The VISHRAM (VIdarbha Stress and Health ProgRAM) Toolkit

Scaling Up Mental Health Care In Rural India

INDEX

PART I
INTRODUCTION

Why Is Mental Health Important ?

Sailesh, a farmer in a small village in central India commits suicide leaving behind a huge debt, responsibility of marriage of his two elder daughters and education of his two younger sons on his widow. Further inquiry reveals that Sailesh had suffered huge losses in agriculture over last three years due to drought and had to borrow large sums from a private money-lender for the marriage of his elder daughter. At least 6 months prior to committing suicide, his family members and neighbours noticed a remarkable change in his behaviour. A hard-working farmer, a caring father, a good-humored friend and very socially active man had become very isolated, looked sad most of the times, irritable on slightest provocation, lost hope of a good crop and few times expressed a strong wish to 'sleep forever'. His couple of attempts to consume pesticide in his farm went unnoticed finally leading to a tragic death.

Sailesh most probably suffered from depression, a common mental health problem, which went completely unnoticed and, without appropriate support and care, ultimately led to his suicide. There is no doubt that suicides are related to very stressful social and economic factors, but it is also true that most persons who commit suicide are experiencing mental health problems of which depression is the most common. It is possible that the timely detection of depression and provision of appropriate care might have potentially saved Sailesh's life. It is in this context that we seriously need to ask the question, 'Why this has not happened?' in India. It is quite likely that the public health system and community do not consider depression (and other mental health problems) as serious public health issues, or they may think that we do not have any interventions to address these problems.

Mental health problems are very common in India. The recent National Mental Health Survey

commissioned by the Government of India reported that about 10.6% of India's adult population suffers from a mental disorder (including alcohol and drug use disorders) [1]. This roughly translates to 80 million adult Indians living with a mental disorder! Although India launched its National Mental Health Program in 1982 with the objective of promoting community participation and accessible mental health services [2], community mental health programs are very poorly developed and mental health care is not available in primary health care for the vast majority of the population [3]. Thus, even though we have very strong evidence on the benefits of medicines and psychosocial interventions for mental disorders [4] and how these could be delivered effectively by front-line health workers [5] in community and primary care settings, about 90% of people with depression and other common mental health problems do not receive these treatments [1].

Suicide is now the leading cause of death in young Indians [6]. The causes of suicide are

complex and involve both social factors such as domestic violence and indebtedness, as well as health related factors. Up to 75% of suicides are due to mental disorders [7]. This means that between half to three-quarters of suicides could be avoided if mental disorders were adequately treated. By far, the most common mental disorders which contribute to suicide are depression and alcohol use disorders [8-10]. In addition to mental disorders being a determinant for suicide, they are also a consequence of suicide affecting the family members, including children, who often experience severe emotional difficulties as a result of a suicide.

No Health Without Mental Health

VISHRAM: An Overview

Objectives

The objective of VISHRAM (VIdarbha Stress and Health progRAM) was to design, implement and evaluate a community mental health care program to reduce the psychosocial distress and suicide risk, through targeted interventions for prevention and management of Depression and Alcohol Use Disorders (AUD).

The setting and partners

VISHRAM was implemented in selected communities of Vidarbha region of Maharashtra. Maharashtra is the third largest state in India. It is a relatively industrialized state with a significant urban population (42.5 % of total population) [11]. The state is amongst the leading states in the country in terms of absolute number of suicides [12]. Vidarbha region in the eastern half of Maharashtra state has been in news in last two decades due to the large number of suicides in agricultural communities [13, 14]. Cash crop production, indebtedness, marginal land holdings, crop failure, alcohol use, mental disorders and familial conflict are some of the most important factors leading to suicide [15, 16]. Beyond the problem of suicides in farmers, suicide mostly kills individuals in their youth, with 40 per cent of suicide deaths in men and 56 per cent of suicide deaths in women occurring before the age of 30 years [6]. Despite a number of programs initiated by the government to address suicide through schemes to reduce agrarian distress, there has been little impact on reducing suicide rates in this region.

Sangath, Prakriti, Watershed Organization Trust (WOTR) and the Public Health Foundation of India (PHFI) came together to implement VISHRAM with the funding support from Tata Trusts (Box 1). Sangath was the lead organization in this program, and provided technical inputs for program design, monitoring and evaluating the program and undertook capacity building activities. Prakriti and WOTR were identified as the implementing partners due to their ongoing work in livelihood programs and watershed development respectively to carry out the early phase piloting of the program (November 2011 to December 2013). The subsequent roll out to a population in 30 villages was carried out by Prakriti (April 2014 to September 2015). PHFI conducted the impact assessment of VISHRAM.

Box 1: The VISHRAM Collaborators and Advisors

A collaborative network of institutions and advisors guided the design, implementation and evaluation of the program. This network comprised of : –

- **Technical resource organization – Sangath**
- **Implementation partners – Prakriti and WOTR (only in Development Phase)**
- **Funder: Tata Trusts**
- **Mental health professionals: Sangath, Regional Medical Colleges (Jawaharlal Nehru Medical College, Wardha; NKP Institute of Medical Sciences, Nagpur) and Dr. Abhishek Mamarde and Dr. Shrikant Deshmukh; Institute for Psychological Health, Thane and District Mental Health Program, Amravati (Dr. Amol Gulhane), Government of Maharashtra**

Phases

VISHRAM was implemented in two phases each lasting for a duration of two years. In the first "Development" phase (November 2011- December 2013), our goal was to design an acceptable and feasible intervention to address psychosocial distress and provide care for mental disorders in the community. This phase was implemented in 15 villages of Chandur Bazaar taluka in Amravati district and 8 villages of Arvi taluka in Wardha district. The evaluation of this phase revealed many important insights which were taken into account in the designing of the program, in particular a strategic shift of focus from "mental disorders" and their treatment to *wellbeing* and addressing *distress* to maximise help-seeking by people with mental disorders. Providing care for suicide survivors and their families was explicitly added as an important component. Provision of care close to the people was a key to enhancing access, and therefore it was decided to have counselling centres in the villages.

The second "Implementation" phase of VISHRAM (April 2014 to September 2015) was envisaged to covered 30 villages in two blocks in Chandur bazar and Dhamangaon talukas of Amravati district, covering a population of 100,555. In Chandur Bazaar taluka, VISHRAM was implemented in Asegaon, Brahmanwada, Deurwada, Dhanora, Ghatladki, Haidatpur, Hirudpurna, Kotgawandi, Madhan, Masod, Pimpari, Rajna, Sarfabad, Sonori, and Surali villages, many of which were also involved in the Development phase. In Dhamangaon taluka, VISHRAM was implemented in Anjansingi, Ashta, Dabhada, Gavhanipan, Jalgaon, Kavli, Mangrul, Nimboli, Savla, Shendurjana, Talegaon, Talni, Vadhona, Vasad and Wagholi villages.

Box 2: VISHRAM PHASES

I. DEVELOPMENT PHASE (NOVEMBER 2011 - DECEMBER 2013)

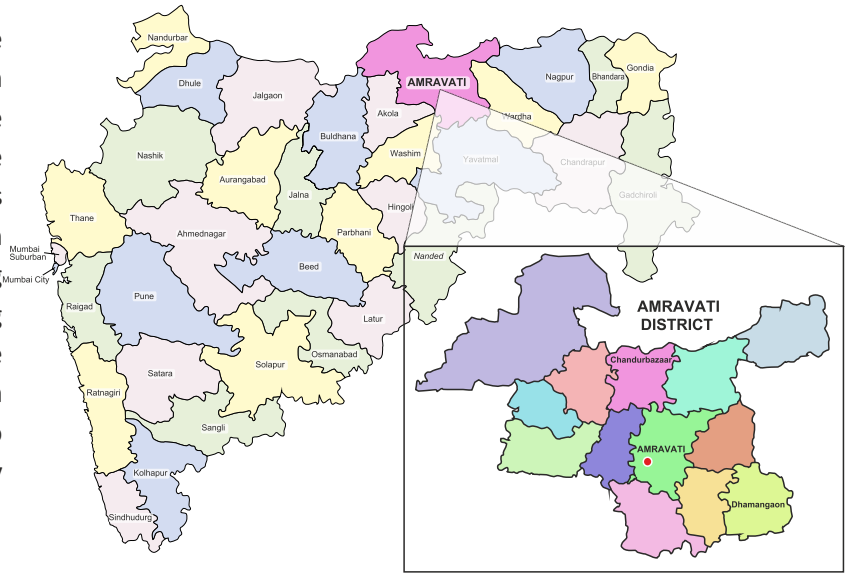
Develop an acceptable and feasible intervention to address psychological distress and provide care for mental disorders and pilot in 15 villages of Chandur Bazaar taluka and 8 villages of Arvi taluka

II. IMPLEMENTATION PHASE (APRIL 2014-SEPTEMBER 2015)

Implement the program in 30 villages with 100555 population in Chandur Bazaar and Dhamangaon talukas in Amravati district

Organization of Health Services in Amravati District

- Amravati district has 14 talukas with district headquarters located in Amravati city.
- In the city of Amravati there is one medical college and one district hospital in public sector and they provide tertiary care. The District hospital has inpatient facilities with 373 beds and the District Mental Health Program (DMHP) is based in this hospital. There is one psychiatrist in the District Hospital who leads DMHP in addition to one psychologist, one occupational therapist and two psychiatric social workers. There are around 15 psychiatrists in private sector and all are based in Amravati city. There are no psychiatrists or psychologists in public as well as in private sector in Chandur Bazaar and Dhamangaon town as well as in these talukas.
- There are ten Rural Hospitals (RH) in the district, 56 Primary Health Centers (PHCs) and 333 sub-centers. RH serves as a First Referral Care unit and is usually located at the taluka headquarters or larger villages and serve the population of the urban centers in which they are situated as well as the adjoining rural areas. Generally, there is one RH per five PHCs and serves a population of approximately 125,000. A typical RH is a 30 beded hospital with four basic specialties; Medicine, Surgery, Obstetrics and Gynaecology, and Paediatrics.
- Prior to VISHRAM implementation phase, mental health services were available only in the District Hospital in the public sector and neither RH nor PHCs provided any of these services.
- During VISHRAM implementation phase specialist clinics were held in RHs in Chandur Bazaar and Dhamangaon. The distance between the villages in the Chandur Bazaar taluka and the RH in this area ranged from 5 to 30 kms. In Dhamangaon taluka, the corresponding range was 7 to 29 kms. The corresponding distances of villages in either taluka to the District Hospital in Amravati ranged from 31 to 72 kms. Traditional healers also provide mental health services and they are located across the district.



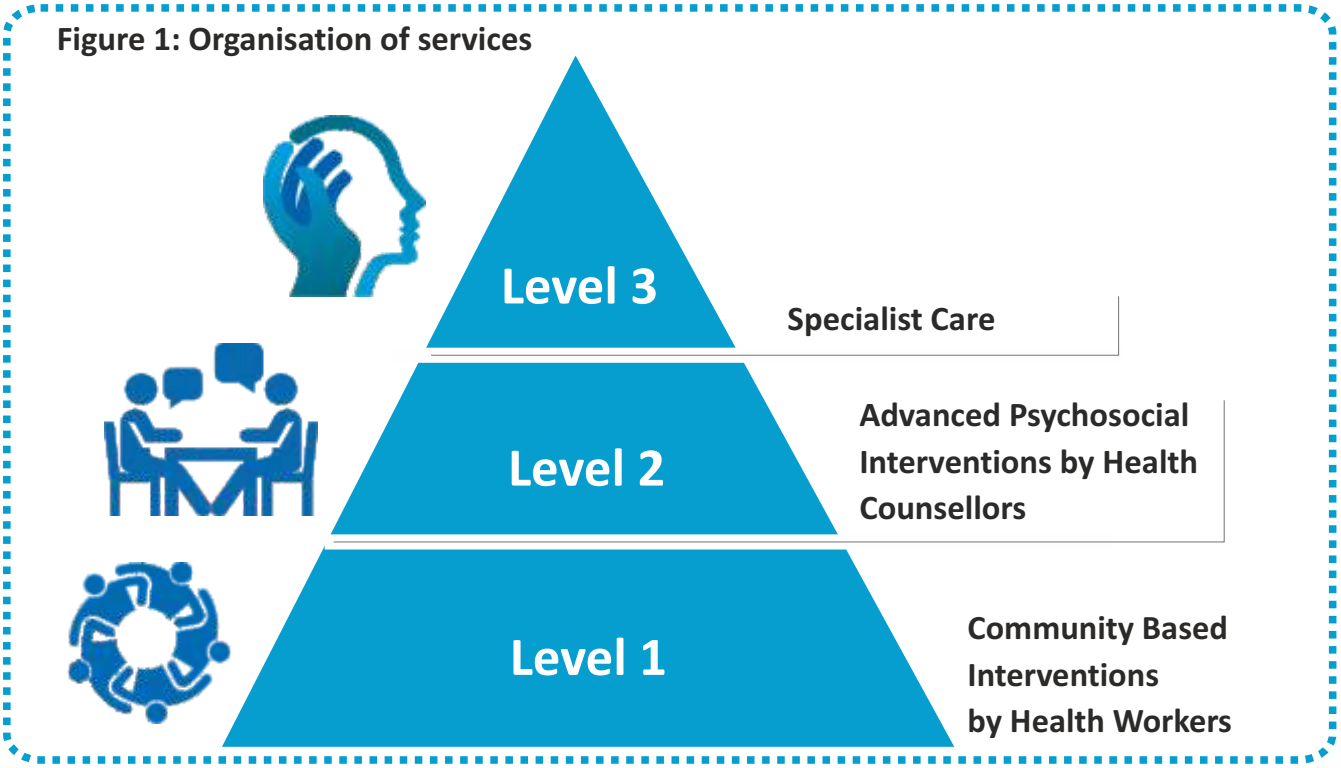
VISHRAM: Guiding Principles

The interventions included in VISHRAM are based on the principles of accessibility, affordability, adaptability, acceptability and assessment of performance elaborated in the National Mental Health Policy: vision 2020 and WHO model of organisation of mental health care (figure 1).

The guiding principles were:

- The twin principles of universal interventions for promotion and prevention for the entire village population alongside targeted interventions for individuals with mental disorders formed the basis of program components for the implementation phase
- The interventions are organised at the community level to promote self-care and provide informal community care by Community Health Workers (CHWs), psychosocial interventions by Health Counsellors (HCs) and referral/ follow-up for the persons requiring medications and specialist care by psychiatrists based in primary health centres or rural hospitals
- Improving mental health literacy through participatory engagement with the community and incorporating community attitudes and beliefs in the awareness interventions, for example avoiding the use of psychiatric labels for common mental health problems
- Providing care for suicide survivors and their families

Figure 1: Organisation of services



VISHRAM Evaluation: Key Findings

- The impact of VISHRAM was evaluated by measuring contact coverage for depression. Contact coverage for depression means the proportion of individuals with depression who seek care for symptoms related to depression. For e.g., if 100 individuals have depression and 10 individuals among them visit a psychiatrist, a physician or a community health worker, then the contact coverage is 10%.

- VISHRAM evaluation was carried out by conducting a survey before the implementation started (baseline survey) and at the end of the implementation phase. In our surveys we observed that the contact coverage for depression rose six-times over the 18 month implementation phase.

- At the baseline, only 4.3% individuals had sought care while at the end of VISHRAM implementation this proportion increased to 27.2%.

- None of the socio-demographic or economic factors such as gender, education, income, religion and caste were related with seeking care and there was significant improvement in knowledge related to mental disorders.

- Most individuals with depression who sought care did so from general physicians, in line with the key message to seek help from these practitioners.

- The details about this evaluation are available online
http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30424-2/abstract

References:

1. Gururaj, G., et al., National Mental Health Survey of India, 2015-16: Summary. 2016, National Institute of Mental Health and Neuro Sciences, NIMHANS Bengaluru.

2. Murthy, R.S., Mental health initiatives in India (1947-2010). Natl Med J India, 2011. 24(2): p. 98-107.

3. Patel, V., et al., The magnitude of and health system responses to the mental health treatment gap in adults in India and China. The Lancet, 2016.

4. Dua, T., et al., Evidence-Based Guidelines for Mental, Neurological, and Substance Use Disorders in Low- and Middle-Income Countries: Summary of WHO Recommendations. PLoS Medicine, 2011. 8(11): p. e1001122.

5. Patel, V., et al., Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition. Lancet, 2016. 387(10028): p. 1672-85.

6. Patel, V., et al., Suicide mortality in India: a nationally representative survey. Lancet, 2012. 379(9834): p. 2343-51.

7. Patel, V., et al., Treatment and prevention of mental disorders in low-income and middle-income countries. Lancet, 2007. 370(9591): p. 991-1005.

8. Andrade, N.N., et al., The National Center on Indigenous Hawaiian Behavioral Health Study of Prevalence of Psychiatric Disorders in Native Hawaiian Adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 2006. 45: p. 26-36.

9. Phillips, M.R., et al., Risk factors for suicide in China: a national case-control psychological autopsy study. Lancet, 2002. 360(9347): p. 1728-36.

10. Vijayakumar, L., et al., Suicide in developing countries (2): risk factors. Crisis, 2005. 26(3): p. 112-9.

11. Economic Survey of Maharashtra 2014-15. Directorate of Economics and Statistics, Planning Department, Government of Maharashtra, Mumbai, 2015. Available online on https://www.maharashtra.gov.in/Site/upload/WhatsNew/Economic%20Survey%20of%20Maharashtra...pdf (Accessed on 19 December 2016).

12. National Crime Records Bureau. Available online http://ncrb.nic.in/StatPublications/ADSI/ADSI2014/chapter-2%20suicides.pdf. 2014 [cited 2016 19 December].

13. Behere, P.B. and A.P. Behere, Farmers' suicide in Vidarbha region of Maharashtra state: A myth or reality? Indian J Psychiatry, 2008. 50(2): p. 124-7.

14. Badiye, A., N. Kapoor, and S. Ahmed, An empirical analysis of suicidal death trends in India: a 5 year retrospective study. J Forensic Leg Med, 2014. 27: p. 29-34.

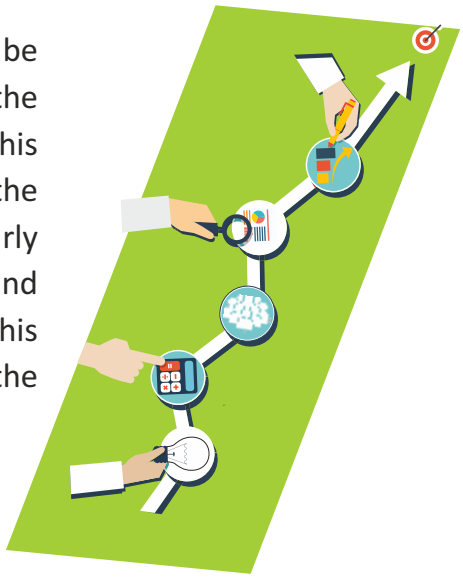
15. Kennedy, J. and L. King, The political economy of farmers' suicides in India: indebted cash-crop farmers with marginal landholdings explain state-level variation in suicide rates. Global Health, 2014. 10: p. 16.

16. Dongre, A.R. and P.R. Deshmukh, Farmers' suicides in the Vidarbha region of Maharashtra, India: a qualitative exploration of their causes. J Inj Violence Res, 2012. 4(1): p. 2-6.

PART II:
THE TOOLKIT

SECTION I: GETTING STARTED

The enthusiasm to develop and rollout a program needs to be coupled with systematic preparatory work which will ensure the success and sustainability of the program in the long run. This requires a detailed understanding of the community, and of the interventions and program design, the development of clearly described protocols, and partnerships with key organizations and individuals with clearly defined roles and responsibilities. In this section we provide the details of the packages which help the program to get started.



SITUATION ANALYSIS

Situation analysis serves at the first step before starting any community mental health program and helps the program planners to understand the broader socio-cultural context in which the new interventions are going to be embedded to address mental health problems.

Objectives

To understand the mental health needs of the community	To assess the status of the organization of the mental health services, availability of human and financial resources and the extent to which mental health services are delivered through public (and private) health system	To assess the attitudes and perceptions of community members towards the existing mental health services as well as for potentially new interventions to be introduced as part of the program	To identify potential barriers to the program implementation as well as potential facilitators and resources.

Approach

- Programs often begin from a pre-set idea about the type of intervention as well as content of the intervention. However, close attention needs to be given to the preparatory work especially situation analysis as a detailed enquiry about the understanding of the needs and priorities of the community, existing services, involvement of local stakeholders and the capacity of the implementing partners plays a crucial role in shaping the program.

- Situation analysis is conducted using a mixed-methods approach which includes document review, in-depth qualitative interviews and focus group discussions and participatory appraisal or social mapping to identify the local resources.

- Document review would typically involve a review of government reports and reports from the private sector assessing the existing mental health situation in the community and measures taken to address them. These documents are generally available online, but if there are very few or no documents available then the office of the District Collector could be contacted for same. The review should mainly focus on any existing studies which have assessed mental health needs of the community, including priority mental health problems, awareness and demand for mental health services including unmet need.

Participatory Rural Appraisal

- In depth interviews and Focus Group Discussions with the stakeholders and community members would generate important information to enhance the understanding about the priorities, preferences and attitudes of the community towards mental disorders. The interviews should focus on perceptions of different stakeholders for development of mental health services and potential barriers and facilitators to implementation of a mental health program in the community. Coping strategies and existing help seeking behavior for mental health problems should also be explored.

Participatory rural appraisal and social mapping also serve as important activities to understand local resources and map vulnerable areas and populations. The emphasis of this activity should be on assessment of available services; public and private services, and their accessibility, acceptability and coordination between its different components, human and infrastructural resources available to deliver mental health interventions, presence of complementary services and other services for addressing mental health problems and other community resources.

VISHRAM Outputs (Appendix)
VISHRAM Resource Mapping Tool

VISHRAM Resource Mapping Tool can be used to collate all the relevant socio-demographic information pertaining to the village and listing the availability of general and specialist health facilities

Village level group discussion

DEVELOP PARTNERSHIPS

Mental health problems are multi-dimensional, require interventions at many levels and involvement of diverse stakeholders. Thus, it is necessary not only to know about the diverse stakeholder groups but also to involve them in the program through the development stage to ensure that the program is appropriate to context, comprehensive and acceptable.

Objectives

To establish and strengthen a collaborative network comprising of technical and implementation partners, specialists in public and private health sector, lay health workers, community leaders and community members.

Approach

It is important to build collaborative relationships with the local experts and service providers, both from public and private sectors including the informal care providers to maximise the outreach and benefits of the program as well as to limit the duplication of efforts.

A golden rule is to develop mutually beneficial partnerships that ultimately improve the accessibility and utilisation of mental health services developed through the program.

Ownership of the program by the local stakeholders should be encouraged as this could be crucial in enhancing the sustainability of the program in the long-term.

BOX 3: Key stakeholder groups that could be involved in the development and implementation of the program include

- Experts in mental health program development and delivery
- Technical domain experts based on the program needs
- Implementation partners comprising of local NGOs, service providers in partnerships
- Partnerships for advocacy and demand generation
- Community members representing the client population

Approach

Of particular importance is the involvement of implementation partners and development of clear understanding of responsibilities and roles in the early stage of the program and that which is appropriate with interest and capacity of partners.

VISHRAM Advisory Group Meetings

Developing and sustaining partnerships could be difficult in absence of appropriate platforms and frequent opportunities to engage with the program. Some examples of platforms that can be established in the early phases of the program include advisory groups, theme based expert groups, local advocacy groups, and community engagement groups. The details of this are provided below. For obvious reasons, the engagement and involvement of the partners is greatly influenced by the coordination and involvement of the program team.

Community Members and VISHRAM Lay Health Workers

DEVELOPING A THEORY OF CHANGE

Theory of Change (TOC) is an outcomes-based approach that applies critical thinking to the design, implementation and evaluation of programs intended to support change in their contexts. Theory of Change developed in a setting of a workshop is recommended as an approach to design mental health care plan.

Objectives




To conduct preliminary TOC workshop with program core team to develop draft TOC map.

To conduct TOC workshop with key stakeholders such as psychiatrists, government officials, donor agency representatives, lay-health workers, community volunteers and community members to further develop the draft TOC.

To refine the draft TOC map developed with program core team based on the discussion in the workshop conducted with the key stakeholder groups mentioned above.

To prepare the final TOC map and use it for finalizing the Mental Health Care Plan.

Approach

- TOC helps to successfully ground the program interventions and service delivery in order to achieve the final goal of the intervention and map all the required steps to achieve the final goal of the program.

- TOC Workshop and the final TOC should be able to answer following key questions about the program:
  1. What is the overall goal of the program?
  2. What is the pathway of change which connects various pre-conditions with outcomes which will ultimately lead to the overall goal?
  3. What are the feasible and acceptable interventions in the pathway of change?
  4. How the various pre-conditions and outcomes be operationalized and measured?
  5. What are the assumptions in the pathway of change which need to be further explored during pilot intervention?

- It is advisable to invite a facilitator who is an expert in conducting TOC workshops.
- Links to the manual describing the step-wise approach to conduct a TOC workshop and other important resources are provided in the box below.
- Important concerns regarding the content of the intervention, program delivery design and ethical implementation should be resolved. As a part of the intervention development, concerns regarding appropriate mechanisms to address adverse events in the program, referral, engagement with complementary services and decision points should be explored and described.
- At the same time, structure of the program and delivery platforms for the intervention need to be decided after taking into consideration the evidence for collaborative care, community-based interventions, evidence for self-care interventions and interventions delivered by lay health workers. Following the completion of TOC map, intervention matrix comprising of platforms of care as rows and activities/treatments as columns should be finalized. The template for the intervention matrix is provided below.
- A stepped care approach involving low intensity psychological interventions as the first step and delivered through lay health workers and supported by specialists through well-established linkages should be explored considering the limited resources in terms of specialists and hospital based services.

Theory of Change Workshop

Template for Intervention Matrix

	Activity 1	Activity 2	Activity 3	Activity 4
Platform 1				
Platform 2				
Platform 3				

- Platform is the level of the health or welfare system at which interventions or packages can be appropriately/ effectively/ efficiently delivered. A particular platform is defined based on WHERE (the setting) the intervention will be delivered and WHO will deliver the intervention (service provider)

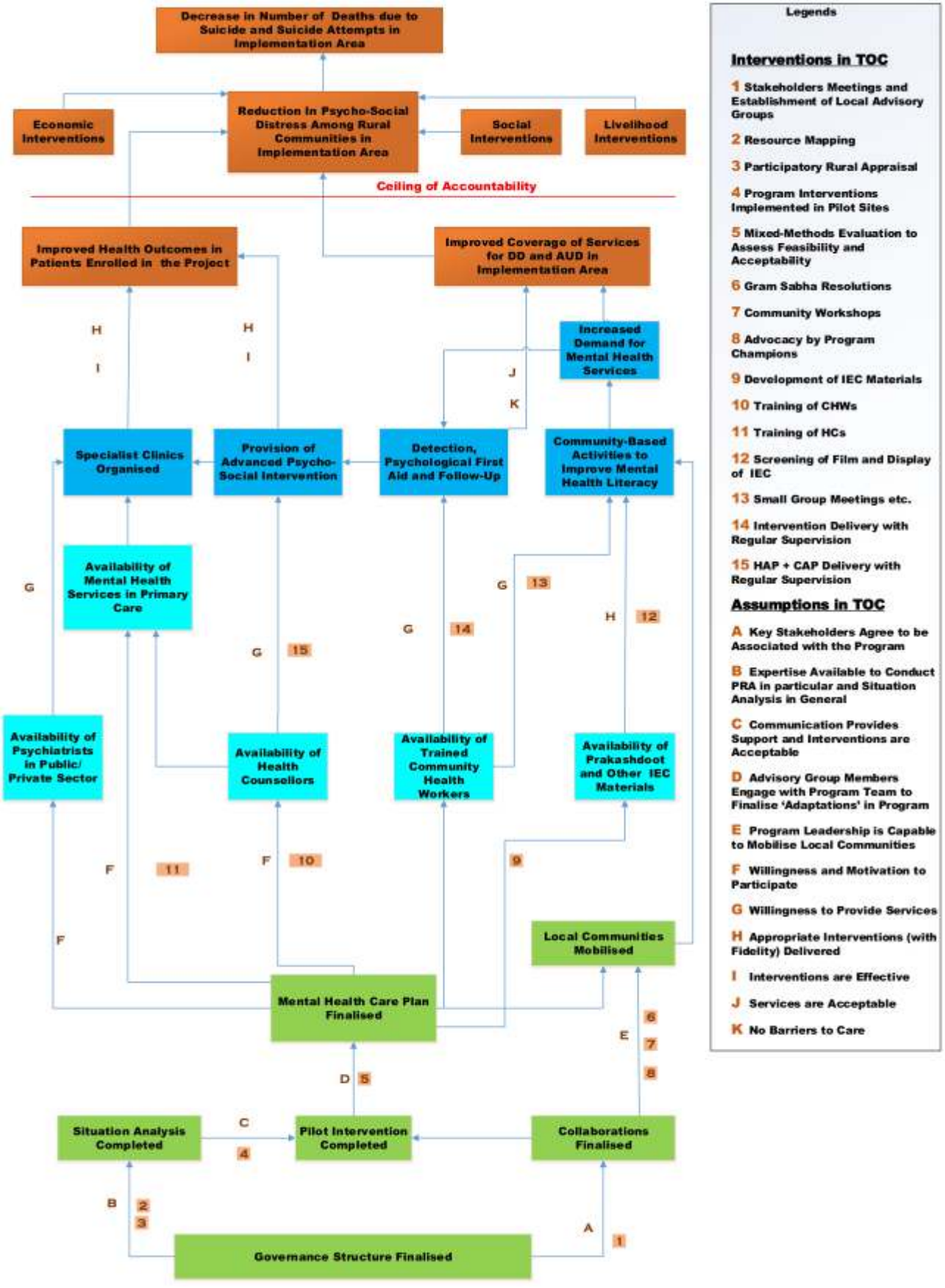
- Theory of Change map along with the intervention matrix comprises the Mental Health Care Plan for the program.

BOX 4: Resources for conducting Theory of Change Workshops

- Theory of Change' guidelines for facilitators:
- The Community Builder's Approach to Theory of Change: A Practical Guide to Theory Development, by Andrea A. Anderson. Washington, D.C.: The Aspen Institute, 2005 http://www.aspeninstitute.org/sites/default/files/content/docs/rcc/rcccommbuildersapproach.pdf
- Acknowledges and related community site Theory of Change Online: http://www.actknowledge.org/
- Theory of Change Online Community: http://www.theoryofchange.org/

Theory of Change online software tool: http://www.theoryofchange.org/toco-software/

VISHRAM Theory of Change map



PILOT INTERVENTION

One of the most important part of the development of the program is to pilot the intervention before the actual implementation phase starts.

Objectives

To implement the interventions as described in the Mental Health Care Plan in small number of sites.

To assess the feasibility and acceptability of various interventions.

To make adaptations in the Mental Health Care Plan and finalize it for implementation phase

Approach

- The pilot should be designed as close to the actual planned intervention and must use the protocols that are developed as part of the Mental Health Care Plan.
- The pilot should be implemented in a setting that is similar to the intervention area and could also be a part of the intervention area.
- Pilot intervention can be implemented in single site (i.e. village) or small number of sites (4-5 villages).
- It is also to fine tune the roles and coordination between different components of the program, including the information systems and monitoring.

Pilot Evaluation (community FGD)

- The pilot should include all the steps that are planned for the program.
- The purpose of the pilot is not to see if the program is effective but to assess the feasibility in terms of barriers and mitigating strategies, acceptability and scalability of the intervention as per the requirements of the program.
- Sufficient reflection on evaluation of the pilot intervention is a key to improve the intervention and its delivery. The changes required in the program design, intervention and the protocols should be well documented and the Mental Health Care Plan should be finalized based on the same.

Table 1: Key findings of VISHRAM Pilot Evaluation and changes made in the Mental Health Care Plan

Findings of pilot evaluation and discussions in VISHRAM Advisory Group	Changes undertaken for Implementation Phase
Philosophy of VISHRAM	
In the development phase the focus essentially was on identification and treatment of 'disorders' rather than addressing psychosocial distress	The goals of VISHRAM were re-aligned to address 'psychosocial distress' in the communities with 'well-being' as the key theme of the program. The emphasis was shifted to 'staying healthy' and improving the resilience of the community in general. Mental Health was delinked from mental disorders and the program provided a balance between social determinants of mental health and detection and treatment of mental disorders.
A third of patients accessing care had Severe Mental Disorders (SMD) such as psychosis and epilepsy. This was not part of the original proposal but had to be included in the development phase as there was a strong felt need for the same **Inclusion of SMD was perceived to be the barrier to access care as the community members linked VISHRAM services with SMD management**	Common Mental Disorders (CMD), Alcohol Use Disorders (AUD) and SMD were delinked from one another. VISHRAM continued providing services for SMD through the OPD and community-based support components, but this was not the emphasis of the program and was not explicitly focused in the community engagement activities
Program Governance	
In the development phase all the three organizations had independent reporting system with the Trust **There was lack of clarity about the roles and responsibilities of resource organization (Sangath) and implementation organization (Prakriti)**	Prakriti staff started reporting to Sangath which then had the overall responsibility of reporting to the Trust. Clear Terms Of Reference (TOR) were drafted which formed the basis of program monitoring during implementation phase.

Findings of pilot evaluation and discussions in VISHRAM Advisory Group	Changes undertaken for Implementation Phase
Capacity Building	
● None of the trainings were systematically evaluated, the need for skills enhancement and competence based assessment was emphasized	● Training, competency assessment and supervision of the HCs was based on final PREMIUM packages. Audio recordings of the counseling sessions were used for supervision.
Awareness and Stigma Reduction	
● Use of 'Prakashdoot' and wall-paintings for awareness creation	● Prakashdoot was piloted after being developed and it was ensured that the content of the Prakashdoot was contextually relevant to the rural settings and in line with broader decisions on the philosophy of the program outlined earlier (i.e. starting with a broader psychosocial distress/coping/well-being perspective and then narrowing down to stress/vulnerability/ill-health) ● Content of wall-paintings was revised based on the feedback from the community and in line with the philosophy of VISHRAM (discussed above) ● CHWs further strengthened small group meetings and participated in the meetings of Self-help groups, Village Health and Nutrition Day meetings and in other such existing platforms to introduce the mental health related topics
Detection and provision of Psychological First Aid	
● There were multiple issues related to implementation of service delivery components such as detection and provision of psychological first aid for CMDs and AUDs	● CHWs increased one-to-one meetings with the individuals with risk factors and actively identified individuals with CMD and AUD ● CHWs provided at least one session of Mental Health First Aid to the identified individuals ● Individuals were referred to HCs based on the risk assessment done by CHWs ● Random assessment of individuals who received care from CHWs was periodically conducted by HCs and Intervention Coordinator

Findings of pilot evaluation and discussions in VISHRAM Advisory Group	Changes undertaken for Implementation Phase
Advanced Psycho-social Interventions	
⭘ **Barriers in delivery and quality of psychosocial interventions were identified**	⭘ Competency assessment of HCs was conducted regularly and quality of psychosocial interventions assessed using audio tapes ⭘ HCs were encouraged to deliver 4-6 sessions of Healthy Activity Program (HAP) and Counselling for Alcohol Problems (CAP) to the individuals who were referred by CHWs

SECTION II: MANAGING THE PROGRAM

This section describes the enabling packages which consist of cross-cutting interventions that will ensure the smooth implementation of core mental health service delivery packages described in next section. There are three enabling packages: Governance, Capacity Building and Community Mobilization.

Even a most well-designed program, might be set-up for failure in absence of the enabling environment created by program leadership, trained human resource and community support. In this section we highlight some of key aspects of governance, building and maintaining the capacity of human resource and community mobilisation. The key implementation steps essential for these enabling packages are described in Table 4.

GOVERNANCE

Program governance is a framework in which all the decisions related to the program development and management are made. Good governance is characterized by responsiveness, accountability, open and transparent processes for decision making, involve community engagement and foster operational capacity of the management teams to plan, manage, and regulate service delivery.

Objectives

To provide overall leadership and oversight for all other packages

To recruit and manage human resource and oversee financial administration

To ensure regular communication with donor agency, government officials and community leaders

To keep track of program activities and ensure timely completion of program deliverables and milestones

To resolve conflicts within various stakeholder groups and program personnel

Approach

- A multi-dimensional community mental health program is generally led by a Principal Investigator/Program Lead who takes the overall responsibility for the fiscal and administrative governance of the program. He/she should recruit the senior leadership of the program or the core team which will oversee the implementation of all the program activities.

- The core team/management team can consist of a Program Coordinator, Intervention Coordinator, Monitoring and Evaluation Officer (M&E Officer), Communication Officer, Finance Officer and Administrative Assistant. The roles and responsibilities of each of these team members is provided in Table 1.

- Program governance takes place at two levels; Steering/ advisory level that is empowered to steer the program and take major decisions related to program design and intervention content. A second level is more related to day-to-day management of the program and ensure that the program is functioning as per the developed design and plan. Additional governance groups can also be constituted to guide key components of the program.

Table 2: Program Management Team/Core Team

Position	Roles and Responsibilities
 **Principal Investigator**	• Overall leadership of the program and responsibility for fiscal accountability and achieving milestones • Communication with donor agency and with senior policy makers • Conflict resolution • Ensuring effective allocation and utilization of program resources • Overall leadership of other governance groups (see below) • Supervision of Program Coordinator

Position	Roles and Responsibilities
 **Program Coordinator**	• Administrative coordination of governance groups • Supervision of financial resource utilization and regularly updating Principal Investigator about the same • Obtain all relevant approvals from donor agency and government organizations • Supervision and appraisal of program staff • Submission of monthly and annual progress reports to governance groups and donor agencies
 **Intervention Coordinator**	• Design and adaptation of core clinical interventions to be delivered in the program • Training and supervision of lay health workers • Regular field visits to assess performance of lay health workers • Monitoring and redressal of any adverse events in the program
 **Monitoring and Evaluation Officer (M&E Officer)**	• Design of monitoring framework • Hand-holding lay health workers to establish information system to ensure regular reporting of key performance indicators • Monitoring and tracking progress of all other program activities • Reporting to Program Coordinator about the program timelines

Position	Roles and Responsibilities
 **Communication Officer**	• Coordination of all communication and dissemination plans including web-site and engagement with policy makers and civil society • Communication between partner institutions • Reporting to Program Coordinator
Finance Officer 	• Monitoring budget and finances & preparing financial reports • Reporting to Program Coordinator
 **Administrative Assistant**	• Coordinating logistics arrangements for all program activities • Obtaining internal approvals for financial administration • Maintaining office filing and storage system and fixed assets management • Reporting to Program Coordinator

A critical aspect of the successful implementation of a community mental health program is the participatory planning of activities and agreement of indicators of progress, their monitoring towards timely completion, anticipation and identification of barriers, and recommending and overseeing strategies to address these. This can be achieved by setting up various governance groups (Table 2).

Meetings of the governance groups should be coordinated and conducted face-to-face or through telecommunication.

Memorandum of Understanding (MOU) should be finalized for all the partner institutions which will specify their roles and entitlement. Terms of reference should be set out for all the governance groups. It is advisable that all governance decisions are taken by consensus; if consensus cannot be reached, decisions be taken by majority vote. Decisions solely taken by Principal Investigator or representative of the donor agency should be avoided. Terms and conditions of the contractual arrangements

should also include steps to be taken in the eventuality of a breakdown of communication at management level or if one of the partner institution chooses to leave the program.

- A risk mitigation plan should be prepared in the beginning of the program to ensure that the key partners are committed to successful implementation of the program.

- Donor agency as well as all the network partners should have access to the internal website and, thus, to all program documents and minutes. Regular progress update reports and financial reports should be submitted as per donor guidelines. These reports should be based on synthesis of the tracking progress towards milestones for all the monitoring indicators.

Table 3: Program Governance Groups

Group	Role	Composition
Program Management Team/Core Team 	• Primary decision making body on policy matters including how fiscal and other resources will be prioritized and managed • Tracking progress milestones of the entire program • Communication with network partners and external audiences, including policy makers • Frequency of meeting: Bi-monthly	• Principal Investigator • Program Coordinator • Intervention Coordinator • Communication Officer • M&E Officer • Donor representative • Representative from partner organizations
Program Advisory Group 	• Review the strategic direction of program and the annual work plan • Review the progress of the work, monitoring reports and outputs for quality assurance of content • Advice on barriers encountered in the effective implementation of the program • Advice on effective partnerships with other institutions working in the area of mental health • Frequency of meeting: Annual	• Advisory Group members to be chosen from academicians and researchers, practitioners, policy-makers, mental health advocates, service user representatives, community representatives • Principal Investigator • Program Coordinator • Donor representative • Representatives from partner organizations

Group	Role	Composition
Community Advisory Board 	• Represent community voice and act as a communication link between local communities, service providers and program core team • Advice on planning of local mental health services and its implementation in the field • Advice on design and facilitate to local community and other stakeholders engagement strategies • Advice on community level interventions • Frequency of meeting: Quarterly	• Service Users • Leaders of local bodies such as Gram Panchayat (Village Council) • Community members • Principal Investigator • Program Coordinator • Intervention Coordinator • Representative from partner organizations

VISHRAM: Key Governance Groups

VISHRAM Advisory Group

The VISHRAM advisory group comprised of community and mental health experts in the country and provided overall guidance to the program. Dr. Abhay Bang, Dr. Lakshmi Vijayakumar, Dr. Prakash Behere, Dr. Nerges Mistry served on VISHRAM Advisory Group. During the course of VISHRAM, four Advisory group meetings were held and the discussions during the meeting played a very significant role in mid-course correction and future directions for the program implementation

VISHRAM Management Team

The VISHRAM Management Team provided oversight to the routine program management and leadership to the implementation of VISHRAM. VISHRAM Management Team meeting was conducted over telephone every 6 weeks and was chaired by VISHRAM Principal Investigator. VISHRAM progress update was discussed during these meetings along with Action Taken Report from the previous meeting. The minutes of these meeting were circulated to all members within one week of the meeting which helped all members to be aware of the progress and activities to be prioritized.

CAPACITY BUILDING

Trained human resource forms the backbone of public health program implementation and mental health programs in the community typically involve a range of human resource including specialists –psychiatrists and psychologists, general physicians as well as lay health workers- Health Counsellors (HCs) and Community Health Workers (CHWs).

Objectives

To train CHWs and HCs to deliver psychosocial interventions and undertake various community-based interventions

To train general physicians in public and private sector to deliver first line pharmacological management based on mhGAP (mental health Gap Action Program) guidelines

To provide regular supportive supervision to CHWs, HCs and general physicians to ensure that the skills and competencies obtained in the initial training are maintained and further improved

Approach

Principal Investigator and the core team under the guidance of various governance groups should develop a policy to recruit human resource and also plan strategies which will retain the trained human resource in the program. This policy should be in alignment with the overall HR policies of the parent organization and guidelines from the donor organization should be taken into consideration. The details about the proposed human resources are in Table 3.

Table 4: Human Resource for a Community Mental Health Program

Care Provider	Recruitment Criteria	Role
Community Health Workers (1 per 1000-1500 adult population i.e. approximately 1 per village (For bigger villages, 2 or more CHWs can be recruited)	• Permanent resident of the village • Completed high school education (grade 10) • Above 18 years of age • Interested in volunteering • Individuals who are members of Self-Help Groups or farmers' clubs can be preferred • Good mix of males and females be ensured	• CHWs are the face of the program in the community • Mental Health awareness activities • Detection of mental disorders • Provision of Psychological First Aid and referral to HCs • Patient Follow-up • Identification of individuals who attempted suicide and suicide affected families and provision of appropriate interventions
Health Counsellors (1 per 4-5 CHWs)	• Graduate degree from a University (e.g. Bachelor of Arts, Bachelor of Science) • Preferable to have a masters degree in social work (e.g. Masters in Social Work) • No formal training in psychology or counselling is required • Preferable that he/she is fluent in the local language • Good mix of males and females be ensured	• Provision of advanced psycho social interventions • Supporting CHWs for community mobilization • Supervision of CHWs
General Physicians	• Medical Officers working in Primary Health Centre or Rural Hospital • Physicians working in private sector • They are not independently recruited by the program	• Diagnosis and first-line pharmacological management of mental disorders • Psycho-education and support • Participation in mental health awareness activities as an expert

Care Provider	Recruitment Criteria	Role
Specialists (Psychiatrist and Psychologists)	• Psychiatrists and psychologists employed in the District Mental Health Program • Psychiatrists and psychologists working in private sector • They may or may not be independently recruited by the program depending on the resources	• Referral source for persons with severe depression, drinking problems or suicidal risk • Training and supervision of general physicians • Training and supervision of HCs • Participation in mental health awareness activities as an expert

Training Resources: Multiple resources and manuals are available for training lay health workers and general physicians. These should be reviewed and the materials should be finalized for training. It is better to use the existing manuals after making appropriate program level adaptations and contextualization instead of developing new training material from scratch.

BOX 5: World Health Organization's mental health Gap Action Program (mhGAP)

mhGAP is the WHO action program developed for countries especially with low and lower middle incomes for scaling up services for mental, neurological, and substance use disorders. The essence of mhGAP is partnerships to reinforce and to accelerate efforts and increase investments towards providing services to those who do not have any.

http://www.who.int/mental_health/mhgap/en/

Psychiatrists can play an important role in training and supportive supervision of general physicians while psychologists can play a similar role for lay health workers (HCs and CHWs). The core team should identify the psychiatrists and psychologists who are interested to be associated with the program and their orientation cum training should be completed.

Intervention Coordinator should then facilitate the training sessions for lay health workers and general physicians.

The most critical aspect of capacity building component is regular supportive supervision. Intervention Coordinator along with the psychologist associated with the program should organize weekly or bi-monthly supervision sessions for HCs.

BOX 6: Some Important Points about Training and Supportive Supervision

- Instead of lectures, emphasis should be on informal group discussions based on real-world and simulated cases. This will help the lay health workers to keep the affected persons and their families at the centre of their mode of thinking about mental disorders.

- The team personnel should be encouraged to discuss their own opinions and experiences as well, so that their fears and misconceptions about mental disorders are elicited and addressed.

- Initially the focus should be on imparting general counselling skills including building a positive relationship with the patient through an empathetic non-judgemental attitude.

- After these basic modules, specific modules for general counselling skills and specific psychological treatment should be discussed with an emphasis on training the counsellor on the conduct of each successive session of the psychological treatment. The sessions can include demonstrations by the trainers, videographs of actual sessions followed by role-plays by the participant trainees. The details about the modules are provided in the HAP and CAP training manuals and VISHRAM training manual for CHWs.

VISHRAM CHW Training

- Standardized role-plays of a set of commonly encountered cases are among the most important parts of training as they assess the competence of counsellors closest to what is required in actual practice. Role-plays are conducted within open fora and the rest of the audience is encouraged to discuss the proceeding. Repeat role-plays of the same case with the same trainee-counsellor are also undertaken, after the feedback from the supervisor and peers in the first round, the trainee-counsellor again counsels the case and incorporates the suggested improvements.

- Group role-plays' in which a person plays a single user and the rest are counsellors turn by turn encourage learning of different counselling styles and perspectives from peers. The trainer ensures that every person in the team is engaged in role-play/case discussions.

- Supervisors periodically assess the training needs of each counsellor and CHW, so that personalized training can be provided in areas where there are gaps in skills.

- Supervisors should maintain a training record file of each counsellor and CHW, to assess progress. The supervisor herself is imparted skills of analysing data, trends and tracing the progress/non-progress of service users, CHWs, counsellors.

- Training of all program personnel should also include a grounding on possible side effects of anti-psychotics and anti-depressants and the protocol on handling such situations.

HC Supervision Session

- The program team should also be sensitized about various laws regarding mental health and common life-stressors like domestic violence and other social and gender disadvantage factors.

VISHRAM Outputs (Appendix)
VISHRAM CHW Training Manual
HAP Manual: Marathi Version
CAP Manual: Marathi Version

COMMUNITY MOBILISATION

Community engagement and mobilisation of community resources is an essential and well-recognised component of mental health programs and has a major impact on sustainability of the program. However, achievements can be affected if community engagement and mobilisation of community resources are not well planned and regularly monitored.

Objectives

To empower service users and carers to increase the demand and access to mental health care services

To engage with community members to ensure their participation in the mental health program

Approach

- Program Coordinator with inputs from other members of the Program Management Team should design the plan for community mobilisation. This can be based on review of various community engagement models such as Basic Needs model of Mental Health and Development and the Banyan model for community integration of mentally ill. The links to these resources are provided below.
  http://www.basicneeds.org/resources/#
  http://banyan.org

  Specific targets and strategies should be developed and included in the community mobilisation plan to identify resources and potential synergies with program implementation plans.

- A detailed map of community-based organizations, informal groups in villages (e.g. Mahila Gat) and key community leaders should be finalized. This can be undertaken during situation analysis (described earlier).

  This can be followed by orientation meetings/half-day workshops with community members. Ultimately, this process should empower the community to identify and articulate mental health as a priority and then effectively organise themselves to demand mental health services.

- Motivated individuals in the village could be trained as CHWs or lead the local advocacy groups. In addition to this, local health care providers and representatives of Panchayat Raj institutions (e.g. Gram Panchayat/Village Council) could also be oriented and they can function as Program Champions/Community Change Agents. They can also be invited on Community Advisory Board (described earlier).

- Further advocacy efforts should be channelized to achieve concrete outcomes like adoption of a resolution by Gram Panchayat or Zilla Parishad (District Council) to demand access to quality mental health care through public health system.

- Program Coordinator can also facilitate formation of service user groups comprising of patients who have recovered from their mental illness and carers/significant others of patients. CHWs can liaison with these groups to conduct stigma reduction activities (described below), to ensure follow-up of other patients and to advocate with the public health system about improved access to care and regular supply of psychotropic drugs.

- Various Self-Help Groups in the village could also be encouraged to involve recovered patients in their economic activities which can help patients to get mainstreamed within the community.

BOX 7: Community mobilisation in VISHRAM

- During the VISHRAM Implementation phase, the association between social distress and physical and mental health problems was emphasized.

- In the community meetings, discussions on major social problems and their impact on health and well-being, the existing resources in the community to deal with these issues and how VISHRAM can strengthen the community's coping abilities were encouraged.

- The focus of VISHRAM's work towards improving the resilience of the community and reducing the suicidal behavior rather than material benefits was communicated exclusively.

- The awareness programs emphasized that while many persons in the community face problems, such as debt, and even as most are able to cope well, the program seeks to address the needs of the whole community, but in particular help those who have difficulty coping with their problems.

- The program staff actively networked with all providers and other community resources to strengthen their engagement.

- Community Advisory Group was formed with representation mainly from the community members from various villages in the implementation area in Amravati district. The group met once every three months, reviewed the progress of program activities and advised on various strategies to further strengthen the program.

- Engagement with community members and community leaders (Sarpanch) of Gram Panchayats (Village Council) was instrumental in passing of resolutions by 26 (out of 30) village councils requesting the Government of Maharashtra to provide mental health services in the nearby Primary Health Centres. The resolution also clearly mentioned that the psychotropic drugs be made available in these Primary Health Centres.

- This led to regular fortnightly visits by Dr. Amol Gulhane (psychiatrist leading the District Mental Health Program, Amravati) to two Rural Hospitals in VISHRAM Implementation area. Specialist services were earlier provided by psychiatrist contracted by VISHRAM.

- The local leadership was also instrumental in finding space and setting up of counselling centres in 14 villages.

Gram Sabha

VISHRAM Outputs (Appendix)
Gram Sabha Resolutions

Table 5: Enabling Packages

Name of the package	Activities	Lead	Other Program Staff
Governance	• Recruitment and supervision of Human Resource • Governance Groups meetings • Program monitoring and evaluation • Procurement and Supply chain management for psychotropic medications • Regular Monitoring and Evaluation	Principal Investigator	Program Coordinator Intervention Coordinator M&E Officer Program and Community Advisory Group members
Capacity Building	• Training of lay health workers (CHWs and HCs) and general physicians • On-site supervision and hand-holding	Intervention Coordinator	Program Coordinator M&E Officer Psychiatrist
Community Mobilization	• Engagement with community members • Supporting Program Champions • Formation of Service User groups	Program Coordinator	CHWs with the community members

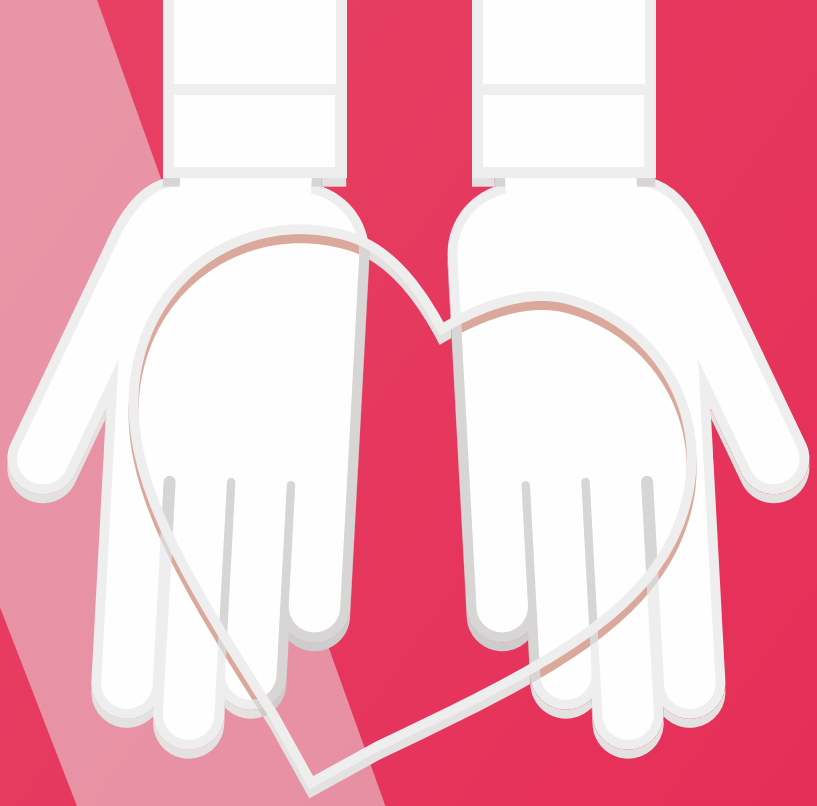
LOKAPRIYA SAMUPADESHAK
A WELL-KNOWN COUNSELLOR

Lokapriya Samupadeshak

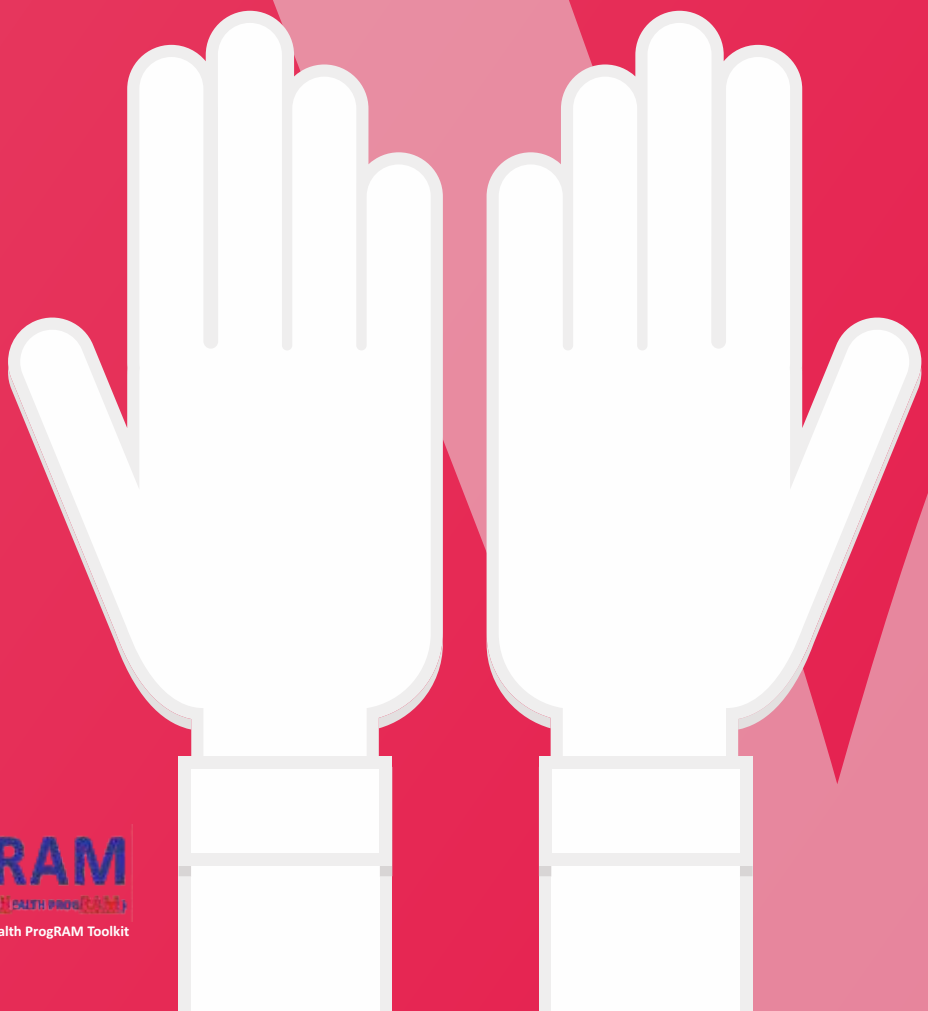
Lokpriya had a rich experience of working in the development sector, but had never worked with persons suffering from mental disorders. This was a big challenge for him when he joined VISHRAM as a health counsellor. “I had worked with HIV positive individuals, cancer patients as well as children, but this was the first experience of working with people with mental disorders.” While he was already adept at community work, VISHRAM required him to develop his skills of communication, especially of listening to his patients. These would serve to be his most important skill sets as he would spent most of his time providing counselling for depression and alcohol use disorders.

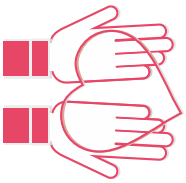
“This type of service was very new to me and was particularly challenging in the initial period.”

The literal translation of the word counsellor in Marathi is '*Samupadeshak*' but the villagers had never heard of a counsellor before. Not knowing what to call Lokpriya, they decided to refer to him as '*Vedyancha Doctor*' i.e. one who treats people with 'madness'. Lokpriya recollects, “seeing us without aprons and stethoscope and medicines, they would find it difficult to trust us for providing any kind of treatment.” Lokpriya struggled to win their confidence in counselling as a therapy for depression. He worked with the community health workers in the villages to help spread awareness about mental disorders and counselling. After working for two years he is proud to be recognised as a counsellor in villages and is looking forward to work with larger programs of the government as a counsellor.

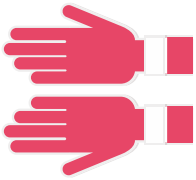


SECTION III
WHAT TO DELIVER?





This section describes the service delivery packages which form the core of any community mental health program. These packages comprise of the interventions delivered at three levels or platforms of care; community-based, primary care facility based and specialist care. The summary of service delivery packages is presented in Table 6.



Level 1: Community-based Packages

The overall goal of the community-based packages is to improve the mental health literacy of the community members, reduce stigma, promote help-seeking, facilitate detection at community level and provide psychological first-aid. Community Health Workers (CHWs) primarily can lead the provision and recording of the interventions outlined in this package, supervised by the Health counsellors (HCs).

AWARENESS AND STIGMA REDUCTION

Objectives

To improve awareness about mental disorders

To improve awareness about services available for treatment of mental disorders

To reduce stigma and discrimination against people with mental disorders

To improve the help seeking behavior for mental disorders and increase the demand for mental health services

Approach

Who is involved in delivering it?

- Community Health Workers (CHWs) are primarily responsible for this and they are supervised and supported by Health Counsellors (HCs).

How is it delivered?

- Three type of activities can be undertaken by CHWs;
  a) mass awareness programs for larger dissemination of information and stimulating discussion within community,
  b) small group meetings to support focused discussion and resolving queries
  c) family and one-to-one meetings to reinforce key messages of the program, query resolution at individual level.

- While CHWs would lead the implementation of these activities, during the initial stage of the program implementation, the mass awareness programs, small group as well as the one-to-one meetings can be moderated by HCs. Thereafter the CHWs can independently lead these activities and the HCs can play a largely supervisory role to ensure quality of these activities.

- In addition to this, Information, Education, Communication (IEC) material relevant to the program can be displayed in the villages.

- The mass awareness programs can include lectures, screening of documentary films like Prakashdoot with debriefing and street plays. A schedule should be prepared for such programs and one such program can be planned every month in each village depending upon the resource availability. Screening of films should be where villagers gathers as a routine, for e.g., village square, panchayat building, tea shops, water pumps, local temple or mosque. Weekly market days, special days specific to the village when people meet like village deity days, village melas etc. can also be chosen. Meetings with key stakeholders including panchayat raj institution members, farmers' groups, mitra mandal and bachat gat heads, other self-help groups, doctors in the village, religious heads prior to the activity could ensure ownership of all the community members. An attempt should be made that this activity covers every community/caste/religious group within the village.

Prakashdoot Screening in Villages

Wall paintings in villages (VISHRAM project)

- Commonly accessible public spaces like school, panchayat and health clinic walls could be chosen for display of IEC material. Similarly, such material can also be displayed at the village anganwadi centre, the health centres that are frequently visited by the community members, even if they are not in the village.

Self Help Group Meeting

- Preferably, the IEC material displayed should also provide a contact number for gaining more information about the program and the interventions. Writing of program slogans on walls with high visibility in the village can be helpful in generating interest about the program. This can be supplemented with advertisements in local magazines, announcements, songs for awareness from mobile vans/auto-rickshaws/ cycles/group-walks through every locality, films, and street plays within each locality and on occasions when the entire village gathers.

- IEC material should be more pictorial and less verbal. IEC material should be reviewed and finalized by experts to ensure that it is non-judgmental. Ensure that the language in the awareness material is easy to understand: the terminology for mental disorders is taken from the western countries, and the translations in local languages tend to use heavy technical vocabulary. Ensure that this technical vocabulary is either explained in simple terms or replaced by local equivalents. Test out drafts of your material with a few community members. Incorporate their feedback and then finalise the material.

- The small group meetings can also be used to reach out to socio-economically vulnerable parts of the village particularly to improve their interest and participation in mental health program. The meetings could involve story-telling, games, lectures, role plays, case-studies including success stories using posters, symptom cards, and other audio-visual aids like videos and power-points.
- Highlight the role of community in improving mental health outcomes of individuals suffering from mental disorders.
- Family and one-to-one meetings are taken up to take the key messages at homes of the people and provide an opportunity for informal interactions with the health workers. These activities also promote help seeking and thereby generate demand for mental health services.

Box 8: Key discussion points for small group meetings

- One must start with a problem that the group/community recognizes as an important mental health problem.
- Discussions should emphasise that common mental disorders are characterised by a cluster of symptoms that are persistent and have a profound impact on the quality of life of the person suffering as well as their immediate near and dear ones. Treatment options including the interventions of the program need to be introduced to the group.
- Similarly, symptoms and treatment options for severe mental disorders should also be discussed. At the same time, disbeliefs and myths associated with mental disorders should be elicited and addressed.
- Successfully treated patients should be encouraged to come forward and participate in such meetings. This could help in reducing fear, prejudice and stigma and help in increasing trust in the treatments for mental disorders.

How to assure quality ?

Home visit by a CHW

Regular participation and supervision of the activities taken up by HCs involved in delivering psychological intervention should be encouraged. Assessments on training and capacity of the CHWs to undertake the activities as well as participation of the community members in the activities organised by the program should be routinely monitored. For example, a HC could assess a small group meeting conducted by a CHW along the following lines of enquiry:

- Is the CHW trained to deliver material sensitively?
- Is she trained to tailor her messages to suit different audience groups?
- Is the awareness effort participative?
- How does the CHW check if the participants, at the end of the session know the take-home messages of the session?

Finally, geographic and demographic coverage of the planned activities should be routinely monitored and evaluated. Completion of pre-set targets, and demand for mental health services should be routinely assessed as well.

BOX 9: Prakashdoot

- Prakashdoot is an audio-visual film which sought to improve awareness about mental disorders and their management using short clips from popular cinema (Hindi/Bollywood movies).
- This was specially produced for VISHRAM by Dr. Anand Nadkarni, Dr. Anuradha Sovani and Dr. Shubha Thatte from Institute for Psychological Health, Thane.
- Prakashdoot was screened in the villages in sessions moderated by the CHW.

VISHRAM Outputs (Appendix)
Posters
Flip Chart
Films (Prakashdoot)

DETECTION OF MENTAL DISORDERS

Objectives

To detect common mental disorders, severe mental disorders and alcohol use disorders in the community setting

Approach

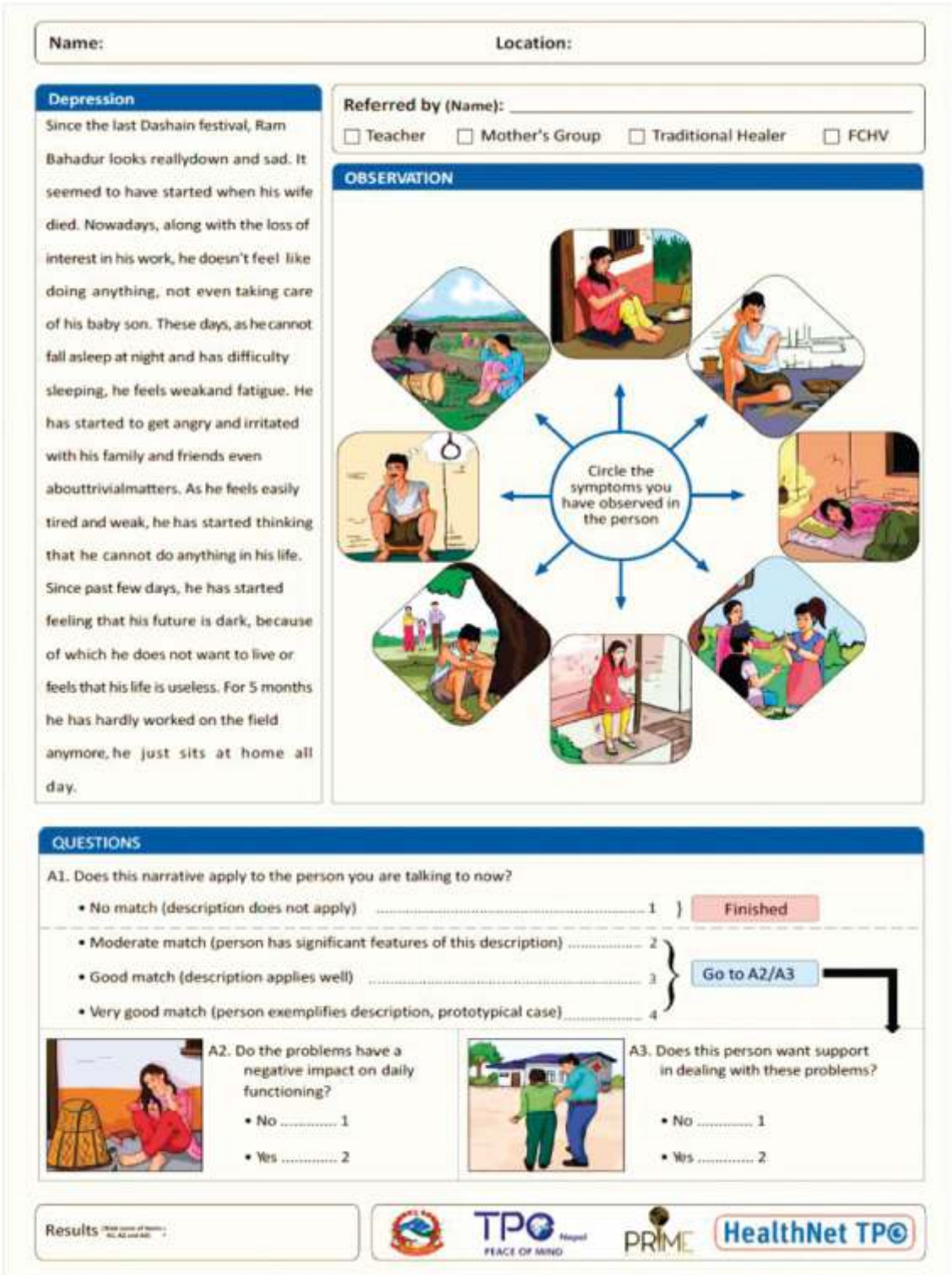
Who is involved in delivering it?

- Community level detection to be done by CHWs, further confirmation of the diagnosis using validated tools to be done by HCs.

How is it delivered?

- During the awareness generation activities, individuals experiencing psychological distress should be motivated to approach the CHWs to discuss their problems.
- CHWs should also try to identify individuals with psychological distress in need of help during their interactions in small group meetings.
- CHWs can also create a network of key informants within the village comprising of social workers, ASHAs, Anganwadi workers, previously treated patients and volunteers to support their activities to identify individuals in need of help.
- Confirmation of the diagnosis by HC should be done by using validated tools, viz; Patient Health Questionnaire-9 (PHQ-9) and Alcohol Use Disorder Identification Test (AUDIT).
- Discussion on reasons of distress and screening should be preferably done in a safe and private setting suitable to the individuals – CHWs could therefore plan home visits to undertake screening.
- Pictorial check list such as the one used in VISHRAM or a validated check list like Community Identification and Detection Tool (BOX 9) should be used for the first level detection of mental disorders.
- Depending on the severity of the condition and risk assessment, CHW should take a decision to refer the individual to HC.
- Identification of severe mental disorders in the community setting is relatively easy as community members and key informants are aware of the behavioural symptoms of severe mental disorders such as psychosis, mania and epilepsy. The key informants should be contacted and using the checklists mentioned above, CHWs can do the detection.

BOX 10: Community Identification and Detection Tool



Name: Location:

Depression

Since the last Dashain festival, Ram Bahadur looks reallydown and sad. It seemed to have started when his wife died. Nowadays, along with the loss of interest in his work, he doesn't feel like doing anything, not even taking care of his baby son. These days, as he cannot fall asleep at night and has difficulty sleeping, he feels weakand fatigue. He has started to get angry and irritated with his family and friends even abouttrivialmatters. As he feels easily tired and weak, he has started thinking that he cannot do anything in his life. Since past few days, he has started feeling that his future is dark, because of which he does not want to live or feels that his life is useless. For 5 months he has hardly worked on the field anymore, he just sits at home all day.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION

Circle the symptoms you have observed in the person

QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) ..... 1 } Finished
- Moderate match (person has significant features of this description) 2
- Good match (description applies well) ..... 3 } Go to A2/A3
- Very good match (person exemplifies description, prototypical case) 4

A2. Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

Results

TPO Nepal PEACE OF MIND PRIME HealthNet TPO©

Source: Jordans et al. Accuracy of proactive case finding for mental disorders by community informants in Nepal. Br J Psychiatry (doi: 10.1192/bjp.bp.113.141077)

How is quality assured?

- CHWs should be initially supervised by HCs as they conduct the first level detection using check lists to ensure that there are no false negatives, i.e. individuals not referred to HCs even if they have mental disorder/high suicide risk.
- Real time monitoring of this package can be achieved using mobile data entry by CHWs and checked by HCs on a daily basis.
- At the end of each day CHW reports to the central database the name, contact number and village name of the individual screened, the result of the detection and the date and time of the next step suggested.
- The M& E Officer (or the central database coordinator) at the end of the day prepares a master list of individuals who have been screened and the people who have been given appointments for counselling by the HCs. This list is then sent to HCs and program coordinator by SMS or applications such as Whatsapp.
- HCs should randomly visit those individuals who were provided psychological first aid but were not referred to HC and assess if the non-referral was appropriate.
- Weekly target for number of individuals screened per CHW can be set and this can be supervised by HC in weekly review meetings.

VISHRAM Outputs (Appendix)
VISHRAM Pictorial Check list

PSYCHOLOGICAL FIRST AID

Objectives

To provide psychological first aid to those individuals who experience psychosocial distress.

Approach

Who is involved in delivering it?

- ☑ Community Health Workers

How is it delivered?

- ☑ Multiple online resources are available which can serve as a guide to provide psychological first aid. In VISHRAM, the Mental Health First Aid (MHFA) Guidelines developed by Prof Anthony Jorm and team at the University of Melbourne were adapted for use in the local context.
- ☑ CHWs should be first trained in basic counselling skills and then in delivery of MHFA.
- ☑ The PREMIUM Counselling Relationships (CR) manual developed by Sangath can be used for training CHWs in basic counselling. The CR manual provides information about the basic skills required for counselling in a practical and simple to understand format. It is meant to accompany the Healthy Activity Program (HAP) and Counselling for Alcohol Problems (CAP) manuals (described below).
- ☑ Course in CR is available online at http://staging.nextgenu.org/course/view.php?id=179#0
  The course consists of 17 modules of online study which include text content, presentations, role-play video demonstrations and self-assessment tests. The course provides a step-by-step guide on how to be a good counsellor.

☑ MHFA should be delivered to any individual who reports experiencing psychosocial distress. MHFA consists of five essential steps

1. Listening non-judgmentally
2. Assessing risk of harm to self or others
3. Giving reassurance and information
4. Encouraging the person to get appropriate help if needed
5. Encouraging self-help strategies

☑ MHFA guidelines are available on https://mhfa.com.au/

How is quality assured?

HCs should regularly accompany CHWs during their home visits and supervise the delivery of MHFA sessions. In the initial sessions after trainings, HCs should lead and moderate MHFA sessions to ensure hand-holding of CHWs and field-based learning. Additional supervision visits by Intervention Coordinator should also be planned, especially during the initial implementation phase.

☑ Quality of MHFA delivery could be assessed using the following points:

- Adequate participation from the individual receiving the intervention and his/her near-and-dear ones, if present
- Listening skills of the CHW and maintenance of a non-judgemental attitude during the session
- Appropriate assessment of the risk of self-harm (and harm to others) and referral to the HC
- Capacity of the CHW to provide reassurance appropriately
- Encouragement provided by the CHW to adopt self-help strategies and help-seeking

VISHRAM Outputs (Appendix)
Mental Health First Aid Flip Chart

PATIENT FOLLOW-UP

Objectives

To provide follow-up care and ensure adherence to therapy (both pharmacological and psychosocial) and to prevent patient drop-out

Approach

Who is involved in delivering it?

- ☑ Community Health Workers

How is it delivered?

- ☑ M&E Officer (with help from database coordinator) should develop a follow-up schedule based on the data entered on a daily basis.
- ☑ The schedule should be sent to CHWs using SMS or Whatsapp and this well help CHWs to plan their daily follow-up visits in the village.
- ☑ CHWs should follow up on activity reminders for HAP users and motivation for AUD patients.
- ☑ Medication side-effects and adherence should be checked for patients who have received pharmacological treatment either from general physician or psychiatrist.
- ☑ CHWs should maintain a record in their diaries which should include details of the follow-up visit such as name of the patient, medication side-effects, adherence to medications and psychosocial interventions. This record can be uploaded to central database by mobile data entry

How is quality assured?

- ☑ HCs, Intervention Coordinator and Program Coordinator should review follow-up data during weekly meetings.
- ☑ Reasons for patient drop-out should be discussed with each individual CHW.
- ☑ HCs, Intervention Coordinator and Program Coordinator should plan random visits in villages to contact enrolled patients and enquire with them if the local CHW has visited them, the number of times of these visits and what was discussed during the visits.

VISHRAM Outputs (Appendix)
Patient Follow_up Sheet

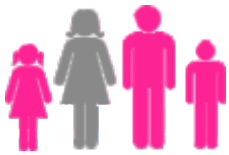
INTERVENTIONS FOR SUICIDE ATTEMPTERS AND SUICIDE AFFECTED FAMILIES

Objectives

To identify individuals who have attempted suicide

To follow-up these individuals to reduce the risk of a repeated suicide attempt

To identify the families of individuals who have died by committing suicide



To follow-up these families and identify family members with suicide risk

Approach

Who is involved in delivering it?

☑ Community Health Workers and Health Counsellors

How is it delivered?

☑ **Identification:**

CHWs should try to create a network of key informants within their villages who will inform them immediately if any individual in the village attempts a suicide or commits suicide. A list of all the facilities which provide emergency medical services should be prepared and they can be contacted to identify individuals admitted in the emergency units for pesticide poisoning or any other suicide attempt.

Intervention:

CHWs should try to contact these individuals who attempted suicide and families of suicide affected individuals within one week of the incidence. It is advisable to take a prior appointment before the meeting. CHWs can then interview affected individual and his/her significant others and affected family (in case of suicide) using the tools develop in VISHRAM. It is critical to assess the risk of suicide in both the scenarios mentioned above and HC should be informed about the same. After the visit of CHW, HC should also contact the affected individual or affected family along with CHW and review the situation. They can be registered to receive into HAP or CAP intervention and if HC finds that the symptoms are severe and there is persistent high risk of suicide then they should be referred to the psychiatrist. The affected individual can be assessed by the psychiatrist at home (if feasible) or in the outpatient clinic, diagnosis of any co-morbid psychiatric illness can be made, and a treatment plan can be developed.

Follow-up:

CHWs should schedule regular visits to affected individuals and affected families. If a particular scheduled visit is missed then at least a phone call should be made. During each visit or phone call, the individual will be asked how he or she feels and if any other social support is needed. If the person needs support he or she will be referred to an appropriate organisation. If the person does not need support, but a risk is noted, referral to HC be made. CHWs should facilitate to build a local support system within the network of the individual and discuss various ways of supporting the family. Youth and other social welfare organisations can be involved to provide support for the affected families. CHWs and HCs can provide information on existing social welfare schemes and attempts should be made to link them with Governmental or Non-Governmental Organizations.

Community level interventions:

CHWs, HCs and Program Coordinator can organize meetings within villages to orient all the community stakeholders on how suicides can be prevented. Various ways to reduce access to means such as safe pesticide storage practices can be discussed with the community members. Safe storage in households (locked cupboards) should also be encouraged.

How is quality assured?

Program Coordinator and HC should ensure that all the cases of suicide attempts and completed suicides in a village are recorded by CHW. This can be done during supervision visits to the village by interacting with community stakeholders and key informants and enquiring about suicide attempts and completed suicides. HCs and Intervention Coordinator should accompany CHWs during their visit to affected individuals and affected families to supervise the delivery of interventions mentioned above. Psychosocial interventions delivered by HCs should be audio-recorded (after obtaining appropriate consent) and should be rated by Intervention Coordinator and peers (i.e. other HCs).

VISHRAM Outputs (Appendix)
Guide for interviewing individual who attempted suicide
Guide for interviewing members of suicide-affected family

LIFE AFTER A SUICIDE ATTEMPT

Ms. M was married for eight years to an alcoholic husband. Her mother passed away when she was a child. Originally from Jalna her marriage took her first to Wardha and then to Asegaon near Chandur Bazaar. She was her husband's second wife, the first had been abandoned as she couldn't become a mother. Ms. M has two daughters and a son. The daughters aged 7 and 6 are in a hostel where education is free; the son, 4 is yet to go to school and lives with her husband's parents and brothers.

Ms. M tried to get her husband off alcohol but she was unsuccessful. Unfortunately, he spent all his income on drinking. She faced domestic violence at her home. Her in-laws beat her and threw her out of the house on two occasions. Her husband was also with her in-laws. Once she even had to beg alms in the village. Once she ran away to Pune with her son. Her husband called her back, saying that he had given up drinking. After she returned, he again started drinking. To make a living, Ms. M started selling small stationery items in the village. Her husband started accusing her of having extra-marital affair. Things became unbearable for her and she consumed pesticide. She was admitted to Rural Hospital where she recovered.

The VISHRAM community health worker reported her case to the health counsellor. The counsellor met her and conducted 5-6 sessions with her. Ms. M now lives separately from her in-laws. Her husband still shouts at her on very minor issues, but she does not react. She feels she should live for her children, that their condition would be much worse without her. She says she felt much better after counselling. Especially, the thoughts of suicide has stopped entering her mind. Before being counselled she says, she would have frequent thoughts of whether to live or die, to hang herself or take poison. Thankfully, these thoughts have now ceased to come post counselling.

Level 2: Facility-based Packages

The overall goal of the facility-based packages is to provide advanced psychosocial interventions and first line pharmacological management.

ADVANCED PSYCHOSOCIAL INTERVENTIONS

Objectives

To deliver advanced psychosocial interventions to patients who screen positive for depression or AUD.

Approach

Who is involved in delivering it?

- ☑ Health Counsellors

How is it delivered?

- ☑ **Registration:** Individuals who are referred by CHWs or those who directly come to HCs should be first screened with validated screening tools such as PHQ-9 for depression and AUDIT for AUD. If they screen positive on these tools then they should be provided advanced interventions.

- ☑ **Intervention:** Healthy Activity Program (HAP) is delivered for patients with Depression and Counselling for Alcohol Problems (CAP) is delivered for patients with AUD. HCs should be first trained in Counselling Relationships and then in delivery of HAP and CAP. A brief description of HAP and CAP is provided below (Box 10 and 11 below) and the details about the intervention are in the respective manuals. Both the interventions should be tailored to deal with life stressors and it is preferable to include significant other. CHW may also participate in the initial counselling session (provided that the patient gives a consent) as it will help CHW to get oriented about the approach to treatment and can follow up with the patient regularly on the specific activities finalized during the session. HCs must ensure that after every session the patient is clear about the next day, time and site of follow-up/ counselling session. The total number of sessions to be delivered and completion of treatment is based on the guidelines mentioned in the intervention manuals. The counselling sessions are generally delivered in a facility (Primary Health Centre or Rural Hospital) in a separate room to ensure privacy. If a similar room is made available within a village then these sessions can be delivered their as well, especially for those patients who find it difficult to travel to the facility. Days and timing should be fixed for counselling in facility and villages. Phone-based remote counselling options can be explored for patients who do not visit HCs in either of the sites mentioned above. Individuals who require immediate crisis intervention such as those who have attempted suicide or those who have strong suicidal ideation can also be contacted on phone.

- **Documentation:** The details about each counselling session should be recorded in the case-sheet files provided as part of HAP and CAP manuals. Some of the counselling sessions should be audio-recorded for supervision purposes after taking due consent from patient.

- **Referral:** Patients with severe symptoms, or those who attempted suicide or had made suicidal plans and those who do not respond to the therapy are referred to the psychiatrist.

How is quality assured?

- It is critical to ensure that the delivery of HAP and CAP is as per the guidelines laid down in the respective manuals. This is best done by peer and expert supervision of the audio-recorded counselling sessions.

- Each audio-recorded session is rated using tools (Q-HAP and Q-CAP) by the peers of the HC and the Intervention Coordinator.

- The feedback is then given to the HC based on this rating and overall assessment done by peers and supervisor.

- It is advisable to schedule weekly supervision sessions, but if this is not feasible then at least one such session should be conducted per month.

- Intervention Coordinator to make regular field visits to do active on-the-job training of the HCs and co-counsel cases that the counsellor finds difficult.

- Intervention Coordinator may also schedule a call to each HC at the beginning of each day for a short feedback on cases done the previous day and a brief treatment plan for cases set for that day.

- Intervention Coordinator should also take immediate action for emergency situations such as serious medication side-effects, patient death due to suicide etc. with immediate patient visit and community visit to find out the cause and take corrective actions. All emergency situations should be immediately informed to the program coordinator, possible actions evaluated, course of action decided and action taken informed.

Box 11: Healthy Activity Program

- Healthy Activity Program (HAP) is a manualized psychological treatment based on behavioral activation

HAP includes following strategies
a) Psycho-education
b) Behavioral assessment
c) Activity monitoring
d) Activity structuring and scheduling
e) Activation of social networks
f) Problem solving

- Additional strategies used in response to specific needs consist of behavioral strategies to improve interpersonal communication skills and decrease rumination, advice regarding sleep problems and tobacco cessation, and relaxation training.

- HAP treatment has three phases, delivered in 6 to 8 sessions depending on severity of depression and progress made by the person being treated.

- HAP is delivered in an individual format, with each session lasting 30–40 minutes and initial sessions at weekly intervals.

- Sessions can be conducted face-to-face, at the PHC or patient's home or a place provided by the Gram Panchayat.

Source:

Patel V, Weobong B, Weiss HA, et al. The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: a randomised controlled trial. *The Lancet* 2017; **389**(10065): 176-85.

HAP Online Course

HAP online course is designed on the Moodle platform.

- The course is available on http://staging.nextgenu.org/course/view.php?id=178

- HAP course manual is converted into 12 modules, each module comprising text, power point video lectures, and role play videos with transcripts to demonstrate skills, and references to counsellor material and patient resources which can be downloaded along with the manual for self-study.

- It is mandatory to first complete the Counselling Relationship course, based on the Counselling Relationship manual. Once students complete this course, they are provided with an enrolment key to access the HAP online course.

- HAP manual is available on http://www.sangath.com/images/manuals/Counselling%20Relationship_Manual.pdf

Box 12: Counselling for Alcohol Problems

- Counselling for Alcohol Problems (CAP) is a manualized psychological treatment based on motivational interviewing.
- CAP is delivered in three phases over a maximum of four sessions (each lasting approximately 30–45 minutes) at weekly/fortnightly intervals.
- The initial phase involves detailed assessment followed by personalized feedback; the middle phase involves helping the patient to develop cognitive and behavioral skills and techniques, consisting of drink-refusal skills, handling of peer pressure, problem-solving skills, and handling of difficult emotions; and the ending phase involves the patient learning how to manage potential or actual relapses using the skills acquired in the middle phase.
- The general counselling and problem-solving strategies are shared between CAP and HAP treatments.
- Sessions can be conducted face-to-face, at the PHC or patient's home or a place provided by the Gram Panchayat.

Source:

Nadkarni A, Weobong B, Weiss HA, et al. Counselling for Alcohol Problems (CAP), a lay counsellor-delivered brief psychological treatment for harmful drinking in men, in primary care in India: a randomised controlled trial. *The Lancet* 2017; **389**(10065): 186-95.

CAP Online Course

- CAP online course is designed on the Moodle platform.

  The course is available on http://staging.nextgenu.org/course/view.php?id=167#0
- CAP course manual is converted into 10 modules, each module comprising text, power point video lectures, and role-play videos with transcripts to demonstrate skills, and references to counsellor material and patient resources which can be downloaded along with the manual for self-study.
- It is mandatory to first complete the Counselling Relationship course, based on the Counselling Relationship manual. Once they complete this training, students are provided with an enrolment key to access the CAP online course.
- CAP manual is available on http://www.sangath.com/images/manuals/Counselling%20for%20Alcohol%20Problems_Manual.pdf

PHARMACOLOGICAL MANAGEMENT

Objectives

To assess and deliver pharmacological treatment to patients with mental disorders who visit the Primary Health Centre or Rural Hospital (and it can be private clinic as well).

Approach

Who is involved in delivering it?

- General Physicians working as Medical Officers in the Primary Health Centre or Rural Hospitals or working in the private sector.

How is it delivered?

- Program team should first complete the training of general physicians using the modules developed by WHO mhGAP program.
- During the OPD hours, general physicians can then undertake the assessment, diagnosis and clinical management of mental disorders based on mhGAP Intervention Guide.
- Primarily patients with common mental disorders and alcohol use disorders access services in these settings and it is very uncommon for patients with severe mental disorders to visit a general physician.
- General physicians should ensure that they diagnose individuals with common mental disorders such as depression, prescribe anti-depressants in case of moderate to severe depression and then refer these patients to HCs for delivery of psychosocial interventions (Healthy Activity Program).
- General physicians should also screen and provide brief interventions for AUD as recommended in mhGAP Intervention guide and then refer these patients to HCs for delivery of psychosocial interventions (Counselling for Alcohol Problems).
- Patients who need further diagnostic assessment, have severe symptoms or high suicide risk, should be referred to psychiatrist.

How is quality assured?

- Program Coordinator should review the data from general health facilities on regular basis to assess if the referrals are appropriate and whether patients receive appropriate diagnosis and pharmacological treatment. This could be done by undertaking a prescription audit.
- Program Coordinator and M&E Officer should review the availability of psychotropic drugs in the facility.
- A meeting with general physician could be scheduled once a month to review the delivery of mental health services.

BHARATI, BRIDGING EMOTIONAL GAP

Bharti Dongare

Bharati was listening intently to Ms. S as she described how she was going for a walk regularly and had started listening to music again and simultaneously her recurrent headaches and fatigue had reduced. Her family was appreciative of her cooking again. Ms. S was introduced to Bharati, a health counsellor in VISHRAM, a couple of weeks ago by Savita who is an ASHA worker and also working as a community health worker in VISHRAM. Before Ms. S met Bharati, she suffered from recurrent headaches and several visits to local doctors did not result in any relief. Unfortunately, some of the doctors had even commented that Ms. S was simply trying to gain attention and did not have any real medical problem. As a newly-wed, Ms. S had no close friends in the new village and she felt very tired since the time of her marriage. Then Savita had visited her one morning and asked her to meet Bharati.

Bharati had a strong impression on Ms. S in their first meeting. This was the first time that someone had asked her if she was feeling stressed and unhappy and made a connection between her feelings and her headache and fatigue. Together they made a plan that included a walk in the morning and light yoga later after her husband went off to work. She also decided to listen to music while cooking in the kitchen just as she would while doing household work before marriage. Bharati was skillful at using 'Healthy Activity Program' which is based on behavioural activation to address depression. She visited Ms. S regularly for a few weeks to ensure that Ms. S felt better.

Level 3: Specialist Care

Objectives

To assess and deliver pharmacological treatment to patients with mental disorders referred by HCs, general physicians and those who directly contact the psychiatrist.

To supervise and provide hand-holding supporvt to the general physicians and HCs.

Approach

Who is involved in delivering it?

- Psychiatrist either involved with the District Mental Health Program or working in the private sector.

How is it delivered?

- Psychiatrists are generally based in big towns such as district headquarters which makes the access to mental health care very difficult. Specialists care can be provided closer to the community by organizing out-reach clinics/specialist clinics in public health facilities such as the Rural Hospitals or Primary Health Centres in the district.
- The clinics can be organized once a month per facility depending on the availability of the psychiatrist and overall feasibility based on program resources.
- It is very helpful to decide a particular day (e.g. first Tuesday of every month) for specialist clinic in a particular facility as then the patients and community members in the neighborhood can remember this easily and can schedule their follow-up visits.
- Specialist clinics conducted within the premises of the general health facility instead of a separate facility or location within the village/town help in increased interaction of patients with mental disorders and general community members which can help in stigma reduction.

- Program Management Team in association with the District Mental Health Program and Department of Health Services should make all the logistic arrangements for these clinics.
- Program Management Team must ensure that all the essential psychotropic drugs are available during the specialist clinic as well as between the clinics if patients come for prescription refill. Psychotropic drugs are generally included in the Essential Drug List (EDL) and engagement with health services staff should be undertaken to procure these drugs.
- CHWs should inform community members and patients in the villages about the specialist clinics at least one week in advance and should make sure that patients who need specialist interventions are particularly reminded of the specialist clinic and their travel to the facility is facilitated.
- HCs should make a list of patients enrolled in HAP and CAP who require a referral to the psychiatrist and ensure that these patients reach the specialist clinic.
- In the specialist clinic, psychiatrist should make a thorough assessment of all the patients referred by HCs, especially those who have not responded to psychosocial interventions, who have high suicide risk, previous suicide attempters and suicide affected family members.
- Psychiatrist can then take a decision about the pharmacological treatment and if required can refer the patient to tertiary care centre for further management.
- In addition to clinical service delivery, psychiatrist should also discuss the case with the HC and provide the feedback on the way the case was handled.
- Psychiatrist can also organize a small group or one-on-one discussion with general physicians within the facility to discuss issues in assessment and treatment of mental disorders and can provide feedback on pharmacological management initiated by them.

MOVING OUT OF THE SHADOWS OF DEPRESSION

In a single room on the edge of the large village of Ghatladki in Chandur Bazaar taluka lives a 50 year old illiterate woman Ms. D with her husband. An adivasi, she speaks Korku and Hindi. Four years ago, Ms. D's older son was allegedly murdered by some known persons in the village. The alleged murderers were jailed and released after six months. Ms. D developed 'tension' because of this incident; she stopped eating, began to gather stones and keep them in the house. She would run out of the house with stones in her hand and tie her legs with a rope till she could hardly walk. She could get no sleep and if someone slept, she would not let them sleep and kept on speaking. She stopped going out to work or cook at home.

Two years ago, VISHRAM Community Health Worker took her to the specialist clinic where she was prescribed medications. Initially, she developed dizziness, but subsequently the dosage was reduced. With continued medication, her symptoms decreased, and around one year ago she restarted working. She also attended 2-3 counselling sessions by VISHRAM Health Counsellor. She feels she has got a lot of relief because of the medication and the compassionate care she received from the community health worker and the health counsellor.

How is quality assured?

- Program Management Team including the Principal Investigator and the Program Coordinator should review the data of specialist clinics on regular basis to assess if the referrals are appropriate and whether patients with severe symptoms receive specialist interventions.
- Program Coordinator and M&E Officer should review the availability of psychotropic drugs.

Specialist Clinic

VISHRAM Outputs (Appendix)
Patient Record Form_First_Consultation
Patient Record Form_Follow_up
Narrative Case History Sheet

Table 6: Service Delivery Packages

Package	Target Population	Activities	Platform/Level of Care	Service Provider
Awareness and Stigma reduction	**General Community**	Mass Awareness Programs (e.g. screening of Prakashdoot) Small group meetings Family and one-to-one meetings	**Community-based**	CHW
Detection of Mental Disorders	**Individuals at risk in the community**	Screening of mental disorders using pictorial checklist	**Community-based**	CHW
	Individuals attending primary care (PHC and RH)	Identification of depression using PHQ-9, and AUD using AUDIT	**Facility-based**	HC
		mhGAP based assessment and diagnosis	**Facility-based**	General Physician
Treatment of Mental Disorders	**Individuals with Mental disorders**	Psychological First Aid	**Community-based**	CHW
	Individuals with diagnosed depression and AUD	Healthy Activity Program for depression and Counselling for Alcohol Problems for AUD	**Facility-based**	HC

Package	Target Population	Activities	Platform/Level of Care	Service Provider
	Individuals attending primary care (PHC and RH facilities	mhGAP based pharmacological management	**Facility-based**	General Physician
	Individuals not responding to counselling, with high suicide risk and individuals with severe mental disorders (psychosis, epilepsy etc..)	Diagnostic assessment and pharmacological management	**Specialist Care**	Psychiatrist
Patient Follow-up	**Individuals enrolled in HAP/CAP and those receiving pharmacological treatment**	Follow-up for treatment through family and one-to-one meetings in the community	**Community-based**	CHW
Suicide prevention	**Individuals who have attempted suicide and family members of individuals who have committed suicide**	Identification of individuals who have attempted suicide and family members of individuals who have committed suicide	**Community based**	CHW
		Risk assessment and psychosocial interventions	**Community-based**	CHW and HC
		HAP and CAP as appropriate	**Facility-based**	HC
		Assessment by Psychiatrist	**Specialist Care**	**Psychiatrist**
		Follow-up care	**Community-based**	CHW

RECOVERY FROM DRINKING PROBLEMS

Mr. N, dropped out of school after the 8th grade. At 15 years of age he went to Pune and spent next five years as a cook. He returned home and since year and a half he and his brother have run a pan, tea and snack stall on the road to Ghatladki in the Chandur Bazaar taluka.

In Pune, Mr. N started consuming alcohol. In the year after returning to Ghatladki he would consume hard liquor in a bar every evening. He would drink alone, return home, have dinner and sleep. This was the time when Janrao, a health counsellor in VISHRAM met him. He asked, “do you want to stop drinking?.” “Yes” said Mr. N immediately, expecting that Janrao would give him some medication. They spoke briefly for 15 to 20 minutes. Janrao took a brief history and then alluded to Mr. N's strengths; his business acumen, hard work, his excellent reputation among villagers.

Janrao posited that stopping drinking would improve Mr. N's status at home. After reaching home someone would get a glass of water for him which won't happen if he were to return home drunk. Being sober would make a difference to the ambience at home, to the way Mr. N would present himself and his overall status in the community. Mr. N heard Janrao and thought that what Janrao said made lots of sense and will be helpful in long run. The interaction was effective as immediately after this meeting Mr. N did not drink for two days. But he couldn't get sleep without alcohol. He resumed drinking but reduced his intake to half. Slowly he tapered off his intake so that in around six months' time his drinking came down to once a month and that too only with his friends. After the first interaction Janrao continued to pay brief visits to Mr. N. Mr. N is now planning to marry and settle down. “Got free of liquor, peace came in”, he reflects.

SECTION IV
PROGRAM EVALUATION

Program Evaluation is a key activity whose goal is to understand whether the program has achieved its intended objectives. Every program must develop monitoring indicators that help in reviewing the progress of the program as it is implemented.

Objectives

To design and pilot the Monitoring and Evaluation (M&E) plan

To train the lay health workers to report on key performance indicators based on finalized M&E plan

To establish the information system to generate weekly, monthly and annual progress reports

To undertake appropriate course correction based on the performance data

Approach

- During the preparatory phase of the program, M&E Officer should lead the design of M&E plan. One of the components of the TOC workshop is to operationalize various pre-conditions and outcomes in the TOC map by finalizing the indicators. During the TOC workshop, the purpose and scope of M&E should be clarified with local stakeholders and M&E plan can be drafted. This can then be presented to the program core team and advisory group and based on their inputs it can be finalized.

- Some of the key aspects to be covered in the M&E plan should include the extent to which the program addresses awareness about mental disorders and help-seeking and mental health needs of the communities, and the impact of the program in assisting in recovery from mental disorders on wider socioeconomic well being, and the resource implications for attaining these goals.

- HCs and CHWs should be then trained to collect and maintain case files, clinical notes, and ensure that complete and accurate data is filled into the formats. Regular, complete and valid reporting on key performance indicators related to clinical interventions and other program activities is crucial. After this training, M&E plan should be piloted in the field and refined based on the operational feasibility of collecting the data. As far as possible, data should be digitally recorded using mobile technology.

- M&E Officer is primarily responsible for setting up the information system. An additional database manager and field researchers could be employed if the resources are available. This team will be responsible for collection, collation, analysis and synthesis of the monitoring data.

- M&E Officer should consider all ethical issues and, if necessary, obtain appropriate ethical approvals.

- M&E Officer should generate monthly reports and present it to the core team to assess the progress of the program implementation and various inputs and outputs of the program. In addition to this, annual progress reports should be generated to be discussed in the advisory group meetings and weekly reports should be used to provide feedback to the lay health workers.

- The most critical aspect of M&E is to use the information from the field to take appropriate course corrective actions. Program core team led by the PI should ensure that there is two-way flow of information which helps in improvement of the overall quality of services delivered.
  M&E officer should also undertake regular audits to analyse the completion, accuracy and timeliness of the data. Finally, data safety, security and confidentiality protocols need to be developed and operationalised.

BOX 13: Three levels of indicators which are critical for monitoring and evaluation of any community mental health program

- **Input or resource indicators** inform us about the utilization of resources, either project financed or financed by external sources, for each activity. These indicators provide an estimate of the actual costs and other resources needed to implement the program and are useful both to estimate the cost-effectiveness of the program and its long-term sustainability. Examples of input indicators include budget allocated for the program, number of health workers recruited, number of health workers trained etc.

- **Process indicators** inform us about what actually took place during the project. These indicators are linked to input indicators, but measure the actual implementation of actions and their immediate outputs, for example, the number of people with depression who were identified and offered psychosocial interventions.

- **Outcome indicators** measure the degree to which the program was able to achieve its overall objectives.

Table 7: Indicative Monitoring Framework for a Community Mental Health Program (Enabling Packages)

Package	Process Indicators	Output indicators
Governance	# of Program staff recruited and frequency of Program Management Team meetings # of participants per Program Management Team meeting and frequency of Program Advisory Group meetings # of participants per Program Advisory Group meeting and frequency of Community Advisory Board meetings of participants per Community Advisory Board meeting	of program staff trained, supervised and appraised in their roles Agenda and progress reports circulated in advance before the meeting Minutes circulated within a week of the meeting Action taken report filed before each subsequent meeting Technical and financial reports and forecasting submitted as required
Capacity Building	# of trainings conducted for lay health workers (CHWs and HCs) # of lay health workers (HCs and CHWs) who participated in training # of visits conducted for supportive supervision/ hand holding support # of trainings conducted for general physicians (e.g. PHC medical officers) # of general physicians who participated in trainings # of orientation program conducted # for specialists (e.g. psychiatrists) # of specialists who participated in orientation programs	Change in knowledge of lay health workers (HCs and CHWs) and of general physicians Competence assessment of lay health workers (HCs and CHWs) and general physicians

Package	Process Indicators	Output indicators
Community Mobilization	# of meetings conducted with leaders of Panchayat Raj Institutions (e.g. Gram Panchayat, Zilla Parishad) # of SHGs and other community-based organizations contacted # of service-users actively engaged with the program	# of meetings held by Panchayat Raj Institutions with an agenda to discuss mental health service delivery # of resolutions passed by Panchayat Raj Institutions to advocate delivery of mental health services # of SHGs supporting recovery of service-users # of community leaders working as program 'champions' # of service-users working as mental health advocates

Table 8: Indicative Monitoring Framework for a Community Mental Health Program (Service Delivery)

Level of Care	Process Indicators	Output indicators
Community-based Packages		
Awareness and Stigma reduction	# of mass awareness programs conducted (e.g. # of screenings of Prakashdoot film) # of small group meetings conducted # of family and one-to-one meetings conducted Display of IEC material (e.g. # of wall-paintings in a village)	# of individuals who participated in mass awareness programs # of individuals who participated in small group meetings # of individuals who participated in family and one-to-one meetings
Detection of mental disorders	# of individuals contacted/interviewed by CHWs # of completed pictorial checklists	# of individuals with CMD, SMD and AUD identified by CHWs
Psychological First Aid	# of individuals contacted by CHWs for psychological first aid	# of individuals who received psychological first aid from CHWs # of individuals referred to HCs
Patient Follow-up	# of individuals registered for follow-up care in the program database	# and proportion of individuals who are followed-up and provided continuing care by CHWs
Interventions for Suicide attempters and Suicide affected families	# of individuals who attempted suicide identified by CHWs # of completed suicides identified by CHWs	# of individuals who attempted suicide, provided intervention by CHWs (and reviewed by Hcs) # of suicide affected families provided intervention by CHWs (and reviewed by HCs) # of individuals who attempted suicide and # of suicide affected family members registered by HCs in Healthy Activity Program # of individuals who attempted suicide and # of suicide affected family members referred to psychiatrist

Level of Care	Process Indicators	Output indicators
Facility-based Packages		
Advanced Psychosocial interventions	# of individuals enrolled by HCs to receive HAP and CAP # of HAP sessions delivered per patient # of CAP sessions delivered per patient	# and proportion of patients enrolled in HAP who received planned discharge and those who were drop-outs # and proportion of patients enrolled in CAP who received planned discharge and those who were drop-outs # and proportion of patients referred to specialists
Pharmacological management	# of CMD, SMD and AUD patients diagnosed by PHC medical officers	# of patients with CMD, SMD and AUD who received pharmacotherapy from PHC medical officers
Specialist Care		
Interventions by Psychiatrist	#of CMD, SMD and AUD patients referred to psychiatrists of Specialist Clinics conducted in PHC and RH	# and proportion of patients with CMD, SMD and AUD who received pharmacotherapy from the psychiatrist # of follow-up visits in specialist clinic per patient # and proportion of patients with CMD, SMD and AUD referred to the tertiary center for further management (e.g. detoxification for AUD, in-patient care for SMD)

VISHRAM Outputs (Appendix)
Individual Patient Tracking Sheet_HC_CHW
Individual Patient Tracking Sheet_Specialist_Clinic
Medicine Stock Record Sheet
CHW Monthly Monitoring Sheet
HC Monthly Monitoring Sheet
Training Sheet

SECTION V
TROUBLE SHOOTING

Implementation of a community mental health program can present several challenges. The table below lists a set of commonly encountered challenges and potential solutions for them. It is necessary to discuss anticipated challenges and develop a plan for mitigating them. A list of common challenges is presented below, but by no means is this exhaustive and readers are encouraged to think about challenges and risks in their setting while developing a community mental health program.

Challenges in Program Implementation	Potential Solutions
Patient and Family Level	
Low level of awareness and help seeking for mental disorders and high level of stigma	● Community-based interventions led by lay health workers using awareness raising materials such as films (e.g. Prakashdoot), posters, flip-charts in the mass awareness programs and small-group meetings help in improving knowledge about mental disorders, availability of services for same and also help in reducing negative attitudes towards mental disorders. ● Wall paintings in the village and distribution of IEC material should be done. ● Face-to-face contact and interaction of community members with treated patients is beneficial in reducing stigma.
Low level of acceptability of psychosocial interventions in the community	● The goal of the program should be to address the psychosocial distress in the communities with 'well-being' as the key theme instead of only diagnosing and treating the 'disorders'. This will help to emphasize the point that psychosocial interventions are also legitimate methods to reduce individual distress and will help to shift the focus from purely bio-medical conceptualization of mental disorders to a more broader biopsychosocial approach

Challenges in Program Implementation	Potential Solutions
	• Interventions should have a strong component of strengthening social networks and linking affected individuals to various social welfare schemes as this will underline the practical utility of psychosocial interventions. • Patients who have successfully completed the counselling treatment should be invited to volunteer as program champions.
Community Level	
Huge unmet need of people with severe mental disorders competing with the programme priorities.	• It is important to 'de-link' common mental disorders, substance use disorders and severe mental disorders from one another as the community level conceptualization and beliefs about these disorders, perceptions and attitudes towards these disorders and intention to seek professional care are markedly different. • Community engagement activities should primarily focus on common mental disorders and substance use disorders and educate them about the availability of robust psycho social interventions. • A slightly different approach can be employed for severe mental disorders where key informants can help detect patients who can then be initiated on pharmacological management supported by psycho-education of family members.

Challenges in Program Implementation	Potential Solution
Achieving and sustaining engagement with communities	• Engage with communities through institutions and individuals with established local history to build trust, destigmatize mental illness and emphasize the benefits of the program. • Program can be introduced in the village by a Medical Officer from the PHC or a key member of the Panchayat Raj Institution to ensure community buy-in. • Program should emphasis the link between social distress and physical and mental health problems. • Establishment and active engagement of Community Advisory Boards in communities.
Missing out of certain population groups that are more vulnerable	• Participatory Rural Appraisal and Social Mapping can be used to engage with community members. This exercise can focus on developing the understanding of how village population is segregated on religious, caste and socio-economic status. • The program staff can then actively network with various community groups, services providers and other community resources to strengthen their engagement.
Provider Level	
High level of patient drop-out	• Regular tracking of patient follow-up data by M&E Officer and Intervention Coordinator to assess the proportion of patients completing the treatment and those who are dropping-out.

Challenges in Program Implementation	Potential Solution
	• Feedback this data to individual HCs and request them to follow-up with patients who are not regular in the treatment or have dropped-out. • Home visits by HCs and CHWs to encourage adherence to pharmacological and psychosocial interventions. • Intervention Coordinator to undertake in-depth interviews with drop-out patients to understand the factors leading to dis-continuation of treatment. Appropriate actions to be initiated to address these barriers.
High workload on healthcare workers and high turn-over of trained resources	• Integrate mental health interventions with interventions for other physical health problems. • Design or adapt existing interventions such as HAP to be delivered to health workers to reduce their distress and burn-out. • Appointment of additional work-force depending on the feasibility and resource availability. • Develop a group of peer-volunteers and expert patients to help health workers. • Introduce non-monetary incentives for health workers such as 'performer of the month' award or formal accreditation.
Ensuring high quality of psychosocial interventions administered by the CHWs and HCs in the community	• Hand-holding and on-job training of HCs and CHWs to ensure appropriate delivery of interventions.

Challenges in Program Implementation	Potential Solutions
	• Weekly (or at least bi-monthly) supervision of audio-taped sessions of psychosocial interventions by peers and Intervention Coordinator (and Psychologists if resources are available) to assess the quality of service delivery.
Program Level	
Effective coordination with all the program partners	• Establish MOU and TOR with partner organizations to clarify the roles and responsibilities. • Periodic (at least once in a quarter) site visits by project PI and the core team and use of facilities such as teleconferencing to ensure optimum communication
Developing and maintaining a low resource intensive yet efficient information system and ensuring timeliness and completeness of clinical data of the patients	• Mobile based data collection ensures timeliness of data entry and multiple built-in checks can be designed to ensure the validity and completeness of data. • Regular on-site and distant supervision by Program Coordinator and M&E Officer.
Policy Level	
Achieving and sustaining interest and commitment of the local governments, local public and private sector health care providers in implementation and evaluation of the program	• Engage with the health leadership at local and regional level from the start. • Establish MOU and TOR with the government agencies. • Obtain government resolution or directives in the beginning to ensure smooth implementation of program activities. • Invite officials to monitor the program delivery and contribute to the project. • Participation of diverse stakeholder groups, including civil society groups and media, who can advocate based on the lessons of the program.

Box 14: Challenges in VISHRAM

Continuing Care: Most of the patients enrolled in HAP received two to three counselling sessions as it was difficult to retain them in the treatment. This might be due to several reasons, but the key challenge was low acceptability of 'counselling' as an 'intervention'. In addition to this, the process of individual follow-up in the village by CHW following a counselling session by HC or after the specialist clinic was not well established. It is critical to ensure that the full dosage of the psychosocial intervention is delivered and there is adherence to the psychotropic medications prescribed.

Quality of Care: During the VISHRAM implementation phase, supervision of psychosocial interventions was undertaken by reviewing audio-taped sessions by peers, Intervention Coordinator and a Specialist (psychiatrist). However, ensuring regular submission of recordings was a challenge probably indicating reluctance of the HCs to provide recordings of the sessions they had delivered. Field-based supervision of HCs by Intervention Coordinator was also limited due to feasibility related issues.

Alcohol Use Disorders: One of the major challenges was to involve persons with the alcohol use disorder in the program. In VISHRAM, only 27 individuals with AUD were enrolled for treatment during 18 months implementation period compared to 505 individuals with depression enrolled in HAP.

Community Involvement: VISHRAM community-based interventions were able to increase the demand for mental health services, even reaching out to vulnerable sections of the population, yet it was felt that the ownership of the program by the community was limited and it would have been helpful to further mobilize community members effectively.

Role of Specialists: The role of the doctors, particularly the Medical Officers of the Primary Health Centre and the Psychiatrists involved with the program remained limited to providing services and their involvement as facilitators and champions of the program was limited.

VISHRAM
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Contributors

Vikram Patel and Rahul Shidhaye provided overall leadership to VISHRAM and conceptualized this toolkit. Rahul Shidhaye wrote the first draft and edited all versions of the draft. Rahul Shastri and Rachana Parikh contributed various sections of the draft. Vaibhav Murhar provided major editorial inputs. Siddharth Gangale and Suvarna Damle provided inputs at various stages of the preparation of the toolkit. Hritu Shrivastava, Azaz Khan, Abhishek Singh and Ram Vishwakarma did the proof-reading and provided comments on the advanced version of the draft.

Vikram Patel finalized the basic structure of the toolkit and provided editorial comments.

Sharmila Coutinho copy-edited the draft and designed the layout.

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About Sangath

Sangath (www.sangath.com) is a non-governmental organisation (headquartered in Goa, India); its pioneering strategy has been to use relatively low-cost human resources, by empowering ordinary people and community health workers, to deliver mental healthcare with appropriate training and supervision from experts. The strong emphasis on innovative solutions to challenges in low resource settings has gained relevance and acceptance locally and globally.

Usage of this toolkit

This toolkit is freely available for use and adaptation by professionals working in the area of public mental health. Please acknowledge this document if it is used for program design and implementation and kindly share experiences of using this toolkit.

CELEBRATING 20 YEARS
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20 YEARS OF INNOVATING, CREATING KNOWLEDGE, AND MAKING A DIFFERENCE

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