Improving Dementia Care in Northern Kerala:

Lessons From the Rythm Community Mental Health Care Program

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Community psychiatry plays a crucial role in delivering mental health services within local settings, particularly in low-resource regions. With a population of over 1.4 billion, India has surpassed China in 2024 to become the world's most populous country.[1] Additionally, the proportion of individuals aged 60 years and older is expected to reach nearly 20% of the population by 2050 (319 million), representing 15.4% of the global elderly population.[2]

Dementia prevalence in India varies significantly across studies, ranging from 1% to 10%, with a recent estimate suggesting a prevalence of 7.4% among those aged 60 years and above.[3] This variation is influenced by factors such as age, education, gender, and urban-rural disparities.[3,4] In Western countries, most individuals are diagnosed with and receive initial care for dementia in community or primary care settings. However, studies indicate that dementia remains substantially underdiagnosed in Indian primary care settings.[5] Early identification is essential for accessing appropriate services, with community-based interventions serving as the foundation of dementia care and specialist referrals made as necessary. In a country such as India where there is a shortage of specialized dementia care, community psychiatry clinics can play a significant role in mitigating the treatment gap. This study reports the identification and management of dementia patients in 4 community psychiatry clinics run under Rhythm-Comprehensive Mental Health Program, an initiative of IQRAA International Hospital and Research Centre.

Methods

This was a retrospective, chart-based, descriptive study in which patient records from Rhythm community psychiatry clinics in Northern Kerala were analyzed to describe their impact on dementia care. This program is operated by the psychiatric wing of a reputed tertiary care hospital. The psychiatric team collaborates closely with other medical and surgical departments, facilitating referrals and ensuring continuity of care for patients with comorbid physical and mental health conditions. The program is funded by the hospital and local community organizations, allowing all services to be provided free of cost to patients. Access to the program is based on a community-driven, need-based selection process. Patients are identified in the community using financial and clinical criteria, ensuring that those with the greatest need and limited resources receive care.

Data were collected from clinics specifically addressing dementia cases since August 2022 using a case-finding approach in which trained community volunteers facilitated early identification of dementia patients in the community, leading to home-based psychiatric consultations and timely referrals when needed. Patient records provided sociodemographic, clinical, medication, and community intervention data. Demographic information included age, gender, and residence. Clinical data covered dementia diagnosis, model of care, and medications used. Community intervention data documented the multimodal services provided to the patients and their caregivers. Data collection was completed from August 20, 2024, to December 20, 2024.

Results

Among 8 Rhythm community clinics serving 298 psychiatry patients, 4 (50%) specifically addressed dementia cases. Within these clinics, 29 dementia cases were identified in the community. Patients ranged in age from 68 to 95 years (mean age: 77.5 years). The gender distribution showed a predominance of females, with 25 being female and 4 being male, resulting in a male-to-female ratio of 1:6. A community-based organization (CBO), specifically a postretirement group in Kodenchery, played a significant role in case identification, identifying 17 of the 29 cases (58%). Due to mobility restrictions, nearly 90% of patients remained under homecare follow-up, while the remaining 10% utilized clinic-based consultations. Two rural community clinics also extended services to tribal dementia patients. The identified dementia cases were attributed to Alzheimer disease, vascular dementia, and Parkinson disease. The provided dementia care included caregiver education, behavioral management, symptomatic relief, psychological services, and specialist referrals. Medications such as donepezil, memantine, quetiapine, and melatonin were utilized based on individual symptom profiles, with quetiapine being the most frequently prescribed antipsychotic.

Discussion

A dementia care model implemented across 4 Rhythm community clinics underscores the importance of community-based approaches in identifying and managing dementia cases. The identification of 29 cases within a

Clinical Points

- The 1:6 male-to-female ratio aligns with global dementia trends, emphasizing the need for gender-sensitive care strategies in community programs.
- Mobility challenges necessitated home care for 90% of patients, highlighting a critical adaptation for elderly populations in rural/tribal areas.
- Symptom-targeted pharmacotherapy and caregiver education reflect evidence-based management of behavioral and cognitive symptoms.

population of 298 psychiatry patients highlights the growing burden of dementia, particularly in aging populations. The mean age of 77.5 years aligns with global epidemiological trends, indicating increased dementia prevalence with advancing age.[6] The pronounced female predominance (1:6 male-to-female ratio) is also consistent with existing literature, which attributes the higher incidence of dementia in women to longer life expectancy and potential hormonal influences.[7]

A key strength of this initiative is the role of the CBO. The involvement of CBOs and trained community volunteers in case identification and referral aligns with previous findings that community-driven interventions improve early dementia detection and engagement in care. This approach is particularly significant in rural settings where health care accessibility is often limited.[8] The reliance on home-based follow-up for nearly 90% of cases due to mobility issues further underscores the necessity of decentralized care models for dementia management.

The inclusion of tribal dementia patients within rural community clinics addresses a critical gap in dementia care among marginalized populations. Studies have shown that dementia remains underdiagnosed in indigenous and tribal communities due to cultural perceptions, stigma, and health care barriers.[9] Therefore, the integration of culturally sensitive outreach and care strategies in these settings is an important step toward equitable dementia care.

The pharmacologic approach observed in this study—primarily utilizing donepezil, memantine, quetiapine, and melatonin—reflects current evidence-based recommendations for dementia management.[10] The frequent use of quetiapine as an antipsychotic raises concerns, as antipsychotic use in dementia has been associated with increased risks of adverse effects, including falls, cerebrovascular events, and mortality.[11] This highlights the need for cautious prescribing, with an emphasis on behavioral and nonpharmacologic interventions as first-line strategies where possible.

The pharmacologic approach utilizing donepezil, memantine, quetiapine, and melatonin aligns with evidence-based recommendations for dementia management; however, the use of quetiapine as an antipsychotic requires careful consideration due to the increased risks of adverse effects, including falls, cerebrovascular events, and mortality, associated with antipsychotic use in dementia.[10,11] Though antipsychotic agents can be used when patients pose a risk to themselves or others or experience severe distress from agitation, hallucinations, or delusions, it is critical to discuss the benefits and risks in detail with the patient and caregivers before starting treatment. Health care providers should also adhere to international guidelines, such as those of the National Institute for Health and Care Excellence, by using the lowest effective dose for the shortest duration; reassess patients every 6 weeks; and discontinue antipsychotics if there is no clear ongoing benefit after consulting with the patient, relatives, and/or caregivers.[12] Behavioral and nonpharmacologic interventions should be prioritized as first-line strategies whenever feasible.

Despite its strengths, this study has limitations. The reliance on community volunteers for case identification may introduce variability in diagnostic accuracy. Additionally, the study does not assess caregiver burden and psychological interventions. Future research should evaluate long-term outcomes of community-based dementia care, including patient quality of life and caregiver support strategies.

A critical appraisal of our model indicates the potential benefit of implementing an outreach program within primary care services to pinpoint suspected cases of incipient dementia. This program could involve health professionals or trained volunteer personnel. Mental health professionals (nurses and/or psychiatrists) should provide training for the volunteers to ensure accurate case identification and appropriate referral pathways. This would also address the need for early diagnosis.

Conclusion

Community psychiatry clinics play a vital role in dementia care by enabling early identification, caregiver education, and comprehensive services. This approach helps bridge the treatment gap and enhances dementia care in underserved regions. While promising, further refinements in medication safety and caregiver support are essential for optimizing patient outcomes.

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Relevant Financial Relationships: None.

Funding/Support: None.

Previous Presentation: This work was presented virtually as a poster at the Alzheimer's Association International Conference; July 28–August 1, 2024; Philadelphia, Pennsylvania.

Article Information

Published Online: August 7, 2025. https://doi.org/10.4088/PCC.25br03938

Prim Care Companion CNS Disord 2025;27(4):25br03938

Submitted: February 9, 2025; accepted May 9, 2025.

To Cite: Vaseel M, Uvais NA. Improving dementia care in northern Kerala: lessons from the Rythm community mental health care program. *Prim Care Companion CNS Disord* 2025;27(4):25br03938.

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