Joint initiative of IHBAS, AAA and DLSA for

Treatment of Homeless People with Severe Mental Illness

Making A Difference

Report of Pilot Phase (2009-2010)

Joint initiative of
IHBAS, AAA and DLSA for

Treatment of Homeless with severe Mental Illness

Making a Difference

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Foreword

INSTITUTE OF HUMAN BEHAVIOUR & ALLIED SCIENCES (IHBAS)

Since its inception in May, 2000, Aashray Adhikar Abhiyan (AAA) has championed the cause of those living in a vast city of Delhi without a roofs surviving on the streets, under the bridges, in the parks and anywhere under the sky, the homeless are usually stripped of all human rights and dignity. AAA has been working on for realization of rights of this population which are enshrined in the constitution of our country and United Nations Convention.

The social neglect of the mentally ill homeless persons (MIHP) coupled with the difficulties involved in the implementation of the provisions of the Mental Health Act, 1987, often lead to these persons continuing to be living in the street, with virtually no social support or sense of self care of protection, and so they deteriorate further into vegetative existence. This is certainly true for persons with Severe Mental Illness (SMIs).

The experience of reaching out to the Mentally Ill Homeless Persons (MIHP), specially those with Sever Mental Illnesses (SMIs), has been difficult and unsatisfactory. The HIGH team has on various occasions and in different forums has highlighted this striking gap in mental health interventions particularly in cases of severe mental illness and dilemmas related to involuntary treatment. The team has also been actively negotiating with the various government and legal agencies like Ministry of health and social welfare, Govt. NCT of Delhi, Delhi Legal Services Authorities (DLSA) to take some measures in this regard for past seven years. After years of persistent efforts on part of HIGH team finally in November, 2008 the new health initiative for treatment of homeless persons with severe mental illness was launched

IHBAS & AAA have joined hands in the endevour to provide mental health services to the homeless population of Delhi. For 10 years, the collaboration has gained from strength to strength. The provision of legal aid to these patients and Magistrate visiting the centre to authorize treatment of those suffering from severe mentally illness.

IHBAS & AAA plan to extend the umbrella of care to homeless mentally ill in other districts of Delhi i.e. Nizammudin, Connaught Place and Old Delhi Railway Station and gradually to cover the entire city of Delhi.

It has been a privilege and a learning opportunity for us at IHBAS, to have been a part of this model experiment not only as specialists in the fields of mental health & behavioural sciences, but also as health professionals interested in community health and public health.

IHBAS TEAM

Foreword

Homelessness in Delhi is largely an outcome of skewed development resulting people leaving their native places to urban areas in search of livelihood. On one side urbanisation is closely linked to modernisation and physical development of a city, on other side it has an inherent component of sub-human conditions of habitations for its poor. Among the urban poor, is a section of excluded population viz: '*people sleeping rough*' or the *homeless*. Delhi is estimated to have more than one lakh such homeless.

Homelessness is a complex situation often resulting into complex effects. In cities, the homeless not only lose their identity but also community support. They live in state of anomy. Though the homeless contribute to unorganised labour market, yet their acceptability by the society is not there. Many of the homeless are disconnected from their families and communities, they belonged to. Persistent disconnect and the growing alienation, exclusion makes an overwhelming majority of them cynical and gloomy about the state which falls much short of responding to their needs in the light of civil, political rights of a citizen. Continuous struggle for survival in harsh conditions of erratic employment, illegal existence on pavements, sufferings from violence and abuse, hostility and legal powers against urban vagrancy, occupational health hazards, reducing stamina to cope up with difficult situations often make them susceptible to poor health. *(live as invisible ,socially excluded).*

Homeless people are more likely to suffer injuries and medical problems from their living conditions on the street, which includes poor nutrition, substance abuse, exposure to the severe elements of weather, and a higher exposure to violence (robberies, beatings, and so on). Yet at the same time, they have negligible access to public medical services.

In the light of this unmet need of accessing public health care services, Health Intervention for the Homeless(HIGH), began its outreach services exclusively for the homeless at Jama Masjid, an area of highest concentration of homeless population.

The study, 'Health care beyond Zero'2003, revealed that though HIGH has been successful in reaching out to CMD patients yet there was a great need to reach out to homeless with severe mental illness(SMI) who are unable to give consent for the treatment as prescribed under MHA,1987. Since then, the partner organizations of HIGH, had a number of consultations, discussions to seek advice &/or intervention from the court of law for involuntary treatment of homeless patients with SMI.

In year 2008, Institute of Human Behaviour and Allied Sciences (IHBAS), Aashray Adhikar Abhiyan(AAA) and Delhi Legal services Authority(DLSA) came together to launch a joint initiative of treatment for the severally mentally ill homeless people in Delhi. This model uses multidisciplinary approach for the treatment. The main objective of this initiative has been to minimize the gap in getting the legal order to begin the treatment of a homeless patient with SMI on the basis of diagnostic made by psychiatrist. The initiative combines the three prerequisites – social support, legal sanction and medical expertise – for successful treatment of the people suffering from 'severe mental illness' in the form of well trained and committed volunteers from AAA, judicial officers from DLSA and exceptionally qualified doctors from IHBAS. The initiative aims at taking the health services beyond formal institutional healthcare system to the streets for such people who are unable to reach the formal institutional healthcare system. This study attempts to collate the experiences of the initiative and is brought out with the hope that it will prove helpful in replication of the initiatives' model at national level.

Paramjeet Kaur
Director
Aashray Adhikar Abhiyan

Foreword

Delhi State Legal Services Authority is a Statutory Authority constituted under the Legal Services Authorities Act, 1987 with the mandate to provide legal services to the weaker sections of the society and to organize Lok Adalats so that there is equal opportunity for securing justice. Legal services mean something more than legal aid and assistance in litigation through assignment of lawyers or meeting of litigation expenses. The involvement of the Delhi State Legal Services Authority (DSLSA) in the initiative of Institute of Human Behaviour and Allied Sciences (IHBAS) and Aashray Adhikar Abhiyan (AAA) in the involuntary treatment of mentally ill homeless people is one instance of rendering of legal services to the weaker sections of the society.

The right to live a life of dignity inheres in all human beings and is thus a human right. It is also a Constitutional Right as the Preamble of the Constitution of India secures to all its citizens, Justice, Liberty, Equality, Fraternity, assuring the dignity of the individual.

The Homeless are a truly compromised lot. Just because they have no homes they are denied an identity. There is also a degree of contempt attached to the homeless as if being homeless meant being useless and having no source of livelihood. Add to this mental health issues and the situation of the homeless mentally ill persons can be seen as truly heart rending.

IHBAS and AAA were doing a magnificent job, giving medical assistance to the mentally ill homeless persons, that when the difficulty being faced in respect of involuntary treatment, was brought to the DSLSA, the matter was taken up earnestly and the approval at the highest levels i.e. from the Executive Chairman of the DSLSA, and its Patron-in-Chief, the then Hon'ble Chief Justice ,High Court of Delhi, was taken for permitting the Secretaries of the District Legal Services Committees (as they were then) to attend, as Mobile Courts, the clinics organized by IHBAS and AAA at Jama Masjid, Urdu Park every Monday from 6:00 to 8:00 p.m. Thus was born a unique project which commenced on 8th November, 2008, when five homeless patients were produced before the Ld. Magistrate.

Significantly, this happened during the Mental Health Month, which was being observed by the National Legal Services Authority in 2008 from October 10th to November, 10th 2008 . Since then, our Secretaries have regularly visited the clinics every Monday, interacted with the patients, followed up with those who had already commenced their treatment either voluntarily or involuntarily, passed reception orders, where necessary – thus fulfilling the mandate of the DSLSA.

DSLSA also provides a legal aid lawyer to represent the interest of the mentally ill person before the Ld. Magistrate. Through this service, the time taken otherwise for grant of permission for the medical treatment of the mentally ill homeless, as provided for by the Mental Health Act, has been drastically shortened as otherwise, a person/policeman who finds a mentally ill homeless person, has to take him to the Ld. Magistrate who directs for the assessment by a doctor at a Psychiatric Home or facility and thereafter he is brought back again before the Ld. Magistrate for orders on the basis of the opinion given by the Psychiatrist, that treatment is required, after which appropriate orders are passed.

Recently, the Hon'ble High Court has been pleased to generally authorize all Metropolitan Magistrates to attend the Outreach Programme either at Jama Masjid or any other place in Delhi, on a request made by DSLSA, to facilitate the treatment of mentally ill homeless persons and other persons who are entitled to legal aid, such as industrial workers and other labour force.

This has indeed been a gratifying experience for the DSLSA and as an organization, we feel proud to have been a part of this initiative, for even one life saved is worth all the effort.

Introduction

There is accumulating evidence linking mental illness to poverty, powerlessness and alienation. The relationship between severe mental illnesses like schizophrenia and other psychoses with homelessness is often complex. The nature and symptoms of the illness may be a direct cause of homelessness for some while in others; the cause may be an interplay of the economic factors, design of mental health care and welfare services and the existing social systems. The overall course reflects the difficulties patients experience in accessing the existing care and services. Homelessness may also result from stigmatization of people who are or have been mentally ill. The person's inability to perceive need for help and the social neglect of the mentally ill homeless persons (MIHP) when coupled with the difficulties involved in the implementation of the provisions of the Mental Health Act, 1987, often lead to these persons continuing to be living in the street, with virtually no social support or sense of self care or protection, and so they deteriorate further into vegetative existence. This is certainly true for persons with Severe Mental Illness (SMIs).

This report is a description of the innovative joint initiative for providing health outreach services to homeless persons with severe mental illnesses in need of treatment through integrated mental health outreach service with provision of mobile courts in the community. The report has been prepared with the larger purpose of sharing experiences and stimulating further action.

Homelessness and Severe Mental Illness:

Mental health is recognized globally as having enormous public health importance. The mental health problems are known to constitute for about eight percent of global burden of disease and more than fifteen percent of adults in developing countries are estimated to suffer from mental illness. With regard to the link between homelessness and mental illnesses it is estimated that in a third of all

cases, those who lose their accommodation are suffering from mental illness (Nieto et al,2008). This perpetuates a vicious cycle in which the stress of homelessness often exacerbates the illness and makes it difficult for those suffering to gain access to housing and healthcare in the future. Once homeless, many mentally ill people can remain without permanent housing for several years.

It has been estimated that half of all homeless persons have some form of mental illness. In some cases, it is not always clear which came first; the homelessness or the mental illness. Nearly one fifth of those sleeping rough are estimated to be suffering from severe mental illness like schizophrenia with many having history of prior hospitalization for psychiatric illness, long duration of illness coupled with one or more physical problems. The likelihood of developing comorbiod medical problems is more in the homeless mentally ill persons due to persistent neglect by the society as well as the person himself/herself. This group is also vulnerable to substance abuse/ dependence and the chronic infections including HIV. The problem of dual and triple diagnosis is also significant and forms the most disadvantaged group among the homeless (Dean R., Craig T., "Pressure Points: Why people with mental health problems become homeless", Crisis, London, 1999; Talukdar 2008, Neito et al 2008)

There are not many studies on the mental health of homeless in India. Study by Patel, (Patel, 1996) reveals that poverty is strongly associated with common mental illnesses, such as depression and anxiety, because they are triggered by adverse life-events such as physical illness, housing problems and unemployment, events more likely to affect the poor. This association between homelessness and common mental illnesses was also reported in the studies by IHBAS & AAA (2003, 2008). Besides the common mental disorders and substance use disorders, these studies also highlighted the link between homelessness, destitution and mental illnesses. The homeless mentally ill were found to be the most vulnerable subgroup among the homeless and are subjected to extreme marginalization, isolation and exploitation.

The existing Treatment options & Dilemmas

The task of initiating treatment for the mentally ill homeless persons specially the persons with severe mental illnesses is difficult. At present the treatment options for the mentally ill homeless persons are mainly the existing psychiatric services at public hospitals. The utilization of these facilities by the mentally ill homeless persons is however minimal. The lack of social support and lack of ability to perceive the need for help because of the nature of illness are often the major barriers to treatment. The provision for involuntary treatment for persons with severe mental illness also has limited application; with many chronic mentally ill homeless in need of treatment remaining invisible.

There are virtually no effective community outreach models for treatment for homeless mentally ill persons in India barring the exception of Banyan in Chennai and Health Outreach Service Model by IHBAS & AAA. Banyan has been an example of an effective health initiative for mentally ill homeless women since 1993. The program uses a three-step approach of rescue of a mentally ill woman on the street, inpatient treatment and rehabilitation. It also offers short stay and long stay shelter facilities and community reintegration opportunities to women with no family support.

The Health outreach service model initiated by IHBAS and AAA in 2000 under the District Mental Health Program (DMHP), Delhi is another such initiative which was evolved as low cost community outreach service model for providing health intervention for the homeless. Patients in need of hospitalization were referred to the public hospitals. Such patients were provided with an attendant. This model has been well accepted by the community and has proved particularly useful in reaching out to homeless persons with general health problems and those with substance use disorders over past ten years. The reach of this model with regards to patients with mental illness remained limited. The initial two years revealed that patients with psychiatric disorders, seeking help was very low. In its experience of working with homeless people for eight years the team found that the psychological needs of the homeless persons with common mental disorders like depression and anxiety or other such

disorders are hardly even recognized leave alone met with. The most fatal complication of the psychosocial adversities in form of suicide is not even reported.

With regards to severe mental illnesses the situation was even more difficult. The team would often come across patients with severe mental illness in need of treatment but unable to appreciate or acknowledge the same and with no legal guardian or support to ensure it. It was also noted that though there is a provision of police help for involuntary treatment as per Mental Health Act, 1987; the numbers reached were far too less and happened only if there was disruption or inconvenience to public caused by such patients. The rest went unnoticed. The need for involuntary treatment was more difficult to meet with in homeless persons. The Banyan model though proved effective for over two decades had also its own limitations. It is primarily a residential care approach wherein patients are institutionalized for variable period of time till further rehabilitation takes place. But the team observed that many homeless persons with mental illness did not require hospitalization. Adequate treatment made available locally without the need for restrictive care and catered to the individual specific needs can help many of these individuals to lead productive life within community.

The possibility of initiating involuntary treatment of these persons within community with periodic antipsychotic depot injections was promising in terms of clinical science, but had obvious legal and ethical dilemmas and pitfalls. Thus despite availability of mental health services free of cost, the utilization of these services by homeless mentally ill patients remained poor. Lack of adequate treatment further worsened the illness leading to chronicity and less chances of recovery. It was therefore envisaged that the combined health and legal assistance be made available at the community outreach clinics to help initiate treatment for number of such patients. This would help in process of recovery and further rehabilitation.

The Joint Initiative model: reaching the unreached

The Health outreach team on various occasions and in different forums highlighted this striking gap in mental health interventions particularly in cases of severe mental illness and dilemmas related to involuntary treatment. The team was also actively negotiating with

the various government and legal agencies including Ministry of health and social welfare, Govt. NCT of Delhi, Delhi Legal Services Authorities (DLSA) to take some measures in this regard for past seven years. After years of persistent efforts finally in November, 2008 the new health initiative for treatment of homeless persons with severe mental illness was launched as a pilot experience with active support and participation by DLSA at Jama Masjid. This was started as an outreach service for persons in need of treatment within the community setting without any restrictions to individual mobility or freedom. The Mobile Courts were started along with HIGH clinic for legal facilitation of involuntary treatment of patient with severe mental illness in need of treatment. The major objectives were to ensure provision of competent and adequate treatment for homeless persons with severe mental illness in an ethically sound and legally appropriate manner. It was expected that with treatment it may be possible to obtain information about patient's family and reintegrating the patients with family. In case the family is not available, to help patient recover or reach adequate functional capacity so as to facilitate independent living within her/his own community.

The Joint Health Outreach Model for treatment of persons with severe mental illness

Identifying patient with Mental illness

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Treatment Engagement with Help of the Local Community

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Initiating pharmacological treatment with consent of the person if possible

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If not able to provide consent obtain legal authorization for involuntary treatment as per the provisions of the MHA, 1987

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Involuntary treatment with oral medications/ Depot Anti Psychotics

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Appointment of Case Manager to ensure monitoring within community

↓

Weekly Follow up and Review team and the Legal team

Operative Mechanism

The stepwise mechanism was worked out for ensuring the uniformity of the approach in keeping with legal and ethical consideration. This included important steps such as identification of patients and engaging them into treatment, process of obtaining legal authorization, sequential treatment strategy (box 1), monitoring and follow up strategies, emergency consultation mechanism, periodic case reviews and record maintenance.

The details of the steps

1. Identifying and engaging patients in treatment process

The volunteers / staff for HIGH at Jama Masjid ensure that homeless patients with severe mental illness are identified within the community and are brought to the clinic with help of local people every week for assessment and treatment. The volunteers are given basic training for identifying the probable cases in the community. The patients are examined by the qualified psychiatrist and the trained medical officer in charge of the clinic, independently and the need for treatment is certified with a record of the symptoms and signs of mental illness and a diagnosis if possible.

A simple, easy to use field guideline was developed to help volunteers identify the cases in the field. A semi-structured proforma was used to record the socio demographic details, clinical details about the psychopathology, duration, past treatment records if any, and signs elicited during mental status examination and follow up details. Diagnosis was made using International Classifications of Diseases 10th revision (ICD-10) criteria.

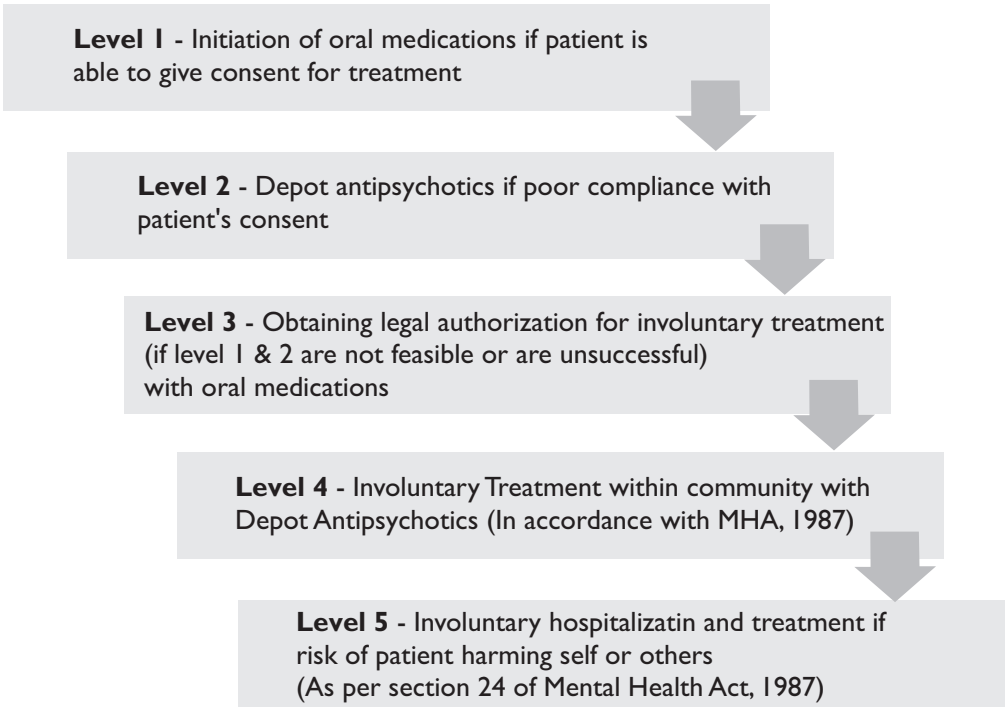
2. Obtaining legal authorization

The Legal assistance through facility of mobile court is provided at the outreach clinic every week. The patients diagnosed with severe mental illness are produced before the Magistrate on the assigned day for legal authorization for initiation and continuation of treatment as per the requirements of the individual case. The Magistrate examines the evidence in the form of the opinion of the medical officers and other records, as well as interview with the patient and after satisfying himself / herself about the need for involuntary treatment, authorize the same for a period of 3 months with fortnightly progress reports.

3. Treatment strategies

The sequential treatment strategy specially designed included five levels to be considered in a sequence starting with voluntary treatment with oral medications at level one to involuntary hospitalization as the provisions of the section 24, Mental Health Act, 1987 at level five. Considering the difficulties with long term compliance and continuity of care, the algorithm included use of depot antipsychotics as a scientifically justified approach to ensure compliance. The depot antipsychotics are the long acting antipsychotic medications which when administered through intramuscular route , release the drug gradually ensuring a sustained drug delivery over a period of fifteen days to one month. This helps in avoiding the daily dose of oral medications and at the same time ensure the therapeutic cover of the medicine. These long acting medication are available for well tested antipsychotics and are proven to be efficacious in long term management of psychosis. The injectables are administered as fortnightly or monthly regime. Another important addition was administering the involuntary treatment within community in keeping with provisions of Mental Health Act, 1987. This option is not routinely practiced in clinical settings but provide benefits of treatment to individuals in need without the restrictive hospitalization option. The precaution in terms of careful monitoring by case managers within community was exercised to ensure that any medical emergencies or treatment associated difficulties are timely managed. The sequential algorithm also provided the clinical flexibility of moving up or down the sequence as per the requirements of the patients. E.g. A patient who is in severe symptomatic state and likely to be harm to either self or others could be provided hospitalization as per section 24 of Mental Health Act, 1987 and similarly a partially recovered patient can be given the option of voluntary treatment with medications or long acting antipsychotics once he/she is competent to provide the consent.

Sequential Treatment Strategy using Five Sequential Steps



4. Monitoring & Follow up strategies

Active follow up strategies with help of case managers are used to ensure adequate monitoring and follow up. The community volunteers preferably from same locality are appointed as case manager for each case, closely monitor the patient for any evidence of medication side effects or high-risk behavior. Easy to use Field observation chart was developed for systematic monitoring of improvement and side effects using likert scale (-5 to +5) in addition to weekly behaviour observation reports from case managers.

5. Emergency Consultation

In case the patient is found to have any difficulties that need emergency consultation on non-clinic days, the same is provided by IHBAS, which has 24-hour emergency services. The consultation is coordinated by AAA staff.

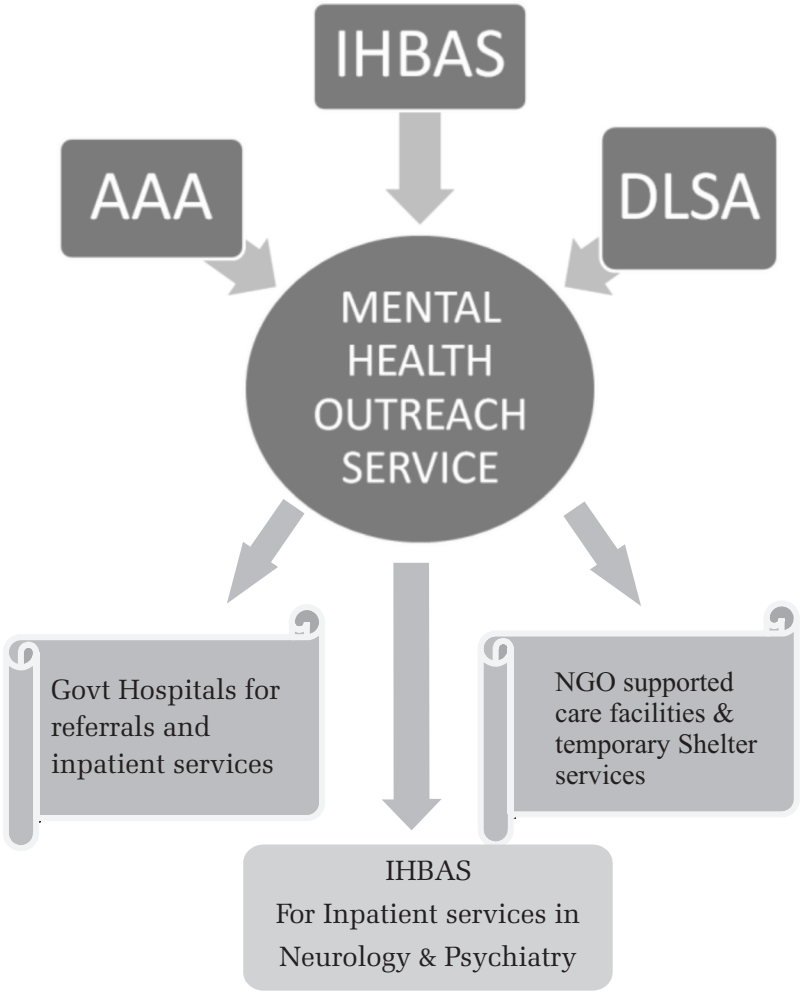
6. Record keeping

Patient's initial assessment and periodic follow up records are maintained by the clinic staff and the safety of the records and confidentiality is ensured.

7. Case review by Magistrate

The patients are produced before the Magistrate periodically and at the end of 3 months, a joint assessment for further treatment and rehabilitation are done by the HIGH team.

THE TEAM



Role of each Agency

Delhi Legal Services Authority (DLSA): -

- Availability of a Magistrate for 2 hours at the Outreach Clinic Service at Jama Masjid – once every week (Mondays)
- Scrutiny of the medical reports / certificates and the patient by the Magistrate, for authorizing involuntary treatment for 3 / 6 month period.
- Review of the need for further authorization after the stipulated 3 / 6 month period.

Institute of Human Behaviour & Allied Sciences (IHBAS): -

- Availability of two Medical Officers, including one qualified psychiatrist at the Outreach Clinic for examination and certification of the mentally ill persons, as a "patient in need of involuntary treatment".
- Initiation of suitable treatment and follow up care of the patients authorized by the Magistrate.
- Regular supply and availability of medicines as required.
- Sensitizing and orienting the volunteers for identification and follow up case (including side effects and possible toxic effects)
- OPD and admission facilities at the hospital, by senior faculty consultants, for difficult or doubtful cases.
- Backup emergency care (24 Hours X 7 days) at the hospital, whenever required.

Aashray Adhikar Abhiyan (AAA): -

- All assistance and facilitation at the ground level.
- Keeping track of identified patients, started on treatment, through volunteers and local community leaders.
- Monitoring for side effects and possible toxic effects in the patients on treatment. Coordinating hospital backup services for patients who need it
- Record keeping of the medical and legal papers.

The Beginning

The first clinic was held on 10th November 2008, which was the closing day of the mental health month observed by DLSA. Prior to the clinic, on 10th November 2008 in a brief sensitization meeting was held for AAA volunteers and clinic staff at Urdu Park, Jama Masjid. The volunteers were briefed about the need and the scope of this new mental health initiative for the homeless.

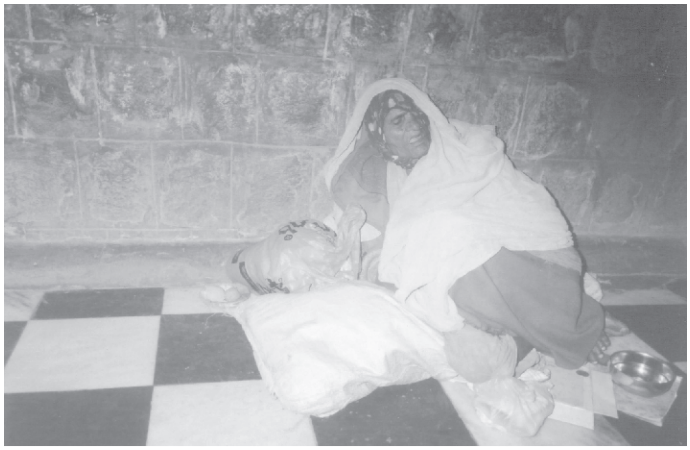
The volunteers were initially oriented and trained for basic mental health needs and identification of disorders particularly the severe mental illnesses. The volunteers were sensitized and explained about difficulties commonly encountered in engaging such patients in treatment, the possibility of treatment within their community with depot Antipsychotics, the concept of involuntary treatment, legal aspects etc. using role play techniques. The facilitatory role of the volunteers who are in close contact with the homeless and thus are able to keep a track of such patients while on the treatment was discussed.

Monday was assigned as the day for mobile court and registration of new patients. Follow up were planned on Monday and Thursday of each week. Additionally it was decided that a case manager from within the community will be assigned for each patient registered to keep daily follow up of the patients and monitor for any side effects as well as other medical emergencies.

PROFILE OF HOMELESS PATIENTS WITH SEVERE MENTAL ILLNESS ATTENDING THE SERVICE

The clinic registered 49 cases in last one year with severe mental illness. On an average 5-6 cases were seen per clinic with one or two new cases every fortnight and the rest being follow up cases. About 69 percent were diagnosed with non affective psychosis, 10 percent with bipolar affective disorder, ten percent with severe depressive episode, 8 percent with Mental retardation with behavior problems and two percent with seizure disorder.

Total 28 patients were initiated at level 1 treatment ie. voluntary treatment after obtaining the consent of the patients with oral medication. Two of them opted for depot antipsychotics on their own (Level 2). The rest fifteen patients were having significant symptoms with no understanding about the illness and so required legal



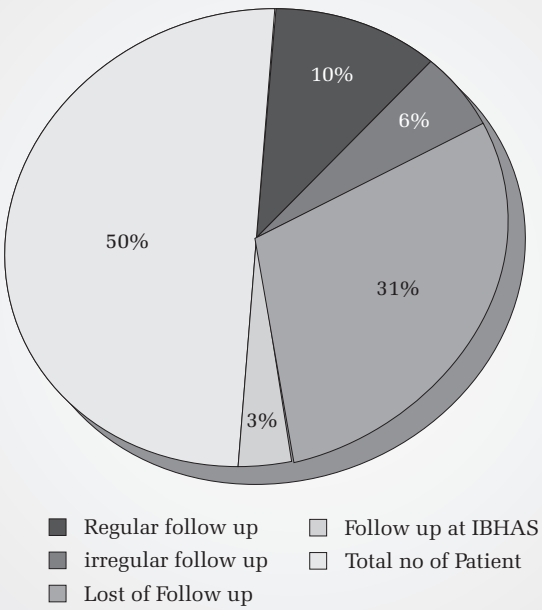
facilitation for involuntary treatment (Level 3). Out of these fifteen, eleven patients were initiated on involuntary treatment within community with long acting depot antipsychotics at level 4 while four patients who presented with acute violent state required involuntary hospitalization and treatment as per section 24 of MHA, 1987 (Level 5).

It was found that the patients treated at the clinic could be grouped in two categories ie. First one being the homeless persons with mental illness (HMIP) and second the mentally ill persons rendered homeless (MIHP) during the course of mental illness. The rehabilitation was more feasible in latter group where after recovering the patients gave the details of the family and could be subsequently reintegrated with their families. For the other group more modest rehabilitation options in form of emphasis on productivity and economic empowerment was considered. Out of the total registered patients, sixteen patients were on regular follow up at the end of the year and are presently in various stages of rehabilitation process. The team could successfully reunite seven patients with their families. Barring one the rest six belonged to the second group and were rendered homeless during the course of their mental illness. Four patients had to be referred to IHBAS for intensive treatment. Six patients were on irregular follow up ie. less than 50% expected follow ups and hence no rehabilitation could be planned for these patients till date. The team is now planning to consider more intensive treatment options for this group. About sixteen patients were lost to follow up at various stages of treatment.

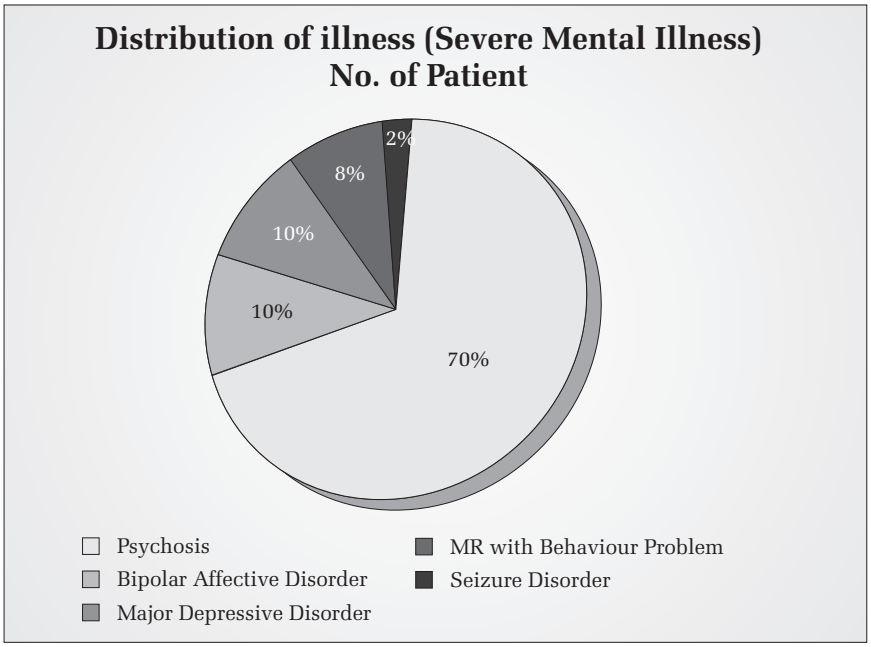
The four patients who required hospitalization for stabilization of symptoms, one is successfully rehabilitated back in community with her live-in partner. She currently works as a small scale vendor selling dry fruits at Jama Masjid. The other three were reintegrated back with their family in Bihar, Himachal Pradesh and Nepal respectively. Their families were educated about the illness and need for regular treatment.

Follow up Data (At the end of one year)			
	Male	*Female*	*Total*
Regular follow up	7	9	16
Irregular Follow up	4	2	6
Lost of Follow up	21	3	24
Follow up at IHBAS	2	1	3
Total No. of Patient	34	15	49

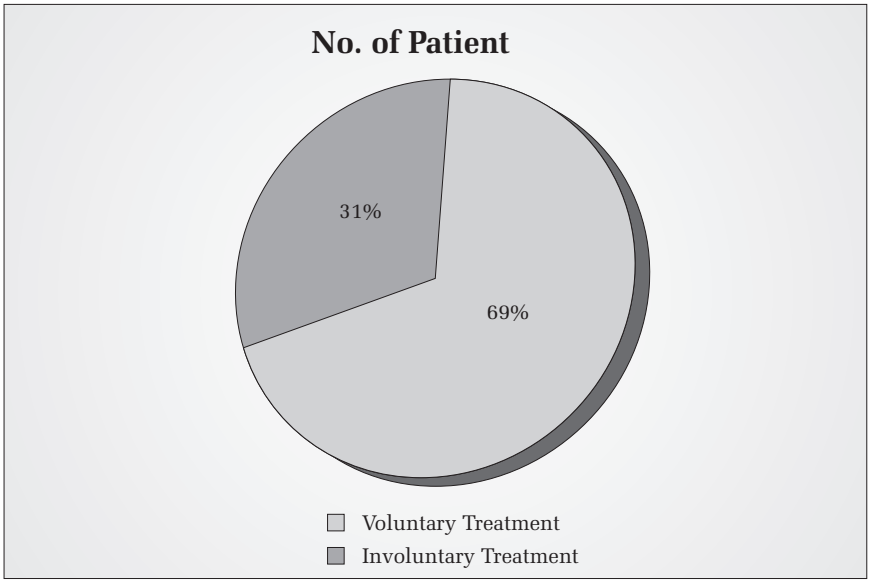
Follow up Data (At the end of one year) Male



Distribution of Illness (Severe Mental Illness)		
Diagnose	*No. of Patient*	*Total No. %*
Psychosis	34	69%
Bipolar Affective Disorder	5	10%
Major Depressive Disorder	5	10%
MR with Behaviour Problem	4	8%
Seizure Disorder	1	2%
	49	**100%**



Type of Treatment	*No. of Patient*	*Total No. of %*
Voluntary Treatment	34	69.39%
Involuntary Treatment	15	30.61%
Total No. of Patient	49	100.00%



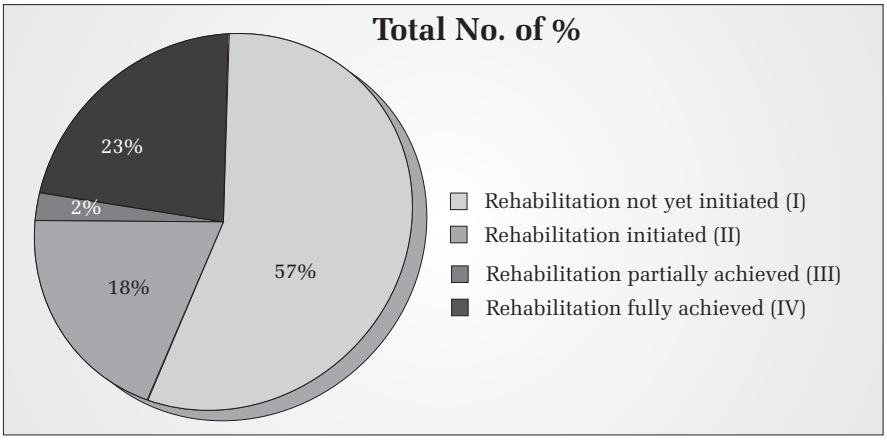
Rehabilitation

For structured uniform assessment across the cases, rehabilitation was assessed on the basis of the following stages. The information was obtained from the case records as well as the accounts of team members.

Stage-I	0- Not yet initiated	
Stage-II	1- Rehabilitation initiated	(family contacted/talk with alternative care provider, initiated with some improvement in activities of daily living)
Stage-III	2- Rehabilitation partially achieved	(patient placed with family/with care giver with significant improvement in the activities of daily living but not yet occupationally productive)
Stage-IV	3- Rehabilitation fully achieved	(Patient with family/care giver, able to take care of activities of daily living, engaged in productive work)

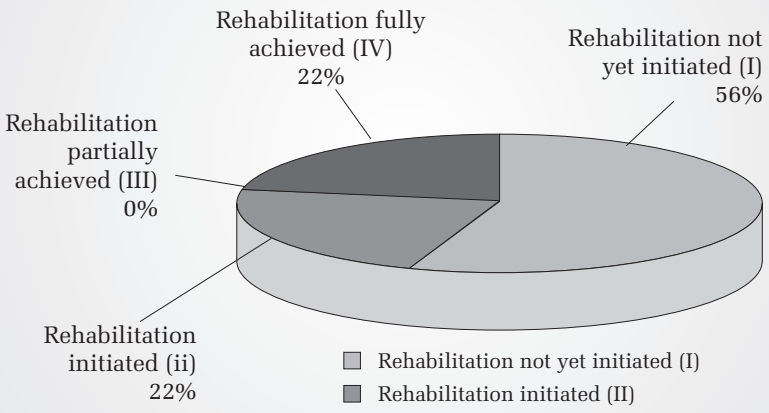
Stage wise distribution of the Rehabilitation status

	Rehabilitation not yet initiated (I)	*Rehabilitation initiated (II)*	*Rehabilitation partially achieved (III)*	*Rehabilitation fully achieved (IV)*	*Total No. of Patient*
Regular follow up	4	5	1	6	16
Irregular follow up*	5	1	0	0	6
Lost to follow up	19	3	0	2	24
IHBAS Follow up	0	0	0	3	3
Total No. of Patient	28	9	1	11	49
Total No. of %	57.14%	18.37%	2.04%	22.45%	100%



**For irregular follow up group more intensive follow up strategies to be adopted with admission if required*

Fig 3 (iii) Rehabilitation status of patients with regular follow up



Few success stories:

CASE 1

MB was brought to the clinic by a *paanwala* from Hanuman Temple who had been seeing her for past year and half. According to him she keeps sitting near his *theli* muttering to self. She does not trouble others but her self hygiene is extremely poor and has been seen disrobing occasionally. He had been providing her food since one year which she accepts willingly. All efforts to communicate with her had been in vain because most of her talk has been meaningless. He reported that on many occasions he had found *rikshaw pullers* and others exploiting her sexually but had not been able to help as MB goes with anyone who asks her to come along. He had never seen any sign of distress ever in MB and often wondered if she registers such incidences. He said that when AAA volunteers approached he was initially skeptical and asked them to come with woman volunteer. He was still not sure when they did follow up with woman volunteer and decided to accompany himself. He agreed to help the team in treatment. MB was started on oral medications as he *paanwala* took responsibility of giving her medicines daily. MB has been following since November and has shown remarkable improvement. She now asks for medicines and can communicate some of her needs. Activity scheduling has been initiated for MB and according to the *pujari* and people near Hanuman Temple MB has started sweeping the temple stairs. She also reported that she is now able to take care of herself better and likes coming to clinics for treatment.

CASE 2

GA was first brought to the clinic by volunteers with large ulcerative wound nearly covering the entire right leg from knee to ankle. GA was unable to walk. He was not even cooperative for any help. He would abuse anyone who would approach him threatening to harm them. After some initial resistance the doctors were able to talk to GA. In initial assessment GA was found to have significant psychopathology in terms of grandiose and persecutory delusions, auditory hallucinations with no insight into the illness. He could not give any coherent information about self but he accepted to take help for the wound. GA was thus put on oral medication which subsequently shifted over to depot antipsychotics for better compliance after obtaining the permission from magistrates for involuntary treatment. A case manager was appointed who would ensure the medications as well as monitoring. The case manager also helped in getting the treatment for the physical problems. After about eight weeks GA was able to move about though with significant limp. He gave his address in Bihar. GA's family was contacted. They had apparently lost contact with GA after he left home in symptomatic state. GA's family contacted AAA after receiving the information. The family was educated about patient's condition and need for medications. GA has now been sent to his residence with family members.

CASE 3

SB was first seen wandering about near clinic site abusing the people passing by. When approached she turned hostile towards team members, started disrobing, abusing them. No meaningful conversation was possible with SB. T was learnt from local people that SB had been sleeping in this area since three years and often seen to have this kind of behaviour. Considering SB's status it was involuntary hospitalization and treatment was considered necessary. SB was admitted at IHBAS under section 24 of MHA, 1987. SB improved significantly with treatment and was discharged after four weeks. She told doctors that she was suffering from mental illness since long and her first husband left her because of same. SB had married daughters in Bihar and a brother. However she said she would not like to go back to Bihar instead would stay in Delhi near Jama Masjid with her three years companion. SB was given depot Antipsychotics along with oral medications in initial period. SB has now gained understanding about her illness and has agreed to take depot injectables for ensuring

compliance. During this time AAA had also contacted her companion. He was then explained about the illness and need for regular medicines. A detailed rehabilitation plan was made for SB. SB also helped doctors in convincing her companion to start treatment for his alcohol and cannabis abuse. She now helps her companion who sells dry fruits near Urdu Park at Jama Masjid. AAA case manager ensures medicines and compliance of both SB and her partner. It is also planned to help SB get voter identity card and bank account with help of AAA. SB also helps getting other patients to clinic.

CASE 4

VJ 32 year old male was seen by AAA volunteers near the footpath of Hanuman Mandir, Yamuna Bazar. He was found sitting with his head upwards, muttering to self, not interacting with anyone and would take Cannabis. He was enrolled as Jama Masjid outreach client on 21.12.2009. He was given medication by the treating team on footpath. However, after providing services on footpath for 25 days, it was decided that the patient needs hospital admission. So he was admitted at IHBAS where he remained for three months under the supervision of multidisciplinary team. Gradually it was found that the patient started interacting with other people and would take care of himself. Other symptoms also started remitting and were found improving. So after three months, patient requested for discharge, so as to live with his family. He gave his detailed address and the treating team of IHBAS communicated with the family members. Patient's maternal uncle visited to IHBAS and was glad to see his nephew in good condition and took him away to his home.

Challenges and Difficulties:

The beginning had not been easy for the team. There were multiple expected as well as unexpected obstacles and difficulties faced in ensuring the intensive monitoring and follow up of these patients. Even getting the patients motivated to come to the clinic, convincing the local people for need for treatment to given individual and handle the skepticism and suspicions towards the volunteers had to be managed effectively to get the desired cooperation and help. The AAA volunteers had particular difficulty in case of women patients as often the women would protest and the local people too would be suspicious of the motives of the volunteers.

Case study

"LM, about 40 years old had been staying at Town hall of old Delhi for quite some time, as told by the people around. He was noticed by AAA's mental health programme. LM couldn't even tell his name properly. After one week' observation of LM by AAA team, the AAA team brought the patient (LM) to the mental health clinic at Jama maszid area on one Monday evening. Thus, the treatment began. AAA volunteers began encouraging the local community to keep a track of the patient after being dropped at the same spot after medication. The AAA volunteer kept visiting the patient for giving the medicine, arrange food and observe the process for few days. The approach of this programme based on community based/deinstitutionalized treatment was being followed. One day , AAA volunteer, D.K. went to see LM at his place at Town hall, Chandni Chowk, the local people from street caught them and started shouting at him,

'This man is from a group of professional blood sellers, who forcefully take blood from poor and then sell it in the market'. Gradually, D.K was surrounded by a mob of about 50-100 people.

D.K was shocked to see the reaction of crowd; no body was willing to listen to him. He was not allowed to say anything. Any how, D.K managed to telephone at AAA office. S.K, a senior team member immediately reached the spot along with other AAA volunteers. S.K called the police. The police came and intervened. After seeing the medical documents of the patient, police scattered the mob. The patient recovered after complete treatment and was reunited with his family from U.P.

Also the volunteers had to be sensitized and trained about approaching potentially violent and uncooperative patients. Volunteers were explained to involve and take help of local people, police persons for getting patients to the clinic. The major emphasis was on involving the local people in this initiative which helped in both getting patients to the clinic as well as helping in monitoring. The police persons from the local police stations covering the district were sensitized by AAA & DLSA to ensure their cooperation in entire activity.

Homeless persons with severe mental illness were found to be having peculiar mobility pattern. In the initial few clinics the patients registered were new to the AAA volunteers so their daily patterns of

mobility were not known. Keeping track of the patients and ensuring daily monitoring and follow up was thus found to be difficult task in the beginning. Some of the patients would have their tour plans particularly during religious seasons and festivals thus would not be traceable around 'Eid' or other such festivals. Patients who were on follow up would often complain of theft and losing medicines given to them. All these factors were invariably interfering with the treatment compliance and follow ups. The team also lost some patients in this period. To overcome these difficulties it was decided to observe the sleeping habits and area of mobility of the identified patients before engaging them in treatment to ensure adequate monitoring and follow up. Also for the pilot phase the team considered to include patients from within ten-kilometer radius of the HIGH Jama Masjid clinic for ensuring the feasibility for monitoring and follow up. The volunteers were identified and assigned for the activity exclusively.

Apart from this, the clinic being located outside Jama Masjid, the team would not be allowed to hold few of the clinics during festivals and social events like Eid, Independence Day. Eviction of the homeless groups was also the other unavoidable problem. During common wealth games, quite a few homeless patients were either arrested under Anti Beggary Act(BPBA,1959) and sent to Beggar's home or forced to relocate to other peripheral areas leading to discontinuation of treatment.

Besides the difficulties in tracking patients and maintaining follow ups, the other difficulties that were encountered were multiple physical co morbidities requiring specialist treatment which had to be managed through other Government hospitals which were already crowded and the staff would not be sensitive towards needs of the homeless patients. The cooperation at these places would often be so lacking that volunteers would end up spending almost entire day for one consultation. Transporting these patients to the adjacent government hospitals had also been difficult as auto drivers and rickshaw pullers would refuse to take these patients and taking them via public transport was difficult task. Cooperation from local police personnel was found to be minimal despite multiple rounds of sensitization. In many such instances case managers took help from local people.

Also with regards to the rehabilitation process the team had significant difficulty particularly for those patients whose family could not be

traced. There was no facility of residential homes or after care for such patients. The team managed to rehabilitate some of them with available local resources but many others are still waiting.

Reflections

The initiative of treating the homeless patients suffering from severe mental illness within the community turned out to be an enormous task considering the intensive efforts , resources and network required in treatment engagement, monitoring and follow ups. The pilot experience was only the modest step. There were periodic review meetings among the three partner agencies to discuss the difficulties and possible solutions. As per group discussion the overall numbers were kept limited with considered view that emphasis on proper application of the model was more essential than the overall numbers registered. Thus more efforts were directed towards follow up and monitoring with area of work being restricted within the ten kilometers radius of Jama Masjid.

Multiple practical difficulties were realized in the process, which were handled using measures as described earlier. In addition to providing treatment the team also had to ensure the safety and other needs of the patients. In some cases the experience was rewarding with patients showing significant improvement while in others it proved to be difficult to keep patients in treatment. Despite intensive efforts some of the patients were lost to follow up. There had been differences of opinions regarding the need for involuntary treatment among the HIGH members and the Magistrates in few of the cases that were then resolved by active discussion among the members, which helped in further clarifying the treatment policies. It was also realized that periodic interactions among the members and sharing sessions helped the team in planning the activities in more effective way.

The role of DLSA in particular has been significant not only for the cases where direct legal facilitation was obtained but also for the other cases with severe mental illnesses whom the HIGH team could approach and initiate treatment because of the back up of the DLSA team. Moreover the team has been able to create some awareness among local people who also started helping the volunteers get patients to the clinic. The need and utility of the initiative was appreciated at various levels. The treatment model that has emerged through collaborative efforts appears to be feasible to be applied on wider scale.

Taking the initiative forward

The overall experience of the pilot phase has been positive. The team is now looking forward to continue this service initiative and consider applying this model to various other pockets of Delhi with high proportion of the homeless persons. The dream of carrying the initiative to its completion, reaching all the homeless persons with mental illness, can be realized only if right to health with mental health being integral part of overall health is recognized as fundamental right of every homeless and specific directives are taken to ensure this. The application of this model quite naturally will have to be with sensitivity to the local situations and the needs as well as resources. However this and similar such collaborative models can be feasible and effective way of providing mental health services to this group.

The team has been working towards ensuring these goals and has so far been able to help some of the patients successfully. The team considers that the current understanding of keeping the efforts restricted within the ten kilometer radius of the HIGH clinic should continue till most of the patients in this area are reached and effective follow-up strategies are evolved and practiced adequately.

Proposed Short term targets for the team:

- Recruit more case managers (especially female volunteers) to ensure the follow-ups
- Sensitization of all the service providers including the other general hospitals, police personnel more vigorously
- Evolve multilayer monitoring mechanism
- Enhance awareness and involvement of local community to a larger extent
- More active focus on full rehabilitation at all stages (integration with family members and occupation) of the improved cases

Proposed Long term Activities :

The future course of action has been discussed among the partners from time to time. The following targets have been considered which involves many levels of programmatic and conceptual tasks.

- Improvement in the functioning of the clinic and the services

- Fulfilling the Services Gaps
- Strengthening Treatment for Mentally Ill Homeless Persons (MIHPs)
- Focus on homeless mentally ill patients with co morbid substance abuse/ dependence with medical illness and chronic infectious and communicable diseases particularly HIV/AIDS
- Strengthening the Networking with other NGOs, community workers
- Replication of this joint mental health outreach model to other districts of Delhi
- Efforts towards integrating this programme into mainstream health care services.

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ANNEXURE: 1

Field guidelines for volunteers

How to identify patients with severe mental illness

- Gross disorganization of behaviour eg. disrobing in public places, wandering aimlessly, collecting garbage etc. with poor self care
- Frequent episodes of aggression, violence with minimal or no provocation
- Irrelevant, un-understandable speech
- Hallucinatory inappropriately, Muttering to self
- Suspicious, fearful, acting on imaginary threat
- Significant deterioration in daily activities
- Lack of initiation, apathy, complete emotional withdrawal
- Impaired reality contact

How to approach Patient with SMI

- Always have additional staff present while approaching a patient
- Before approaching the patient, remove any objects that can potentially be used as a weapon
- Approach the patient in a relaxed friendly manner
- Always remain at least 3 to 6 feet away from the patient
- Introduce oneself and purpose of interaction
- If the patient agrees for verbal communication, invite the patient to sit down with you in open area and discuss the problem
- Explain the patient about availability of help through trained doctors and medications at HIGH clinic
- If patient turns violent, abusive, do not argue with patient
- Never use physical force
- If patient is uncooperative or aggressive, take help of local police to get the patient to the HIGH clinic/IHBAS

How to monitor

Case manger will monitor the patient daily for 10-15 minute to aware the following parameters. He can also collect information from other person sleeping in the area of the patient.

Behaviour:

1. Level of alertness
2. Self care
3. Sleep, appetite patterns
4. Interest and initiation of activities
5. Social interactions
6. Psychomotor activity
7. Aggression, violence
8. Abnormal behaviours eg. suspicious fearful talking to self, laughing without reason, Hallucinatory behaviour, disorganization
9. Does he take medicine
10. Does any difficulties / problem with medicine.
11. Has any improvement taken place in above parameters
12. Any drug side effect evident

- Tremors
- Rigidity
- Dystonia
- Sedation
- Restlessness etc

In case of any emergency, bring the patient to the Emergency, IHBAS which remain open round the clock,

Emergency Phone Nos. 22114021, 29, 32; 22591911, 12, 13,14, 15, 16

Emergency Extn. 282
For any other advice consult Jama Masjid Contact Persons:
Dr. Rupali P. Shivalkar 9312667822
Dr. Ajit Kumar Yadav 9818088718

मरीज की देख–रेख कैसे करें?

Case Manager की यह जिम्मेदारी होगी कि वह प्रतिदिन 10–15 मिनट तक मरीज के संर्पक में रहें और मरीज से तथा उसके आस–पास रहने वाले लोगों से संबंधित जानकारी एकत्रित करें।

मरीज का व्यवहार

1. एकाग्रता
2. स्वयं की देख रेख
3. नींद और खान–पान का तरीका
4. कार्यों में रूचि या प्रारम्भ करना
5. सामाजिक मेल–जोल
6. साइकोमोटर एक्टीविटी (च्लबीवउवजवत ।बजपअपजल)
7. गुस्सा और उग्रता
8. आसाधारण व्यवहार जैसे–शंकालु होना
9. भयभित होकर खुद से बाते करना, बिना वजह हसना, ऐसी चीजें देखना व सुनना जो दूसरों को दिखाई व सुनाई नही देती। (दिग्भ्रमित)
10. मरीज दवा खा रहा है या नहीं ?
11. दवा के सेवन से कोई कठिनाई या परेशानी
12. उपरोक्त व्यवहार के प्रति कोई सुधार
13. दवा का कोई दुशप्रभाव जैसे– कंपन, अकड़पन, बेचैनी, ज्यादा नींद आना, बोलने में या खाने में कठिनाई इत्यादि।

आपातकालिन स्थिति में मरीज को इहबास अस्पताल के आपातकालिन विभाग में लेकर आए आपातकालिन विभाग की सुविधा 24 घंटे उपलब्ध है।

गंभीर मानसिक रोगी की पहचान कैसे करें ?

- बिना कारण मारपीट, तोड़फोड़ करना।
- अकेले बैठे–बैठे इशारे करते रहना ।
- अकेले बैठे–बैठे अपने आप से बाते करना।
- ऐसी चीजे देखना व सुनना जो दूसरों के दिखाई नहीं देती।
- अपने आप से बातें करना, बेवजह हंसना।
- नहाने–धोने, बाल–दाढ़ी बनाने, पहनने–ओढ़ने का ध्यान न रहना, गन्दे बने रहना।

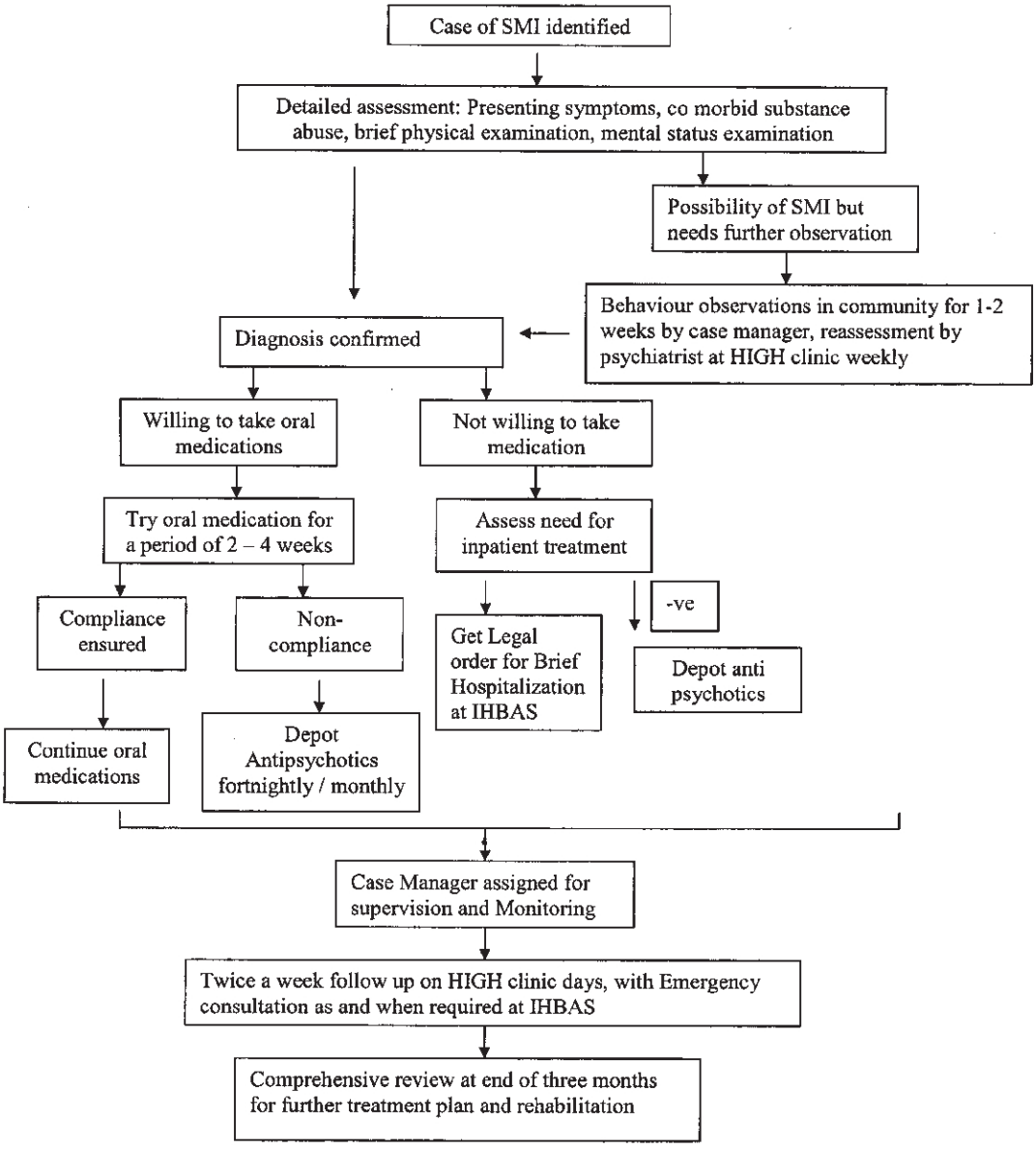
- अकारण कूड़ा–करकट बीनते रहना या जमीन पर पड़ी चीज बीनना या मुँह में डालना।
- अकारण कपड़े उतार देना या फाड़ना।
- बेवजह अत्यधिक गुस्सा आना।
- बेवजह हंसना या रोने लगना।
- बेढ़ंगे या सामाजिक रूप से अस्वीकृत व्यवहार करना।
- बिना मकसद के इधर–उधर घूमना।
- दूसरों के प्रति असामान्य रूप से शंकालू हो जाना।
- बेवजह जरूरत से ज्यादा डरे रहना।
- नींद में गड़बड़ी, भूख का कम हो जाना।
- हमेशा गूमसुम रहना, न किसी बात पर खुश होना न किसी बात का फर्क पड़ना।
- उल्टी सीधी (अंट–शंट) बातें करना।

मरीज को कैसे संम्पर्क करें या पेश आएं ?

- जब भी मरीज से संपर्क करें, अपने साथ एक और व्यक्ति को रखें।
- मरीज के पहुंचने से पहले, अपने आस–पास की सारी वस्तुएं जो नुकसान पहुंचा सकती है, हटा दें।
- मरीज से दोस्तों की तरह व्यवहार करें।
- हमेशा मरीज से 3 से 6 फिट की दूरी बना कर रहें।
- खुद की पहचान बताते हुए, मरीज से मिलने का उद्वेश्य बताएं।
- यदि मरीज बात– चीज करने के लिए सहमत हो तो किसी खुले स्थान पर मरीज को बैठने के लिए आमन्त्रित करें, और उसकी समस्याओं के बारे में वार्तालाप करें।
- मरीज को उपलब्ध सेवाओं जैसे–प्रशिछित डाक्टर और विशेश (भ्ळभ) क्लीनिक के बारे में बताए।
- यदि मरीज का व्यवहार उग्र एवं गाली–गलौच वाला है, तो उसके साथ बहस (वाद–विवाद) न करें।
- मरीज के साथ जोर–जबरदस्ती न करें।
- यदि मरीज का व्यवहार सहयोगात्मक नही है तो स्थानीय पुलिस की सहायता से विशेश (जामा मस्जिद) क्लीनिक/इहबास (IHBAS) ले जाएं।

ANNEXURE:2

Treatment Protocol For SMI cases at HIGH Clinic



Detailed Assessment

- This is carried out by the medical officer/ Psychiatrist
- Information is taken from patient when possible and/ or community volunteers and other informants around the sleeping area
- Brief physical examination is carried out.
- Detailed mental status assessment is carried out by two medical officers/ Psychiatrist independently
- A provisional Diagnosis, if any, is formed with assessment of co morbid conditions such as substance abuse, physical illnesses etc.
- Effort is made to explore personal information and family details if feasible.

Treatment Available

- Oral Antipsychotic medications
  - Tablet Haloperidol
  - Tablet Trifluoperazine
  - Tablet Resperidone
- Injectable Depot Antipsychotic medications
  - Fluphenazine decanoate
  - Haloperidol Decanoate

Criteria for Depot Antipsychotics

- Patient not willing to take oral medications
- Prior history of non compliance
- Patient preference

Initiation of treatment

Key Factor/ Important tip: Always initiate treatment in low doses and gradually increase dose as per the requirement.

- Patient explained the need for treatment and follow up at the clinic
- Those who are willing to take treatment will be initiated on oral antipsychotics freely available as given below in once or twice daily doses.

- Haloperidol tablets (10mg- 30 mg/ day)
- Trifluoperazine tablets (10 mg -30 mg/ day)
- Resperidone tablets (4mg- 10mg/ day)

- Patients who are unwilling or refusing to take treatment or are not able to take treatment decisions but found to be in need of treatment are produced before the Magistrate at HIGH Clinic for Legal authorization order for involuntary treatment for mental illness.
- For those who are unwilling to take any treatment or are found to be non- compliant but are in need of treatment will be initiated on Injectable depot antipsychotic medications such as
  - Depot Haloperidol injection every 4 weeks (50-100 mg)
  - Depot Fluphenazine injection every 2-3 weeks (12.5 – 25 mg)
- Injectables will be administered deep intramuscular by medical officer/ psychiatrist or by staff nurse under supervision of medical officer/ Psychiatrist.
- Those requiring brief hospitalizations will be considered for admission at IHBAS for a brief period of 2 to 4 weeks.

Criteria for In-patient treatment

- Risk of harm to self or others
- Significant violent or disruptive behaviour
- Gross disorganization
- Co morbid medical illness requiring immediate intervention

Follow up schedule

- Each patient will be followed up initially twice a week on Monday and Thursday ie. HIGH clinic days up to six weeks.
- Each patient will be followed up initially twice a week on Monday and Thursday ie. HIGH clinic days up to six weeks.
- Thereafter the follow up is maintained as once a week ie on Monday
- Patients is assessed for improvement in clinical status (target symptoms graded on five point clinical observation scale), response to treatment, adverse effects of medications such as

signs of extrapyramidal symptoms, additional physical problems if any or any other medical or psychosocial problems requiring attention.

Supervision and Monitoring

- A case Manager is assigned for each individual patient to monitor and supervise medications, which are dispensed every three days.
- Patient will not be given medications for more than three days.
- The case manager also monitors the patient for any side effects during the course of treatment.
- In case of any emergency consultation is needed the designated case manager coordinates with IHBAS for advice.
- Visit to hospital emergency services are arranged by the AAA volunteer in indicated cases.
- IHBAS has 24 hrs emergency services and the psychiatrist on call at IHBAS attends all emergency calls.

Case review at the end of three months

- Improvement in target symptoms of the illness
- Improvement in activities of daily living, socio-occupational functioning
- Improvement in insight/ understanding of the illness, acceptance of need for treatment and willingness to continue treatment
- Compliance difficulties
- Further treatment plan
- Rehabilitation possibilities –
  - Re union with family
  - Placement in shelter facilities
  - Placement with help of local NGOs
  - Facilitate Independent/ assisted community living

HIGH CLINIC
Patient Follow-up/Observation Form

मरीज का नाम : _____ आयु/लिंग_____

पंजीयन संख्या : _____

दिनांक :								
1.	मारपीट / झगडा / पत्थर फेंकना ।							
	वे वजह गुस्सा या गाली गलौच करना ।							
	बुदबुदाना / अपने आपसे बात करना या मुस्कुराना ।							
2.	खुद का / अपने सामान का ध्यान रखना ।							
	सवालो का ठीक से जवाब देना अर्थपूण वार्तालाप ।							
3.	दवाई निरंतर रूप से खाना ।							
4.	हाथ पैर में कंपन या खिचाव ।							
	शरीर में अकडाहट या खिंचाव ।							
	आंखो का ऊपर जाना ।							
	मापदण्ड के आधार पर प'तिदिन की छवि							

सम्पुर्ण छवि (पूरे सप्ताह की)

-5 -4 -3 -2 -1 | 1 2 3 4 5

(Name of case Manager)

IHBAS Contact Number (for emergency): 22583322, 22583056, 22114029, 22114032
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