Sattva Knowledge Institute SKI perspective

INTEGRATION OF MENTAL HEALTH IN PRIMARY HEALTHCARE

Best practices and learnings from models in low resource settings in India

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Acknowledgements

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Executive Summary

The World Health Organization (WHO) recognises the need for integrating mental health into primary healthcare. Community-based models, focusing on active community engagement have proven effective for delivering comprehensive care, and bridging care and access gaps in the service delivery mechanism.

The implementation of such models, however, is impeded by three primary barriers. These are the **demand** for mental health services at the individual and community levels, **evidence generation** to demonstrate the success of initiatives, and resource and infrastructural constraints in **service delivery**. This perspective analyses forty-one community-based mental health programmes, identifying the best practices that have addressed barriers to implementation and enabled impact outcomes.

Across these programmes, there are a shared set of seven fundamental principles that have enabled them to successfully integrate mental healthcare within primary healthcare. These are (i) community involvement and ownership, (ii) building community trust and acceptance, (iii) financial sustainability and affordability of services, (iv) monetary incentives for community workers and to support patients, (v) adoption of technology, (vi) enabling task sharing through capacity building of a non-specialist cadre of human resources and (vii) integration with existing Indian government systems. Each of these principles, in turn, enables multiple outcomes for these programmes including the ability to scale, ease of replication, financial and programme sustainability, and societal acceptance.

These best practices can guide the development of **comprehensive and inclusive mental health solutions** across the continuum of care in India.

Integration of Mental Health into Primary Healthcare is a Recognised Practice

It is widely accepted that health has both a physical and a mental component. In fact, the WHO (WHO 2020, p. 1) constitution defines health as "a state of complete physical, mental and social well-being, and not only the absence of disease or disability." Despite this, most healthcare systems worldwide prioritise physical care while neglecting mental healthcare for their citizens. A fundamental transformation is required in the way healthcare, especially mental healthcare, is provided (Thornicroft et al. 2016).

Across the globe, coercive procedures like forced admission and forced treatment, isolation, physical or pharmacological restraint have been recognised as shortcomings in approaches to care delivery. Current interventions are beginning to focus on addressing inequities in patients receiving treatment.

Interventions focused on integrating mental health into primary health-care have been successful, and accepted by communities around the world. A community-based strategy is essential to ensure that mental health services reach the last mile (WHO 2021 c).

Since the early 2000s, non-governmental organisations (NGOs) have successfully incorporated mental health programmes into the Indian landscape (Balagopal & Kapanee 2019). They have developed innovative delivery systems and have uncovered the factors that contribute to comprehensive mental healthcare among communities. Crisis intervention, community outreach, peer support, hospital-based programmes, supported living facilities, and community mental health institutions were some of their key ideas which emerged around delivering community mental health services. Some of these interventions have even been recognised globally for their approach and potential for replication. The WHO has listed the Atmiyata Programme by the Centre for Mental Health Law & Policy (CMHLP) as one of the 25 good practices for community outreach mental health services around the world (WHO 2021 c; CMHLP n.d. a). Other programmes like the Promoting Effective Mental Healthcare through Peer Supervision (PEERS) programme by Sangath (n.d. b) have been replicated in Canada, and are a testament to the impact showcased by community-integrated models for mental health.

The WHO (2008) recognises community-integrated models as effective methods of addressing stigma and providing a continuum of care for mental health. Active community participation has been critical to the success of these models, as it promotes and protects the rights of persons suffering from mental disorders, aids their recovery and facilitates their participation and inclusion in their families and communities. It has showcased success in boosting mental health-seeking behaviour, and enabling the development of highly effective mental health solutions for those affected.

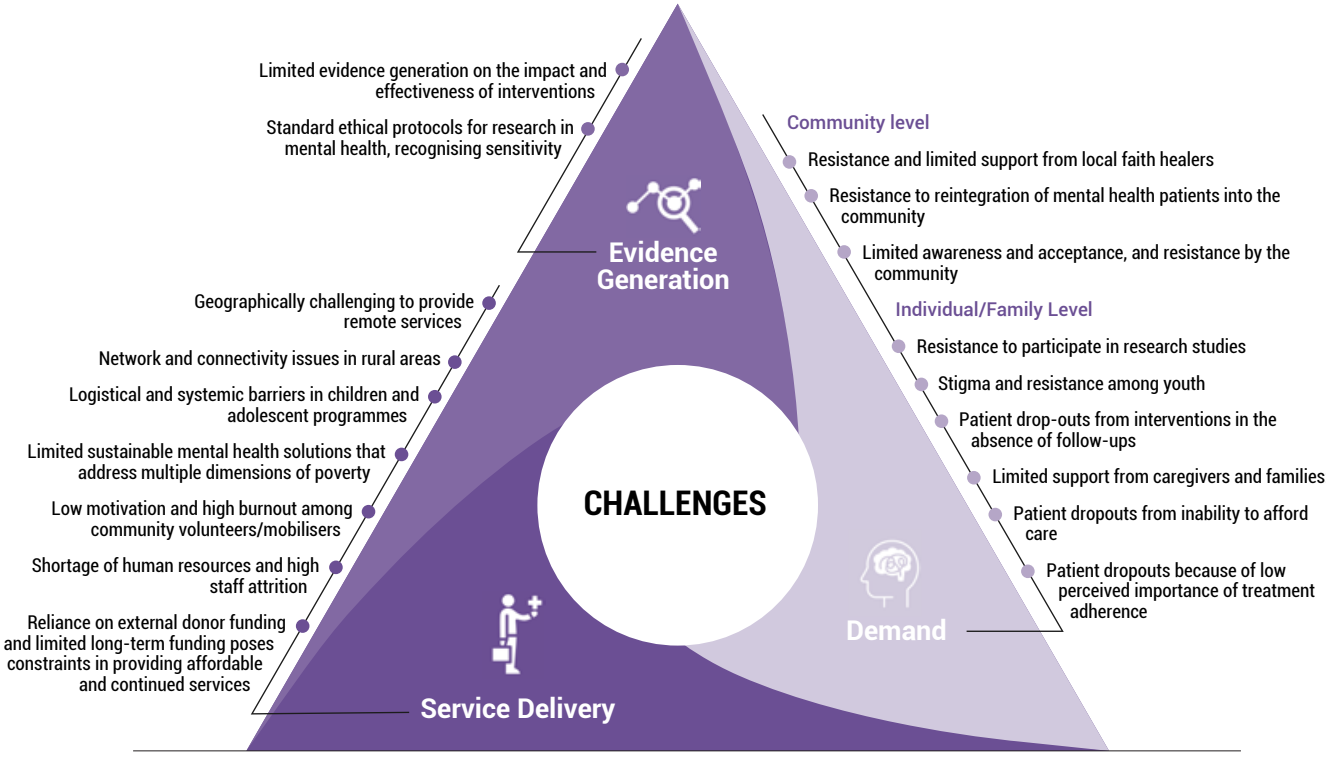
Challenges at Three Levels Act as Barriers to Implementation

Over the years, several interventions have been effective across the continuum of mental healthcare. However, many barriers in implementation of community-based interventions in mental health persist and will be important considerations for newer interventions in this space.

Several systemic challenges need to be addressed to ensure last-mile access to mental healthcare. Sub-optimal implementation of the District Mental Health Programme (DMHP) across the states poses a systemic challenge for integration with other such programmes. The shortage of trained human resources, including psychiatrists, psychologists, and social workers, creates impediments in the treatment of those with severe mental disorders and those requiring medication.

> ***"There is a need to ensure that information and evidence that programmes have gathered, whether good, bad or ugly, reaches the public domain, allowing for cross-learning and strengthening of programmes. This is a challenge in India. There is a huge negative bias about publishing negative outputs in our country."***
>
> – **Dr. Tasneem Raja**, Head, Mental Health, Indira Foundation

Figure 1: Challenges faced by community-based mental health programmes



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Prioritisation of other health issues over mental health, and limited provision of mental health services in primary healthcare facilities in certain regions, pose challenges that external programmes often cannot address. Access to welfare schemes is also limited, which affects the affordability of mental health services. This widens the care and access gap, especially for the vulnerable and marginalised population.

The programmes analysed in this Perspective faced challenges on three fronts — demand-side, service delivery, and evidence generation. Most challenges are interconnected, and often, addressing one challenge has a direct or indirect impact in addressing other barriers as well.

The insights in this section are derived from a cumulative analysis of all the forty-one programmes studied. Please refer to *Annexure 1* for a complete list of these programmes.

DEMAND-SIDE BARRIERS

Community level

1. **Resistance and limited support from local faith healers:** Faith healers often refused formal partnerships with intervention programmes due to strong monetary motivation and the need to maintain their clientele. Hence, they would spread myths, misconceptions and incorrect information about mental health.

   Example: In the **Rural Mental Health Programme (RMHP)** by **The Banyan**, the faith healers would speak about "curing a person of ghosts and suicidal thoughts in an hour, eating disorders in an hour, sadness in a day and menstrual disorders in 3 days" in order to maintain their clientele (Balagopal & Kapanee 2019, p. 147). On an average, these faith healers would earn around ₹2 lakhs per month.

2. **Resistance to the reintegration of mental health patients into the community:** High stigma and prejudice towards people with mental illness makes it difficult to obtain buy-in from the community and staff to discharge them from 'institutional care' (WHO 2021 b).

   Example: The **Home Again Programme** by **The Banyan** faces challenges with the local community refusing to accept and include people with mental illness in the community (WHO 2021, p. 26).

3. **Limited awareness and acceptance, and resistance by the community:** This is a result of the high prevalence of stigma and low demand for mental health services. People with mental illnesses are often perceived to be suffering from a "form of possession" that can only be exorcised by oracles, sorcerers or faith healers (Balagopal & Kapanee 2019). Due to limited awareness about mental health and misconceptions, communities can resist new approaches to mental health care.

Example: In the **Community Mental Health Programme by the Association for Health Welfare in the Nilgiris (ASHWINI)**, oracles (local faith healers) continue to be the first point of contact for treatment among the tribal community despite their interventions in the community (Balagopal & Kapanee 2019, pp 71-193).

Individual and family level

1. **Resistance to participating in research studies:** Due to high stigma and limited awareness about mental health, as well as prevalent socio-cultural barriers such as caste, gender and religion within the community, people are unwilling to participate and share their experiences in the research studies. In addition to a direct resistance, people with mental illnesses also find it difficult to communicate what they are going through due to paucity in awareness of mental health terminology and clarity regarding mental illness.

   Example: The **Atmiyata Programme** by the **CMHLP** faced challenges in collecting data in the community. Garnering participation in the study was difficult because of the stigma and silence surrounding mental illness. Participants' refusal were commonly attributed to caste, gender, religion based social stigmas in the neighbourhood (Joag et al. 2020).

2. **Stigma and resistance among youth:** There is a high likelihood that adolescents who suffer from mental illnesses feel more socially isolated. Compared to adults, young people are less likely to seek treatment for mental health issues due to concerns such as lack of privacy, peer pressure, a desire to be independent, and a lack of information about mental health-related services. Structural factors, as well as fear of social exclusion and discrimination by their peers lead to low health-seeking behaviour among youth (WHO 2021 a).

   Example: Participants in **Schizophrenia Research Foundation's (SCARF) Youth Mental Health Programme** openly stated that they preferred talking to their friends than to school counsellors about issues that they were facing. They also did not want to be seen entering the college counsellors' room as this would socially isolate them from their peer groups due to the stigma associated with it

> *"We went back to one of our community programmes ten years after we stopped the programme in 1999. And we found that 70% of patients had stopped treatment. Of course, at that point in time, the district mental health programmes and facilities were not as developed as they are now. We have gained from this knowledge, and ensured that in our telemedicine STEP programme, we started working much ahead of time and ensured that 80 to 90% of our patients are getting care from either the district hospital or the district mental health programme in the province."*
>
> — **Dr. R Thara**, Vice Chairman, Schizophrenia Research Foundation

3. **Patient drop-outs from interventions in the absence of a follow up:** Challenges in the ongoing follow up and monitoring of people who are reintegrating within their community after recovery from mental illness, programmes witness patient dropouts and limited adherence to treatment and care. In addition, programmes shut down and discontinued interventions due to limited programme funding which also resulted in drop-outs.

   Example: The **Satellite Clinics or Mobile Mental Health Clinics** operated by **Antara** faced challenges such as ensuring pharmacological therapy, home visits and social care, in follow-up care due to limited human resources. Follow-up care was only available for clients under the Care and Support Group programme. As a result, clients registered under satellite clinics or outpatient departments (OPD) faced reversals in their clinical outcomes (Balagopal & Kapanee 2019, p. 95).

4. **Limited support from caregivers and families:** This increases social, economic and financial difficulties for people with mental illness to seek treatment, and it also increases the risk of relapse or injury. It becomes difficult for patients with severe mental illnesses to attend specialised clinics without any caregiver to accompany them. Caregivers who refuse to cooperate or are ill-equipped to provide care and support make it challenging for recovered patients to reintegrate into families.

   Example: In the **Navachetana programme** by **Ashadeep**, it was noticed that while 15-20% of treated women became functional, their families could not be traced. For 10% of those who were severely disabled, locating their families and reintegrating them was very difficult (Ashadeep Society n.d.).

5. **Patients dropping out due to inability to afford care:** Socio-economic factors such as unemployment and poverty influence patients' ability to continue treatment and medications.

   Example: In the **Emergency Care and Recovery Centres (ECRCs)** and **Home Again Programme** by **The Banyan**, it is observed that mental health is exacerbated within families with poor resources. This increases out-of-pocket expenditure (OOPE) for accessing mental health services, and continuity of care becomes difficult (Narasimhan 2019).

6. **Low perceived importance of treatment:** Low perceived importance of continuing treatment especially for people with severe and chronic mental disorders due to limited awareness about mental health, results in dropouts and sometimes in reversal in their outcomes (Olfson et al. 2009).

   Example: In the **Janamanas Programme** by **Anjali**, it was observed that poor awareness about continuing treatment among caregivers led to the patients discontinuing treatment and resorting to faith healers for recovery (Balagopal & Kapanee 2019, p. 39-70).

EVIDENCE GENERATION BARRIERS

1. **Limited evidence generation on the impact and effectiveness of interventions:** There is limited focus on research and evidence generation. This poses barriers to replication and scaling up of programmes. There are no standardised criteria to measure the efficacy of mental health programmes and therefore, it is challenging to define and measure positive outcomes of the interventions.

   Example: In the **Implementation of Evidence-Based Facility and Community Interventions to Reduce the Treatment Gap for Depression (PREMIUM) Programme** by **Sangath**, the Healthy Activity Program (HAP) tool presented challenges for the programme as it required additional evaluation of its efficacy and cost-effectiveness, and there were no standardised models to evaluate it (Sangath n.d. c).

2. **Standard ethical protocols for research in mental health, recognising sensitivity:** Programmes often find it challenging to ensure quality and ethical protocols are undertaken for research in mental health due to inadequate standardised guidelines and inaccessibility of specific tools that are required in the Indian context. Limited focus on these aspects by organisations due to various barriers affects the quality of data and affects the researchers' understanding of the challenges faced by people living with mental health issues. Given the sensitive nature of mental health issues, it is critical to ensure that ethical protocols and privacy are maintained while collecting data for research.

   Example: **SCARF** highlighted that the data collection for **Post-Disaster Mental Health Programme** was extremely difficult while delivering psychosocial support and mental health services (PSSMHS) to people in tsunami-affected areas, because field volunteers were either not aware or did not follow ethical procedures that were necessary during a research project (Padmavati et al. 2020).

SERVICE DELIVERY BARRIERS

1. **Challenging to provide services in remote geographies:** Remote regions and difficult terrains pose a hurdle to easy access to mental health services. Programmes report that only a few patients visit regularly as they are geographically dispersed among villages or districts. Additionally, NGOs find it difficult to provide services till the last mile, given the challenges in engaging with specialists like psychiatrists and psychologists who are unwilling to provide services in remote regions. Limited programme funding and human resources form a barrier to continued services in remote regions.

   Example: The **Mental Illness Treatment Alliance (MITA) Programme** by **The Action North**

East Trust (ANT) faces challenges in care provision in remote areas of Assam, where one-way travel from their central location takes the team roughly two hours. To mitigate this, the programme has tried to connect with primary health centres present in these regions to provide clients with at least basic counselling or psychoeducation, in the absence of comprehensive care.

2. **Network and connectivity issues in rural areas:** Inconsistent network connectivity hinders the use of technology-based solutions, especially in rural and remote areas. It affects access to mental healthcare in areas with limited or no public facilities for mental health, and for individuals who are unable to travel long distances to get treatment or medication.

   Example: The **Telepsychiatry in Pudukkottai (STEP) programme** by **SCARF** faced the challenge of recurring power outages that would cause 'electronic medical records to break down or cause delays in service delivery' (Thara & Tharoor 2020).

3. **Logistical and systemic barriers in programmes involving children and adolescents:** These include finding the right time to meet with each student individually, setting up meetings between instructors and parents, and operational challenges in implementing certain programme tools. Other barriers to effective implementation of school-based mental health interventions include limited time for school professionals to deliver the intervention, poor coordination of mental healthcare with academic scheduling, conflicting priorities of the health and education systems, and limited support from families.

   Example: Issues that emerged in the **Teacher Leading Frontline (TeaLeaF) programme** by **Darjeeling Ladenla Road Prerna (DLR Prerna) in collaboration with Broadleaf** included subpar quality of therapy training, longer time required for school professionals to deliver the intervention, coordination of mental health care with academic scheduling, conflicting priorities of the health and education systems, community stigma, and lack of support from families (Vanderburg et al. 2022).

4. **Limited sustainable mental health solutions that address multiple dimensions of poverty:** Since mental health is exacerbated and influenced by various social-economic and cultural determinants, most programmes faced the challenge of designing mental health solutions that also addressed the "multiple dimensions of poverty" (WHO & Calouste Gulbenkian Foundation 2014, p. 08; Mental Health Innovation Network 2016 b). It becomes difficult to offer disadvantaged communities appropriate mental health care as often, and thus community awareness initiatives are not implemented until the very last step. This results in excluding the most vulnerable and marginalised elements of society from using the services.

   Example: In the **Nalam Programme** by **The Banyan**, the Nalam mobilisers and clients themselves are facing complex socio-cultural and economic barriers such as "poverty, alcohol use among spouses, suicides of kin, an episode of acute psychosis, depression following the discovery of husband's extra marital affair" and others (Mental Health Innovation 2016 b).

In the **Udaan District Mental Health Programme (DMHP) programme** by **TATA Trusts**, despite all efforts to standardise interventions, community awareness programmes did not reach the last mile, due to the highly complex interplay of various socioeconomic and disability-related issues (TATA Trusts 2019).

5. **Low motivation and high burnout among community volunteers or mobilisers:** Community mobilisers often find it difficult to sustain their motivation to continuously provide care and support to clients' longstanding and complicated problems, drive awareness and ensure follow up due to limited or no financial incentives, and high emotional exhaustion. Not all community programmes are able to provide remuneration or incentives to volunteers due to limited funding. Maintaining their motivation to offer care becomes more challenging as a result.

   Example: The **Community Mental Health Programme** by **Mental Health Action Trust (MHAT)** observed high burn-out among volunteers in the case of psychiatry care, due to the long duration of follow up that is required for people with mental illness (Balagopal & Kapanee 2019, p.161-184).

> *"Organisations are only recently beginning to look at mental health of frontline workers and this has not been studied enough. Both the positives and negatives need more research. The journey of empowerment of a frontline worker in becoming an important member of the community impacts their mental health positively and this also needs to be studied along with the burden they face. Programmes have had frontline workers share their concerns saying "You are training us to support others in the community but how do we handle concerns like substance abuse in our own homes?" This is the start of a very important conversation and they are now equipped to at least identify such issues."*
>
> — **Dr. Tasneem Raja**, Head, Mental Health, Indira Foundation

6. **Shortage of human resources and high staff attrition** due to limited financial incentives and high burnout. The lack of standardised tools to train healthcare workers creates barriers to providing care till the last mile. It leads to poor follow up and completion rates for psychological intervention and low rates of detection of mental disorders. The supply shortage results in insufficient human resources to watch over the patients, provide adherence monitoring, and facilitate community-based rehabilitation. As a result, many recovery plans are not carried out. Recruitment of volunteers and retention of participants for longer periods of research adds to the challenge.

   Example: In the **Care and Support Programme** by **Antara**, they were unable to provide home visits and ensure follow up to clients who were visiting the OPD or Satellite clinics due to the limited availability of trained human resources. While in the **SCARF's Care for people**

with Schizophrenia in India (COPSI) Programme, they found it difficult to recruit volunteers and retain them through the study period of twelve months (Chatterjee et al. 2014).

7. **Reliance on external donor funding and limited long-term funding poses constraints in providing affordable and continued services:** Programmes dependent on external donor funding for a limited duration are unable to continue care and address the high demand in the communities they work with. Fixed external funding also hinders the provision of free services, which affects the most vulnerable groups with poor socioeconomic backgrounds. Programmes which are able to create an additional corpus of funds by pooling resources from the community are unable to replenish these funds. As programmes expand, it becomes difficult to maintain funding for long-term sustainability and operations.

   Example: In the **Care and Support Programme (CSP)** by **Antara**, the case detection camps in the community had to be discontinued due to inability to provide free services to a large number of clients as a result of monetary constraints (Balagopal & Kapanee 2019, p.104).

Programmes have been able to successfully address barriers in many ways and provide learnings for other interventions. While systemic challenges require a more comprehensive approach by multiple stakeholders, interventions have been successful in developing solutions to address various kinds of challenges.

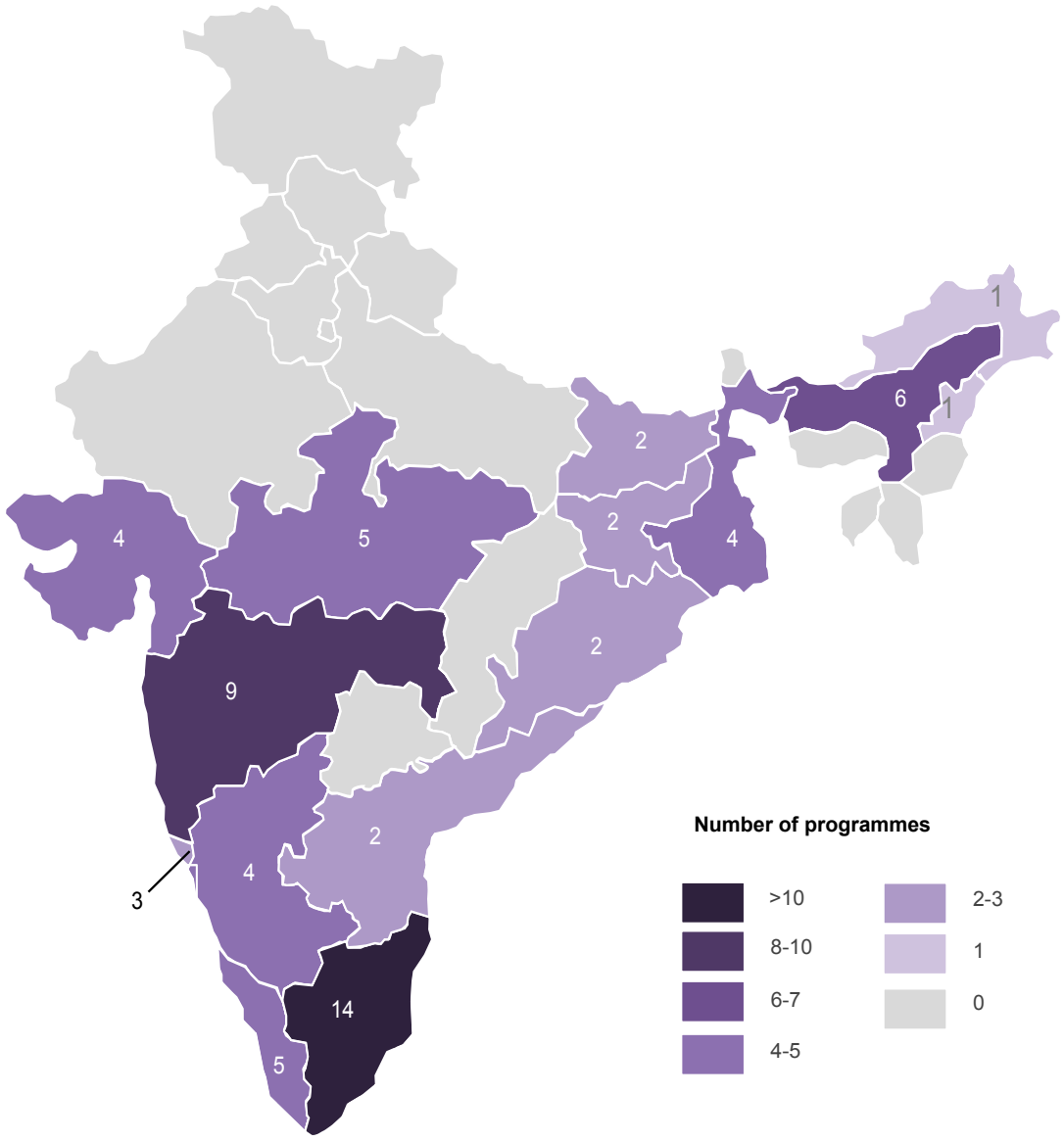
Best Practices have Enabled Critical Impact Outcomes Across Programmes

Programmes have been able to successfully address barriers in many ways and provide learnings on enabling better outcomes. While systemic challenges require a more comprehensive approach by multiple stakeholders, interventions have been successful in developing solutions to address various kinds of community-level challenges.

This section explores methods employed by non-governmental organisations (NGOs) in developing and implementing mental healthcare in India, a country with a high treatment gap, insufficient public health spending, shortage of human resources, and diverse cultures and cultural attitudes.

This perspective is based on an analysis of forty-one community-based mental health programmes implemented in India (please refer to *Annexure 1* for the list of programmes). Nuanced insights on best practices and learnings were obtained from qualitative primary interviews with programme teams and organisational leadership. *This perspective does not cover all mental health interventions in the country. Insights shared in this document are limited to the select programmes studied, and the sections on best practices are based on the cumulative analysis of all the forty-one programmes.*

Figure 2: State-level mapping of the forty-one programmes analysed in this perspective



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The map presents the geographic spread of the programmes analysed in this document. These programmes have been implemented across fifteen states. Many interventions were implemented in multiple states, adding up to 64 in the map. A majority of programmes have been implemented in South, West and Central India, with limited presence in East India. Community-based mental health interventions in North India are fewer as compared to other regions, and none of the programmes analysed in this perspective were implemented in northern states.

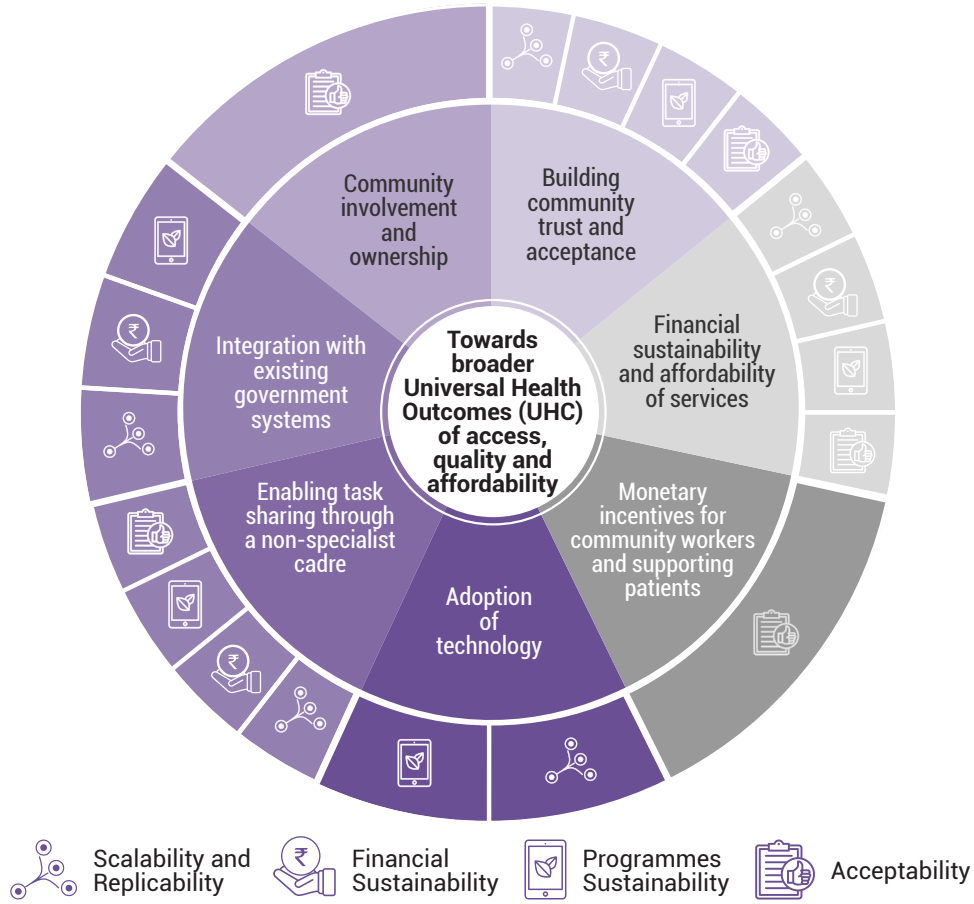
This analysis will be helpful in providing insights on how programmes operated in the context of various communities and their varied mental health needs, modes of community engagement and best practices in implementation.

Key Principles for Integrating Mental Health within Primary Health

Across programmes, mental healthcare models across programmes have adopted various forms of service delivery and integration within communities. The approach to service delivery has been determined by several factors, including the availability of existing health infrastructure, the capability of the public health systems to provide mental health services, ease of accessing the region, and the nature of mental health issues.

The programmes studied in this perspective involved setting up satellite clinics and monthly camps for those living in remote regions, and establishing two tier systems of service delivery, including a basket of home-based psychosocial services provided by informal caregivers and formal care services (referral services, social services, medical and psychosocial clinical services and Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy [AYUSH]). Those targeting a specific vulnerable target group set up free outdoor clinics to enable easy access, and centres for rehabilitation and vocational training for those suffering from severe mental disorders.

Figure 3: Key principles across community-based mental health programmes and outcomes enabled



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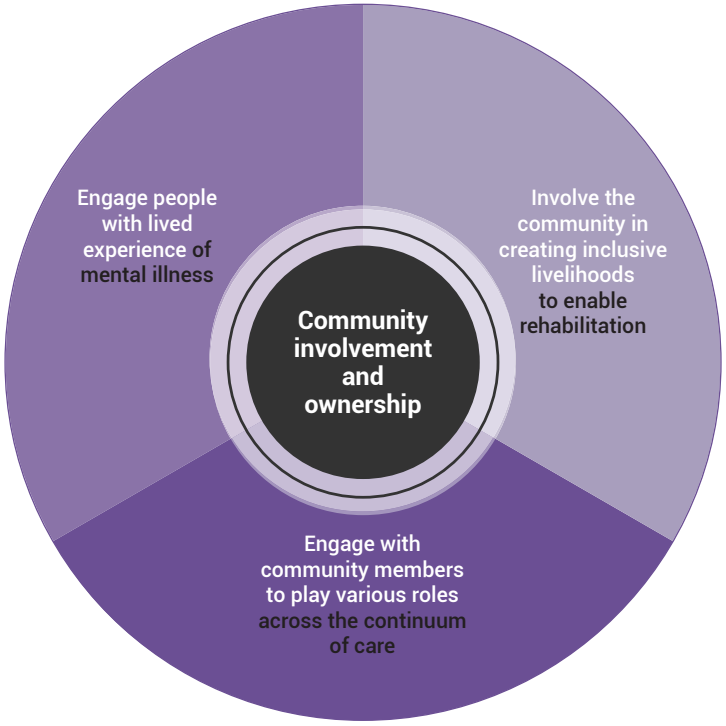
Programmes that were able to successfully integrate mental health with primary healthcare in low resource settings through active community engagement, resulted in multiple outcomes and hence greater impact at various levels (Luke et al. 2014). These outcomes can ultimately enable Universal Health Coverage (UHC) via accessibility, quality and affordability in care. (Refer to *Annexure 2* for more details on outcomes)

An analysis of the forty-one programmes brings to light several key principles adopted in various contexts. Each key principle enables at least one or more outcomes, as showcased in the framework (*Figure 3*). Best practices for each principle provide a nuanced understanding of the approaches and innovations which enabled outcomes at four levels i.e. enabling programme acceptability, ensuring sustainability of the programme, enabled financial sustainability of efforts and contributing to scalability and replicability.

COMMUNITY INVOLVEMENT AND OWNERSHIP

Figure 4: Ways to ensure community involvement and promote ownership



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Ensuring community ownership and engaging with them actively is critical to ensure community programme sustainability and acceptability. Programmes have engaged with communities in multiple ways to promote health-seeking behaviour, promote mental health, provide accurate information, address myths, alleviate resistance in mental healthcare and enable community ownership of mental health. By engaging communities actively, interventions have been able to make them see the importance of mental health, at par with physical health and increase acceptance of interventions. Community involvement in the design of the programme can help ensure that the community is at the centre of the intervention and that the programme is suited to their needs and contexts.

> *"You need to make communities understand why mental health should be one of the various kinds of health services which are available to them, in the same way that they would expect maternal and child healthcare to be available. When you work with communities towards that, they also recognise the importance of mental health, destigmatise it and agree that mental health is not something on the basis of which discrimination should exist."*
>
> — **Dr Anant Bhan**, Mentor and Principal Investigator, Sangath (Bhopal Hub)

Engage with community members to play various roles across the continuum of care.

Across programmes, community members have been inducted and trained by health professionals in identifying persons with mental health disorders in the community, spreading awareness, enrolling patients for treatment and referring vulnerable cases to the tertiary centres. They can be enabled to take up many roles and responsibilities, as showcased by a number of programmes.

Given that these mobilisers are from the same community, the acceptance and receptiveness to their engagement is higher, and they are able to enable mental health awareness in locally contextualised ways. Recruiting people from the community who do not have formal education in mental health, and are passionate and motivated to help people with mental illness, has proven successful and provides an opportunity to address community resistance. Programmes have shown the value of integrating community members from myriad sections of the society along the continuum of care - young people, school teachers, children, different religion and caste-based groups, neighbourhood community groups and others. Young people within the community can act as change agents, run the mental health camps conducting awareness activities and providing basic counselling support, and dispensing medicines. This enables a sense of belonging and creates an inclusive space for people with mental illness to thrive in the community.

Trained community members also help minimise the collective burden of care in the event of major disasters, following precise guidelines on disaster response, psychosocial treatments and disaster management as a whole. They are especially important in these scenarios where, in the absence of clear policy guidelines and directives on care, deploying and engaging a cadre of health workers to provide exclusive and critical mental health care can be difficult (Padmavati et al. 2020).

Across all the models, these community mobilisers have undertaken a number of roles. The use of local resources can encourage mental health-seeking behaviour and complement the trained mental health professionals (psychiatrists and psychiatric nurses), thus improving access and ensuring greater acceptability of the interventions.

Under the supervision of mental health specialists, community members acting as Community Level Workers (CLWs) can be taught to identify, diagnose, treat, and monitor individuals with mild to moderate mental health issues. Training CLWs on quasi-psychosocial intervention techniques enables task sharing and also reduces the burden on caregivers. They can undertake home visits to check treatment adherence, reasons for irregularity with follow ups, check on a patient's condition, provide a chance for family members to share their emotions and share reminders about follow-up care (Padmavati et al. 2020). With established referral systems in place, they are able to refer moderate and severe cases to specialised facilities.

EXAMPLES

1. TRAINING COMMUNITY MEMBERS AS COMMUNITY LEVEL WORKERS (CLWS)

- The **TeaLeaf programme by DLR Prerna in collaboration with Broadleaf** is training primary school teachers to deliver mental health care in classrooms (BroadLeaf n.d).
- The **Community Mental Health Programme** by **ASHWINI** trains faith healers to drive awareness, screen people with mental illness, treat minor illness and refer persons with severe mental illnesses (ASHWINI 2009).

2. COMMUNITY MEMBERS AS MOBILISERS

- In the **Telepsychiatry programme (STEP)** by **SCARF**, the human resource structure of the programme indicates the predominance of community-level women workers. Community level workers (CLW) with educational qualifications ranging from high school to undergraduate levels are recruited from the programme area (Thara & Tharoor 2020).
- **Society for Nutrition, Education & Health Action (SNEHA)** identifies local women volunteers from the community, called Sanginis, who are trained to provide support to victims of domestic violence, connect them to crisis intervention and counselling services and also provide basic mental health interventions (Daruwalla et al. 2019)
- The **Nalam Programme** by **The Banyan** recruited Nalam Mobilisers who are women from the intervention villages and perform many of the functions of community health workers such as identifying people with mental illness, conducting home-visits and referral to specialised care. In addition to this, the mobilisers also provide supportive counselling and respond to social and economic distress (The Banyan n.d.; Mental Health Innovation 2016 b).
- The **Community Mental Health Programme** by **MHAT** identifies volunteers from various sections of society which includes "students, school teachers, caregivers, users of palliative care, farmers' groups from various religious backgrounds including Muslims, Hindus and Christians", who are collectivised to provide services to the most needy individuals, including persons with terminal illnesses, severe disability, mental illness, and so on, regardless of caste, gender, or religion, without expectation of incentives (Balagopal & Kapanee 2019, p. 161).
- The **Care and Support Programme (CSP)** by **Antara** involves the local population for promotion of mental health, prevention of mental illness, early identification and treatment of mental illness, and alleviation of suffering due to mental illness within the community (Balagopal & Kapanee 2019, pp. 95-120).

3. COMMUNITY MEMBERS AS PERSONAL ASSISTANTS FOR PEOPLE WITH SEVERE MENTAL DISORDERS

- In the **Home Again Programme** by **The Banyan**, personal assistants undergo a week-long induction programme, drawn from a curriculum co-developed with the University of Pennsylvania, especially for this cadre. Personal Assistants are recruited from local communities and are motivated by their passion to support people in the recovery process (WHO 2021).

4. COMMUNITY MEMBERS AS HEALTH WORKERS

- In the **Community Mental Health Programme** by **ASHWINI**, the doctors trained and recruited tribal women as health workers who would act at the forefront in the health transformation of their community. The health workers' efforts were complemented by mobile clinics, which visited the villages to provide medical care (Association for Health Welfare in the Nilgiris 2004 a; Association for Health Welfare in the Nilgiris 2004 b).
- The **Care for people with Schizophrenia in India – RCT (COPSI) intervention** by **SCARF** promoted a "close collaboration between the person with schizophrenia, family members, the treating Psychiatrist and the Lay Community Health Worker (LCHW)" to work as a team to help the person get better. The LCHWs, with no previous qualifications or experience in the field were rigorously trained by experts and supervised by the treating psychiatrists (Chatterjee et al. 2014).
- The **Post-Disaster Mental Health Programme** by **SCARF** identified and trained CLWs in psychosocial intervention methods. The CLWs were trained to "detect, diagnose, treat, and monitor individuals with mental disorders and reduce caregiver burden" (Padmavati et al. 2020).

5. COMMUNITY LEADERS/RESPECTED MEMBERS AS CHAMPIONS

- In the **Atmiyata Project** by **CMHLP**, Atmiyata Champions are important community members (e.g. former teachers, community leaders) with leadership and communication skills, who are well-known and approachable in their village. Atmiyata Champions are trained to identify and provide structured counselling to people with high mental distress, including the people referred by Atmiyata Mitras, who are trained to identify, and refer persons with mental distress (Joag et al. 2020).

Engage people with lived experience of mental illness.

Programmes involving people who have lived experiences of mental illness in co-designing training content for community health officers and mobilisers have been impactful. Such participation ensures services that are human-centric, culturally and locally relevant in nature. Since people with lived experience have been users of services and are able to connect their own experiences with those of others, they can highlight gaps in systems and identify needs in the community. In addition, they can play the role of peer support or caregivers to help people with mental illness recover and reintegrate in the community.

EXAMPLES

1. The **Seher Community Mental Health and Inclusion Programme** by **Bapu Trust** employed people with lived experiences with psychosocial disabilities in the capacity of "experts by experience" (Bapu Trust n.d. b).
2. The **RMHP** by **The Banyan** employed recovered patients as Vocational Training

assistants. It destigmatised mental health within the community by showcasing that mental health is treatable (Balagopal & Kapanee 2019, p. 154).

3. In the **Naya Daur Programme** by **Iswar Sankalpa**, recovered clients often take on the role of peer-support or caregivers for the new clients (WHO 2021 b). The clients' voices and feedback are integrated "informally in the 'service design and implementation" of the programme (WHO 2021 b). The trained caregivers share their own lived experiences with mental health, and this increases bond and self-acceptance among the clients that encourages them to move towards the path of recovery.
4. In the **Schizophrenia Assessment, Referral, and Awareness Training for Health Auxiliaries (SARATHA) programme** by **Sangath**, a cohort of community health workers and people living with severe mental disorders are involved in the co-creation and design of culturally and locally relevant training content (Sangath n.d. e).

Involve the community in creating inclusive livelihoods to enable rehabilitation

Families and individuals with mental illnesses are commonly subjected to prejudice and exclusion from social and economic activities. People who suffer from mental illness and their families are mocked and marginalised, which traps them in a cycle of poverty. In low-resource settings, families are ill-equipped to take care of people with mental illnesses and severe mental disorders.

However, encouraging community ownership of the mentally ill has proved effective in certain contexts. Identifying people in the community who are motivated and willing to provide opportunities for livelihood to people with mental illnesses can be an effective means of rehabilitation and reintegration into the community. By engaging people from within communities who can own solutions, reintegration can be made more sustainable and acceptable by both communities and people suffering from mental illness.

EXAMPLE

1. The **Naya Daur** by **Iswar Sankalpa** identifies potential caregivers from the community to organise care and support for the mentally ill. People in the neighbourhood are also encouraged to employ and rehabilitate people with mental illness via small businesses. When a homeless individual who is "willing and feels able to work" is identified in the community, these care-givers employ them in shops and small businesses (Iswar Sankalpa n.d.).

BUILDING COMMUNITY TRUST AND ACCEPTANCE

Figure 5: Ways to build community trust and acceptance.

(Sattva 2022)

Programmes are able to maximise impact and are accepted among communities when interventions recognise local cultures, needs, beliefs, and contexts. Understanding local perceptions about mental health, stigma, resistance, and factors determining prevalence of mental health issues are critical to design holistic interventions.

Contextualise approach to the local environment and language.

It is essential that the content for information dissemination reflects local contexts, and is in the vernacular language in order to create rapport amongst residents, and increase acceptability of the intervention. There is no one size fits all method for producing and disseminating information, especially when it comes to mental health. Information needs to be translated and tailored to the regional settings. To make the content thorough and appetising, it should also go through community quality control.

> ***"Words like "stress" and "tension" translate very well in Indian languages. When you inquire whether it would be acceptable to offer services to deal with stress and tension in the community, they are very receptive to it. You also get individuals from the community who are willing to volunteer and take training for it. If you say "mental illness" they may refuse. Everything depends on the terminology that you use."***
>
> – **Dr. Soumitra Pathare**, Consultant Psychiatrist and Director, Centre for Mental Health Law & Policy

EXAMPLES

1. The **Udaan DMHP** by **Tata Trusts** contextualised mental health in the local language (Hindi/Marathi) and professional psychologists explained the concepts of mental health and illness in either Hindi or Marathi to high school students (TATA Trusts 2019).
2. The **MITA programme** by **The ANT** recognised the diversity in ethnicities in the north-eastern part of India and within the state of Assam. As the programme expanded within Assam and beyond the state, the service delivery model largely stayed the same while also ensuring that the approach to engage with communities was customised to the local community cultures and practices.

Employ hyperlocal and interactive modes of mental health literacy.

Awareness-raising is a process that aims to educate people about a topic or issue with the aim of changing their attitudes, behaviours, and beliefs. Raising awareness and disseminating information on mental health is essential to fostering an atmosphere that encourages trust, supports accountability, promotes inclusive and participatory methods for follow up and review, and fosters ownership.

Older techniques of knowledge dissemination can be tedious, uninteresting, and futile. The following programmes have used a variety of strategies, techniques, and instruments to disseminate messages and amass the support required to influence public opinion.

EXAMPLES

AWARENESS PROGRAMME AND WORKSHOPS

1. The **Care and Support Programme** by **Antara** conducts community awareness programmes by involving local stakeholders who are well-trusted and recognised in the community, such as neighbourhood residents, school and college students, police officials and caregivers of persons with mental illness. Antara leverages the "neighbourhood concept" where the affairs of the neighbourhood are looked after and led by the social group (Balagopal & Kapanee 2019, p. 101).
2. The **Daur Programme** by **Iswar Sankalpa** conducts awareness camps in local clubs or near places where clients reside. In addition, monthly awareness workshops on mental health and homelessness are conducted by the team to destigmatise mental health, and sensitise the community to the 'challenges faced by many people' in their daily lives (WHO 2021 c).
3. The **Janamanas programme** by **Anjali** conducts awareness camps and workshops to spread awareness regarding "mental health queries, rights and service delivery," to ensure that there is continuous dialogue with the community, and concerns regarding mental health are addressed (Anjali 2011).

STREET PLAYS, SKITS AND PAMPHLET DISTRIBUTION

1. The **Integrated Community Care for the Needs of Vulnerable People with Severe Mental Disorders (INCENSE) programme** by **Parivartan Trust** conducted awareness programmes in the community, which were delivered by Recovery Support Workers (RSWs), and Peer and Family Support Workers (Parivartan Trust 2015).
2. **Seher Community Mental Health and Inclusion Programme** by **Bapu Trust** conducts street-plays and uses amateur videos on "peace-practise" to spread the message of "peace, care and inclusion" since family conflict and disturbance in the neighbourhood is the leading cause of high stress 'among families, especially those with persons with mental health disabilities (CAMH 2015).
3. The **Janamanas programme** by **Anjali** engages with outreach workers to organise street plays on mental health for awareness generation once every three months (Anjali 2011).
4. The **Community Mental Health Programme** by **ASHWINI** conducts mental health awareness via street plays, skits, posters, flip charts, video clippings and Powerpoint presentations. Their awareness programme adopts a holistic approach, whereby discussions on mental health are included with all aspects of health such as antenatal care, tuberculosis, HIV infection, dental health, etc., so that "health education on mental illness is mainstream" in the community (Balagopal & Kapanee 2019, p. 73).
5. In the **Strengthening the evidence base on effective school-based interventions for promoting adolescent health (SEHER) programme** by **Sangath**, the teachers promoted mental health during the school assembly via various activities such as skit presentation, role play, and group discussion (Shinde et al. 2017).

COMMUNITY FAIRS AND EVENTS

1. **Seher Community Mental Health and Inclusion Programme** by **Bapu Trust** organises mass communication events around significant days, such as Erwadi Memorial Day or Mental Health Week. They invite local mandals to share their work on mental health during Ganesh festival, Durga festival and other such occasions, during which they showcase their film 'Aadhar' to interact and discuss mental health with the community (CAMH 2015).
2. The **School-Based Mental Health Justice Programme** by **Anubhuti** organises "Mann Melas" or 'Mental Health Fairs' to drive mental health-seeking behaviour among students, their parents and the communities that they live in (Mariwala Health Initiative n.d. a; Anubhuti 2021).

USING MOVIES

1. The **Atmiyata Programme** by **CMHLP** conducted community awareness on social issues by narrow-casting four 10-minute films based on commonly experienced social issues in the community such as unemployment, family conflict, domestic

violence, and alcohol-use (Joag et al. 2020). These are dubbed in the local language and viewed by a group of 3-4 community members at a time. This role model film showing local community members accessing care and support is screened. Another community-oriented film on acceptance and support for people coping with mental distress and illness, detection and referral is also broadcasted. It also includes myth-busting in the form of frequently asked questions (FAQ's) with a psychiatrist in the local language (Joag et al. 2020).

2. The **Telepsychiatry (STEP) programme** by **SCARF** in Pudukkottai used a bus with a public address system and a large flat-screen television panel to screen movies and short films on mental health when the bus was parked in the evenings at public places, like the bus terminus (Thara & Tharoor 2020).

USING TOLL-FREE HOTLINE NUMBERS

1. The **Samiya Baani Programme by Innovators In Health (IIH) in collaboration with SCARF** used hotline numbers to disseminate information and provide treatment. Everyone who called the hotline number was offered two options, where they could either listen to pre-recorded messages, skits or songs about maternal mental wellbeing or talk to a counsellor. Some callers were also provided with the option of receiving talk therapy sessions at home (IIH n.d.).

SET UP OF MENTAL HEALTH KIOSKS

1. The **Janamanas Programme** by **Anjali** has set up mental health kiosks in partnership with the government to deliver mental health services in areas of high socioeconomic deprivation. The kiosk operators and outreach workers also involve themselves in government campaigns like immunisation and education. They ensure that the most vulnerable population in the slums, such as women, and those belonging to disadvantaged socioeconomic backgrounds have access to mental health services (Anjali 2011).

Engage with faith healers and places of religious gatherings.

Faith healers and traditional health practitioners are trusted within the community as they are able to contextualise mental health while maintaining the community's traditional belief systems. Given they are well-established within the community, they can play an important role in shaping the community's attitudes towards mental health.

In India, traditional healers and places of religious gathering provide a parallel system of thought to conventional medicine about the causes of, and hence the proper care for, mental health issues. While programmes have encountered resistance among them to engage in non-traditional interventions, they have been able to secure support by showcasing positive impact through recovery of people with mental illness and their reintegration within communities.

"One thing we will have to accept as organisations is that before we came into the community, the community had a kind of support system, an informal health system. Informal practitioners are a very important part of that and we need to acknowledge that and engage with that system."

– **Dr. Mintu Moni Sarma**, Programme Lead,
Mental Illness Treatment Alliance (MITA), The Action North East Trust

EXAMPLES

1. The **RMHP** by **The Banyan** engaged with Dargah functionaries who have not been provided with any formal training on identification of mental illness. While the functionaries are aware of the symptoms of mental illness, as they offer faith healing services to persons with mental illness, the decision to refer their clients to the RMHP came after community health workers established a rapport with them and they began to see recovered clients of the RMHP in their locality (Balagopal & Kapanee 2019, p. 121).
2. The **Community Based Rehabilitation (CBR) programme** by **SCARF** established an active liaison with the traditional healing centres in Thiruporur, Tamil Nadu (one temple and one mosque frequented for healing of mental disorders), ensuring that the process of traditional or religious healing was not interfered with while persuading the patient to also accept the medicines. It was accomplished in many cases with the help of volunteers and authorities at the places of worship (Thara et al. 2008).
3. The **Community Mental Health Programme** by **ASHWINI** employs spiritual healers (referred to as health animators) in the capacity of health educators to engage with indigenous tribes (ASHWINI 2017; ASHWINI 2004). They are trained to drive mental health-seeking behaviour while "maintaining the traditional belief in healing by oracles". In addition, they identify and refer people with mental illness, conduct follow up with the doctors, maintain registers and dispense medicines. The health animators provide faith healing services if requested and only refer those in need of treatment for their mental illness to higher facilities (Balagopal & Kapanee 2019, p. 71-93)

Create safe spaces to enable collective health seeking behaviour.

Programmes noticed that refuting common myths can be challenging without the assistance of people whom the community trusts. It was found to be relatively simpler to persuade the community by using existing spaces (such as hospitals and schools) and by health professionals (local doctors). In any environment, it is critical to attend to the emotional needs of the people to ensure that people feel included, valued, listened to, and accommodated. In order to build places that encourage open, honest and private discussions and promote a sense of emotional safety, programmes can design new spaces or repurpose old ones.

This approach is especially useful in the case of marginalised groups. Women are often excluded from decision-making, which affects their physical and mental health. Creation of social groups for women encourages collective action among women and increases the proportion of female participation in mental health. Social groups also offer women safe and private spaces to talk without fear and discrimination about issues that they are unable to discuss in other social settings. These also promote positive health-seeking behaviour through the actions of peers.

> ***"In our programme in Bihar on postpartum depression among women, we saw that women got together as one group, sat together in the evenings and played out the informational content from the interactive voice response system (IVRS) and heard the information as a group. And they started discussing what it means and how that can be used, among themselves."***
>
> – **Dr. Vijaya Raghavan**, Consultant Psychiatrist, Schizophrenia Research Foundation

Conducting meetings with small groups of individuals coming to hospitals, involving a medical practitioner to explain the importance of mental health and the role of medication has proven important in order to overcome the community's suspicion about the services. Programmes also repurposed hospitals and schools as tutoring centres where misconceptions about mental diseases are addressed and corrected.

EXAMPLES

1. In the **Janamanas programme** by **Anjali**, a women's meet is organised every quarter, where women and young girls from the community are invited to talk about mental health. The community centre is promoted as a "safe space for women" (Anjali 2011).
2. The **Youth Mental Health programme** by **SCARF** leverages the organisation's resource centre, which is co-designed and 'maintained by the youth volunteers', and provides a safe space for them to host events and programmes on driving mental health awareness (Srinivasan et al. 2021).

Leverage established community relationships as a segue into mental health.

In communities where conversations about mental illness are met with resistance and stigma, it is critical for programmes to first establish trust before engaging with them about mental health. Programmes have found that entering new communities with traditionally more acceptable issues such as maternal health, child health and nutrition can first help establish trust and familiarity. Wellbeing of the unborn and newborn child is regarded as one of the most critical priorities for families with pregnant and new mothers, which creates an opportunity for community engagement. Programmes have been linking the wellbeing of the child to the mental wellbeing of the mother, thus promoting active health-seeking behaviour

among families. By leveraging this trust, organisations are able to introduce work on mental health and wellbeing within the same communities, thereby increasing acceptability and receptiveness of mental health services.

> *"We found in our experience that most of the time depression and anxiety among perinatal mothers in the region was not because of societal issues but because of a new stressor like a baby entering their lives and nobody to rely upon to get accurate information. So our volunteers talked to them about how to take care of themselves, how to breastfeed the baby, what is nutritious for the baby etc. and it was very helpful for their mental health."*
>
> – **Dr. Vijaya Raghavan**, Consultant Psychiatrist, Schizophrenia Research Foundation

EXAMPLES

1. The **Telepsychiatry programme (STEP)** by **SCARF** was effectively implemented due to the presence of a local NGO named Rural Development Society in Pudukkottai (Mental Health Innovation Network 2014). The local NGO was already established and well-trusted in the community due its intensive work in the areas of agriculture, health and nutrition. The local NGO was well-aware of the needs of the people, their language, geography of the land, and was an essential link between the SCARF and the community (Thara & Tharoor 2020).
2. For the **Samya Baani Mobile programme by Innovators in Health (IIH) in collaboration with SCARF**, the key aspect that aided introduction and implementation of the mental health intervention was that IIH had been working in the community already. People quickly accepted SCARF's efforts in maternal mental health since IIH was already well-known and trusted in the community through their successful implementation of previous programmes. In addition, SCARF observed that the workers were allowed to enter the homes of families with pregnant women or new mothers when they emphasised on the well-being of the newborn or the foetus, since it is a priority for the family and also considered acceptable. Hence women volunteers used this as an opportunity to find a private space with mothers and have conversations about mental health and wellbeing (IIH n.d.)
3. **SNEHA** enters a community with maternal and child health intervention as it helps establish trust for them and the programme. In a sequential approach, they introduce family planning, domestic violence, and mental health only after being in the community for two years.

Create livelihood opportunities to increase community acceptance.

Ensuring the employment of community members with mental health issues promotes trust in the community, given that people with mental disabilities and severe disorders are unable to contribute to their families financially, and can strain the limited financial resources of the family for continued care. Providing opportunities for employment in the programmes creates a sense of belonging and enables active participation, especially in communities with economic challenges.

EXAMPLE

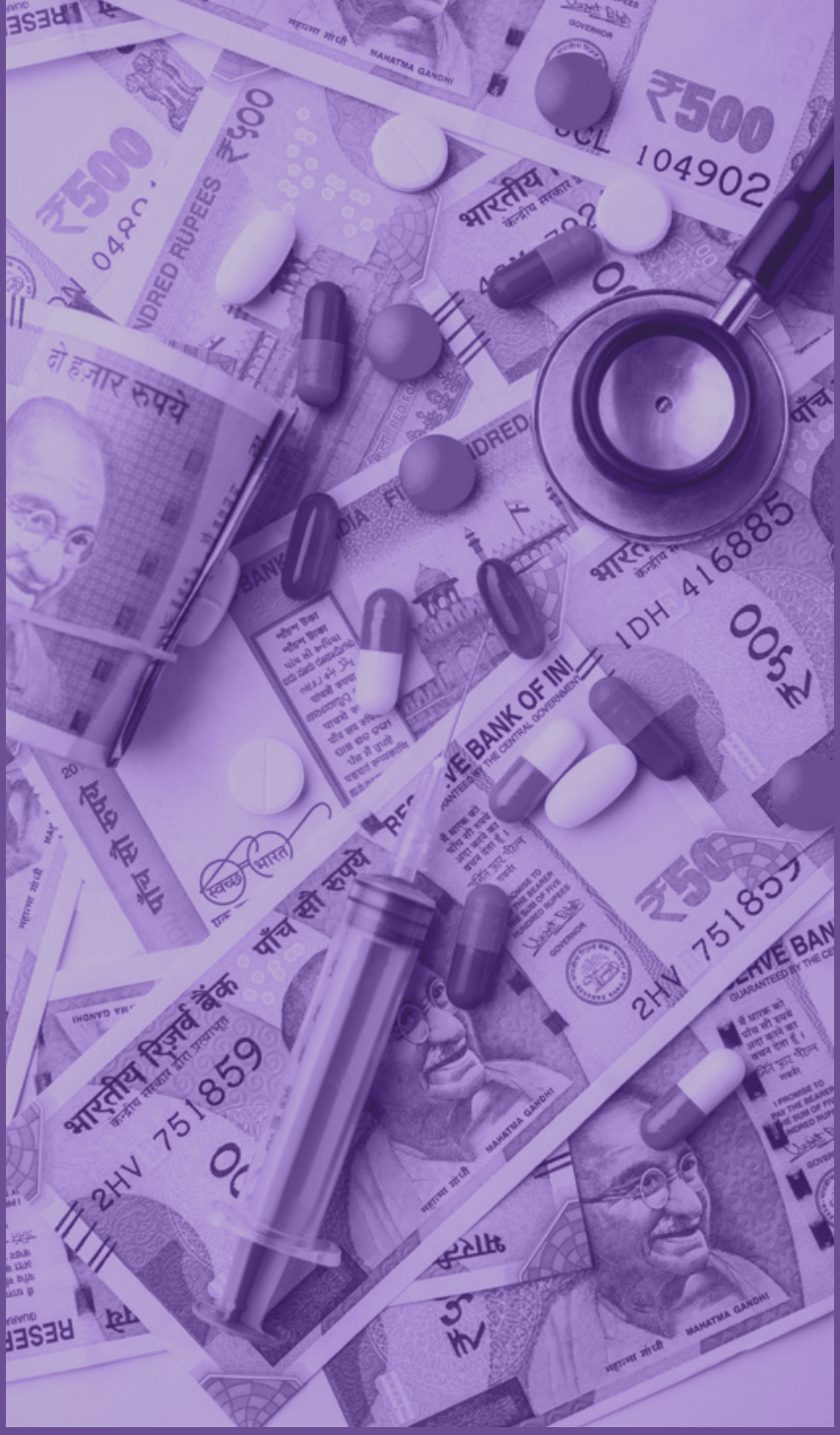
1. The **Janamanas Programme** by **Anjali** is employing women from the community, making their mental health programme more acceptable to residents of that locality. In addition, provision of livelihood especially to women from marginalised communities not only empowers them, but also ensures sustainable local community mental health in "resource poor communities" (Anjali 2011).

Engage with existing community platforms.

Community platforms like panchayats, self-help groups, school, and religious institutions are important forums of local community leaders who are well-trusted and respected within the community and are also aware of the needs of the community. Engaging with panchayat members, self-help group members, village leaders, school teachers and heads of religious institutions to promote mental health awareness in the community can lead to increase in health-seeking behaviour, and prevention of mental illness.

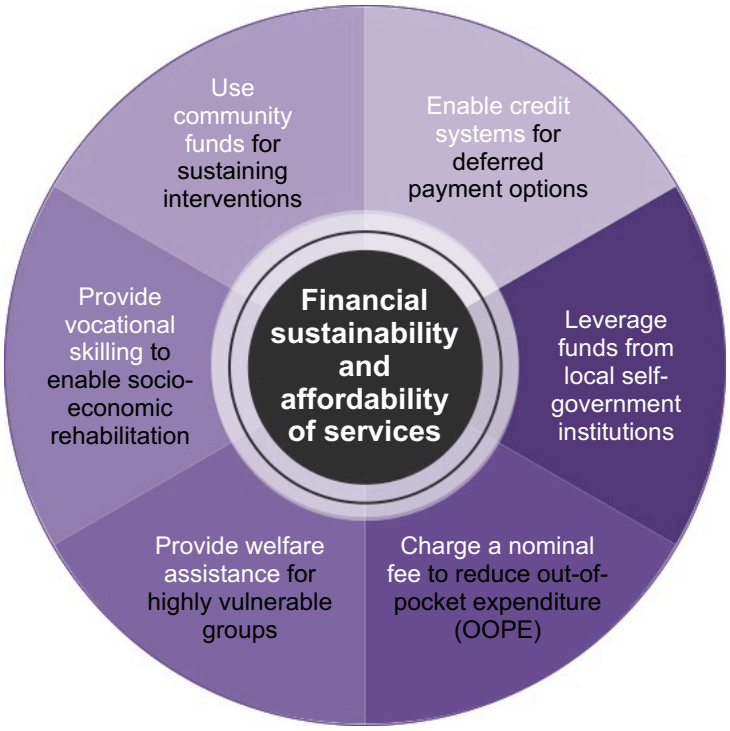
EXAMPLES

1. The **Janamanas Programme** by **Anjali** has leveraged existing women's self-help groups (SHGs) in the community to "identify, counsel and refer people with mental health issues in the community" (Balagopal & Kapanee 2019, p. 39). The programme also engages with local government institutions (panchayats) whereby the community leaders from rural and semi-rural regions "promote mental health awareness, facilitate connections, and drive mental health awareness through community-based networks" (Balagopal & Kapanee 2019, p. 41).
2. The **Community Mental Health Programme** by **SCARF** formed citizen's groups which comprised village leaders, school teachers, heads of religious institutions in the area and interested community persons. They would drive awareness in the community, encourage health-seeking, set up mental health camps across the village, destigmatise mental health and involve the entire community in the rehabilitation of the patients (Thara et al. 2008).



FINANCIAL SUSTAINABILITY AND AFFORDABILITY OF SERVICES

Figure 6: Ways to ensure financial sustainability and affordability of services



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Charge a nominal fee to reduce out-of-pocket expenditure (OOPE).

Models have showcased that charging a nominal fee for outpatient consultation and medication can increase the sustainability of programmes and reduce OOPE for those seeking mental health services. Certain interventions have started charging a nominal fee, making exceptions for users below the poverty line (BPL). The provision of free treatment and medicines is based on evaluation and proof of a person's financial background.

The nominal fee helps support the operational aspects of the programme, including the supply of medicines, shelters and treatment for chronic and long-term mental illness, manpower and other overheads. In addition, the costs of the services can be managed via task sharing and employing social workers instead of trained mental health professionals such as psychiatrists and psychologists. These social workers are able to provide mental health and train lay-community members in the 'basics of daily support' for people with mental illness.

EXAMPLES

1. The **Community Mental Health Programme** by **ASHWINI** charges a user fee of ₹10 for outpatient consultation and medication (ASHWINI 2017; ASHWINI 2004).
2. The **Naya Daur Programme** by **Iswar Sankalpa** charges ~ ₹107 ($1.50) per person per day which is ~₹3,580 ($45) per month. In comparison, shelters run by Iswar

Sankalpa charge ~₹4,773 ($60) per person per month, and institutional support at privately-run centres is around ~₹11,933 ($150) per person per month. All cost estimates include food, medicines, treatment, hygiene materials, clothes, manpower, and overheads (WHO 2021 b; WHO 2021 c).

3. Under the **Care and Support Programme (CSP)** by **Antara**, clients are first screened by a social worker during OPD to assess whether they require psychiatric treatment. If the client needs treatment, they are assigned a number and registered for treatment upon payment of ₹100. Clients belonging to BPL families are exempted from the payment of user fees. The Day Treatment Unit (DTU) provides outpatient services within a hospital setting and charges a monthly fee of ₹1,500. Although CSP clients are given a concession, they are expected to make their own arrangements to travel to the DTU (Balagopal & Kapanee 2019, p. 100).

Provide welfare assistance for highly vulnerable groups.

Family caregiving forms an integral part of care for persons with mental illness, but it is often challenging and stressful for those families. Programmes can support by encouraging and providing community assistance for both handicapped and homeless adults, and their caregivers. Supporting the financial and educational needs of those with mental illness promotes health-seeking behaviour from families and enables them to be better care-givers.

EXAMPLE

1. The **RMHP** by **The Banyan** recognised that educational needs were a priority in the community and supported the educational expenses of children whose parents could not afford to pay their school fees. The staff also took care of destitute persons by providing food, clothing and if required pharmacological support (Balagopal & Kapanee 2019, p. 121 - 159).

Provide vocational skilling to enable socio-economic rehabilitation.

For those with severe mental illness, employment has been linked to personal healing and increased health-seeking behaviour, which is why integrating vocational training as part of rehabilitation in programmes is very important. Vocational skilling and rehabilitation of people with mental illness allows them to live self-sustaining and dignified lives with livelihoods, after they exit the support system. Skills acquired through vocational training enables people recovering from mental illness to generate income and fosters a sense of self sufficiency among them. It may also provide them a way to contribute to their family income beyond self-sustenance which can help sustain family support and minimise drop-outs. The income generated through products made can also be used to sustain programmes activities.

"Rehabilitation programmes need to find areas where you can help sustain efforts because the investment is not too much and you can find minimum resources for people to actually carry it on themselves. Making jute bags and tailoring are such examples."

– **Dr R Padmavati,** Director, Schizophrenia Research Foundation

EXAMPLES

1. **Mission Ashra** by **The Peoples Forum** provides vocational training for "mentally ill destitute women" on tailoring, chalk-making, making soft toys, envelope-making, embroidery, making greeting cards and more (Peoples Forum n.d.). This enables such women to sustain themselves, secure employment and lead a "meaningful, dignified and productive life" (Peoples Forum n.d.).
2. **SCARF** actively worked with people with severe mental illness in the Kovalam region, teaching them how to manufacture and repair to mend fishing nets as a part of their vocational training. Given the presence of a fishing community, people recovering from mental illness were able to sustain their own livelihood by manufacturing fishing nets.
3. **Udayan Rehabilitation Home for Homeless Men with Mental Illness** by **Ashadeep Society** recognised that farming activities provided therapeutic relief in the rehabilitation process of the residents and ensured early recovery. The residents engaged in these activities are paid an incentive which they keep as savings for them to take back home. They cultivate seasonal crops such as okra, brinjal, chillies, cabbage, cauliflower, spinach, and other leafy vegetables on a regular basis. The area also has a vacant plot of land which provides enough space to undertake farming activities in a professional manner (Ashadeep Society 2020).

Use community funds for sustaining interventions.

The community can actively participate in ensuring the well-being of its members by setting aside funds to support and pay for various programmes. Leveraging community funds can have dual advantages of community ownership and financial sustainability. Apart from meeting the primary objective of securing funding, community-based funds can be an important way to generate funds for hyper-local solutions in certain regions. Additionally, it would also help inculcate active, health-seeking behaviour among the community, who can also provide inputs and feedback on the quality of care they receive.

EXAMPLE

1. In the **Community Mental Health Programme** by **MHAT**, trained community volunteers from palliative care helped raise funds via the palliative care clinics (Balagopal & Kapanee 2019, p. 161-184). They also collected funds from the community members, thus ensuring the sustainability of the programme in the long run (Balagopal & Kapanee 2019). Additionally, funding is received by donations to palliative care clinics directly, where the community mental health programme is implemented.

Enable credit systems for deferred payment options.

A credit system enables people to continue accessing mental health services and medications, whereby the payment for a particular month gets deferred to the next month. The system is beneficial especially for those who are unable to pay for services due to varied reasons such as unemployment, financial crisis, and other issues. Overall this would improve affordability and acceptance by the community of the services.

EXAMPLE

1. The **MITA** by **The ANT** has a credit system in place, whereby people who are unable to pay for the services are able to defer their payment to the next month.

Leverage funds from local self-government institutions.

Financial support from local self-government institutions, like village panchayats, to promote mental health awareness programmes, ensures their sustainability in the long run. It also enables community-ownership, and drives active mental health-seeking behaviour within the community.

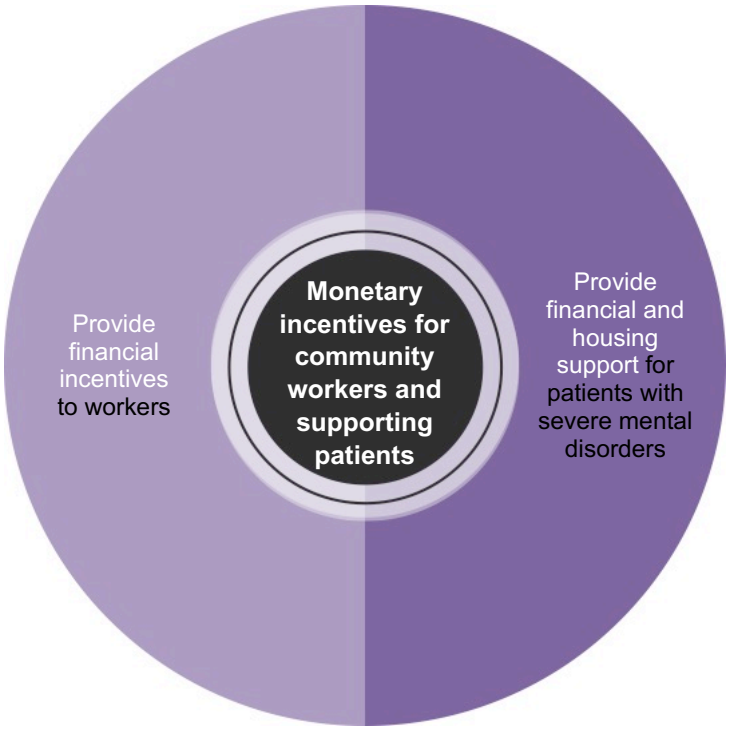
> *"There are funds and resources available in the system and often allocated funds in public health systems that go underutilised. The staff in one of the programmes were trained to advocate with officials and identify key influencers in the community like the Sarpanch of the Gram Panchayat to utilise existing funds towards mental health."*
>
> — **Dr. Tasneem Raja,** Head, Mental Health, Indira Foundation

EXAMPLE

1. In the **Care and Support Programme** by **Antara**, the local self-government institution pays fifty to one-hundred percent of the costs incurred by Anatara to conduct and drive community awareness programmes (Balagopal & Kapanee 2019, p.102). The local self-government institution has seen an increase in health-seeking behaviour among the villagers, whereby faith healers are no longer the first point of contact for treatment. Furthermore, villagers are able to access medicines free of cost or at concessional rates (Balagopal & Kapanee 2019, p. 102).

MONETARY INCENTIVES FOR COMMUNITY WORKERS AND SUPPORTING PATIENTS

Figure 7: Ways to ensure monetary incentives to community workers and supporting patients.



(Sattva 2022)

Community members who actively contribute to programmes and support provision of mental health services in the capacity of volunteers, assistants, mobilisers or community health workers, often find it challenging to sustain work in the absence of incentives.

On the other hand, patients from vulnerable and marginalised sections of society, who are economically challenged, struggle with adherence to treatment, especially for families with people who have severe mental disorders. A nominal allowance enables greater treatment adherence, an essential factor for positive outcomes and recovery. In the case of homeless individuals, housing and other support are also critical to enable long-term recovery.

Provide financial incentives to workers.

Provision of honorarium and financial incentives to health workers and mobilisers helps with staff attrition as well as motivates them to deliver mental health care, which they may see as an additional workload in the absence of compensation. Also, it helps maintain the competency of health cadres and ensures quality mental health service delivery.

EXAMPLES

1. In the **Programme for Improving Mental Health Care (PRIME)** by **Sangath**, the community health workers (CHW) were paid remuneration of ₹1,500 per month from the project funds to conduct various community interventions. The remuneration

provided an incentive to CHWs to provide and improve mental health literacy in the community (Shidhaye et al. 2019 a).

2. The **Post-Disaster Mental Health Programme** by **SCARF** provided funds to community-level workers (CLWs) from their funding gathered from various humanitarian organisations across the globe, motivating the CLWs to provide psychological care and support to people affected by the tsunami which affected Tamil Nadu in 2004 (Padmavati et al. 2020).

Provide financial and housing support for patients with severe mental disorders.

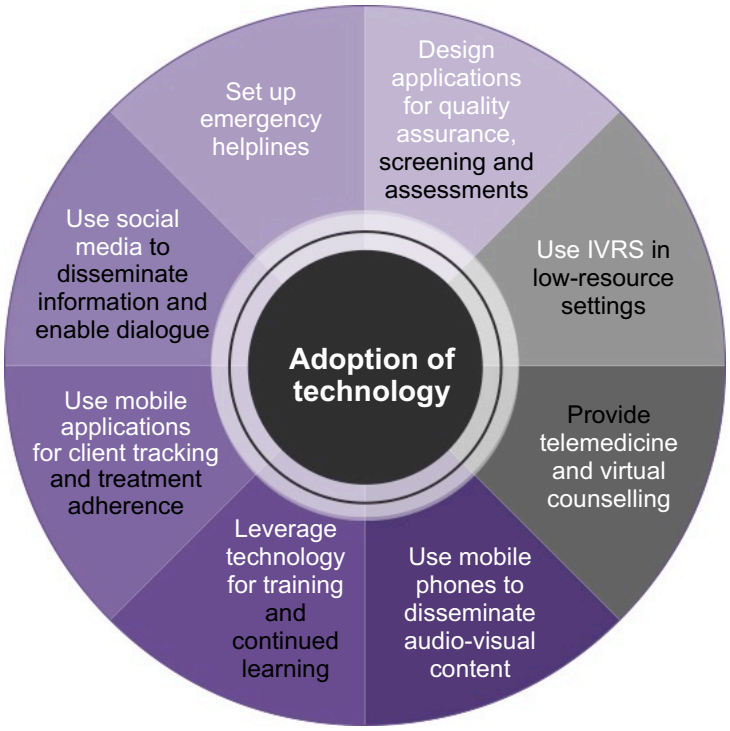
The provision of an allowance for people living BPL and in other vulnerable sections of the society, enables them to access and continue any treatment, and medications, for mental health. In addition, it ensures that caregivers of people with mental illness are not financially stretched while providing care and support. In light of the prevalence of individuals who drop out of treatment, due to an inability to afford it, an allowance becomes especially important.

EXAMPLES

1. In the **ECRCs programme** by **The Banyan**, there is the provision of cash transfers to facilitate "continued care support" to people who are transitioning from ECRC back to the community (The Banyan n.d. a).
2. In **RMHP** by **The Banyan**, there is the provision of a disability and a transport allowance of ₹200 and ₹80 respectively, given to the caregivers of clients who are facing "severe economic hardships" (Balagopal & Kapanee 2019, p. 148). The programme also provides livelihood options to clients and caregivers, access to a vocational training unit and support group for caregivers The allowances ensured that the clients were able to continue their treatment.
3. The **Home Again Programme** by **The Banyan** offers accommodation and supportive services to those with mental illnesses and psychosocial impairments, to help the vulnerable and homeless. (The Banyan n.d. b).

ADOPTION OF TECHNOLOGY

Figure 8: Ways to ensure adoption of technology



(Sattva 2022)

Digital technology in medicine and healthcare could help to make unsustainable healthcare systems more viable. It could democratise the interaction between people and healthcare professionals, and offer less expensive and more efficient ways to screen, prevent and treat diseases (Ventola 2014). The rapid expansion of wireless broadband internet coupled with low-cost hardware especially in certain states is also enabling the successful implementation of technology-driven programmes.

Use mobile phones to disseminate audio-visual content.

Technology and mass media has diversified the way information can be disseminated. Mental health programmes have showcased that making and sharing video content on mobile devices, showcasing information on getting care and support locally, not only involves the neighbourhood members but also fosters trust by using local language and customised content.

Across mental health programmes, the use of smartphones and mobile devices have improved access to information, making adoption simple and practical. Organisations can leverage mobile devices as a gateway through which they can share advice with community leaders on how to promote and identify common mental illnesses and disorders. Information on well-being, detection and referral systems could make up the bulk of the content.

EXAMPLES

1. The **Atmiyata Project** by the **CMHLP** developed films in multiple languages that focused on driving mental health awareness and different ways to provide care for people with mental illness (Mental Health Innovation 2015, CMHLP n.d. a):
   - A role model film which showcases how local community members are accessing care and support.
   - Community-oriented film on mental health acceptance and how the community can support people with mental illness, detection and referral.
   - Films which highlight the role of all the stakeholders in the community in treating mental illness.
2. The **Chetna Community Wellness Programme in Canacona** by **Sangath** created video content across different types of mental health topics to drive mental health awareness and to ensure that pandemic did not affect their outreach work. Partially recorded in Canacona and featuring Canacona residents, the video was distributed over WhatsApp and other platforms by major Canacona stakeholders and community workers (Sangath n.d. a).

Leverage technology for training and continued learning.

Technology can be leveraged to serve as a tool for delivering trainings and creating learning platforms for access to knowledge. Programmes are using hybrid models for the provision of training. In-person training is conducted to ensure it is comprehensive, especially for programmes engaging with community members and health workers that have no previous knowledge of mental health. Following this, digital tools are being used to periodically reinforce learning from sessions as well as providing ongoing support to guide the practical application of new knowledge and skills.

Organisations have also created technology-based applications for digital training using mobile phones. These applications host training content and enable monitoring and assessments in an easy manner. These mobile devices loaded with essential training information can be used by community mobilisers in identifying and screening for mental health issues.

The development of an interactive learning platform and the incorporation of the content into existing technological frameworks can create a one-stop destination for mental health information. Programmes have developed platforms that contain videos, posts on video quizzes, reading materials, end-of-module assessment quizzes and a grading system, among other features. Integration into a single platform means content can be compressed, which enables faster streaming and a simpler user experience overall. These measures were employed by EMPOWER 1 Programme in Gujarat by Sangath where all videos were compressed to save space and for faster streaming on smartphones. The quality of the content was monitored, assessed and modified by experts. In addition, it is important to conduct initial pilot testing of the modified programme to determine viability and acceptability of the intervention (Lakshmi Mittal and Family South Asia Institute n.d.).

EXAMPLES

1. **EMPOWER I Programme in Gujarat** by **Sangath** used a Sangath Learning Management System (LMS) and Technology enabled Community Health Operation (TeCHO) platform containing various interactive mental health content to aid in training. Subsequent to the course formation, it was thoroughly checked by the experts and the changes were updated. Sangath has piloted and tested its LMS and TeCHO platform with a group of twenty Accredited Social Health Activists (ASHA) and ten Community Health Officers (CHO) to ensure feasibility and acceptability at Society for Education, Welfare and Action–Rural (SEWA) Rural, Jhagadia in Gujarat (Lakshmi Mittal and Family South Asia Institute n.d.).
2. The **Atimayata Programme** by **CMHLP** uses mobiles as a training tool to take advantage of high-impact new technology. Mobiles are being supplied with all the essential data that community mobilisers will require for training and identifying mental health issues. Information via films on well-being, detection, referral, and follow up are all included in the content (CMHLP n.d. a).
3. The **Samiya Baani Programme** by **IIH in collaboration with SCARF** adopted a hybrid model to train programme staff. Community health workers were given three training sessions at SCARF's office in Chennai which covered the operation of the IVRS system, screening, diagnosis and treatment through counselling. Post the training, community health workers and ASHAs were able to access SCARF's support through virtual and telephonic modes to address challenges in translating knowledge to practice and on-the-job queries on providing counselling.

Use mobile applications for client tracking and treatment adherence.

Any form of treatment has the risk of poor patient adherence. Mobile and web-based applications aim to provide a solution to this by setting up reminders for timely consumption of medications and follow ups with the treating physician. Simple alarm applications on the phone have been used as a reminder about follow-up visits or medication intake.

Programmes have effectively used applications to monitor scheduled appointments or share updates on changes in a clinic's schedule with families via Short Message Service (SMS) and telephone helplines. Follow up and support are built in for better medicine adherence and telephone helplines are set up for managing side effects. Client tracking systems with data on progress, shifts, choices and needs of the clients provide critical data of evaluation and impact of the programme.

Mobile and web applications also act as an electronic journal or planner, where client work plans are assessed every month through a client tracking system and intervention goals are revised in accordance with shifts, choices and needs of the clients.

EXAMPLES

1. The **Telepsychiatry (STEP) Programme** by **SCARF** in Pudukkottai, allowed monitoring of scheduled appointments. It also updated any changes in clinic schedules to families via SMS, while alarm applications on the phone were used as a reminder about follow-up visits or medication intake (Thara & Tharoor 2020).
2. For the **MITA Programme, The ANT** has developed a mobile application that has treatment protocols for doctors. Thus ensuring that doctors only prescribe those medicines to the patients that are mentioned in the treatment protocol, ensuring affordability of the services and accountability towards clients.
3. In the **Community Mental Health Worker (CMHW) programme** by **the Mental Illness and Neurological Disorders (MINDS) Foundation**, the community mental health workers otherwise referred to as lay-workers from the community used mobiles equipped with SMS data collection software to screen the population. The information was "automatically integrated into a digital map", which aided MINDS social workers and their psychiatry team to conduct house visits of at-risk-persons, confirm the symptoms and provide care (Wadhwa 2021,p.8; Mental Health Innovation Network 2013 b)

Use social media to disseminate information and enable dialogue.

WhatsApp and other messaging apps are used often as tools for communication and information sharing. It can be a low-cost and highly efficient tool to disseminate information on mental health. Messages can primarily contain information on the promotion and prevention of mental health and adopting a healthy lifestyle.

Given the reach of social media platforms, it opens up a new horizon to create spaces for discussion and address queries with regard to mental health, especially amongst youngsters who are the primary users of these platforms.

EXAMPLE

1. The **Youth Mental Health Programme** by **SCARF** uses different social media platforms such as Instagram, Facebook, and Twitter to disseminate information about various mental health programmes. In addition, they collaborated with youth based organisations such National Youth Council to ensure that there was continuous support and conversations about mental health during the pandemic (Srinivasan et al. 2021).

Set up emergency helplines.

Helplines are used to provide a round-the-clock platform for people experiencing distress. Helplines have been used not only for suicide prevention, but also for substance abuse and counselling. Programmes have engaged lay community members without a medical background and trained them to play the role of crisis professionals who are available on call

twenty-four hours a day, seven days a week (Samhsa n.d.). Helplines can be set up toll-free to ensure anonymity for all callers. The helpline system can be further linked with facilities that offer crisis intervention and mental health resource referrals.

EXAMPLES

1. **Sneha Suicide Prevention Centre's Helpline** by **Sneha Foundation Trust** in Chennai provides twenty-four hour on-call emotional support to any individual feeling distressed, depressed or suicidal (Sneha n.d.). Sneha is run entirely by volunteers, who are self-motivated and spend four to five hours a day answering calls in Tamil and English on the SNEHA hotline (Sneha n.d.).
2. The **MITA Programme** by **The ANT** offers telephone helplines to promote treatment compliance, and aid in the early treatment of side effects before entering a tertiary care facility (The ANT n.d).

Design applications for quality assurance, screening and assessments.

Programmes are often limited by traditional ways of evaluating the quality of programme activities, and the performance of the staff. A few mental health programmes have created and used digital platforms and applications to teach community health workers and nurses brief psychological therapies, evaluate their competency and ensure quality when they deliver them at scale. Technology also plays an important role in reinforcing evidence-based therapy and the continuum of care post treatment and during the rehabilitation of clients.

Screening students in a school-based setting can be challenging to conceptualise and implement and more so for mental health. Instead integrating the programme into mobile application technology could enable a simple and quick screening process. In the process, students would undergo a general mental health assessment at the beginning of the school or college year. This would make it easier for anyone to spot students who need early assistance while preserving student confidentiality.

EXAMPLES

1. **EMPOWER programme 1** by **Sangath** has developed a Moodle-based application to assess front-line workers and their progress to generate performance reports ((Lakshmi Mittal and Family South Asia Institute n.d.). The digital training intervention for the programme was supported by the Moodle platform and consisted of metrics to evaluate user inputs and learner performance through the smartphone application (Lakshmi Mittal and Family South Asia Institute n.d.).
2. The **Atmiyata Programme** by the **CMHLP** used an application to host mental health content on training and supporting community mobilisers in identifying mental health issues (Mental Health Innovation Network 2015). The application provided the means

for responding to a questionnaire to gauge the knowledge of the mobilisers after each video. Monthly reports containing the answers to the questions, the number of times the films were viewed, and the specific films that were viewed were created. Using the information gathered from these questionnaires, learning could be assessed among workers (Shields-Zeeman 2017).

3. The **Youth Mental Health Programme** by **SCARF** developed a mobile-based application allowing trained teachers and counsellors to easily detect and screen for mental illness among students while maintaining their anonymity (SCARF n.d). The application was used to send follow-up reminder messages via text messaging to enable treatment adherence.

Use IVRS in low-resource settings.

Introducing and integrating IVRS can be an efficient telehealth tool that has the capacity to extend hospital-based care beyond facilities. Programmes added the clients' mobile numbers to IVRS, which broadcasted tailored content in local languages on a regular basis, to foster resilience and well-being. The service was available to users around-the-clock while maintaining their privacy. Programmes can employ recorded telephone messages to track medication compliance or behaviour adjustment in addition to providing access to a counsellor, and they are especially useful in areas with no nearby health facilities.

> *"What we observed (after the community was aware of and using the IVRS) was that they may not make a call as such, but we found that the idea that there is someone out there is itself very helpful to them. They said knowing that somebody is there whom they could call at any point in time gave them the confidence to go on with their life."*
>
> **– Dr. Vijaya Raghavan**, Consultant Psychiatrist, Schizophrenia Research Foundation

EXAMPLE

1. The **Samiya Baani Programme** by **IIH in collaboration with SCARF** used IVRS which could be accessed anonymously twenty-four hours a day, seven days a week. It also sent out content at regular intervals in the local dialect to promote and create awareness about maternal mental health. Users could also speak to a counsellor if they wished to (Innovators in Health n.d.).

Provide telemedicine and virtual counselling.

Consultations in telepsychiatry have the potential to bridge the high demand and supply gap in the current scenarios. For people who can not obtain psychiatric care due to difficulties in access, these consultations could bridge the gap. Typically, after a consultation over a video call, patients are given a prescription to avail free medication from partnered pharmacies.

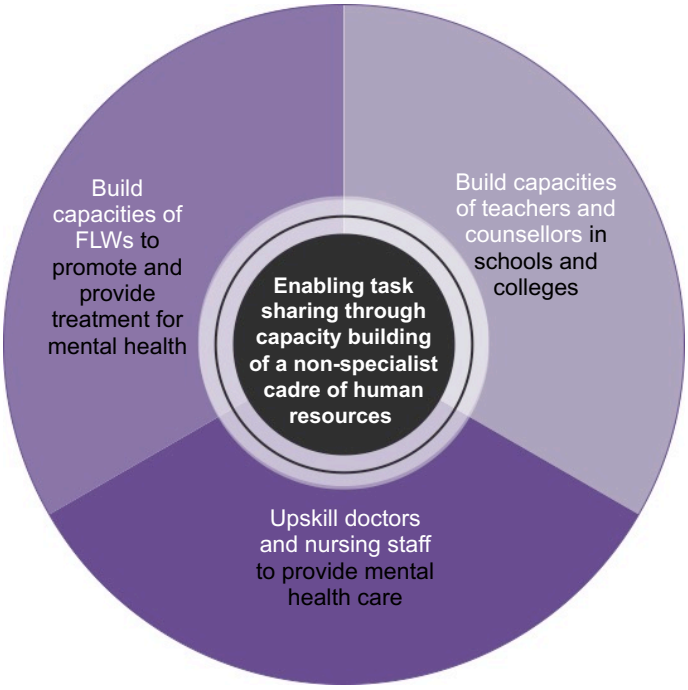
The potential for this kind of virtual support and intervention can be bolstered through external funding support.

EXAMPLES

1. The **Telepsychiatry (STEP) Programme** by **SCARF** was able to embrace technology for awareness activities, training, and services. They were also able to provide virtual counselling and online prescriptions for their patients through applications such as Whatsapp.
2. The **MITA Programme** by **The ANT** incorporated technology, notably during the pandemic. Through online therapy and digitised prescriptions, their patients were able to continue accessing treatment during the pandemic.

ENABLING TASK SHARING THROUGH A NON-SPECIALIST CADRE

Figure 9 : Enabling task sharing through capacity building of a non-specialist cadre of human resources



(Sattva 2022)

Task sharing involves the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health (WHO 2008).

A stepped care model is considered a possible solution to reduce the existing healthcare burden, given the discrepancy between demand and supply of available healthcare services. In this model, evidence-based psychological treatments are distributed across different steps, based on varying levels of severity of the mental health issue and the nature of intervention required (Ho 2016). There is strong evidence supporting the effectiveness of collaborative stepped care models for the treatment of mental disorders (Ho 2016).

The act of allocating responsibilities to less specialised health workers, when appropriate, can help health systems utilise their cadre more effectively. It also ultimately reduces service delivery bottlenecks while increasing workforce capacity.

> *"Healthcare systems in most nations resemble a pyramid, with the least skilled people at the base being more abundant and the pyramid gets smaller as we climb up to the highest level of expertise. We have an inverted pyramid in India's mental health system with many more skilled workers at the top than we have workers at the bottom. In our country, we should invest in the base of the pryramid to correct the skewed focus on specialists. Non-specialists can be trained faster and are more cost effective."*
>
> – **Dr. Soumitra Pathare**, Consultant Psychiatrist and Director, Centre for Mental Health Law & Policy

Task sharing across community-based mental health programmes have been enabled through capacity building of two groups of non specialist cadres:

- **Training of non-specialist health workers to provide basic services, including treatment for mild to moderate mental health issues.** These health workers could be ASHA, Auxiliary Nurse Midwife (ANM), Angandwadi Workers (AWW), other community health workers, PHC or CHC doctors, general healthcare practitioners, AYUSH practitioners, and Village Health, Sanitation and Nutrition Committee (VHSNC) members.

- **Training of teachers and counsellors to engage in the continuum of care** of mental health, for children and adolescents. Teachers and counsellors engage with children and adolescents on a continuous basis throughout their learning and growth and have the potential to play an active role in the mental health of students through adequate capacity building.

Programmes studied in this perspective designed their own curriculums and also adapted existing tools and content, contextualised to local needs. The WHO Mental Health Gap Action Programme (mhGAP) is a globally recognised tool focused on scaling up services for mental, neurological and substance use disorders, especially in low and middle-income countries, and has been used by programmes in India.

Build capacities of FLWs to promote and provide treatment for mental health.

Training frontline workers (FLWs) is a widely used task-sharing approach for care provision of mental health across the continuum of care. FLWs can engage in prevention and promotion by destigmatising mental health and encouraging health-seeking behaviours. They can also be trained to undertake screening with the use of technology-based solutions and facilitate a channel for referral when required. Equipped with the basics of cognitive behavioural therapy, they are able to provide basic counselling and address mild mental health issues effectively. It is critical to ensure that FLWs are trained to apply knowledge on mental health in a manner that is contextualised to the needs of the community in their geography.

In the event of disasters where external support from organisations is present to provide care on-ground, training FLWs guarantees that trained personnel will stay in the area to care for and support the population, even after the probable departure of the external support (Padmavati et al. 2020).

> *"By way of example, gender-based violence, intimate partner violence and other issues might have a higher prevalence in a particular geography. So of course, you need to reinforce those elements in programmes and ensure that providers are tuned into recognising those sources of stressors, responding to them and understanding that mental health is not just about doing a workup, but also looking at some of these other broader determinants of mental health. So that kind of flexibility needs to be there, but the broader sort of framework of training for healthcare providers can be the standardised for a particular kind of approach."*
>
> **– Dr Anant Bhan**, Mentor and Principal Investigator, Sangath (Bhopal Hub)

EXAMPLES

1. The **Spastic Society of Karnataka** has a rural outreach programme where they train FLWs using local songs, that help to identify intellectual disability and or developmental disorders among children in the community.
2. The **EMPOWER programme** by **Sangath** trained FLWs such as community health workers and nurses in 'evidence based psychological care provision', so as to provide treatment for depression (Sangath n.d. d).
3. The **Udaan DMHP** by **Tata Trusts** are training ASHAs to conduct household screening that helps with identifying people with mental illness. This enables the creation of 'referral linkages' for further diagnosis and treatment (Tata Trusts 2019, pp.27-28).

Upskill doctors and nursing staff to provide mental health care.

In primary healthcare there needs to be adequate provision of mental health support from all staff, for any individual who may visit the facility, to ensure both the timely detection of symptoms and the provision of adequate treatment. Training staff in PHCs and CHCs in the diagnosis and treatment of mental health issues will also help reduce the burden on tertiary hospitals.

EXAMPLES

1. The Department of Health Services scaled the **PRIME programme** by **Sangath** across fifty-one district hospitals in Madhya Pradesh. As a part of this initiative, "Mann-Kaksha" was established in district hospitals, and a minimum of two nurses and one medical officer from each district were trained to provide mental health services (Shidhaye et al. 2019 b, p.10).

2. The **MITA Programme** by **The ANT** held a series of workshops with healthcare providers including physicians, other medical professionals and ASHA workers as part of their work across Assam, with a view to strengthening care provided in the government health system.

Build capacities of teachers and counsellors in schools and colleges.

One of the initial points of interaction for students and kids are their teachers. It has been demonstrated that teachers, academic staff, and college counsellors can be educated and trained to address issues with students' mental health. The training would primarily involve mental health promotion and instilling positive mental health among students, screening and early identification of common mental health symptoms, and referral and management.

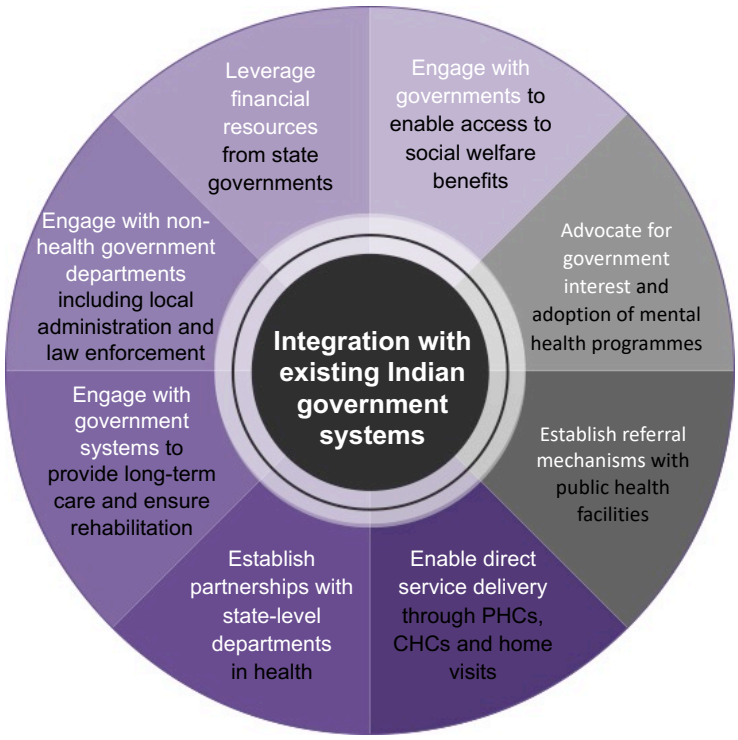
The aim would be to equip teachers with the abilities they need to support students and assist them in managing stress and difficult behaviours. With the ability to spot early indications of common mental health disorders, teachers would also be better equipped to provide early intervention and prevent worse outcomes later in life.

EXAMPLES

1. The **TeaLeaf Programme** by **Darjeeling Ladenla Road Prerna (DLR Prerna)** in collaboration with Broadleaf trains teachers on evidence-based behavioural and therapeutic techniques that cater to child mental health. The teachers are able to identify children with mental health concerns and are able to deliver evidence-based interventions with the support of qualified mental health professionals (Vanderburg et al. 2022).
2. The **School-Based Mental Health Justice Programme** by **Anubhati** have developed a 'rights-based and intersectional feminist training module of mental health' to enable school teachers and management to 'set up counselling, curriculum and other associated processes' in their school that make it a mental health friendly system (Mental Health Innovation Network 2013 a).

INTEGRATION WITH EXISTING INDIAN GOVERNMENT SYSTEMS

Figure 10: Ways to integrate with existing Indian government systems



(Sattva 2022)

Programmes working to enable long-term, sustainable impact have strived to integrate efforts with government bodies and public systems at the state, district, block and village levels. Across the forty-one programmes analysed, this integration was done at two levels:

- Programmes established partnerships with state health departments and the state National Health Mission (NHM) to secure buy-in and support
- Programmes integrated care provision and community engagement within local health systems, the DMHP and other local bodies.

Enable direct service delivery through PHCs, CHCs and home visits.

Programmes can leverage existing public health systems for direct service provision. Establishing service delivery at two tiers, at both the household and the facility level, ensures that a basket of home-based psychosocial services is provided by non-formal caregivers, complemented with formal care services provided via social services, medical and psychosocial clinical services, AYUSH and other doctors in health facilities.

In this way, care can be provided by local facilities without relying solely on specialist mental health professionals, such as psychiatrists and psychologists, by also engaging with existing non-specialist cadres like FLWs. Across programmes, they were trained to provide home based counselling as well as mental health interventions in facilities within the block. To sustain these efforts, partnership and capacity building of local Civil Society

Organisations (CSOs) and public health delivery systems was undertaken. In such cases, persons with mental illness were able to access the same health workforce and facilities as those for physical illness, allowing for a holistic care system. Psychiatric OPDs can be held at regular intervals, weekly or fortnightly or monthly, at these facilities to provide ongoing clinical interventions via a stepped care model.

EXAMPLES

1. Under the **Udaan DMHP** by **TATA Trusts**, the pharmacological intervention of clinical services was facilitated within the public health system. Currently, there are twenty-six service points where medical officers run thirteen blocks, and the rest are run by other specialists in mental health in the district. After consistent training, thirteen medical officers are running the programme and have sustained provision of mental health services in the region.
2. The **Community Mental Health Care Programme** by **SCARF** actively liaised with the government health departments and medical service departments to ensure a continuous supply of basic psychotropic medicines at the PHC. As a result, the programme referred most of its patients to the PHCs in that area to receive medication and help establish an effective referral mechanism (Thara & Padmavathi 1999).

Establish partnerships with state-level departments in health.

Multiple mental health programmes have been implemented in partnership with state governments with a view to secure programme support. This would include securing support for service delivery through public health facilities, for long-term facility-based care, training public health workers for care provision, certification of mentally disabled persons and state-level adoption, replication and scale-up of models. Programmes have been successfully implemented in partnership with state departments and NHM in multiple states, including notable partnerships in Tamil Nadu, Maharashtra, Madhya Pradesh and Gujarat.

A functional DMHP run by states is a critical element in ensuring effective provision of mental health services across the continuum of care that is accessible, affordable and contextualised to local needs. Organisations are also collaborating with governments to strengthen DMHP systems.

EXAMPLES

1. The **Seher Community Mental Health and Inclusion Programme** by **Bapu Trust** in partnership with Mariwala Health Initiative and with active collaboration with the municipality, such as the Departments of Health, Urban Community Development and Disability, upscaled and replicated the Seher model across the five designated slum regions of Pune city (Mariwala Health Initiative n.d. b).

2. The **Nalam programme** by **The Banyan** collaborated with the Government of Tamil Nadu in two districts to strengthen the state-run District Mental Health Programme using the community engagement components of their Nalam programme (Narasimhan et al. 2019; The Banyan n.d. c).
3. The **Janamanas programme** by **Anjali** is working with the West Bengal state government on 'mainstream mental health care in the District Development Plan' (Janmanas 2011). The programme is creating a continuous dialogue with the political leadership to materialise the vision of integrating mental health in the District Development Plan, followed by all the municipalities of the state. The Rajarhat Gopalpur municipality has already incorporated mental healthcare needs in their development plan (One World Foundation India 2011, p.8)

Engage with non-health government departments including local administration and law enforcement.

Establishing linkages with local stakeholders like administration, police stations, NGOs and municipalities in the area is critical to strengthening the referral service and effectively reaching out to the last mile community. In addition to health workers, the Mental Healthcare Act, 2017 ensures that the appropriate government across states to take all measures and ensures that government officials, including police officers and other officers of the government, are given periodic sensitisation and awareness training (Press Information Bureau 2019). Programmes should recognise the role of officials and others in the prevention, promotion and support of mental health services to establish more effective referrals. Programmes have also adopted a consultative approach with the government and held workshops with municipal councillors, community organisers and other authorities to disseminate information about the programme and raise awareness about mental health.

EXAMPLES

1. In the final stages of the **Naya Daur intervention** by **Iswar Sankalpa**, the programme built a network of care around clients that promoted coordination between health services, local officials, law enforcement, NGOs, caregivers and community members (WHO 2021).
2. **SNEHA** has built strong networks with the police across five jurisdictions in Mumbai and conducts sensitisation training for police on mental health, as a part of their overall training on gender-based violence and victim support (Daruwalla et.al 2019).

Leverage financial resources from state governments.

Programmes can engage with state governments to leverage financial resources of the state for mental health. Often, state government funds for mental health are underutilised and there are resources available for interventions to use. This may be in the form of long-term or one-time funding and can serve as a means to secure government buy-in, with an opportunity for a formal integration into the system.

EXAMPLE

1. The **Home Again programme** by **The Banyan** in Tamil Nadu received ₹1.38 Cr from the government for continued implementation and provision of mental health support to the most vulnerable populations (WHO 2021 p.25). The funding ensures that people with psychosocial disabilities and mental illness continue to receive mental health care and support, and there are low rates of drop-out.

Engage with governments to enable access to social welfare benefits.

Active engagement with local government is often essential to helping vulnerable groups access social welfare benefits. The government systems can be challenging to navigate, especially if communities do not have the awareness or agency to access these benefits and in case of people with mental illness and disabled people and their families. Organisations have engaged with governments to secure this support for individuals with mental illness and has shown to be a critical way to gain the community's trust and acceptance of mental health care.

EXAMPLE

1. The **Nalam Programme** by **The Banyan** ensured that mobilisers are trained to facilitate solutions in the face of economic distress for vulnerable families, by engaging with local governments to access benefits (The Banyan n.d. c).

Advocate for government interest and adoption of mental health programmes.

An essential component of programme sustainability lies in government adoption of programmes and integrating them within existing public health systems. Advocating interventions with governments proactively, help to generate interest and leverage evidence to showcase impact and potential. In states where mental health is being prioritised, programmes have implemented initiatives in partnership with the government and also enabled state government adoption of successful models.

To enable adoption, it is important for programmes to undertake research and provide evidence of impact. The absence of evidence on the model and its implementation becomes a barrier for the government to adopt these models.

EXAMPLE

1. The **PRIME model** by **Sangath** was adopted by the Government of Madhya Pradesh for a 'state-wide scale-up of mental health services' (Shidhaye et al. 2019).

Establish referral mechanisms with public health facilities.

In the primary health context, ensuring well-defined and established referral systems is essential for referring critical patients to an advanced health facility. Programmes in the Indian context have been able to establish referral mechanisms with block and district

hospitals, and in some cases, with state-level centres of excellence. However, a critical feature of the effectiveness of these referrals is the availability and quality of care in higher facilities.

EXAMPLES

1. Under the **Seher Community Mental Health and Inclusion Programme** by **Bapu Trust**, the programme partnered with Kamla Nehru Hospital and their PHC, Sonawane Hospital to provide comprehensive medical care through well-established referrals (Bapu Trust n.d. a).
2. The **Janamanas programme** by **Anjali** is developing linkages with local stakeholders like SHGs, health workers, local administration, local police stations, NGOs, clubs, schools, colleges, and orphanages for strengthening referral services and reaching the last mile with established pathways to access care (Anjali n.d.)

Engage with government systems to provide long-term care and ensure rehabilitation.

People needing institutional long-term care could find better quality and greater sustainability through programmes that partner with government facilities. For people with severe mental disorders, living in NGO-based facilities for long periods of time with no exit options, relocating them to state psychiatric facilities could provide them with continued, cost-efficient and quality care. Organisations have also established rehabilitation homes for vulnerable people with mental illness, such as the homeless, in collaboration with the government's Social Welfare Departments. For example, the Government of Kerala and The Banyan partnered to offer the Home Again Programme to people living for over a year or more with no exit options, across three state psychiatric facilities in Kozhikode, Thrissur and Thiruvananthapuram.

While long-term care is critical, an essential part of the continuum of care is to ensure that clients do not stay in mental hospitals and acute care facilities longer than they need to and that care is provided and sustained in the community. This requires partnering with the government to ensure that an active effort is made to identify patients, monitor progress, and facilitate reintegration.

EXAMPLES

1. The **Emergency Care and Recovery Centres (ECRCs) Programme** by **The Banyan** in Guruvayur was established in collaboration with the Government of Kerala. In order to facilitate the reunification of long-stay clients with their families, the reintegration and aftercare elements of the ECRC approach have been reproduced in cooperation with the Government of Kerala across state-run psychiatric facilities. The National Health Mission, Government of Tamil Nadu, has also replicated ECRC by integrating the services across five district hospitals (Narasimhan et al. 2019).

2. The **Telepsychiatry (STEP) programme** by **SCARF** upon closure, facilitated a transfer of its clinic patients into Pudukkottai's DMHP via a systematic process. Volunteers at SCARF assisted clients in approaching, and enrolling patients in DMHP for the first time, and making sure that they received their medications before returning for follow-up visits each month. In some cases where certain medications were not available in the government system, patients continue to avail medication from SCARF (Tharoor & Thara 2020).

Conclusion

In the Indian context, interventions in mental health have been successful in creating an impact by adopting varied best practices. This has enabled outcomes such as acceptability, financial and programme sustainability and replicating at scale across multiple levels. These community-based mental health programmes have recognised and adapted to local contexts, including their needs, beliefs, systems, and socio-cultural practices, and moved away from a one-size-fits-all approach to ensure effectiveness.

At the design stage itself, interventions should be strategically planned to enable the outcomes for beneficiaries. Sustainability is of course critical for community-led interventions, but this needs to include elements of monitoring, evaluation, and research to ensure programme evidence and systems' integration play a key role and should be included in models at a conceptual stage. There is a growing policy prioritisation of mental health, with a focus on strengthening systems and translating policy to action, especially in certain states. Programmes have been able to align local interests and leverage evidence to advocate for adoption by public health systems and sustain efforts through systemic integration.

The financial sustainability of programmes needs to be balanced with the affordability of services and as demonstrated, charging nominal fees and leveraging government funds have already been effective across certain programmes. While outcome-based funding through impact financing shows promise, evidence on its applicability in various settings is in its early stages.

There is tremendous potential for model and process innovations in community-based mental health interventions in India, and harnessing existing knowledge will be crucial. What is evident now is that we are at a critical inflexion to leverage cross-learning from the rich experiences of organisations that have worked in varied contexts, and use this to leapfrog holistic interventions across the continuum of care for mental health in India.

Annexure 1

Programmes and organisations

Sl. No.	Organisation	Programme
1.	**Antara**	• Care and Support Programme (CSP) • Mobile Mental Health Clinic or Satellite Clinics
2.	**Anubhuti**	• "School-Based Mental Health Justice Programme"
3.	**Ashadeep Society**	• Community Mental Health Programme (CMHP) • Navachetana' Rehabilitation homes for homeless women with mental illness • Udayan Rehabilitation Home for Homeless Men with Mental Illness
4.	**Association for Health Welfare in the Nilgiris (ASHWINI)**	• Community Mental Health Programme : Integration of Mental Healthcare with General Healthcare Services for Tribals
5.	**Bapu Trust**	• Seher Community Mental Health and Inclusion Programme
6.	**Centre for Mental Health Law and Policy (CMHLP)**	• The Atmiyata Project: Providing Evidence-based Mental Health Support • Suicide Prevention & Implementation Research Initiative (SPIRIT)
7.	**Darjeeling Ladenla Road Prerna (DLR Prerna) in collaboration with Broadleaf**	• Teacher Leading Frontline (TeaLeaF) Programme
8.	**Innovators in Health (IIH) in collaboration with SCARF**	• Samya Baani Mobile Helpline
9.	**Iswar Sankalpa**	• Daur (New Age) is the flagship project of the Kolkata-based NGO
10.	**Mental Health Action Trust (MHAT)**	• Community Mental Health Programme (CMHP): Altruism and Activating Neighbourhood Care for Persons with Mental Illness in the Community
11.	**Parivartan Trust**	• Integrated Community Care for the Needs of Vulnerable People with Severe Mental Disorders (INCENSE) • Jan Man Swasthya (People's Mental Health) Programme
12.	**People's Forum**	• Mission Ashra-Rescue operation (for care unit)

Sl. No.	Organisation	Programme
13.	**Sangath**	• Chetana Community Wellness • Programme for Improving Mental Health Care (PRIME) • EMPOWER: Building India's Mental Health Workforce • EMPOWER I – Gujarat • SARATHA: (Schizophrenia Assessment, Referral, and Awareness Training for Health Auxiliaries) • Addressing ASHA well beiNg And burnout for improviNg Depression care (AANAND) • Promoting Effective Mental Healthcare Through Peer Supervision (PEERS) • Implementation Of Evidence-Based Facility And Community Interventions To Reduce The Treatment Gap For Depression (PREMIUM) • Strengthening the evidence base on effective school-based interventions for promoting adolescent health programme (SEHER)
14.	**Schizophrenia Research Foundation (SCARF)**	• Telepsychiatry (STEP) Programme in Pudukkottai • Community Mental Health Care Programme • Community Based Rehabilitation (CBR) programme • Youth Mental Health Programme • Post disaster mental health programme • SCARF-COPSI (Care for people with Schizophrenia in India – RCT)
15.	**Sneha Foundation Trust**	• Suicide Helpline
16.	**Tata Trusts**	• Udaan - District Mental Health Programme (DMHP)
17.	**The Action North East Trust (ANT)**	• Mental Illness Treatment Alliance (MITA) - Mental Health Programme
18.	**The Banyan**	• Nalam Programme • Rural Mental Health Programme (RMHP) • Home Again Programme • Emergency Care and Recovery Centres (ECRCs)
19.	**The Mental Illness and Neurological Disorders (MINDS) Foundation**	• Community Mental Health Worker (CMHW) Programme

Annexure 2
Defining outcomes at all levels

Accessibility
Accessibility is a precondition for an inclusive society for all, and may be defined as the provision of flexibility to accommodate each user's needs and preferences (United Nations n.d). A population may have access to services if services are readily available and there is a sufficient supply of them (Gulliford et al. 2002). The degree to which a population "gains access" is also influenced by institutional, organisational, and social or cultural constraints that restrict the use of services (Gulliford et al. 2002). Access is therefore contingent on affordability, physical accessibility, and acceptance of services, not only enough supply, when measured in terms of utilisation (Gulliford et al. 2002). Services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes' (Gulliford et al. 2002).

Affordability
According to WHO (n.d. c) "equitable access to essential medicines and other medical technologies depends on affordable pricing and effective financing." In order to achieve Universal Health Coverage, it is essential to promote fair prices and cost-effective interventions (WHO n.d. c).

Quality
The definition of healthcare quality is the "assessment and provision of effective and safe care, reflected in a culture of excellence, resulting in the attainment of optimal or desired health" (Allen-Duck et al. 2017). According to WHO (n.d. b), there are various ways to describe great health care, however it is becoming increasingly recognised that quality services should include the following: "effective – providing evidence-based healthcare services; safe – preventing harm to those who will benefit from the care; and people-centred – delivering care that takes into account a patient's preferences, needs, and values" (WHO n.d. b).

Scalability and replicability
Scaling up is defined by WHO (2016) as "deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis" (ExpandNet WHO, 2009). The scalability of an intervention is decided by its effectiveness as well as its anticipated reach and adoption, the costs of operating at a greater scale, and the acceptability and fit of the intervention within the local policy environment (Indig et al. 2017). Replicability is the "process of achieving consistent findings from research that try to address the same scientific question but each have their own set of data" (National Academies Press 2019; McManus et al. 2019).

Scale is the end objective of all programmes, and to achieve scale, various programme components are required. As a result, scale is the final level of success for programmes, demonstrating adoption of the essential ideas below, which are pertinent to mental health models and contribute to intermediate outcomes (Luke et al. 2014).

- Government support
- Funding Stability
- Partnerships with community and local stakeholders
- Communication and awareness generation

Financial sustainability

It refers to the program's ability to continue offering services at a level that will enable for ongoing health problem prevention and treatment when major financial, managerial, and technical support from an outside donor has ended (Walugembe et al. 2020).

Programme sustainability

Programme sustainability is the preservation of health benefits, the continuance of a programme inside an organisation, and the establishment of capacity in the recipient community to keep running the programme on its own (Bodkin & Hakimi 2020). It refers to the continued use of programme components and activities in order to continue achieving desired programme and population outcomes (Scheirer & Dearing 2011).

Acceptability

The degree to which those providing or receiving healthcare interventions believe they are acceptable based on expected or actual cognitive and emotional reactions to the intervention is referred to as acceptability (Sekhon, Cartwright & Francis 2017).

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