The MANAS Program

DOCTOR'S MANUAL

Manashanti Sudhar Shodh

A Program To Improve The Care
For Patients With Common Mental Disorders
In Primary Health Care

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Sangath

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For further information contact:
841/1, Near Electricity Dept.,
Alto Porvorim, Bardez-Goa -India.
(91-832) 2414916
(91-832) 2417914
(91-832) 2411709
contactus@sangath.com
www.sangath.com

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Introduction

Common Mental Disorder (CMD) is a term used to collectively describe depression and anxiety disorders. Since there is an extensive overlap of symptoms between the two conditions, similarities in their natural course and outcomes and, since the treatments for these conditions are remarkably similar, from a public health perspective, it is useful to consider the specific categories of depression and anxiety disorders collectively as CMD.

Recent research suggests that at any given point in time, CMD affects between 10-15% of the adult population. CMD is a leading cause of non-communicable disease burden in all parts of the world, including in low and middle income countries. Those afflicted with CMD are distressed and cannot lead fully productive lives and may even take the drastic step of committing suicide. Thus, responding to the needs of persons with CMD is a pressing public health concern in any country.

There is a range of simple and effective treatments available for patients with CMD; unfortunately, most patients with CMD go untreated or receive inappropriate care. The MANAS program was initiated in Goa, India, to develop and evaluate a model for delivering treatment in primary care settings where most patients with CMD present for help. The guiding philosophy of MANAS was that the care for CMD required a team approach involving three key players: the primary care doctor, a visiting mental health specialist and a Health Counselor (HC). The HC could be a person with no previous experience in mental health treatment but trained to provide psychosocial treatment and work as a member of the primary health care team.

The essence of the MANAS model is to shift mental health care from mental health specialists to primary care doctors and lay HCs (someone similar to other more widely available health workers) working as a primary care team to improve the coverage and efficiency in treating CMD. This manual has been prepared based on the experience gained through the MANAS program and incorporates feedback from doctors who were involved in the program implementation. It outlines the details of the MANAS model and provides information on treatments that are relevant to doctors working in Primary Health Clinics.

The manual is organized in two sections:

Section A describes the clinical presentation and diagnosis of CMD and the challenges commonly faced in integrating CMD treatments in primary care.

Section B describes the MANAS model for treatment of CMD and guides the doctor through steps involved with a specific focus on the use of antidepressants. A description of the key personnel in the program and their various roles is also described.

The **Appendix** contains diagrammatic outlines for specific treatments that summarize information in the manual in a user friendly format. Pullouts are provided for doctors to use in the clinics.

We hope doctors providing care to patients with CMD will find the manual useful in their daily practice.

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Sudipto Chatterjee, Neerja Chowdhary and Vikram Patel

Sangath, Goa, India and LSHTM, London, UK

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MANAS PUBLICATIONS

1. Patel, V., Weiss, H., Chowdhary, N., et al. The effectiveness of a lay health worker led collaborative stepped care intervention for depressive and anxiety disorders on clinical, suicide and disability outcomes over 12 months; the Manas cluster randomized controlled trial from Goa, India. British Journal of Psychiatry (in press)

2. Patel, V., Chowdhary, N., Rahman, A. & Verdeli, H. Improving access to psychological treatments: Lessons from developing countries. *Behav Res Ther*. 2011. July 7. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=21788012

3. Patel, V., Weiss, H., Chowdhary, N., et al. The effectiveness of a lay health worker led intervention for depressive and anxiety disorders in primary care: the Manas cluster randomized controlled trial in Goa, India. Lancet 2010;376: 2086-2095.

4. Patel, V., Kirkwood, B.R., Pednekar, S., et al. Improving the outcomes of primary care attenders with common mental disorders in developing countries: a cluster randomized controlled trial of a collaborative stepped care intervention in Goa, India. Trials (2008);9:4.

5. Chatterjee, S., Chowdhary, N., Pednekar, S., et al. Integrating evidence-based treatments for common mental disorders in routine primary care: feasibility and acceptability of the MANAS intervention in Goa, India. World Psychiatry 2008;7:39-46.

6. Patel, V., Araya, R., Chowdhary, N., et al. Detecting common mental disorders in primary care in India: a comparison of five screening questionnaires. Psychological Medicine (2008);38:221-228.

SECTION A

Common Mental Disorders

What are Common Mental Disorders (CMD)?

CMD is a term used to collectively describe Depressive Disorders, Mixed Anxiety – Depressive Disorder and Anxiety Disorders. The criteria to diagnose these disorders are described in the International Classification of Diseases (ICD-10) (Primary Care version) and is reproduced below. Although it may appear that these are all different disorders in the classification system, in reality there is considerable overlap between these diagnoses and their treatments. Thus, even though we talk about depression and anxiety as different emotional states, in reality, they are like the two sides of the same coin. When a person is feeling sad, he/she may also worry more than usual. When a person is feeling tensed, he/she may also lose interest in meeting friends. In fact, in clinical practice, the vast majority of patients with anxiety and depression have symptoms of both emotional states.

How does CMD present in clinical settings?

Depression means feeling low, sad, fed up or miserable. It is a normal emotion that everyone experiences at some time in their lives in response to difficult events unfolding around them. The challenge is to determine when a normal physical or mental state becomes 'abnormal' or an illness that requires treatment. This is not unique to mental health problems but is also applicable to common physical health problems like hypertension or diabetes.

To distinguish when a normally occurring phenomenon is considered to be an illness, we usually take into account three features: the extent of *distress* caused by the phenomenon, the *duration* of the problem and the *disability* or inability to meet expected role requirements. In the context of depression, we make the diagnosis when the low mood continues, at least for more than 2 weeks, accompanied by disabling symptoms such as tiredness and difficulty in concentrating that affect daily life, for example, by making it more difficult to work or look after small children at home. When depression significantly interferes with normal life, then we conclude that the patient is suffering from the medical condition of depression.

It is important to note that most patients with depression and anxiety do not complain of psychological or emotional symptoms as their main problem; their **main complaints are often physical and behavioral symptoms** like lack of sleep and energy, aches and pains and loss of interest in their usual work patterns.

Anxiety is the experience of fear and nervousness. Like depression, this is normal in certain situations. For example, a student before examinations often feels anxious and tensed. Like depression, anxiety can become an illness if it continues over a long period of time, i.e. more than 2 weeks, and starts interfering with the person's daily life and causes marked distress.

There are two specific kinds of anxiety symptoms that are common. **These are panic attacks and phobias.**

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

- Occurs suddenly without any warning.
- It can be accompanied by physical symptoms such as palpitations (i.e. feeling one's heart beating fast) or difficulty in breathing that may make a person terrified that he/she will die or collapse or lose mental stability. Usually these feelings last from a few minutes to half an hour.
- These symptoms disappear as suddenly as they appear.

Panic attacks are quite common. Many people will experience one or two panic attacks during their lives. Sometimes, panic attacks become more frequent and can be disabling. When they occur regularly, for example, once or twice a week, it is called Panic Disorder.

Some people **get scared of specific situations**. These fears are not reasonable because the situations are not themselves dangerous. These fears are called **phobias**.

Most of us have one phobia or another, for example, of spiders or snakes. However, some people have phobias of everyday situations, such as:

- Crowded places such as public buses or markets
- Open places includes anywhere out of the house
- Social situations such as meeting people at a social function/party.

If a person experiences fear in these situations and starts avoiding them, it may severely affect his life. That is why some phobias become health problems.

Presenting symptoms of CMD

In the MANAS primary care clinics, the commonest presentations of patients with CMD were:

- Tiredness and weakness
- Aches and pains, especially generalized bodyache, backache and headache
- Sleep difficulties
- Autonomic complaints, especially palpitations, numbness of hands and legs, giddiness

Thus, physical or somatic complaints were the most frequent. Amongst the emotional/psychological complaints, the most common presenting complaints were:

- Irritability
- Lack of concentration
- Feeling sad
- Forgetfulness
- Worry, fear, anxiety

The ICD 10 criteria for the diagnoses of Depression, Anxiety and Mixed Anxiety-Depression:

Diagnosing Depression in ICD - 10

Clinical features of Depression

A. Low mood **/**sadness

B. Loss of interest or pleasure

C. Decreased energy and / or increased fatigue

If YES to any TWO of the above, continue below

1. Difficulty falling asleep or early morning awakening
2. Appetite disturbance: Reduced (or less commonly, increased)
3. Concentration difficulty
4. Psychomotor retardation or agitation
5. Decreased libido (sexual drive)
6. Loss of self-confidence or self-esteem
7. Thoughts / acts of death or suicide
8. Feelings of guilt

Summing up

Positive to **any two** of A, B or C and at least **four positive from 1-8**

Occurring most of the time for **two weeks** or more indicates presence of **Depression**

Diagnosing Anxiety in ICD-10

A. Feeling tensed or anxious
B. Worrying a lot about things

If YES to any of the above, continue below

1. Symptoms of arousal and anxiety like palpitation, hyperventilation, breathlessness, sweating.
2. Experience intense or sudden fear unexpectedly or for no apparent reason.

   These attacks may be **accompanied by some of these symptoms:**

   - Fear of dying
   - Feeling dizzy,
   - Fear of losing control
   - Pounding heart
   - Numbness or tingling
   - Sweating
   - Trembling or shaking
   - Feelings of unreality
   - Chest pain
   - Nausea
   - Difficulty breathing

3. Experiences fear / anxiety in specific situations like
   - Leaving familiar places
   - Traveling alone or in a train, car, plane
   - In crowds / confined places / public places
4. Experience fear / anxiety in social interactions like
   - Speaking in front of others; attending social events
   - Eating in front of others
   - Worry a lot about what others think of him/her or self-consciousness

Summing up

Positive to A, B and 1 : Indication of **generalized anxiety**

Positive to A, B and 2: indication of **panic disorder**

Positive to A, B and 3: indication of **agoraphobia**

Positive to A, B and 4: indication of **social phobia**

Mixed anxiety and Depression in ICD-10

Presenting complaints

Patients may present with one or more physical symptoms (for example, various pains, poor sleep and fatigue), accompanied by a variety of anxiety and depressive symptoms that have been present for more than six months. These patients may be well known to their doctors, and have often been treated by a variety of psychotropic agents over the years.

Diagnostic features:

- Low or sad mood
- Loss of interest or pleasure
- Prominent anxiety or worry
- Multiple associated symptoms are usually present:
  - Disturbed sleep
  - Tremor
  - Fatigue or loss of energy
  - Palpitations
  - Poor concentration
  - Dizziness
  - Disrupted appetite
  - Suicidal thoughts or acts
  - Dry mouth
  - Loss of libido
  - Tension and restlessness
  - Irritability

Why do people develop CMD?

To understand why people develop CMD, we need to appreciate two related concepts:

- Stress and its relationship to CMD
- How vulnerability and resilience affect this relationship

Stress and its relationship with CMD

Over the last few years, there has been an increasing awareness of stress and stress related problems in everyday life. As a result, the words ‘stress’ and ‘tension’ have become part of our everyday language.

The inability to deal with stress can lead to difficulties in various areas of the person’s life. For example, it can aggravate health problems, create difficulties in close relationships and negatively influence studies or work performance.

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

Common types of stress

Some of the common ways in which stress is classified are:

- **Stress can be sudden (acute) or long term**

  A common way of understanding stress is to classify it according to its onset i.e. whether stress occurs all of a sudden or is more long standing.

  Acute stress may occur when a family member dies, serious accidents occur or if one is affected by a disaster. Some common longstanding stresses include social and economic disadvantages of being a woman or belonging to a particular social class, poverty, marital problems and disabling illnesses that reduce the quality of life.

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

  Serious problems cause severe stress. Research has consistently shown that there is an increasing incidence of stress related health problems as the severity of the stressful experience increases.

The consequences of stress

What makes an event stressful is *the meaning we attach to it*. This in turn is influenced by the social environment, cultural beliefs and attitudes, past experience and personality type of the individual. For example, someone who is naturally anxious will get upset more easily compared to another person who is more relaxed and easygoing. The social situation in which a person lives can also influence how she deals with stress. For example, after the death of her husband, the wife who lacks a supportive family and faces economic difficulties has much greater chances of experiencing the negative consequences of stress. However, there are some consequences of stress that are common across individuals. These can be described as follows:

a) The physical consequences of stress

The human body is designed to react to stress in a particular manner and this has been well studied in the context of **acute stress reactions**. As soon as a stressful situation is experienced, the brain and body go on an alert mode. This is mediated by the release of certain chemicals in the brain which also influence bodily functions. Norepinephrine or adrenaline is released in large quantities and improves attention, increases the heart and respiration rate and improves blood supply to the muscles (the 'fight or flight' response). Another important chemical that is released when we are stressed is cortisol. This also improves the short term functioning of the body by increasing metabolism and releasing energy.

However, if stress **continues for some time**, the alert mode of functioning slows down as the body uses up too much energy. As a result, with chronic stress there is a general exhaustion of the brain and the body is unable to function at an optimum level. This is when the brain and body 'give up', making the person become more vulnerable to developing chronic physical and/or mental symptoms like fatigue, sleep difficulties, and aches and pains.

b) The emotional consequences of stress

The emotional consequences of acute and chronic stress are similar to the physical responses described above. In the short term, stress has an energizing effect on mental functions like attention span, concentration and memory which are utilized for solving immediate problems. This is helpful in dealing with most daily problems. For example, the heightened/aroused state of readiness helps individuals cope with the strains of work, caring for the family and sorting out interpersonal

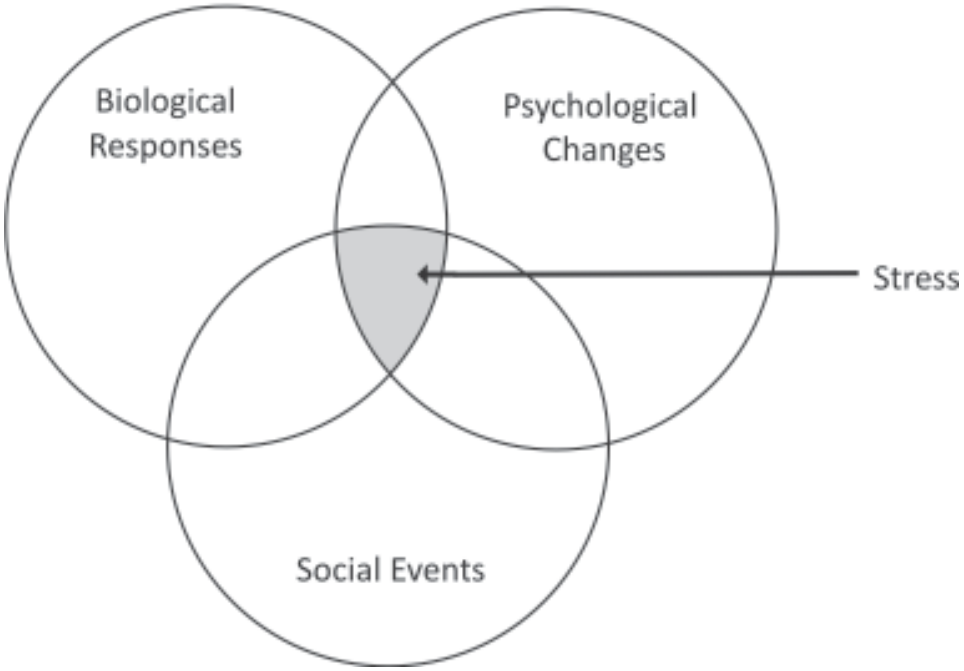
disputes. However, when the stress becomes overwhelming (e.g., loss of employment and social status, being physically or sexually humiliated, loss of home during disasters) or when the stresses are continuous with little possibility of being resolved (e.g. domestic violence, poverty, infection with HIV/AIDS), the psychological resources for coping with them may be exhausted. Individuals may then experience psychological distress in the form of depression or anxiety, lack of concentration and feelings of hopelessness.

c) The social consequences of stress

Social relationships can provide a **safety net at times of stress**. For example, when we are upset about something we talk to parents, friends and family members who support and help us in resolving difficulties. The effects of ongoing, unresolved stress however can also be seen in the social context (office, family and friends); for example, a person who is very stressed often withdraws from social interactions with friends or colleagues.

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

The Biopsychosocial Consequences of Stress



Stress and CMD

Stress and CMD have a close and mutually interlinked relationship. As is described above, a person is at a higher risk of developing CMD when she undergoes a continuous stressful experience. When a person develops CMD, she will find dealing with stress more difficult than usual; the resultant lack of confidence aggravates the CMD. As shown in the figure on page 14, they mutually reinforce each other and make it more difficult for the person to recover.

How do vulnerability and resilience affect the relationship between stress and CMD?

As we noted earlier, stress is produced by events in our environment. After the particular event is experienced, all of us react by giving the event some emotional meaning to the experience**. Because no two persons are the same in terms of their biology, personality or social environment, people will react to**

the same stressful situation in unique and different ways. Failing in examinations is a good illustration of the above. While some persons are very seriously affected to the point of contemplating suicide, others are able to deal with the event by taking the failure as a challenge and excelling the next time.

Two factors determine the relationship between stress and CMD: vulnerability and resilience. Vulnerability increases the likelihood that stressful events will lead to CMD while resilience works in the opposite direction and decreases the likelihood of stress leading to CMD.

What is vulnerability?

Mental health and mental illnesses are influenced by multiple and interacting biological, psychological and social factors. Vulnerability increases the chances that a person, when faced with stressors, will develop CMD. This is called the **Stress - Vulnerability Model of CMD.**

For example, some people have a genetic vulnerability for developing CMD. If there is a close relative, such as a parent or sibling, who suffers from CMD, it will increase the chance of inheriting a tendency to develop the illness when experiencing significant stress in their lives.

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

Other examples of vulnerability factors are the absence of a strong, affectionate relationship during childhood and being a woman in societies where they are undervalued compared to men.

What are risk factors?

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

1. Physical health factors

- Suffering from a chronic physical illness or disability (e.g., heart disease or cancer)
- For women suffering from gynaecological complaints
- Heavy alcohol consumption
- Tobacco use (smoking or chewed)

2. Socioeconomic factors

- Indebtedness
- Unemployment
- Heavy work load (e.g., looking after many children).

3. Relationship factors

- Lack of trusting relationships (e.g., with friends or spouse)
- Living in a violent relationship
- Experiencing child abuse
- Early loss of parents
- Transition of a relationship (e.g., retiring from work or children leaving home)
- Break-up of a relationship

4. Difficult life events

- Bereavement (i.e. when a loved one dies)
- Caring for a loved person who is severely ill
- Experiencing a violent incident or accident.

What is Resilience?

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

A number of inter-related processes can have an important impact on the development of resilience. For example, we know that losing one's parents early in one's life predisposes us to CMD. This is mainly true if the loss of parents leads to inadequate care and to lack of emotional stability in the family. However, the presence of loving relationships from other relatives can build resilience in the child to cope with the loss and build up resistance to developing CMD in adulthood.

What are protective factors?

Protective factors are influences that modify a person's response to a stressor to prevent the stressor from resulting in CMD. Hence, protective factors increase a person's resilience. A number of protective factors exist and these include:

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

What is the relevance of protective and risk factors for you as primary care doctors?

You will be providing treatments for people who suffer from CMD. Understanding vulnerability and resilience has a direct influence on what you might do to help them:

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

Summary points:

- ⊙ Stress is part of everyday life and can be defined as any event that disturbs the biopsychosocial balance of the person.
- ⊙ Stress can be due to changes in the internal or external environment, can be acute or longstanding and of various intensities.
- ⊙ The consequences of stress vary between individuals because of different ways of perceiving and reacting to the problem.
- ⊙ Stress and CMD are closely linked to each other.
- ⊙ Resilience is an individual's ability to cope with stressors and is influenced by the presence of protective factors in the person's life.
- ⊙ Vulnerability is the opposite of resilience and increases the chances that stressors will result in the person developing CMD. Presence of 'risk factors' increase vulnerability and lead to health problems.
- ⊙ Increasing protective factors and reducing risk factors are important strategies in treating patients with CMD.

As a primary care doctor, it is important for you to understand stress properly and the relationship of stress with CMD. Helping a patient to identify and deal with stressful experiences is an essential part of your work; this will help break the link between the two and help the patient recover.

Why is CMD an important public health problem?

Research from around the world has shown that CMD is an important public health problem because:

- It affects between 10 to 20% of all adults attending primary health centres.
- It is associated with high levels of disability and health care seeking.
- It worsens the outcomes of any co-existing physical health problem.
- In mothers, it can affect the growth and development of children.
- In severe cases, it may lead to suicide.

What are the treatments for CMD?

The World Health Organisation (WHO) mhGAP initiative developed guidelines to facilitate delivery of evidence based interventions for mental, neurological and substance use disorders in non-specialised health care settings[1]. These guidelines are based on an intensive process of evidence review that involved the conduct of systematic reviews and expert collaboration. The mhGAP recommends the following treatments for CMD:

1. Psychosocial treatment and advice: This includes provision of psychoeducation (i.e. information to help patients understand their symptoms, offer them hope and motivate them for treatment), addressing current stressors, encouraging the person to resume prior social activities, organization of structured physical activity and offering regular follow up.

2. Antidepressant medication: Either a specific Serotonin Reuptake Inhibitor (SSRI) or Tricyclic Antidepressant (TCA) provided for 6 to 12 months in appropriate dosage.

3. Psychotherapies: These are usually provided by specialists but can be provided by doctors/other non specialists who are specially trained and supervised. These treatments include Cognitive Behaviour Therapy, Interpersonal Psychotherapy, Behavioural Activation, Problem Solving Therapy and Relaxation Training.

The phases of treatment of CMD

The average treatment duration for an episode ranges from 2 to 6 months; the shorter duration is often for mild cases, while the longer duration is often for moderate/severe cases and for patients in whom there is a risk of future episodes. There are three phases of treatment: the acute, maintenance and termination phases.

***Acute phase*:** The treatment goal in the acute phase is remission — recovery from symptoms. The acute treatment phase usually lasts 4 to 8 weeks. The patient should be evaluated once or twice a month by the doctor and the HC.

Maintenance phase: This phase of treatment generally lasts 6 months after the recovery; it aims to eliminate residual symptoms, restore the prior level of functioning and prevent occurrence or early relapse. In special cases where the episode of CMD has lasted more than 6 months, the continuation phase may last upto 12 months.

Termination Phase: The aim here is to stop active treatments, to reinforce the advice on symptom management given by the HC; and to advise the patient that if symptoms recur she should return to the Primary Care Clinic for a fresh assessment.

Why is the primary health facility the ideal place to provide care for CMD?

Worldwide, the majority of persons with CMD seek health care in primary care settings and only a small proportion of patients go to specialist clinics. In line with the recommendations for other non-communicable diseases like heart disease and metabolic disorders, the World Health Organization (WHO) has, for many years recommended that the ideal location for treatment of CMD is in primary care settings. The key reasons for integrating care for CMD in primary care facilities are:

- the high prevalence and burden of CMD in primary care
- the shortage of specialist mental health providers
- the stigma associated with specialist mental health care, and
- the relatively simple and effective treatments for CMD

[1] The mhGAP Intervention Guide for mental, neurological, and substance use disorders in non-specialised health settings is available at www.who.int/mental_health/evidence/mhGAP_intervention_guide/en/index.html.

What are the main challenges in integrating treatments for CMD in primary care?

Though there is consensus that integration of services for people with CMD in primary care facilities is the most feasible and appropriate method of providing care, the actual experience of implementing integrated programs has been challenging in all parts of the world. There are some well recognized obstacles to implementing integrated programs for CMD in primary care which are shown in Table 1 below. In other words, unless these obstacles are explicitly addressed, programs for integration of services are likely to fail.

The first obstacle is the *low rates of recognition of CMD in primary care* with less than one third of clinically significant cases being detected. Secondly, *many patients with CMD receive 'non specific' treatments* like sedatives, analgesics and vitamins, and very few receive specific medications like antidepressants. Thirdly, though there are simple and effective '*talking treatments' or 'counselling' for CMD, these are not available* in primary care facilities.

Fourthly, even when appropriate treatments like antidepressants are used, many *patients with CMD fail to adhere to the treatment* for the required period of time. Finally, while there are often *training programs* for doctors and other primary care staff in the detection and treatment of CMD, there is evidence that in the absence of continuous supervision and support from specialists, the benefits of training are short lived and do not translate into any sustained systemic change or improvement in patient care.

The MANAS model specifically addresses all these obstacles to integrate CMD treatment in primary care. The challenges, the specific solutions and expected outcomes are summarized in the given table below.

Table 1: Addressing the challenges to integration

Challenge	Solution	Expected outcome
Low recognition of patients with CMD	Routine screening of adult attendees in clinics	Improved detection of patients with CMD in clinics
Use of non specific treatments	Training and orientation to the use of specific treatments; continued support and supervision from specialists	Increased use of specific treatments like antidepressants in patients with CMD and decreased use of symptomatic treatments such as sleeping pills and vitamins.
Lack of counselling facilities	Train lay health counselors or primary care nurses to provide basic counselling for patients with CMD in the facility	Routine use of counselling for patients with CMD in clinics
Poor adherence with treatment	Doctor and HC to stress on adherence management in the integrated program	Improved rates of treatment completion and recovery
Absence of ongoing specialist supervision and support	Mental health specialists to provide regular onsite support and supervision; Clear referral mechanism for complex cases	Primary care staff and specialists collaborate to make the program work effectively

SECTION B

The MANAS Model for Management of Common Mental Disorders in Primary Care

Rationale and design

MANAS evaluated the effectiveness of a Health Counselor (HC) led mental health care program in primary care and was a collaboration between the Directorate of Health Services (Government of Goa), the London School of Hygiene & Tropical Medicine (LSHTM), Sangath and the Voluntary Health Association of Goa (VHAG). The goal of the MANAS program was to integrate the recognition and treatment of CMD into routine primary health care facilities. In the MANAS program, a range of effective treatments (for example, psychoeducation and antidepressant medicines) and engagement styles (for example, continuing support and monitoring until recovery) were provided to patients with CMD. These treatments were matched with the individual patient's requirements to improve the effectiveness of the treatments and to use the limited resources efficiently. The method and process of implementing the program is called the **Collaborative Stepped Care Model.**

The MANAS program has been designed in accordance with the most recent guidelines from the World Health Organization (WHO) and after a careful review of the existing literature on the effectiveness of programs for CMD across the world. In operational terms, the program has:

- Incorporated treatments which are evidence-based, i.e. have been evaluated and shown to be effective in good quality clinical trials.
- Consulted with international and national experts in the field of primary health care for CMD.
- Been developed in close collaboration and discussion with regional health care officials including primary care doctors.

The MANAS intervention is based on the WHO principles for chronic disease management. These principles are the same for all chronic diseases, including heart disease and diabetes. This model incorporates four basic principles.

1. **Stepped Care**: This means that not everyone with a chronic disorder needs the same treatment. Everyone might need a simple, relatively cheap and risk-free treatment (for example, lifestyle management, advice about the symptoms and exercise), and only a few will need more expensive and intensive treatments (for example, antidepressants or counseling treatments or both). Treatment is tailored to the needs of the individual patient and is delivered in 'steps' depending on the severity of the illness and the patient's response to the treatment. This ensures that expensive and time consuming treatments are reserved for those who need them most, and that patients with milder problems are not exposed to unnecessary risks associated with these treatments.

2. **Collaborative care**: This means that members of the primary care team work in collaboration with one another to ensure that the patient gets the optimal benefit from the treatment. In this program, the two key members of the primary care team are the doctor and the Health counselor (HC). In addition, the primary care team is supported by a Mental Health Specialist (MHS) (a psychiatrist or psychologist) who provides consultation to patients who are severely ill and/or do not respond to the initial intervention. The MHS also supervises the HC to ensure that the quality of her work meets the required standards.

3. **Combination of health promotion and medical treatments:** The program combines both health promotion components (such as education about symptoms, lifestyle changes, yoga, etc.) and specific medical treatments (e.g., antidepressants and psychological treatments). In addition, emphasis is laid on following up patients regularly to ensure their adherence to treatments (medicines or counseling) and close monitoring of the patient's progress.

4. **Adherence management:** A major challenge in the management of chronic diseases is ensuring that patients follow up regularly and complete their course of treatments. The program addresses this with specific adherence management strategies described in subsequent sections.

The treatments in the program are to be delivered in a stepped manner:

Those with mild CMD should receive Step 1 or psychoeducation only, while those suffering from moderate-severe CMD and those who do not respond to Step 1 treatments should receive Step 2 or antidepressants. Step 3 refers to the referral to the MHS for patients who do not respond to Step 2 treatments and for those who have more complex care needs that only a specialist can provide.

The stepped care method is shown below. The details of the steps are provided in the table below:

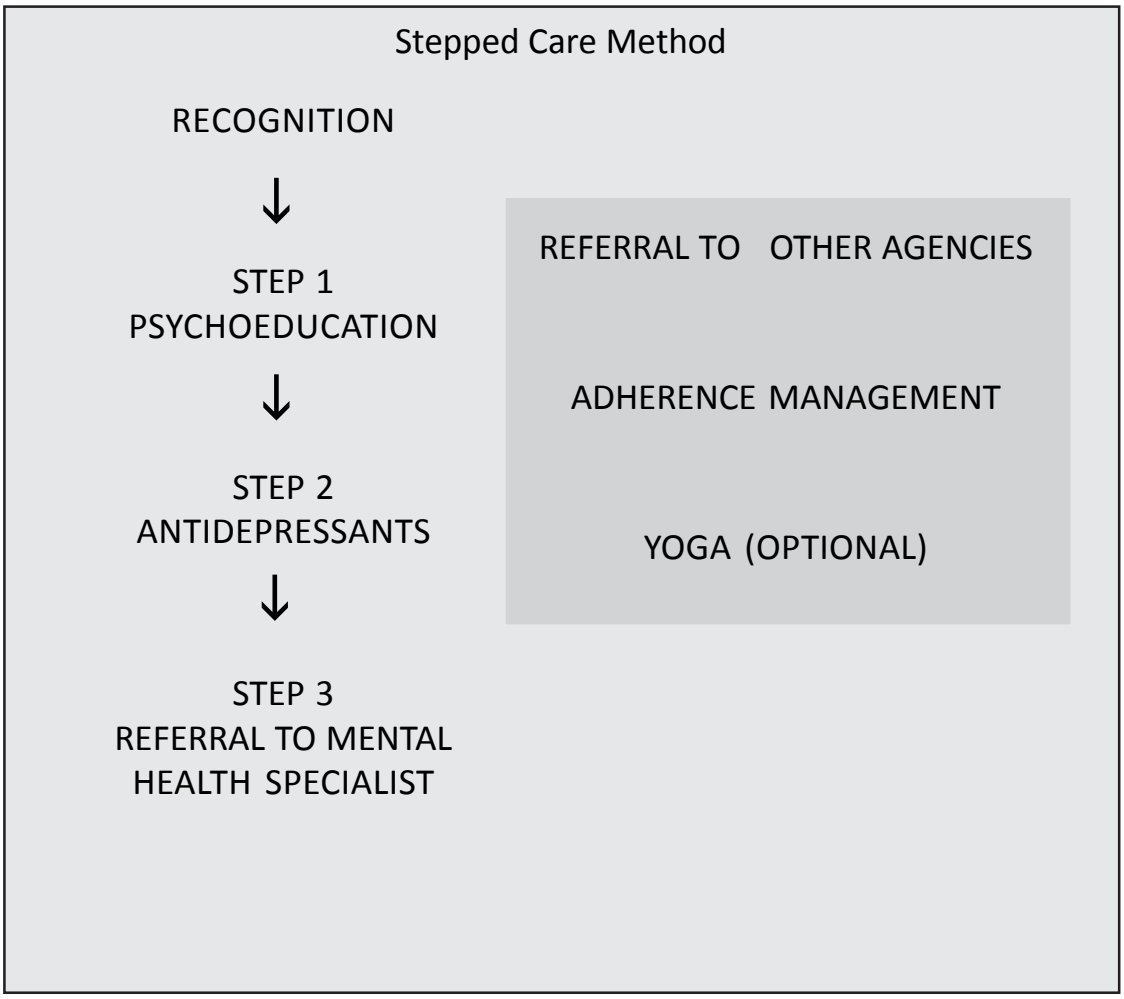


Table 2: The operational details of the steps of care:

Step	For Whom	Timing	Treatment	By Whom
Recognition	Adult patients attending primary care clinics	Before consultation with doctor	Screening questionnaire; report for doctor	Secretary / Registration clerk / HC / Self-administered
1	Patients screened with CMD	At first consultation	• Advice regarding screening questionnaire results; advice regarding seeing HC • Psychoeducation and follow up appointment as appropriate • Information about Yoga sessions (where available)	Doctor HC HC
2	Patients who are severely ill at first consultation or whose symptoms persist.	At first consultation or at first follow up at 2-4 weeks	• Antidepressants • Psychoeducation • Adherence Management	Doctor HC HC
3	For patients who do not respond despite good adherence	Patients who do not respond to Step 3 despite taking the treatment & Patients who are expressing suicidal ideas at any time	• Continue all existing treatments • Add IPT or other structured PT if available • Refer to Mental Health Specialist	HC & Doctor Mental Health Specialist

The evidence

An evaluation of the MANAS collaborative stepped care model was conducted in 24 primary care facilities (public and private) with 2796 patients with CMD. In public facilities, the intervention was consistently associated with strong beneficial effects over the 12 months on depressive symptoms, suicide attempts/ plans and disability. There was about 30% decrease in the prevalence of CMD among baseline ICD-10 cases. Suicide attempts/plans showed a 36% reduction over 12 months among baseline ICD-10 cases. Strong effects were observed on days out of work with patients who received the intervention having 5-6 days less away from work as compared to patients who did not receive the intervention.

This is an important finding in the context of the large burden of depressive and anxiety disorders, the leading psychiatric causes of burden of disease, and the fact that the primary human resource was a lay

health worker. There was little evidence of impact of the intervention on any outcome among patients attending private facilities indicating that contextual factors such as the one-to-one doctor patient relationship and privacy during the consultation are critically important in influencing the effectiveness of this intervention.

The components of the intervention

Below, we discuss the Manas intervention in detail as:

A. Detection of CMD

B. Psychological treatments

C. Antidepressants

D. Other interventions

E. Special Population

A. Detection of CMD

In the previous sections, we described the impact of stress on a person's mental health and that some people develop mental disorders when faced with stressful life situations. There are a number of symptoms (or complaints) that a person who is suffering from CMD may typically experience - these symptoms can affect the person's thinking, emotions, physical health and behaviors.

Despite the awareness about the symptoms of CMD, very few patients with CMD are correctly identified in the primary health care clinics. There are many reasons for this:

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

In this program, we overcome these problems by adopting a systematic method of identification through screening.

What is screening?

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

- Weighing a child regularly to detect malnutrition
- Asking women to self-examine their breasts regularly to detect breast cancer

- Doing blood sugar tests every year after the age of 40 to detect diabetes.

To detect the presence of CMD, there is a standard way of screening patients - this is to ask them a set of questions about their mental health by using what is called a 'Screening Questionnaire'.

The General Health Questionnaire (Appendix 4):

You can use the General Health Questionnaire (GHQ) at the screening stage. The GHQ was originally developed in the UK and is one of the most widely used screening questionnaires in the world, including in India. The GHQ has been found to be effective for detecting CMD. More importantly, 8 out of 10 'screen positives' are ICD 10 cases of Depression.

The GHQ has 12 questions: for details on the questions and scoring the responses refer to Appendix 4. The questionnaire consists of 12 emotional experiences over the *previous two weeks*. Some questions ask about the presence of distress, i.e. the *presence of symptoms* (such as 'losing sleep over worry') while others ask about *well-being*, i.e. the absence of symptoms (such as 'been able to concentrate'). Each question is scored either 0 (which means the symptom is absent) or 1 (which means the symptom is present).

Once the questionnaire is completed, the total score of all 12 questions are added up to give a single summary score for each patient. This score is then used to assess whether a person is suffering from CMD at this point in time. The higher the score, the more likely it is that a person has CMD.

Three diagnostic possibilities:

- **A case of moderate – severe CMD (8 and above on the GHQ):** for these patients, you can be confident about the diagnosis and offer treatment starting at step 2, i.e.psychoeducation and antidepressants.

- **A case of mild CMD (6-7 on the GHQ):** for these patients, if you have time, you can ask some questions (see ICD-10 guidelines presented earlier) to confirm the diagnosis. If you don't have the time, offer treatment starting with **Step 1,** i.e. psychoeducation

- **Not a case (<6 on GHQ):**these patients do not need treatment for CMD at this time.

Who can do the screening in the clinic?

- Anyone can be easily trained to do the screening such as the registration clerk or nurses in the primary health clinic.

- Patients who are literate can answer the GHQ themselves.

- You can sometimes complete the screening using the GHQ, if time permits.

It is important to ensure privacy for the patient while screening is conducted so that the patient can understand and respond to the questions.

Note: *If there are patients who you feel should receive the program irrespective of the screening results, then, please do so. The screening process is only meant to help you in the diagnosis, and not to replace your own clinical judgment.*

B. Psychological treatments

Psycho-education: Psychoeducation is provided by the HC to all patients who screened positive for CMD. It specifically involves educating the person about their symptoms, exploring the association of CMD with interpersonal difficulties, explaining the need to share emotional symptoms with the doctor and to share personal difficulties with family members caring for them or other key people in their social network. Psychoeducation enables patients to learn new strategies to alleviate symptoms, such as breathing exercises for anxiety symptoms and scheduling activities for symptoms of depression.

Encouraging adherence to treatments for these disorders and providing information about social and welfare organizations, when needed, are the other key components of psychoeducation.

What to tell a patient about their illness

1. Provide reassurance and explanation about the link between patient's stress and symptoms
2. Explain the diagnosis and give hope that she will feel better with treatment
3. Giving the sick role and explain that her inability to fulfill her responsibilities are due to her stress related illness and not her 'fault'
4. Explain that medicines and counseling are available in the PHC and will be provided by you and the HC
5. Explain that the patient must see the HC and you regularly to get the maximum benefits of the treatment

Assessment and management of suicide risk

In the initial session and during follow up sessions when the patient does not report improvement, it is important to enquire about suicidal ideas and social support.

This can either be done by you or the HC in your clinic

Direct questions such as those listed below help to assess suicide risk:

- In the recent past have you had thoughts that life is not worth living (death wishes)?
- In the recent past, have you had thoughts of killing yourself (suicidal ideas)?
- In the recent past, have you had thoughts as to how you may do it (suicidal plans)?

Clinical practice often shows that asking questions about suicidal ideation actually improves the doctor-patient relationship, besides informing management plans.

Another question to consider in patients with suicidal ideas is to enquire about **social support**. It helps to know who the patient lives with and whether responsible adults are available to observe the patient and to monitor safe use of antidepressants.

Patients need to be told that they are feeling suicidal because they are suffering from CMD and that the new program available in the clinic will enable them to recover completely.

The management of suicidal risk

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

i. Establishing a trusting relationship with the patient: This is the most crucial part of the interventions and is the foundation on which everything else rests. The aims of adequate engagement are to make the patient feel that her problems are being understood in an empathic manner and that you are not judgmental about her disclosures.

ii. Encouraging the patient to talk about her problems (ventilation): The aim of engagement is to facilitate the patient to talk freely about her concerns and distress. Remember that suicidal ideas cause a lot of distress to patients because of the associated guilt and interpretation of it being a sign of 'weakness'. Ventilation can be a very powerful tool in decreasing the intensity of suicidal thoughts. Frequently, patients will become emotional and tearful during this time and you need to be supportive without encouraging the idea of self-harm.

iii. Giving the patient hope: Hopelessness is commonly associated with CMD and this combined with active suicidal ideas is a strong predictor of an impending suicidal attempt. Acknowledging and managing hopelessness is, therefore, a very important part of the initial interview and should be done explicitly. One of the ways to do this is to tell the patient that you have understood her problems and are concerned about her well-being but that you do not share her lack of optimism. It may also be useful to point out to the patient that hopelessness is a key symptom of CMD and that treatment will lessen that feeling.

iv. Increasing protective factors: This is another key task to be accomplished during the interview. You would need to understand what has stopped the patient from actually carrying out her plans (such as caring for her children, etc). The idea is to make these points explicit during the discussion so that the patient is reminded that there are things in her life which are worth living for.

v. Ensuring safety: This is another essential part of the common interventions that needs to be carried out, especially when the risk of suicide is either moderate or severe. The first principle is to involve immediate family members of the patient and inform them about your concerns for her safety so that she can be observed closely at home. This is best done following a discussion with the patient and obtaining her consent. However, in some circumstances it may be necessary to breach confidentiality as the patient's safety is of paramount concern. Secondly, you must discuss with the patient how access to means of suicide (pesticides, medicines, ropes, sharp weapons) can be limited and explain that this is part of your professional obligations. *Do not let the patient leave the clinic until you are satisfied that you have taken the necessary precautions to ensure her safety.*

vi. Asking for advice: Always discuss your concerns with a colleague. Remember that you should have continuous access to the MHS who is experienced in dealing with the management of suicidal risk. In any situation where you are unsure about what you should be doing, please ask for necessary advice from the MHS without any hesitation.

vii. Enhancing the frequency of contact: One of the more important ways to ensure that suicidal patient is engaged adequately and feel that you are making an effort to meet her needs, is to increase the frequency of contact. Make an agreement with the patient that she will call you (or someone else) if she is feeling suicidal.

viii. Documentation: The importance of adequate documentation of the risk assessment procedure, plans and their implementation on an ongoing basis is absolutely vital and an essential part of the process. For example, documenting that you met with family members and consulted appropriately with the MHS is important.

C. Antidepressants

Choosing an antidepressant: There are a range of antidepressants available which have been used in the treatment of CMDs - these include **TCAs** (Tricyclic Antidepressants) like imipramine, amitryptiline and dothiepin, **SSRIs** (Selective Serotonin Reuptake Inhibitors) like fluoxetine, sertraline and citalopram, **SNRIs** (Serotonergic and Noradrenergic Reuptake Inhibitors) like venlafaxine and **others** like mirtazapine.

While there is a wide choice of antidepressants available, it is important to remember that **no one antidepressant is clearly superior; in other words, they are all equally effective.** Therefore, the two most important factors to keep in mind while choosing an antidepressant are the side effect profile and the tolerability. It is important to use a medicine that matches the symptom profile of the patient. For example, if a patient with CMD complains of insomnia, you might wish to start an antidepressant that is also a sedative like imipramine or mirtazapine at night; this will minimize the need for an additional sedative. To guide you in making a decision about which antidepressant you should use, please refer to Appendix 3.

REMEMBER:

- All antidepressants are equally effective.
- Side effects and costs vary between antidepressants and are important reasons in making a choice of the antidepressant.
- Antidepressants need to be taken for at least 6 months - therefore choose a drug like fluoxetine that is inexpensive for the patient and has a simple once daily dose
- Match the antidepressant to the symptom profile of the patient.
- For prominent insomnia, use sedating antidepressant like amitryptiline or mirtazapine at night.
- If anorexia and gastric discomfort is present, avoid the use of an SSRI.
- Avoid using TCAs in the elderly and in those with heart problems.
- If weight gain is a concern, an SSRI is the best choice.

Principles of using antidepressants

Starting: It is best to **start low and go slow** with the dose of the antidepressant. For example, if you are using fluoxetine, we recommend a starting dose of 10mg in the morning after breakfast. Similarly, if you are using sertaline, 50mg would be appropriate as a starting dosage.

Remember that antidepressants have a lag period before they are effective (usually 1- 2 weeks) in reducing the symptoms of CMDs. A larger dose initially will not produce a quicker response but may cause more side effects and increase the chances the patient will discontinue the treatment. Please refer to details on recommended starting doses in Appendix 3.

Following Up: Please ask the patient to return within 2 weeks of the initial consultation to enable a review of her clinical status and to monitor the tolerability to the antidepressant. If the antidepressant is well tolerated, you might want to increase the dose to an adequate level (see Appendix 3) and ask the patient to come back in 4-6 weeks.

If the patient *claims no improvement* after taking an adequate dose **for at least 4 weeks,** then, increase the dose to the maximum recommended level (see Appendix 3). Review at least once a month until fully recovered, and advise to continue the treatment for 6 months.

Common side effects: Antidepressants can cause side effects in a minority of patients. While the specific side effect profile differs between the individual drugs, most side effects occur in the first few days of treatment (usually before any significant improvements in symptoms occur) and are transient.

SSRIs commonly cause gastrointestinal side effects due to serotonergic receptors present in the gut. TCAs act on a number of receptors and therefore cause a wider range of side effects related to their anticholinergic (constipation, dryness of mouth, tachycardia), noradrenergic (postural hypotension) and histaminergic actions (sedation, weight gain); the range of side effects are the reason why these are to be used with caution in the elderly or those with cardiac problems (see Appendix 3 for further details). Since the side effects are transient, reassure the patient before starting the medication, informing them that they occur in a minority of persons who take the medicine and that they usually go away within a week to 10 days.

If there is no response despite the patient taking the maximum recommended dose for at least 1 month, consider the presence of ongoing social difficulties that are causing the problems. Subsequently, discuss with the MHS for advice on alternative medications or need for specialist psychological treatments (i.e. Step 3).

Ending Treatment

Antidepressants should be continued for at least 6 months to ensure adequate treatment.

Before discharging the patient these steps are useful to consider as they consolidate the gains made during the treatment:

- Reduce the antidepressant gradually; if the patient is taking 20 mgs of Fluoxetine, you may stop it in one step, but if the patient is taking 40 mgs (i.e. 2 capsules of 20 mgs), then you should first reduce to 20 mgs for two weeks and then stop the medication.Advise the patient to continue practicing the health promotion advice (for example, breathing exercise) that the patient has learned from the HC.
- Educate the patient to return to the Primary Health Clinic if she feels that her symptoms are coming back in spite of trying out the health promotion advice.

What to tell a patient about antidepressants

- The medicine is not addictive.
- The medicine will show an effect only after 1-2 weeks.
- The medicine has the best impact if taken regularly as advised; you can give examples of other illnesses for which a full 'course' of tablets must be given to make sure the patient is 'cured' (such as antibiotics for malaria).
- The medicine is safe in the long run and has no irreversible side effects.
- It is very important to take the medicine every day for the best results.
- After recovery, these medicines must be continued for at least 4 - 6 months to minimize the risk of relapse.

Why avoid sleeping pills and vitamins?

Doctors often prescribe sleeping pills for sleep problems and vitamins/tonics for fatigue. We do not recommend using these medicines because:

- Fatigue and sleep problems are typically due to CMD which responds best to antidepressants.
- The MANAS model offers a full package of evidence based treatments for these problems.
- Sleeping pills (such as diazepam and alprazolam) are addictive.
- Indiscriminate use of vitamins can be harmful to physical health.
- The use of injections carries a risk of infection.
- The frequent use of these medicines poses a financial burden on the public health system and to the patients.

D. Other interventions

Adherence management: Ensuring adherence or compliance with treatments is one of the biggest challenges for treating patients with CMD. It means supporting the patient to take the treatments as advised, for example, that she continues with the antidepressant medicine or comes for required follow up sessions. The ultimate goal is to ensure that all patients recover fully and can lead normal, productive lives.

Treatments for CMD can be delivered best only if the challenge of non-adherence is dealt with systematically. We have made an intensive effort to understand the possible reasons why patients do not follow through with treatment recommendations and modified the delivery of the program accordingly.

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

- Lack of information in the clinics about the program
- Patients are working as daily wage earners and do not have the time to come back to meet with you and the HC
- Patients forget about the date when they are supposed to come back for the next appointment
- The doctors sometimes forget to remind patients that regular treatment over a period of time is essential for their recovery
- Patients drop out of treatment when they start feeling better
- Patients are uncomfortable about some of the psychoeducation techniques for the management of CMD
- Patients do not feel they have a ‘mental health problem’
- Patients have important social problems that trigger CMD

What is your role in improving adherence?

- Educate patients briefly about the nature of problems emphasizing the role of stress.
- Emphasize need for regular follow-up for best outcomes.
- Choose an antidepressant that is cheap and convenient for the patient to take once a day.
- If prescribing antidepressants, explain the need for continuation and advise briefly regarding side effect profile.
- Meet HC and MHS to discuss any ideas to improve follow-up rates while specifically discussing patients who have dropped out or stopped using medicines.
- Ensure that adequate stocks of medicines are available in the clinic at all times.
- Personally advocate improving adherence of CMD patients in the clinic during routine staff meetings.

Yoga (if available)

While yoga is not a core element in the MANAS intervention, it is a useful adjunctive treatment for patients with CMD. Where available, patients can be encouraged to attend yoga classes. An integrated approach that combines asanas (physical postures), meditation and relaxation is expected to produce best results.

Interpersonal therapy (IPT) (*if available*)

This is a specialized type of psychological treatment that requires at least 6 sessions with the patient. In IPT, depressive symptoms are closely linked to events in a patient's life. These events fit within one or more of the following categories:

a) **Role dispute, b) Role transition, c) Grief, or d) Interpersonal deficits**.

In IPT the patient learns to understand the relationship between her symptoms and interpersonal triggers, and to reduce depressive symptoms by finding better ways of dealing with the interpersonal problems that have been contributing to her CMD. The MANAS psychoeducation has incorporated some IPT components but there may be a subgroup of patients who require the longer, more structured IPT.

Referral to the Mental Health Specialist (MHS): Despite your best efforts, there will be a small number of patients with CMD who need to see the MHS. Referral may be advisable in the following situations:

1. When the patient is expressing active suicidal intent or has made a recent suicide attempt.
2. If the patient is elderly and confused.
3. If the patient has severe self neglect or severe weight loss or severe physical/medical co-morbidity.
4. If the patient has received antidepressant at the maximum recommended dose for at least 6 weeks and shows none or inadequate response.
5. If the patient has psychotic symptoms.
6. If the patient has complex clinical presentations.
7. If the patient has both CMD and is abusing alcohol or drugs.

E. Special populations

1. Treatment of CMD in the elderly

Both antidepressant medications and short-term counseling treatments like IPT are effective treatments for CMD in the elderly (those above 60 years). Combining counseling with antidepressant medication, however, appears to provide maximum benefit.

If the following symptoms are present, choose antidepressants:

- biological/physiological symptoms such as disturbed sleep, decreased appetite
- diurnal variation of mood
- significant agitation or retardation
- significant suicidal risk
- psychotic symptoms

a. Choice of antidepressant medication:

SSRIs are safe and effective in the treatment of CMD in the elderly. As a general rule, you might wish to start the antidepressant at the lowest available dose and depending on how the patient is tolerating it, build up the dosage gradually over 4-6 weeks.

You need to evaluate the medical co-morbidity and any potential interactions with antidepressants before choosing the medication. For example, it is best to avoid using TCAs in patients with coexisting cardiac problems or those with closed angle glaucoma or prostatic hypertrophy. You may consult with the MHS in case you are concerned about drug interactions (which are rare).

b. Duration of treatment

In general, we define an adequate trial of any antidepressant as the patient taking an adequate dosage for 4-6 weeks. However, there is evidence that older, depressed patients may take longer to recover. Thus, about 8 weeks of treatment would constitute a reasonable therapeutic trial. If there is little improvement after 8 weeks on a maximum recommended dose of the antidepressant, referral to the MHS is necessary.

Once remission has occurred, the same dose should be maintained. Twelve months of maintenance antidepressants treatment has been recommended to prevent recurrence as opposed to 6 months recommended in younger patients.

c. Frequency of review

More frequent review at weekly or fortnightly intervals is recommended in the elderly, especially early on in the treatment, to monitor symptoms and tolerance to medication.

d. Patients who may require to see a MHS

- Suicidal ideas or plans
- Psychotic symptoms
- New and significant cognitive deterioration, e.g., confusion/delirium
- Depression in the context of new physical illness or its treatment

- Diagnostic uncertainty
- Treatment failure

2. Treatment of CMD in pregnant/nursing mothers

CMD is a fairly common problem in this group of patients both in the antenatal and postnatal period. Treatment of CMD is strongly recommended as studies done in many countries show that untreated CMD in mothers can adversely impact foetal growth and the newborn child's growth and development. Since we wish to avoid the use of medicines during pregnancy and lactation, the initial treatment of choice is Step 1. You should strongly encourage the patient to complete sessions of psychoeducation with the HC.

However, if the depression is severe and disabling, interfers with childcare, there is significant suicidal risk, or the patient does not improve with psychoeducation, then treatment with antidepressants is warranted. We would strongly recommend fluoxetine in this group, on clinical grounds, as there is a large body of evidence which shows that that there are no adverse effects on the foetus or newborn child with fluoxetine.

It is advisable to consult with the MHS before initiating treatment and ask the HC to ensure that the mother is followed up closely to make sure that she is tolerating the medicine and is improving. The standard protocol for fluoxetine can be used in this situation and you should stress that the patient completes the required 6 months' course to minimize the chances of relapse.

3. Treatment of CMD in persons using alcohol

CMD can frequently coexist with excessive alcohol use, especially in men and needs to be treated independently. In cases of alcohol abuse and mild-moderate problems, fluoxetine can be started at 20 mg and increased to 40 mg if there is inadequate response. For those patients with alcohol dependence as manifested by early morning drinking, withdrawal symptoms like tremors and intense craving, you might wish to refer the patient for specialist advice to the nearest detoxification facility. In case you are using fluoxetine in patients with alcohol dependence, it is necessary to monitor the Liver Function Tests (LFT) for 3 months and you should specifically advise the patient to stop fluoxetine if he notices any symptoms of jaundice. It is important to remember that CMD is often a reason for patients to continue drinking and that treating CMD may help the patient stop drinking alcohol.

There is good evidence that brief counseling for 5 minutes provided by the doctor in the primary care clinic can help some patients stop drinking. Some of the simple advice that can work include:

- Provide feedback about the results of your clinical assessment, including LFT results when available.
- Discuss the problems that alcohol is causing to the patient's physical and mental health as well as the impact on his family and income.
- Encourage the need to reduce or stop the use of alcohol.
- Be supportive and motivate the patient to reduce or stop drinking.
- Remember, relapses are common while attempting to stop. Support patients and tell them to try again.

Session-wise guide

1. First session:

a. For patients with mild CMD- as identified by screening

What to do in Session 1 (for mild CMD)

- Confirm diagnosis if the screening suggests mild CMD (optional)
- Explain the nature of the problem and treatments available
- Provide reassurance and hope
- Do not use unnecessary treatments (especially sleeping pills and vitamins/tonics)
- Refer the patient for psychoeducation to the HC

b. For patients with moderate-severe CMD- as identified by screening

What to do in Session 1 (for moderate/severe CMD)

- Follow the same guidelines as for mild CMD PLUS
- Inquire about suicidal thoughts or plans
- Initiate antidepressant treatment

The subsequent course of treatments is shown in Flow charts 1 and 2 in the appendix.

2. Follow up sessions

There are 5 simple rules to follow when planning follow up sessions :

- The first follow up session is best organized in 2-3 weeks time to evaluate how the patient is faring.
- If the patient reports improvement, subsequent follow up can be organized after 4-8 weeks.
- If the patient reports no change or is feeling worse despite being an adherent to the suggestions made earlier, step up the interventions; for example, you can add antidepressants to the psychoeducation for mild CMD.
- If the patient has been provided with only Psychoeducation (step1) and reports feeling better on 2 consecutive consultations, discharge the patient from the program (see below).
- If the patient is on antidepressants and reports improvement on 2 consecutive visits, you can see her once in 6-8 weeks till she completes the recommended course of the treatment. The patient can continue to see the HC more frequently as required.

What to do at each follow-up session:

- Review symptoms by asking the patient about changes since the last appointment.
- Check if the patient is seeing the HC and reinforce the need to see her.
- Review, and reinforce need for compliance with medication or psychological therapy as appropriate.
- Increase dose of antidepressants if there is no response.
- Monitor suicidal thoughts if no improvement.

3. Treatment termination

If the patient is receiving only psychoeducation (Step1) and reports improvement in 2 consecutive follow up sessions, discharge her from the program with the advice given below. If she is receiving antidepressants, advise her to complete the course of treatment which will usually be for a minimum of 6 months (and can be extended up to one year). Reduce the antidepressant gradually; if the patient is taking 20 mg of Fluoxetine, you may stop it in one step, but if the patient is taking 40 mgs (i.e. 2 capsules of 20 mg), then you should first reduce to 20 mg for two weeks and then stop the medication.

What to do at the termination session:

- Advise the patient to continue practicing the health promotion advice (for example, yoga) that the patient has learned from the HC.
- Educate the patient about early warning signs i.e. early symptoms of CMD that may indicate a relapse
- Educate the patient to return to the PHC if she feels that her symptoms are coming back inspite of trying out the health promotion advice.

The key personnel and roles

The intervention team consists of a number of members performing different roles in the clinic. This may need some modifications to match individual clinic requirements and any changes would be guided by your experience.

- **The Primary Care doctor**: the doctor is in charge of the entire program in the clinic. The major role that the doctor plays is to: confirm the presence of a CMD that has been detected with the screening questionnaire; to decide the treatment plan for each patient; to encourage patients to take the treatment; and to refer patients to the HC and to prescribe antidepressants when necessary.
- **The Health Counselor (HC)**: this person may be a primary care nurse or lay health worker who is trained to provide all the non drug treatments. She reports daily to the doctor and is also supervised by the MHS. She ensures that patients with CMD adhere to their treatment regimen.
- **The Mental Health Specialist (MHS)**: this is a visiting psychiatrist or a clinical psychologist who has three key roles to train and support the entire Primary Care team, to provide consultation for difficult clinical cases; and to monitor the quality of the program.

- **Other Primary Care staff**: they play crucial roles including screening for CMD and supporting adherence.

Summary points:

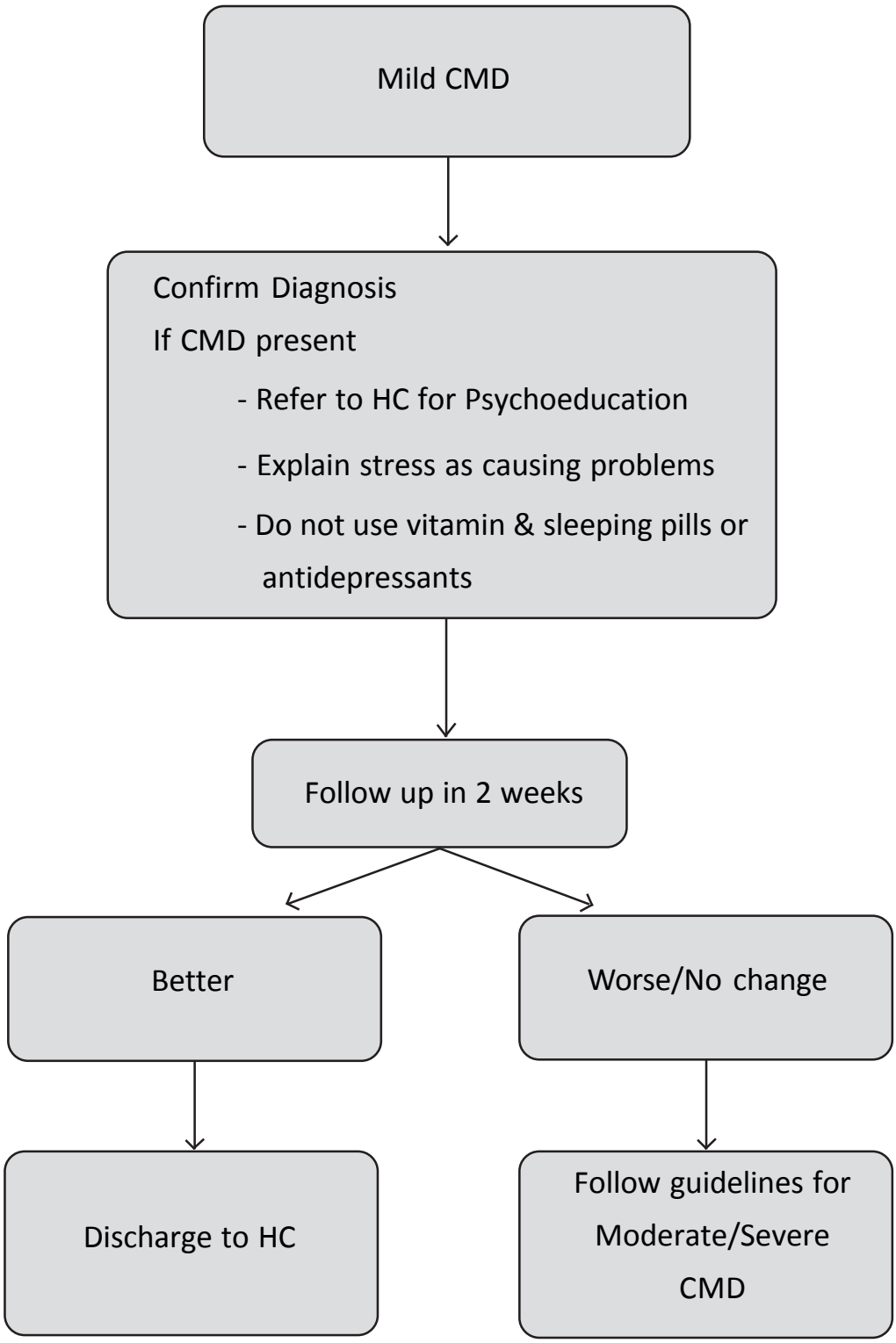
- ⊙ The MANAS program is based on the Collaborative Stepped Care principles that combine effective psychological and medical treatments for CMD.
- ⊙ The treatments are provided in a graded fashion with simpler treatments being provided to all patients and the more sophisticated, resource intensive treatment being reserved for those with more severe illness.
- ⊙ The Doctor, HC, other primary care team members and MHS work collaboratively to ensure that the patient receives an optimum level of care.

Remember:

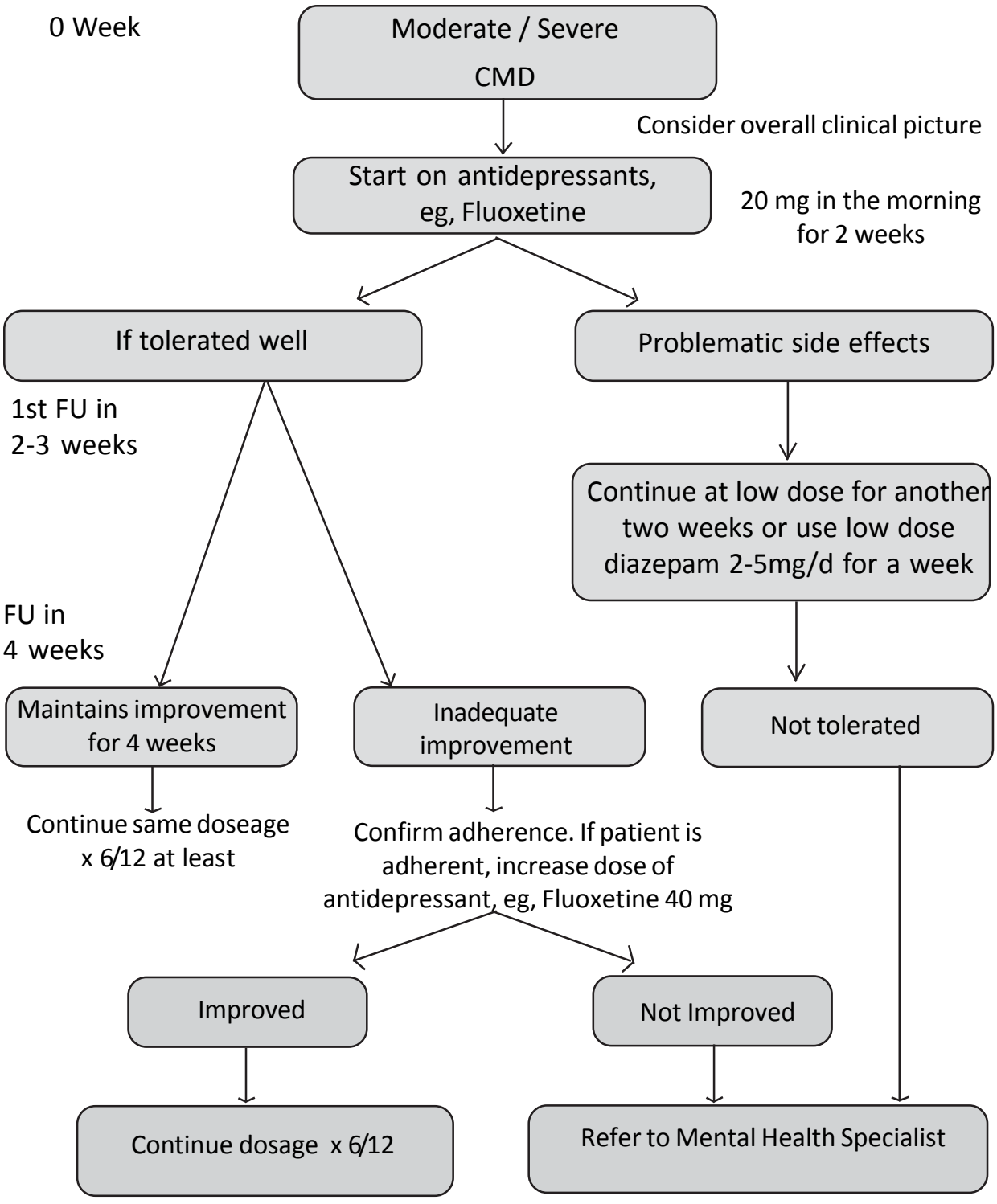
The single most important part of the treatment plan is to ensure that the patient takes the treatment (whether medication or counseling) regularly and for the duration required - most patients will fully recover within 2 to 6 months of the treatment.

Appendix

1. Flow Chart of Guidelines for Treating Mild CMD in Primary Care Clinics



2. Flow Chart of Guidelines for Treating Moderate/Severe CMD in Primary Care Clinics



When starting medication remind patient that:

1) Medication is not addictive
2) Medication shows response only after 2-4 weeks
3) Medication works best if taken regularly for 6 months
4) Medication should not be stopped suddenly if dose is 40mg, as this can cause adverse reactions
5) No long-term or serious side effects

3. Antidepressant Chart

This consists of a list of commonly used antidepressant medication in primary care with their recommended doses and common side effects.Brand names and cost may vary according to the setting and hence these have been left blank.

Name Of Anti-Depressant	Commonly Available brand Names and strength	Monthly Cost of Maintenance Dose	Starting Dose	Maintenance Dose (usually in 2 weeks)	Maximum Recommended dose if no response at 4 weeks	Common side effects	Specific clinical indication/relative Contra indications
Sarotonin Specific Reuptake Inhibitor (SSRI)							
Fluoxetine	Available as 10,20 and 40 mg capsules		10-20 mg in the morning on full stomach	40 mg	20 mg	GI disturbance Headache Sweating Sexual problems	Convenient once daily dose. Generally tend to increase the availability of concurrent medications like warfarin
Sertraline	Available as 25,50 and 100 mg tablets		50 mg in the morning on full stomach	100 mg	20 mg		Non sedating and generally well tolerated. Use in lower doses for patients with hepatic or renal problems. Taper and withdraw
Citalopram	Available as 10,20,30 and 40 mg tablets		10 mg in the morning on full stomach	20 mg	30 mg		

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Tricyclic Antidepressant (TCA)							
Dothiepin (TCA)	Available as 25,50, 100 and 150 mg tablets		50 mg at night	100 mg	150 mg	Dryness of mouth constipation Postural hypotension Sedation Tachycardia	Useful when sedation is required. Weight gain Avoid in patients with cardiac problems and elderly Avoid in patients with high suicidal risk Taper and withdraw
Imipramine (TCA)	Available as 25 and 75 mg tablets		50 mg at night	100 mg	150 mg		
Amitryptline	Available as 10,25, 50 and 75 mg tablets		50 mg at night	100 mg	150 mg		

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Other antidepressants with mixed profile of action							
Venlafaxine (SNRI))	Available as 37.5,75 and 150 mg tablets and XR capsules		75 mg in the morning on full stomach	150 mg (2 Divided doses)	225 mg	Nausea Constipation Headache Sweating Postural Hypotension insomnia	Avoid in pregnancy and during breast feeding Taper by 37.5 mg every 2 weeks while stopping Sudden stoppage causes unpleasant withdrawal symptoms
Mirtazapine	Available in 7.5 and 15, 30 and 45 mg tablets		15 mg at night	30 mg	40 mg	Sedation Weight gain GI Disturbances Swelling of joints	Useful when insomnia and lowered appetite are prominent symptoms

4. Screening Questionnaire (GHQ 12)

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

Instructions : a) Shaded Questions if answered as No code 1 and If Yes code 0

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

HAVE YOU RECENTLY :-		
GHQ 1	been able to concentrate on whatever you're doing?	
GHQ 2	lost much sleep over worry?	
GHQ 3	felt that you are playing a useful part in things?	
GHQ 4	felt capable of making decisions about things?	
GHQ 5	felt constantly under strain?	
GHQ 6	felt you could overcome your difficulties?	
GHQ 7	been able to enjoy your normal day-to-day activities?	
GHQ 8	been able to face up to your problems?	
GHQ 9	been feeling unhappy and depressed?	
GHQ 10	been losing confidence in yourself?	
GHQ 11	been thinking of yourself as a worthless person?	
GHQ 12	been feeling reasonably happy, all things considered?	
	Total Score	

Common mental disorder (CMD), a term used to describe collectively depression, anxiety and somatoform disorders, is a pressing public health concern affecting 10-15% of the adult population. The MANAS program was initiated in Goa, India, to develop and evaluate a model for delivering CMD treatment in primary care settings where most patients go for help.

This manual has been prepared based on the experience gained through the MANAS program and incorporates feedback from doctors who were involved in the program implementation. It outlines the details of the MANAS model and provides information on treatments that are relevant to doctors working in Primary Health Clinics.

The MANAS Program Doctor's Manual is organized in two sections:

Section A is an overview of CMD with specific focus on treatment delivery in primary care settings.

Section B guides the doctor through steps of the MANAS model for treatment of CMD with specific focus on suicide risk assessment / management and antidepressant use.

The Appendix contains diagrammatic outlines for specific treatments that summarize information in the manual in a user friendly format. Two pull-outs are provided that can be used as ready reckoners in the clinic.

Doctors working in primary care clinics will find this manual a useful resource in treating patients with CMD.

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NORTH GOA
841/1, Behind Electricity Dept.,
Alto Porvorim,
Bardez-Goa -India. 403521
contactus@sangath.com
(91-832) 2414916, 2417914, 2411709

www.sangath.com

SOUTH GOA
H. No.1272/A, Santemol,
Sonarwaddo, Raia,
Salcette - Goa - India 403 720
youth1stop@gmail.com
(91-832) 2777307, 2776716