Restlessness, feeling Jumpy			
* Sensitivity to sun			
* Increased salivation (drooling)			
* Abnormal movements			
* Dizziness			
* Nausea, vomiting			
* Constipation			
*#Irregular menstruation			
* Sleep disturbed			
Fatigue			
Breast enlargement in men and leakage of milk in women			
Headache			
Weight gain			
Blurred vision			
Sexual difficulties			
Difficulty in passing Urine			
Advice given:			

Early Warning Signs of Relapse Checklist

☐ Baseline ☐ 6 months ☐ 12 months Date (dd/mm/yy) _____

Early Warning Signs	Experienced in the past (Tick if yes)	If Yes, Describe
Rapid changes in mood	☐	
Unusually high levels of energy	☐	
Unusually low energy levels.	☐	
No interest in doing things	☐	
No interest in taking care of personal appearance	☐	
Feeling hopeless about the future	☐	

Having trouble concentrating and remembering things	☐	
Thoughts are coming too fast (racing thoughts)	☐	
Cannot understand what is going on.	☐	
Religious rituals and thoughts are suddenly more intense	☐	
Feeling bad that something bad was going to happen	☐	
Having trouble sleeping	☐	
Feeling sad and unhappy most of the time	☐	
Worrying about physical health excessively	☐	

Feeling tensed and nervous	☐	
Getting easily angry at little things	☐	
Having trouble sitting still; having to keep moving	☐	
Having trouble remembering things	☐	
Eating less than usual	☐	
Hearing voices or seeing things that others don't hear or see	☐	
Thinking that people are talking about him/ her or staring unnecessarily.	☐	

Assessing Risk of Non-adherence Checklist

☐ Baseline ☐ 6 months ☐ 12 months

(For HL, fill for those on medication)

Date (dd/mm/yy): _____

1. Socio- demographic factors:

☐Female gender
☐Backward caste
☐Poverty in family
☐Illiterate
☐Unemployment
☐Distance
☐Single

2. Psychosocial factors:

☐Different explanations for illness
☐Lack of information about illness and need for adherence
☐Stigma related to taking treatment
☐Poor family support

3. Illness related factors:

☐Lack of understanding (insight) of the need for treatment
☐Positive symptoms (delusion of being poisoned through medicines)
☐Negative symptoms
☐Poor attention/ concentration
☐Depression
☐Alcohol/ drug use

4. Treatment related factors:

☐Complicated dosage schedule

☐Side effects

☐High cost of treatment

☐Poor therapeutic alliance

5. Systemic and social factors:

☐Stigma related to treatment center

☐Negative attitudes of treatment providers

☐Erratic supply of medicines

6. Summary risk of non-adherence:

☐High *(factors from 3 or more domain*s)

☐Moderate *(factors from 2 domains)*

☐Low *(only socio-demographic risks)*

Describe the Action Taken:

Follow up form

Session Number: _____ Date (dd/mm/yy): _____

(Please mention not applicable (N/A)or not covered (N/C) where ever necessary)

1. Session conducted at	☐Home ☐Hospital ☐Street ☐Other community site_____
2. Who were present for session	☐Patient ☐Family ☐Others_____
3. Review of previous session (including homework) Adequate understanding of issues discussed in previous session	
4. Social difficulties (Brief details)	
5. Suicide risk assessment Action Taken: (Please specify)	☐Low ☐Moderate ☐High

6. Side effects of medicine assessment completed Action Taken: (Please specify)	☐Yes ☐No
7. Overall clinical status Action taken: (Please specify)	☐Better ☐No change ☐Worsen
8. Have there been any changes to the medicines since the last visit	☐Yes ☐No If yes, specify the new medication doses below: Date:
9. Psycho-education Brief description of the session	☐Patient ☐Caregiver ☐Any other family member attended

10. General health promotion advice provided	☐Regular meals ☐Regular sleeping pattern ☐Avoid alcohol/ tobacco ☐Maintain personal cleanliness ☐Regular check-up (periodical check-up)
11. Rehabilitation Brief description of the session	☐ADL ☐Social skill ☐Vocation rehabilitation ☐SHG
12. Improving social welfare and employment Brief description of the session	☐Govt./Non Benefits ☐Referrals to other Org.
13. Stigma **Identified issues** Action taken:	

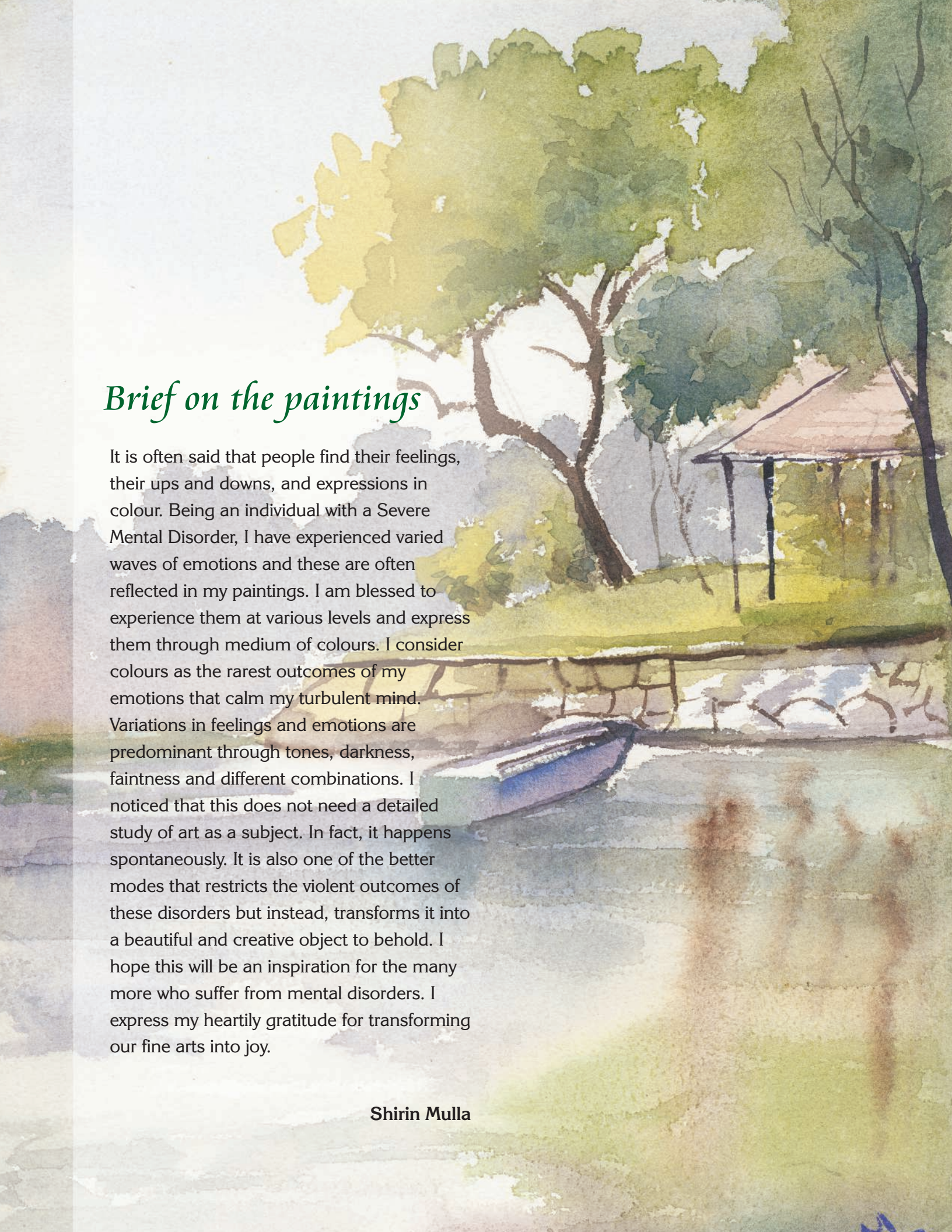
14. Homework assignment Brief details of homework tasks	
15. Tasks for next session identified Brief details of activities for next session	
16. Follow up visit date	
Any additional remarks:	

F18 - Intervention Discharge/Drop out Form

Date (dd/mm/yy): _____

Reason for Leaving the Program	Description	Time spent in the program (in months)	Follow up Plan
☐Dropout			
☐Discharge by the Program Team			

NOTES



Brief on the paintings

It is often said that people find their feelings, their ups and downs, and expressions in colour. Being an individual with a Severe Mental Disorder, I have experienced varied waves of emotions and these are often reflected in my paintings. I am blessed to experience them at various levels and express them through medium of colours. I consider colours as the rarest outcomes of my emotions that calm my turbulent mind. Variations in feelings and emotions are predominant through tones, darkness, faintness and different combinations. I noticed that this does not need a detailed study of art as a subject. In fact, it happens spontaneously. It is also one of the better modes that restricts the violent outcomes of these disorders but instead, transforms it into a beautiful and creative object to behold. I hope this will be an inspiration for the many more who suffer from mental disorders. I express my heartily gratitude for transforming our fine arts into joy.

Shirin Mulla

Parivartan

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