Rural community-based rehabilitation for persons with severe mental illness amidst COVID-19: Jagaluru experience

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Background

- Jagaluru Taluk, Davangere district, Karnataka: economically backward, rural, agrarian area
- Community-based rehabilitation (CBR) for persons with mental illness (PMI) initiated in August 2015 with public-private partnership
- Mental health camps conducted on 1st and 3rd Tuesday of month at 10 primary health centres (PHC), 1 sub-centre & Taluk hospital
- Psychotropic medicines dispensed free for 3 months from PHC/Taluk hospital indent, District Mental Health Program (DMHP) & Chittasanjeevini Charitable Trust
- Ongoing RCT involving Accredited Social Health Activists (ASHA) in CBR for persons with severe mental illness (PSMI): incentives for ASHAs
- Before Pandemic: > 300 PMI on regular follow-up including 169 PSMI

Challenges faced due to COVID-19

- Lockdown: PSMI relying on public transport couldn't reach camps
- Difficulty in transporting case records & psychotropic medications
- Advocacy, welfare schemes and livelihood interventions disrupted
- ASHAs busy in COVID-19 case identification, contact tracing & vaccination: couldn't be trained for CBR
- Funding constraints for disability sector: Most donors diverted funds for COVID-19 related expenditure, APD human resources downsized

Continuity of medical care was prioritized

- Telephone coordination with PSMI, families and ASHAs about camps
- Good 4G mobile network: Mobile internet hotspot used for Skype (video consultations) & WhatsApp (prescription)
- PHC medical officer with vehicle pass for travel during lockdown helped shift psychotropic medications & case records from district headquarters; gave vehicle for local travel to other PHC's for camps
- Psychotropic medication availability ensured with partners support & research project funds
- All mental health camps conducted on schedule despite pandemic
- COVID-19 precautions in mental health camps
- Liaison with DMHP for in-person assessments
- Dry ration kits given to poorest PMI: 85 (1st wave) & 90 (2nd wave)

Pre- COVID	Post-COVID
In-person consultations	Telepsychiatry consultations
Home visits to PSMI	Telephonic follow-ups
Monthly PSMI/ family meeting	Disrupted
Disability certificate/ welfare benefit	Disrupted
Self-help group & livelihood program	Disrupted
Monthly ASHAs training	Discontinued

Teleconsultations for PSMI during lockdowns

Teleconsultations	1st wave (n=111)	2nd wave (n=105)
Patient	21	43
Caregiver	9	16
ASHA	62	31
Absent*	19	15

*Most followed up either in next camp or with DMHP for medications

Clinical status of PSMI on follow-up as of June 2021

N=169	Status	
131	Regular follow-up	Maintaining well
19	Missed at least 1 follow-up	
6	Stopped treatment	
2	Shifted to private psychiatrist	
7	Expired (non-COVID19)	
4^	Relapse: medication non-adherence	Rx restarted

^managed in community without need for hospitalization

Teleconsultations & Task-shifting during COVID-19

- Followed Telemedicine practice guidelines & Telepsychiatry operational guidelines
- Clauses 4.1 - 4.3 of Telemedicine practice guidelines permit consultations of registered medical practitioner with patient or caregiver or health worker
- Caregiver & ASHA consultations with PSMI consent
- Handful PSMI requiring in-person assessment referred to DMHP
- RCT protocol deviation: involved control group ASHAs during lockdown for continued care to PMI

ASHA Teleconsultations

ASHA home-visit for PSMI clinical status update & get follow-up treatment book

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ASHA updates PSMI status & treatment details during teleconsultation

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If PSMI was maintaining well, prescription sent through WhatsApp

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Medicine dispensed & Home delivered by ASHA to PSMI

Differences between 2 waves of pandemic

- More travel restrictions in 1st wave: more ASHA consultations
- Jagaluru more affected in 2nd wave: village hotspots; ASHA teleconsultations to avert 'super-spreader' mental health camp

Conclusion

- Stakeholders goodwill, task-shifting & technology helped medical care continuity
- Other CBR interventions took a backseat due to resource/ logistic constraints
- Need to involve & incentivize ASHAs for care of PSMI in community
- Though telepsychiatry is feasible, PMI/ families value seeing psychiatrist in person

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