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The Jan Man Swasth Programme

Grant closure report

(March 2013 - September 2017)

Supported by

TATA TRUSTS

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The Jan Man Swasth Programme

Collaborating institutions

परिवर्तन

Parivartan Trust

Ashadeep

the ant
the action northeast trust

The Ant

Ramakrishna Mission Home of Services

ASHWINI

Jan Chetna Manch

frch

Foundation for Research In Community Health

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Introduction

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In India, the most recent estimates from the National Mental Health Survey 2015-16, suggest that about 10.8% of the population above the age of 18oraround 150 million persons, are currently suffering from depression, anxiety or psychotic disorders that need active treatment. Unfortunately, only a small proportion of those in need of treatments actually receive them. The gap between the need for and the availability of services ('treatment gap') in India is estimated to be >80% for all disorders other than epilepsy. The lack of treatment has serious human costs- great personal and family distress, greatly increased mortality and disabilities across many domains of everyday life. Making mental health treatments more widely available, affordable and acceptable in India is, therefore, both a health and ethical priority.

More recently, the government is making a renewed effort to address these long standing problems with greater commitment through a systematic framework of enabling policies, plans, budgets and human rights protection laws. On a positive note, there are existing models of providing community based care for a number of mental disorders- both severe illnesses like schizophrenia and the more common ones like depression and anxiety- that have been successfully tried and tested in India at small scale. However, there is a critical gap in the knowledge base of how these policies and programs can be translated at sufficient scale to achieve greater coverage, equity and quality in routine health settings. Overcoming this gapin a concerted manner and making the science and experience of translational science more widely available can help make mental health treatments more widely accessible in India.

In this context, the Jan Man Swasth Program or the JMSP was conceived and developed to translate evidence based treatments into catchment area based, community mental health services in diverse real life settings. The JMSP was

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designed to address the treatment needs of adults with selected priority (as outlined in the Mental Health Gap Action Program- mhGAP of the WHO)mental disorders and their caregivers. This included people with:

- Common Mental Disorders (CMD)- this term describes commonly occurring mental disorders like depression, anxiety and mixed depression and anxiety disorders
- Severe mental Disorders (SMD)- this refers to serious psychotic disorders like schizophrenia, bipolar disorders and other psychoses
- Convulsive epilepsy: those epileptic disorders accompanied by overt convulsions
- Alcohol Use Disorders (AUD): this refers to a range of problems caused by excessive and problematic use of alcohol
- Suicide prevention

Aims and objectives

There were two overarching aims of the Jan Man Swasth program-firstly, to improve the treatment coverage for people with selected mental disorders in defined catchment areas through a structured multidimensional intervention across diverse settings; and, secondly, to address the systemic challenges faced in implementing sustainable mental health interventions.

The specific objectives of the JMSP were to:

- develop, implement and evaluate the feasibility, acceptability and fidelity of the JMSP across sites
- improve the treatment coverage and address social determinants of recovery for people with SMD, CMD, Epilepsy and AUD in catchment area
- engage with and develop partnerships with a range of stakeholders at each site

Partner organizations

The final set of partners involved in the JMSP were drawn from a larger pool of community based organizations, all supported by the Tata Trusts, who had been involved in the successful delivery of general, reproductive or mental health services in the country. A meeting of twelve such potential partners was held over two days to discuss the various aspects of the design and implementation details of the program. In addition, during the course of the program, discussions were held with three other organizations to explore the feasibility of inclusion in the program. Based on their subsequent expression of willingness to implement the program at their respective sites, eventually, a total of seven organizations were involved in the JMSP and are briefly described below.

1. Ashadeep:

Initiated in the year 1996 in Guwahati, Ashadeep has significantly contributed to making mental health care available in the region and has developed a range of interventions with highly vulnerable persons with mental disorders. This includes outstanding work with homeless mentally ill women and men, day care facilities, sheltered workshop and a retail outlet for the products made. Ashadeep has also worked extensively in providing community based services through partnerships with other NGOs and local government in many districts of the State.

2. Ramakrishna Mission Home of Service

For more than a hundred years, the Ramakrishna Mission Home of Service at Varanasi has a continued history of providing health care services to people in eastern U.P and adjoining parts of Bihar and Madhya Pradesh through their 230-bedded multi-specialty hospital. To improve access to general health care in deprived areas, there is a mobile health van based outreach service,supported by trained community health workers, in9 blocks of Mirzapur district with a special emphasis on mother and child health and nutrition. RKMHoS also has a large body of work on health promotional programs with local schools, colleges and slums, sanitation, tobacco cessation, women's empowerment and adolescent health. However, prior to the JMSP, there was no mental health programs in their community health settings.

3. Foundation for Research in Community Health (FRCH)

The Foundation for Research in Community Health (FRCH) was established in 1975 as a non-profit voluntary organization to promote the concept of holistic health care, especially for vulnerable sections of society like women and children. FRCH is engaged in conducting both research and field studies to help in devising alternate models of health and medical care in keeping with the social, economic and cultural reality of the country.

The Foundation has undertaken pioneering work in rural health systems and operations research on issues that affect quality and accessibility to healthcare as well as in the training of lay health workers like ASHAs. Prior to the JMSP, FRCH had no prior experience of implementing community mental health programs.

4. The Ant

The Action for North East (Ant) works in the Chirang district of Assam- a politically volatile area that has suffered decades of insurgent violence and is now administered by the autonomous Bodo Territorial Council. Ant has been working to improve development in the region through highly successful initiatives and through capacity building training and networks with other institutions for advocacy.

Since July 2007, the Ant,has been conducting once a month OPD services for persons with mental disorders and epilepsy in the area. Over time, these monthly services, managed by visiting psychiatrists have become widely known to people in the region and are extremely well attended. Prior to the JMSP, there were no community based mental health services available in the area.

5. Jan Chetna Manch

The Jan Chetna Manch (JCM) at Chamrabad in Jharkhand has been working predominantly on the issue of maternal and child health in ahighly socially deprived area of the country with extremely poor health care indicators. In this context, JCM has developed an innovative and highly effective network of village health workers or Swasth Sakhis who provide the first line of services and also coordinate women's groups in their villages. In response to an obvious need, JCM has also been working to improve the health and nutritional status of mothers and children. These community based health care is backed up by the hospital and OPD at Chandankiari which is managed by staff trained at JCM and augmented by specialists from the nearby Bokaro city. Prior to the JMSP, the Jan Chetna Manch had no prior experience of implementing mental health services.

6. Parivartan

The Parivartan Trust is based at Satara, Maharashtra since 1991 and has worked extensively over the last few years to deliver community centric and evidence based mental health services. Parivartan has a substantial track record of implementing programs that address some of the many challenges in relation to improving mental health services in India in tertiary and primary care settings.The Trust has accumulated an in depth understanding of the diverse needs of people with a range of mental disorders, thehealth system and social contexts that influence access to treatments and the expertise in delivering high quality mental health services. In view of this existing intramural experience, expertise and resources, the Trust was designated as the hub and Secretariat for the JMSP.

7. ASHWINI

Started in 1990, the 'Association for Health Welfare in the Nilgiris (ASHWINI)' is based at the socially deprived Gudalur and Pandalur taluks of the Nilgiris district in Tamil Nadu. Over time, ASHWINI has developed a highly effective three tiered health system for addressing the health needs of more than 20000 adivasis spread over 300 hamlets.

- The first tier consists of trained Village Health Guides (HG) in the village.
- The second tier consists of eight 'Area Centers' (AC), one in each of the eight zones, (each Area Centre covers between 20 to 75 adivasi hamlets.)
- The third tier is the60 bedded Gudalur Adivasi Hospital(run by ASHWINI).

ASHWINI also had prior experience of delivering community mental health services in their catchment area through a prior program that was implemented for a period of three years.

Settings

The JMSP was implemented through a hub and spokes arrangement with Parivartan being the designated technical hub and Secretariat, as shown in Figure 1 below.

Fig 1: Hub and spokes model of JMSP

The individual sites were spread across the states of Assam, Jharkhand, Uttar Pradesh, Maharashtra and Tamil Nadu and are shown in Figure 2 below:

Figure 2: Location of JMSP sites

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The JMSP sites were all predominantly rural and yet, quite diverse in terms of the social characteristics of the population like gender ratio, literacy rates , distribution of vulnerable population groups, economic profile and the availability of public and private health facilities. This was done by collecting the relevant data from a structured questionnaire developed for this purpose that incorporates many of the items of the WHO- AIMS instrument that has been used widely for similar purposes.

Thus, overall, there was a wide spectrum of developmental and health status represented in the program- while sites like Satara and Parinchay ranked high, the sites in Assam at Boko and Chirang had intermediate indicators while Chamrabad and at Mirzapur were severely disadvantaged across a range of social and health system indicators.In keeping with the prevailing situation, a set of different strategies were adopted to implement the program across the sites which are briefly described in Table 1 below.

Table 1:

Diversity across JMSP site and program implementation strategies:

Site	Variables	Strategy
JCM	Good community engagement Poor state of public health facilities No public mental health service	Develop stand-alone mental health service integrated within existing health programs
Ashadeep	Limited community engagement Good state of public health facilities No public mental health service	Work in partnership with existing public health services- supplement with specialist resources
FRCH	Limited community engagement Good state of public health facilities No public mental health service	Work in partnership with existing public health services- supplement with specialist resources
Satara	Limited community engagement Good state of public health facilities Active DMHP	Work in partnership with public health system, including DMHP- specialist inputs from Parivartan
RKM	Good community engagement Poor state of public health facilities No public mental health service	Develop stand-alone mental health service integrated within existing health programs
Ant	Good community engagement Moderate state of public health facilities No public mental health service	Work in partnership with existing public health services- supplement with specialist resources Augmenting existing programs with community based services
ASHWINI	Good community engagement Moderate state of public health facilities No public mental health service	Augmenting existing programs with community based services Work in partnership with existing public health services- supplement with specialist resources

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The phased implementation of the JMSP across sites

The JMSP was initiated in March, 2013 with the Secretariat and the individual partner organizations starting work at different time points. Thus, while the Secretariat started functioning from March, 2013, the first batch of partner organizations- JCM, Ashadeep and FRCH initiated the JMSP in May, 2013. Three other sites- RKMHoS, Ant and the Satara implementation site of Parivartan started the program in November, 2013 while ASHWINI joined the program much later, in April, 2016.

Across the sites, a similar phased approach was used to scale up treatments for people with SMD, CMDs, and convulsive epilepsy for the proposed population of 100,000 persons approximately, using a stepped wedge design.

In the **first, preparatory phase,** the Secretariat put together the senior management team, developed the common program management structure, set up the program Advisory Board, the first set of training materials for the Master Trainers, the prescribing guidelines and formalized the involvement of senior mentors in the program. At each of the sites, the most important preparatory activities included the recruitment of the teams, developing the detailed program implementation plans, the first set of training for the Master Trainers and community health workers, setting up of the program management systems and conducting a baseline situation analysis to systematically determine the population level service needs and all potential local resources available for mental health care in the program areas.

In the **second, formative phase,** the teams started their initial work with persons with the selected mental disorders, family members, local health providers and other relevant stakeholders to understand:

- clinical presentations of the individual disorders and their explanatory models
- service use patterns

- current treatments available
- the perceived gaps in services
- the outcomes desired by persons with the priority disorder and the family
- the problems of stigma and discrimination

This information was systematically collected across the sites through a survey that helped refine and customize the plans for implementation of the interventions and operationalize the structure and functioning of the services (including referrals between components of the service) at each site. In addition to orienting the program towards meeting the unmet and important needs of individuals with mental disorders and families, the formative phase findings also helped understand in more detail the logistic (space, privacy, storage of confidential information, travel arrangements for program staff and safety issues) and technical requirements (psychotropic medications, treatment guidelines, draft manuals, hand-outs, information systems and supervision mechanisms) necessary to conduct the program across the sites with adequate quality assurance and fidelity.

In the **third, pilot phase** of the program, the stepped care intervention for SMDs, CMDs and convulsive epilepsy were initiated in a population of around 30,000 persons to test the feasibility and acceptability of the individual interventions. All Master Trainers, and, in turn, community health workers received additional training across sites to achieve adequate competencies for delivering the interventions. In addition, all aspects of documentation, supervision, reporting and other operational details were rolled out together with efforts to engage with local health systems and other community agencies as relevant. The details of this phase are presented in **Table 2** below.

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Table 2: Summary table for JMSP piloting exercise:

Organization	Population coverage	No: of persons provided intervention
Ashadeep	35000	**63** SMD = 28 CMD = 11 Epilepsy = 24
Parivartan	30,000	**168** CMD- 76 SMD- 67 EPI-25
FRCH	22,908	**215** CMD-119 SMD- 52 Epilepsy-44
Ant	34,824	**141** CMD-55 SMD- 49 Epilepsy-37
RKM	32,000	**201** CMD- 117 SMD- 32 Epilepsy-52

While this exercise was initially planned to last for six months, in practice, for most organizations, this took about 12 months to complete. However, the findings of this exercise were critical in shaping the final JMSP intervention in a number of crucial ways:

- Finalization of the stepped care protocols and guidelines for the treatment of SMDs, CMDs and convulsive epilepsy
- Finalization of the documentation and reporting mechanisms to monitor the progress of the intervention
- Developing the structure and outline of the data management system
- Helping in deciding that, in this phase of the program, it was not feasible to introduce the interventions for alcohol use disorders and suicide prevention, as it would exceed the capacities of many partner organizations
- In deciding the size of the catchment area where the intervention could be delivered across sites with adequate quality and fidelity for individual sites
- In clarifying the moderating influence of sites in the implementation of the program In the final phase, the interventions were delivered at the sites to a larger population group over a period of 18 months.

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The JMSP clinical interventions

Principles underlying choice of individual interventions in the JMSP:

The selection of interventions for these priority disorders is guided by some key principles:

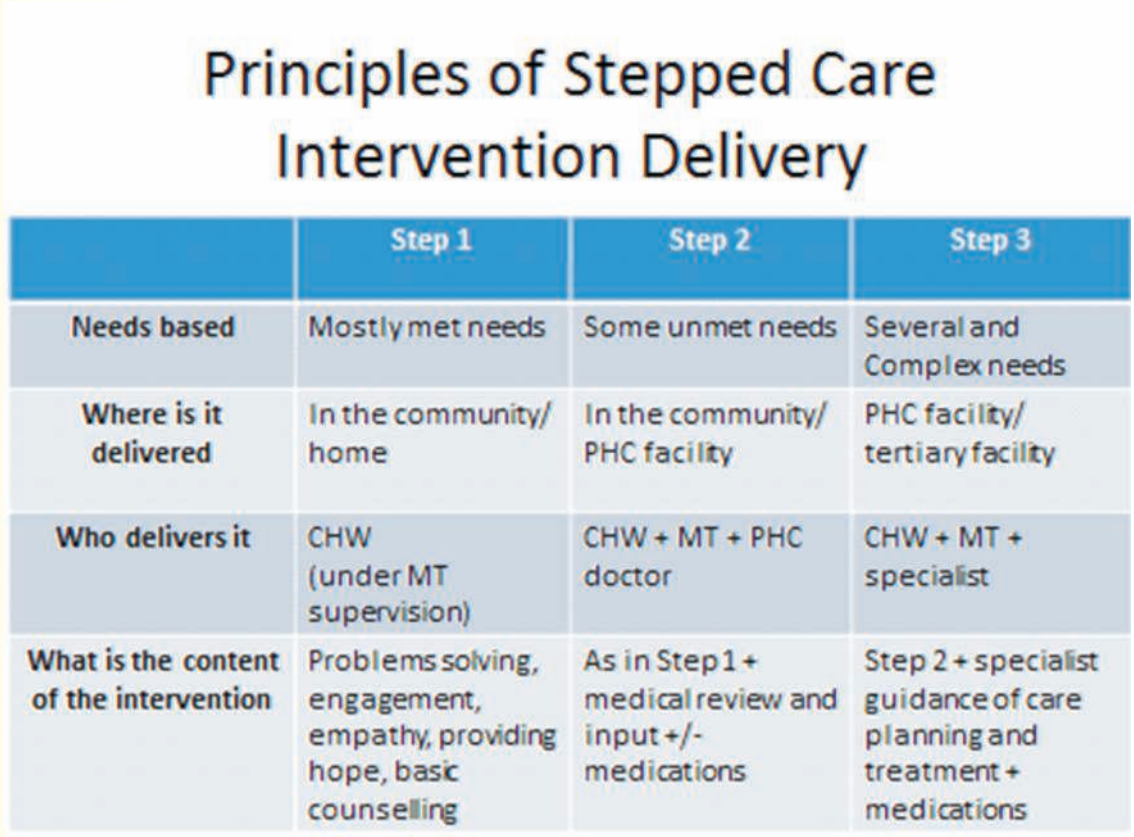
- That these are based on the best available scientific evidence
- That the interventions have been successfully implemented with lay community health workers working in partnership with mental health specialists in India
- That the intervention will be planned and implemented for each participant in close collaboration between the person, the primary care giver(s) and the treatment team members
- That the intervention will be provided in a flexible manner that reflects the unique needs of the person with psychosis and their caregivers and
- That these promote the human rights, dignity and social inclusion of persons with mental disorders

Intervention description:

The individual interventions in the JMSP were planned and implemented in close collaboration between the person, the primary care giver(s) and the treatment team members. The treatments were provided in a flexible manner to reflect the unique needs of the person with the priority condition and their care givers and to promote the human rights, dignity and social inclusion of persons with mental disorders.

Individual interventions for SMD, CMDs and convulsive epilepsy were provided in a stepped care manner with people being provided interventions, based on their level of need, as shown in Figure 3 below.

Figure 3- The stepped care intervention in JMSP:



Principles of Stepped Care Intervention Delivery

	Step 1	Step 2	Step 3
Needs based	Mostly met needs	Some unmet needs	Several and Complex needs
Where is it delivered	In the community/ home	In the community/ PHC facility	PHC facility/ tertiary facility
Who delivers it	CHW (under MT supervision)	CHW + MT + PHC doctor	CHW + MT + specialist
What is the content of the intervention	Problems solving, engagement, empathy, providing hope, basic counselling	As in Step 1 + medical review and input +/- medications	Step 2 + specialist guidance of care planning and treatment + medications

As part of this model detailed guides were prepared describing these Stepped Care Treatment Guidelines for CMD, SMD and Epilepsy and are summarized in **Figures 4, 5 and 6** for CMDs, SMDs and convulsive epilepsy respectively. In addition to these, Step by Step Intervention Guides were also prepared for each of the disorders to enable the community health workers provide a structured and uniform intervention to patients and their families. For instance these guides broke down each session into smaller chunks of how to actually go about delivering the components of the interventions. The guide also provided the necessary structure for the supervisors to provide effective supervision and to map the interventions being delivered over time.

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Figure 4: Stepped Care Treatment for CMD

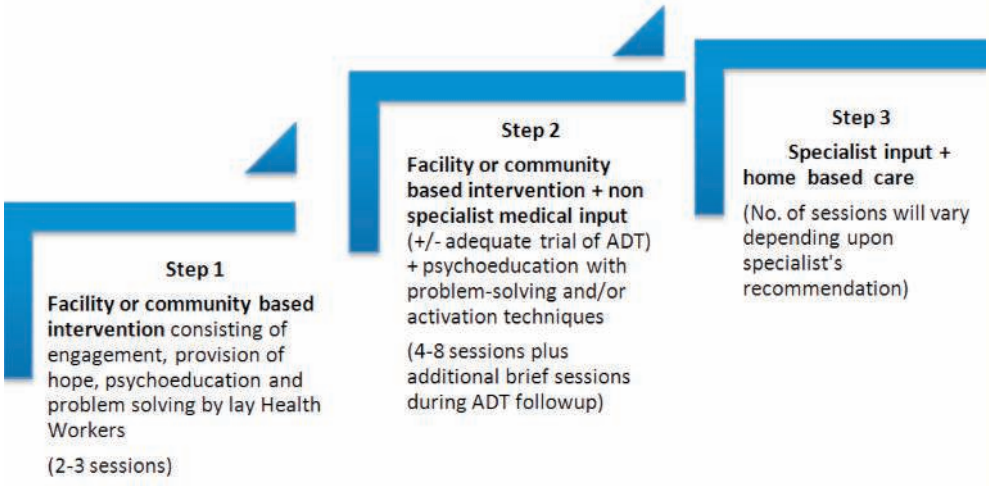


Figure 5: Stepped Care in Epilepsy

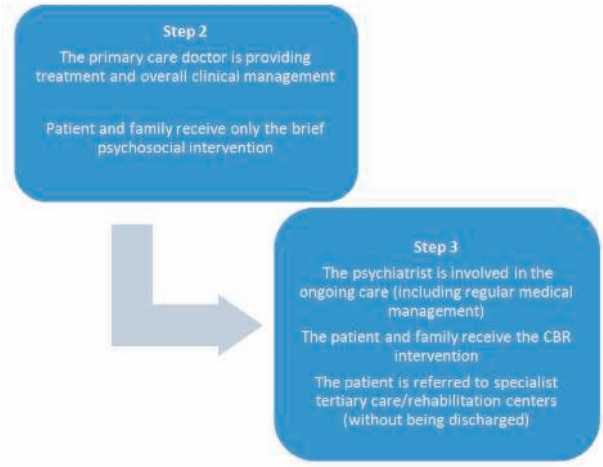
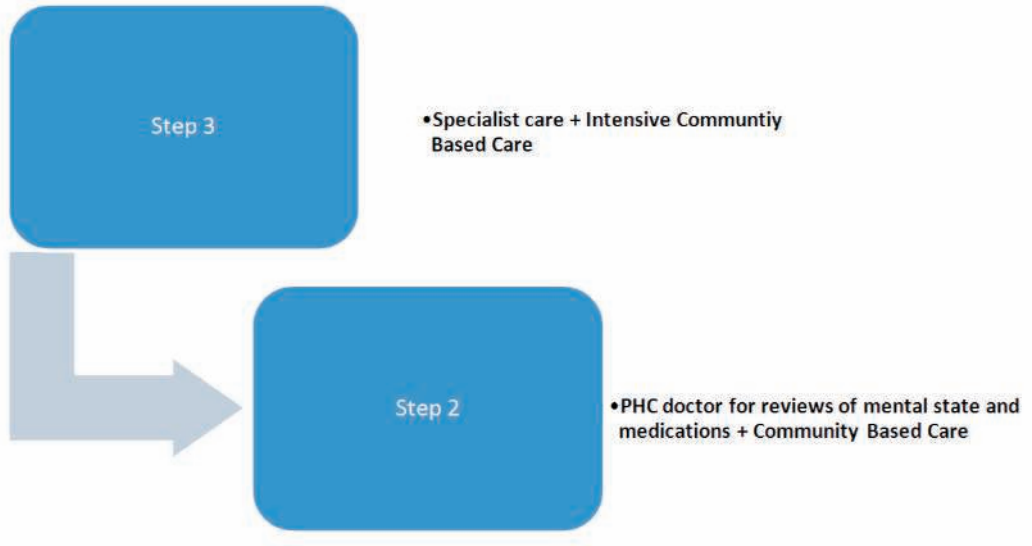


Figure 6: Stepped Care for SMD



Lastly, a Colour Coding Method (Figure 7) was introduced to enable supervisors to decide the intensity of intervention and supervision required for each patient at a particular point in time, to enable case load monitoring and to enable tracking of individual patients over time to see if there has been any improvement towards stability.

Colour Coding – Method

Criteria	RED	ORANGE	GREEN
Symptom Severity	Severe	Moderate to Severe	Mild to Moderate
Risk- to self, others or to property	High-Imminent Risk	Moderate to High Risk	Mild/ Low Risk
Impact of the illness on a person's functioning	Significant/ Severe Impairment	Moderate Impairment	Minimal Impairment
Impact on family members	Significant family burden/ Burnout/ Risk to them	Evident carer stress/ family burden/ Low to moderate risk to them	Minimal impact on carers/ family functioning

A set of Intervention record forms were developed for each disorder to record the details of each visit/ face to face meeting of the CHW with the patients as well as specific interventions provided such as adherence management, assessing social difficulties, suicide risk, etc. These included the CHW Intervention Record form, adherence management checklist, social difficulties checklist, suicide risk assessment checklist, socio-demographic form, etc. In addition for SMD and Epilepsy, Needs Assessment form and Individual Care Plan forms were developed. Separate forms were developed to record interventions provided by doctors like the initial contact and follow up form.

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Intervention delivery teams across sites

Each site had a team which consisted of a Project Coordinator (PC), 1-2 Intervention Facilitators (IFs) and 3-4 Community Health Workers (CHWs) depending on the population covered by each site (1 CHW/ 12000 population covered). Implementation sites had specific positions unique to their site's requirements such as a data entry officer for data management or accountant to provide support with the budget and accounting. The roles of each team member are outlined below:

A) Project Coordinator (PCs) -(Social Workers/ Psychologists with experience of implementing community programs):

a. To coordinate effective and safe program implementation at their site

b. Training and supervision of IFs and CHWs

c. Data collection and reporting from their site

d. Main link with the secretariat and their site

e. Prepare reports of work done at regular intervals

f. Managing budgets at their sites

g. Providing clinical care in complex cases and liaising with mentor/ specialist with regard to complex cases

B) Intervention Facilitators (IFs) (Social Workers/ Psychologists):

a. Provide clinical care such as assessment, screening, providing interventions to complex cases. Conducting needs assessments and preparing individual care plans in collaboration with CHWs, patients, families and the primary care doctor when appropriate

b. Supervision and training of CHWs

c. Supporting the PC in data collection and reporting

d. Community engagement and collaboration with various stakeholders

e. Work towards effective implementation of programme at their site

C) Community Health Workers (CHWs) - (Lay people from local communities or existing generic staff who received specific training in delivering the JMSP interventions)

a. Identification, referral, screening and enrolment of patients with CMD, SMD and Epilepsy

b. Provide frontline clinical care to patients and their families such as psycho-education, adherence management, needs assessment, individual care plan under supervision of IFs.

c. Provide active follow up with attempts to engage patients and their families in the intervention

d. Participating in community engagement activities

Each site also had a D) primary care doctor which was ideally a government doctor at the Primary Health Centre (PHC) because the JMSP program was meant to be linked to the existing government services. If these facilities were not available locally (RKM for instance) a primary care doctor from within the organization provided support to the JMSP team. The aim of the primary care doctor was to provide primary interventions to patients with CMD such as assessment, diagnosis and where appropriate medical treatment. They also contributed to the management of SMD and Epilepsy cases depending on their skills and expertise. In addition, the specialist treatment inputs for people with complex problems was provided by the E) Psychiatrist who was also part of the team. The role of the specialist was to provide expert input in the management of SMDs, Epilepsy and complex cases of CMD while also providing training and supervision to the entire team. The availability of the psychiatrist varied between sites with only ASHWINI having the services of a dedicated psychiatrist- in other sites, this ranged from once every two- four weeks at outpatient clinics. Finally, a F) senior mentor was attached to each of the sites to support and advice the team and also provide expert overview of the clinical aspects of the program.

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Training/ supervision and quality assurance

The JMSP followed a cascade model of training wherein the Secretariat trained senior team members (called Master Trainers- PC, IF) from each site who, in turn, trained the CHWs and auxiliary health staff at their respective sites. The training was based on achieving certain pre-determined set of competencies which were considered essential not only for effective and safe care of patients but also for effective community engagement, collaboration with various stakeholders and ability to train effectively. The training of the CHWs was also competency based and trainings were followed by assessment of competencies. The trainings for Master Trainers and CHWs happened in a staged manner. After the initial training on priority disorders (SMD, CMD and Epilepsy) and providing interventions, later trainings focused on revision of skills, data collection and reporting, Intellectual Disabilities, monitoring and supervision and skills for community engagement using Manasrang techniques. These trainings were supplemented by regular visits to sites by mentors or from the secretariat.

A. Individual intervention delivery by training workforce at each site:

Objectives:

- To provide the necessary knowledge and skills (competencies) for Priority Mental Disorders
- To provide a range of skills necessary for the effective training of CHWs • T o provide MTs with an in depth understanding of service development, planning and monitoring
- To evaluate the feasibility and acceptability of the training program Methods used:
- Didactic lectures
- Demonstrations of skills (modelling)

- Group work
- Role plays (to practice skills learnt)
- Activity based learning
- Audio-visual material such as documentaries and films

Outcomes of Training:

- Development and assessment of competencies
- Ability to practice those skills
- Introduction to concepts of competency based training
- Introduction to concepts of self-guided learning
- Trained and committed work force
- Collaborative working and learning
- Development of leadership skills
- Organization and management skills
- Demonstration of various teaching methods
- Feeling of purpose, sense of belonging and responsibility towards the ethos of JMSP

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The main themes of the trainings conducted by the Secretariat:

When	Themes/ Topics	Duration (Days)
September 2013	-Knowledge of priority disorders -Skills in providing interventions -Skills in training CHWs -Principles of Community Engagement	18
February 2014	-Formative Interviews -Intervention Delivery Processes -Intervention Forms	2
September 2014	-Intellectual Disability Training -Online Process Indicators Training -Revision of processes of Intervention Delivery	3
November 2014	-Revision of Core Clinical Competencies -Online Process Indicators - Revision -Objective Structured Clinical Interviews (OSCI)	12
March 2015*	Manasrang - Using theatre in Community Engagement and Intervention Delivery	5
April 2015	-Stepped care + Colour Coding -Alcohol Use Disorders- Overview -Suicide Prevention -Cultural Assessment- Introduction -Formal OSCI Assessment and feedback -Knowledge test and feedback	9
July 2015	-Stepped care and Colour Coding- Revision -Data reporting - Online/ Monthly/ Tracking sheet	4
	Total Hours of Training	**53 days*6 = 318 hours**

B. CHW Training

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Objectives:

- Develop and improve personal skills, technical/ knowledge based skills, professional skills
- Give an orientation to the CHWs
- Impart knowledge on mental illness
- Develop and enhance their skills and competencies

Methods used:

- Mirrored the Master trainers training
- Competency based
- Focus on skills in delivering interventions, communication skills and engagement, data collection (process indicators)
- Variety of teaching methods- Similar to MTs

Outcomes:

- Development and assessment of competencies necessary for safe and effective intervention delivery
- Ability to practice those skills in a supportive and non-threatening environment
- Preparation of a trained and committed work force
- Ability to assess the knowledge and skills of the CHWs
- Collaborative working and learning
- Feeling of purpose, sense of belonging and responsibility towards the ethos of the JMSP

C. Training for Primary Care Doctors:

Primary care doctors were provided training in assessment and management of CMDs, Epilepsy and SMDs using the mhGAP guidelines version 1. A set of prescribing guidelines were developed using best available evidence and taking into consideration the ground realities of the areas where the program was being implemented. Primary care doctors received training on using these guidelines while prescribing medicines for CMDs.

- Based on MhGAP guidelines
- Done by mentor/psychiatrist
- Wide variation in uptake of this training
- Did not translate into uniform collaboration by doctors with JMSP
- Going ahead- Need to explore the barriers to collaboration

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Outcomes:

- Limited engagement and interest
- No incentives
- High workload
- Anxiety of prescribing/ insufficient training
- Legal issues (Ayush doctors)
- Better uptake if doctor is in-house
- Lack of access to specialist for advice and support

D. Training for other Health Care Professionals:

- ASHAs/ ANMs (collaborations variable)- Awareness, identification, screening, info. about JMSP
- Staff from other programmes- Overview of JMSP, awareness, identification, referral
- DMHP staff- Info. About JMSP, assessment of schizophrenia
- Anganwadi Workers- Awareness of JMSP, identification, referral

E. Assessment of Competencies (MTs and CHWs)

- MTs- 2 Assessments

  - Structured clinical scenarios

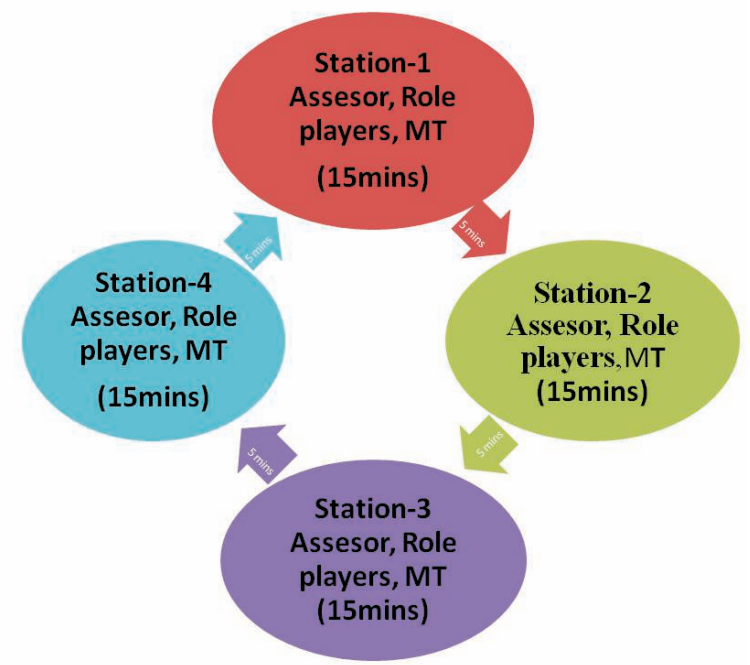
  - Assessing specific skills

    - Immediate structured feedback

    - Feedback report provided later

- CHWs also participated in the Observed Structured Clinical Interactions (OSCIs) purposively designed for the requirements of the JMSP and were formally assessed for their competencies in providing core interventions (Figure 8 below)

Figure 8: Process of OSCIs:



F. Assessment of competency as a trainer (MTs only)

- Assessed on ability to conduct a training session
- Structured feedback provided on their skills as a trainer

Example of structured feedback provided to Master Trainers

Each master trainer was evaluated on specific dimensions under three broad performance criteria – presentation skills, session organizational skills and knowledge base. Performance on two of these (presentation skills and session organizational skills) was evaluated by other master trainers and supervisors; performance on the third (knowledge base) was evaluated only by supervisors. The overall ratings are yellow, green or orange (refer to key). The supervisors also gave comments, and suggestions for improvement. This report shows the results of the evaluation.

No.	Performance criteria	Evaluation by master trainers	Evaluation by supervisors
	A. Presentation skills		
1	Eye to eye contact		
2	Delivery style		
3	Engaging and encouraging participation of trainees		
4	Summarizing and providing periodic feedback from participants about any unresolved queries		
5	Competence in answering questions effectively		
6	Appropriate use of training material		
	B. Session Organization Skills		
1	Overall preparation		
2	Organization of material		
3	Coverage of key points that needed to be emphasized in the session		
4	Used appropriate examples to illustrate concepts		
5	Demonstrated skills satisfactory		
	C. Knowledge base	Not applicable	

Rating key (evaluation by master trainers)

	Excellent	Majority of the master trainers rated either "Excellent" or "Satisfactory" with more trainers rating "Excellent"
	Satisfactory	Majority of the master trainers rated either "Excellent" or "Satisfactory" with more trainers rating "Satisfactory"
	Needs improvement	Majority of the master trainers rated "Needs improvement" or "Needs significant improvement"

Rating key (evaluation by supervisors)

	Excellent	Both supervisors rated "Excellent"
	Satisfactory	One or both supervisors rated "Satisfactory"
	Needs improvement	One or both supervisors rated "Needs improvement" or "Needs significant improvement"

Comments by supervisors:

Things done well:

Suggestions for improvement by supervisors

G. Supervision:

Aim of supervision:

- Supporting the delivery of safe and effective interventions (patient safety)
- Facilitating learning
- Monitoring competence and skills development
- Caseload review
- Ensure quality and fidelity of the JMSP intervention

Supervision happened between:

- MT and CHW
- Mentor/ Psychiatrist and MT/CHW
- Mostly face to face during joint home visits
- During clinics
- During routine case discussions
- At times of case load reviews
- During one to one time with CHW whenever possible

Data regarding the frequency and type of supervision was collected using the Supervision Monitoring Form which captured the summary of supervision contacts (defined as any contact where the "content" is monitoring the CHWs/MTs delivering the session) happening during the implementation of the programmes. So all face to face (rarely telephone contacts) where the MT/Specialist was observing, giving feedback to the way CHWs/MTs were delivering intervention was a supervision contact.

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H. Adverse Events recording and reporting policy

Adverse Events recording and reporting policy was developed. Adverse events such as deaths and hospitalizations due to any cause, suicide attempts, homicide attempts, medication errors were identified as important indicators of safety and quality of care being provided.

Summary

The structured training, competency assessment, feedback, supervision and monitoring of adverse events were critical in delivering a safe and effective intervention to patients and families. This provided the framework for quality control and effectiveness of the program interventions.

B) Systemic interventions- community engagement:

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In addition to providing individual interventions, in the JMSP, there was considerable attention paid to the issue of community engagement through dialogue and partnership with a wide range of local stakeholders across the sites such as:

- Individuals with mental disorders and their families who are the primary stakeholders
- Public, private and other systems of health care that already exist in the program areas as the critical vehicle for making mental health care more widely available in the longer term
- Other community agencies in the government (political, administrative, justice, social justice and empowerment, panchayat, women and child development), self-help groups, other NGO's and the private sector
- Local community to enhance awareness about these disorders, address issues of stigma and discrimination to help reduce the environmental barriers to full participation and social inclusion for persons with mental disorders through self-help groups and other community initiatives

Since the partners involved in the JMSP had prior experience of engagement around various health related issues in their local communities, in the first instance, Master Trainers were asked to prepare case vignettes of effective methods of community engagement that the partners had followed in the past on say for example, reproductive health. Based on these discussions and inputs provided by the senior program manager of the Tata Trusts, each organization was asked to develop specific plans for community engagement with the stakeholders mentioned earlier. This process was followed through a dedicated monthly reporting system that described the specific engagement activities and outputs at each site.

JMSP Data management

The Community Health Workers (CHW) at the sites were responsible for collecting data on patients involved in the program and collected quantitative and qualitative baseline and outcome data in the hospital and conducted door to door interviews at home. Trained CHW's in each site used pen and paper method and care was taken to ensure adequate privacy during these visits, although was sometimes a challenge, particularly where an entire family was living in one room.

Three types of data were collected:

1. Baseline Data: as a measure of the overall socio demographic and clinical profile of participants.
2. Process Indicators: as a measure of the intervention fidelity on an ongoing basis and as an overall measure of the receipt of the various components of the intervention by each participant.
3. Outcome Evaluation Data: to monitor the progress of the program's outcome evaluations.

The baseline data provided information on the basic socio-demographic details, clinical status of the patients and current use of medication. The process indicator data was used to assess the adherence of the participants with the intervention and the outcome evaluation data provided information on the health status of the participants at midpoint and end point to evaluate the recovery in participants.

Supervision and quality control of data collection was regulated by the data consultant. CHW's were supervised by the coordinators in each site for all tasks related to obtaining informed consent, contacting families and carrying out home visits, collecting data and data entry. Onsite supervision (for which the coordinator accompanied CHW's on their house visit and was physically present during the interview process) was carried out. In addition, regular team meetings were held to discuss cases, check the administration and scoring for each instrument, identify

problems and clarify them through group discussion.

Data collected on paper was entered into a database at each site by one data entry clerk. Data from each site was managed by the data consultant and stored in secure computers. Back-up versions were maintained off-site and separation of program data and patient identifiable data was ensured. Data was entered and maintained in excel spreadsheets. Errors, if any, were identified and logged into an excel file by Program ID. Identical versions of softwares and databases were used for data management across sites and were provided by the data consultant to the site coordinators. The master database comprising the two sites data were checked, cleaned and managed by the data consultant and finally merged and provided to the research consultant for analyses. The IT enabled data management system was developed with initial inputs from the Swasth India which allowed all sites to enter data and selected senior team members to access the data from the cloud based application.

Good practices through the JMSP at individual sites

The JMSP has spawned a number of good practices in relation to various aspects of mental health service provision at the individual sites. These include effective liaison with health care providers in the government, private and traditional healing sectors, an in depth understanding of the role of community health workers as well as the involvement and collectivization of peers and care givers.

1. Engagement and working with traditional healers at the Ant:

Traditional healers have been existing in India since ancient times and continue to be an important part of the overall health system. The traditional healers are persons from the community itself, the people accept them rather than doctors. In most cases patients do not visit the modern treatment either because of the inaccessibility of the health care services especially in rural areas or another reason could be because these traditional healers have been treating people long before the modern treatment started and people have more faith in them as they provide culturally sensitive care. To understand the types of treatment used by the traditional healers in providing health care to the people with mental illnesses, the JMSP program at the Ant engaged with traditional healers working in the catchment area of the JMSP. The main objectives of the study were to know the role of traditional healers in treatment of mental illness, to know the numbers of people being positively and negatively treated and to analyze how to provide collaborative care to the patients. The majority of the respondents were generalists and treated patients with different illnesses like jaundice, malaria, epilepsy, typhoid, and also problems with mental illness. They also help those who have family problems and problems in their marriage life especially those who have problem with pregnancy. The respondents believe that the cause of mental illness is bad notion from God, enter of evil spirit, spoilt brain, thinking too much and meeting bad air. It is found that respondents are able to diagnose their patient only when they enter the temple and conduct the puja. Only after the puja they can tell the cause of the illness. Most of the respondents got their power to heal people form gods and goddesses.

Most respondents reported that that all illnesses- both physical and psychological are being treated with the same methods. The types of treatment used for treating patient with mental illness are puja along with mantras, tabbies and kachinnis, water and tulsi which has been blessed by them and herbal medicines which they made and which are available from their forest and garden. They usually get their tabbis from the market. While the mantras comes out naturally when they enter the temple. When they are outside the temple and not doing any puja they do not know any mantras but when they enter the temple they have the power to say the mantras.

The respondents felt that they can treat patients of different illnesses caused by evil spirit or bad notion from God however some felt that illnesses caused by stress and tension cannot be cured and needs modern treatment. They also express that they do have many patients that comes to them who have visited modern treatment and later come to them and get cured. However, they do also refer doctors as when their patients are weak and cannot be cured by traditional healing. Majority of the respondents did not have any indicator to say that the patient is cured from the sickness but when a patient is cured he comes to the temple and offer

donation and this is how they maintain their expenses. From the study conducted it is also found that most of the respondents do not share their knowledge as they feel it cannot be transferred to others as they got it as a power from god. However, some do share it with other traditional healers and this helps them to give proper treatment to the patients. After the study, we continued the dialogue with them and proposed a conference which met with a positive response. Around 60-70 traditional healers from our working area gathered for the conference. In the conference they shared their experiences with us and we also shared our experiences. They also asked for some clarifications regarding the causes of mental illness. After the conference they started referring patients to us and some of them even refused to treat patients with mental illness. A follow up meeting was then conducted at their request to discuss issues around the treatment of epilepsy which was very useful. They shared their views regarding mental illness. They said that it would be very beneficial for the people if we could collaborate. Now, there are good relationships with the local traditional healers and they refer patients to us.

2. Caregivers' support group at FRCH site of JMSP

Mental illness can affect not only the person with disorder, but also their family members. It is also a fact that family members play an important role in the recovery of these patients. However, many times family members face difficulties in dealing with patients and their illness due not having much information about illness and ways to deal with it. An intervention that empowers family members/ care givers in dealing with patient with mental disorders has been recommended as an important component of mental health care program. There are number of examples of such interventions and peer support group of caregivers is one of such intervention. Support groups of caregivers of people suffering from mental disorders have been showcased as extremely helpful in the recovery of patients. These groups are usually formed with care-givers to share their problems in dealing with patient and seek solutions from other members based on their similar experience. Such groups also help in mobilizing support for persons with mental health disorders in the community and empowering them for further action towards reducing stigma and

discrimination. A rapid assessment was done to understand the care-givers knowledge on these disorders, understanding on symptoms, treatment, skills required for handling the patients etc. It was noticed that the main lacunae in the care-givers was found to be in areas of understanding the cause of the disorder, dealing with the behavioural symptoms of patients, problems in providing medications, recognizing relapses in the patients etc.

Hence, it was decided by the FRCH to initiate care-giver support groups which will empower the care-givers in dealing with the day-to-day issues of their patients, understand the needs of the patients and enable them to take better care even when no other support structures are available. As a pilot of this large scale exercise, one support group has been initiated in Walha since Oct, 2016. Group members meet once in a month and the CHWs, PC and IC also attend these meetings. Patients and their care-giver were first approached by the program staff separately and they were explained about the usefulness the care-giver meetings before involving them in the care-giver groups. About 6-12 people participate in these meetings and average time of meeting is about two hours. The group meetings starts with a round of introductions. During these meetings, patients and caregivers share their illness related experiences, problems in managing behavioural issues; social stigma and discuss treatment related issues such as difficulties caregiver face when patient refuse medications. Caregivers of patients with improved condition share their experience of bad days and how they are feeling now when patient has recovered emphasizing importance of adherence to treatment. There was good exchange of suggestions among group members for dealing with day to day problems in managing patient with mental disorders. At each meeting, one person from the group narrates his/her own illness related experience in detail, the problems they faced and how they overcame or tried to overcome the problems. Group then discuss and the program staff also give additional details about how such challenges can be overcome. The patients and caregivers expressed that this initiative will definitely be helpful for everyone and the care-givers also felt that this will be a good platform to share their problems and experiences with others. They

may be able to get certain ideas about care-taking which will go a long way in helping their patients. FRCH plans to form similar caregivers group over the program area. Ideally, each group will be limited to 10-12 members and initially the PC or IC along with the CHW will be part of each of these meetings to facilitate the meeting. Once the CHWs are well-versed with handling these meetings, the CHWs will conduct these group meetings. Over a period this intervention intend to increasing participants knowledge about dealing with patient of mental disorder and improving their coping skills to the extent possible, equipping them with as much referral information as possible and crafting a handholding. This program also envisages development of interactive support system amongst the members of this group through creation of local leadership.

3. Working collaboratively with local government and caregivers at Boko:

Since the very beginning of the JMSP activities, Ashadeep has worked very closely with the local government. The Joint Director of Health services of Kamrup district was approached for due permission to work in association with Boko CHC/PHC for the clinical intervention. The application was forwarded to Director of State Health Services. The official order was received from the director's office vide

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letter no. HSE/MH/247/2010/20042 dated 13/12/2013 to implement the Community Mental Health Program at Boko block. The Deputy Superintendent of Boko CHC and the Sub Divisional Medical & Health Officer of Boko PHC were instructed to extend full support to the program. The District Commissioner was duly informed about the proposed activities. This official order was of tremendous help in getting co-operation from the entire health infrastructure of the block. Another example of working with the local government was the two screening camps that were conducted in collaboration with District Social Welfare and the Health Departments for issuance of disability certificates to the chronic mentally ill patients enrolled under JMSP. A total of 48 patients were issued certificates in these two camps.

At the Boko CHC, an intensive effort was made to initiate treatments for mental disorders within the facilities as well as in the public health facilities in the entire block. Towards this end, the health staff at the CHC as well as in the block were engaged with through sensitization and training sessions over the course of the program. This included training for all ASHA workers of the entire Boko block in eight batches during June 2016. Topics covered in the training were, the concept of mental health, identification of SMD, CMD and Epilepsy, stigma related to these illnesses, myths and facts about mental illness and difference between mental illness and intellectual disabilities. Official orders from the Sub Divisional Medical Officer's (SDMO) were obtained to conduct this training. A total of 170 ASHA workers and their supervisors attended the training. The training programs helped immensely as the ASHAs took a lot of initiative in identifying and referring patients to the program while some even became caregivers of patients they had identified as the families were not literate. Similarly, with an aim of treating patients with CMD at the peripheral health facilities of the Boko block, 14 Medical Officers of 5 State Dispensaries and 3 Mini PHCs were trained on the management of CMDs by the program psychiatrist in June 2015. Prior to that, in April 2015, 31 ANM & GNMs attached to the periphery hospitals were trained on identification of common mental disorders and basic counselling skills.

A caregivers' group of SMD patients was initiated in May 2016. The group had been empowered by the JMSP team during their monthly meetings to act as a pressure group to advocate for regular supply of government medicines and also appointment of a psychiatrist at the CHC. The objective of creating this pressure group was to sustain the mental health interventions at the block after phase out of JMSP. This group had submitted a few memorandums to the deputy superintendent of the CHC demanding for regular supply of medicines. The Programme Co-ordinator also had met Joint Director of Health Services of Kamrup (Rural) District quite a few times with request letters for facilitating services of a government psychiatrist at the CHC. These activities have resulted in deputation of a psychiatrist at the CHC once in every month from January, 2017.

4. Working with the DMHP, ASHAs and support groups at Satara:

As the only site with a concurrently functional District Mental Health Program (DMHP), the program at Satara has worked closely with the DMHP and has developed innovative service collaborations. For example, a District Counselling Centre (DCC) has been established in collaboration with DMHP and the Satara Civil Hospital. This has a shared team in place for six days a week with the dedicated purpose of providing psycho-social and rehabilitation support to patients with

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SMDs who are taking treatment from the DMHP but have unmet psychosocial needs. This includes on site needs assessment, psycho-education as well as access to community based rehabilitation (CBR) services from the JMSP team, when required.

In addition, the DCC team contact patients and their families in the Civil Hospital who have been admitted with a suicide attempt for an assessment of risk, brief counselling, referral to the DMHP psychiatrist if there is an ongoing mental disorders like depression and follow up for those residing within the JMSP catchment area. Another important domain of collaboration with the DMHP has been the issue of shared care practices, particularly around the issue of continued medical treatments. A large number of people with SMD and epilepsy from within the catchment area who were not previously enrolled with the DMHP services, including provision of medications, are now enrolled. This linkage has also seen an increasing number of people with CMDs access the DMHP services for their continued treatments while also being engaged with the JMSP team. This arrangement has also helped the process of discharging people from the JMSP intervention to ongoing care arrangements very successfully.

Another positive experience has been the inclusion of existing ASHA workers formally within the program workforce. These workers have been trained and developed very robust linkages with the local community on making mental health treatments more accessible and acceptable. This is reflected in the referral rates of patients to the program as well as the exceptional level of retaining people in treatment. Each such worker provides the critical link between the program and smaller units of population of around 5,000 persons each. Building on their existing contacts in the village, these workers have established linkages with almost every household in the catchment area and are first contact points for mental health problems in these villages. These part time mental health workers are also the focal point of all community engagement activities within their respective populations through existing institutions like SHGs, women's groups leading to a continued dialogue on issues like stress, suicide, stigma, employment and human rights. Finally, the JMSP at Satara has seen the development of a vibrant collaboration of people with mental disorders and their caregiver with the program through support groups animated by the Manasrang method. At present, there are four such groups in the area who meet once every month and the initial results are very positive. These sessions have been very well received by the participants and are very useful for developing rapport with patient and caregivers, improved illness management, building confidence among patients about their abilities andsupport for getting back to work. Within the town of Satara, a similar caregiver and peer led initiative has resulted in setting up of a day facility with a specific focus on promoting access to employment.

5. Time motion study of community health workers at FRCH:

The time motion study conducted by FRCH in Nov/Dec 2015 was based on the methodology developed by F.W. Taylor and Frank and Lillian M. Gilbreth that aims at improving the work environment, leading to increased worker efficiency. This method establishes the sequence of motions in a job to ensure that the task is being performed in the most efficient and effective manner through the elimination of waste and simplification of work. In recent times, Time Motion studies have been

gaining prominence in healthcare and several such studies have been conducted in various setups in this field.

Time Motion methodology has been used extensively in healthcare settings to study work patterns, resource utilization and impact of new technology. The results of these studies in turn have been used to increase the efficiency and effectiveness of work systems and support strategy formulation, policy planning and budgeting. However, the focus of the Time Motion studies has predominantly been on professionals in healthcare facilities such as clinics or hospitals. In contrast, the numbers of studies at the community level focused upon the activities of the Lay Health Worker (LHW) or Community Health Worker (CHW) are fewer in number. In the CMHP at FRCH it was felt essential to undertake a time motion study of CHWs given the steady expansion in their work profile and an increase in their roles and responsibilities. Hence a time motion study of CHWs was planned to study how they organize and structure their work on a daily/monthly basis and analyse their workload at the time the program was evolving. The aim of this study was to provide evidence for proper allotment of the work activities of the CHWs as well as help in identifying the drivers of inefficiency thereby enabling formulation of a targeted approach to reduce any unproductive time or task.

The specific objectives of the study were:

1. To gain an understanding of how the CHWs structure and organize their daily/monthly work activities
2. To determine the amount of time CHWs spend on specific activities during their work hours
3. To determine the average distance travelled by the CHWs while executing their duties

The Time Motion study was conducted on two CHWs in CMHP) selected through purposive sampling. These CHWs covered a population of 22,000. The observations were recorded by a researcher (observer) who was external to the organization and the programme to neutralize any personal biases. The researcher

collected all the data on a pre-designed and pre-tested recording sheet listing the activities of the CHW and noted any additional information manually. The two Community Health Workers were "shadowed" by the researcher for the duration of an entire working day (9:30 am-4:30 pm) on 10 random days (5 days for each CHW) staggered during a period of one month. Analysis showed that the CHWs broadly performed any or all of the following 14 independent activities during any given day (OPD Clinic, Field or Staff meeting day). There was no overlap between these activities:

1. Home visits: Home visits are conducted by the CHW in the field and include visiting the home of the patient or community member with the purpose of: spreading awareness about mental health disorders and the programme, identifying probable patients, following up with patients regarding medicines and their current status.

2. Community interaction: This activity includes awareness meetings conducted by the CHWs for groups of people in the community.

3. Counselling: This activity is a part of the psychosocial support component of the programme and these sessions are conducted with the patients and their family members.

4. Screening: During this activity the CHWs use a tool to screen patients for probable symptoms of Common Mental Disorders (CMD) and assess their status according to the results.

5. Doctor consultation: The CHWs accompany the patient to the doctor's room to discuss the case history and treatment plan.

6. Patient interaction: During this activity CHWs meet the patients and talk as a form of rapport building.

7. Documentation: CHWs' document their activities in a daily log in the prescribed format.

8. Administrative work: This activity encompasses several administrative tasks

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such as arrangements for the OPD, managing files and stationery, regulating patients in the OPD, patient registration at OPD, logistics arrangement (furniture, room) etc.

9. Review meeting: The review meetings are held once every week and are attended by the coordinators and all the CHWs. Complex cases, reporting, weekly work and difficulties encountered in the field are discussed in these meetings.

10. Staff interactions: Interactions that take place between the coordinators and the CHWs or among the CHWs themselves regarding patients, care takers or any aspect of the programme are classified under this activity.

11. Travelling: This activity includes the travel undertaken by the CHWs to reach office or the PHC as well as travel during field work or in any other circumstance.

12. Break: Lunch, tea, washroom breaks etc.

13. Miscellaneous: Miscellaneous activities include everything occurring outside the ambit of the programme but during the working hours such as tending to a punctured vehicle, visit to the petrol pump etc.

14. Waiting: This is usually the time during which the CHWs wait for people to assemble for a community meeting or for the patient/care taker to be available for a session. Activities which took less than one minute time were not considered in the final analysis as they were insignificant in number.

Both CHWs spent approximately 50% of their time on "Administrative work" during the OPD clinic day. On Field days, the CHWs spent most of their time on "Home visits", "Travelling" and "Documentation". On the Staff meeting days, the CHWs spend their time in a similar manner with "Review meeting" and "Documentation" accounting for approximately 85% of their total time.

It was seen that "Documentation", "Travelling" and "Administrative work" were the major allied activities which took significant amount of time. It may not be practically possible to reduce travel time and make travel more efficient,

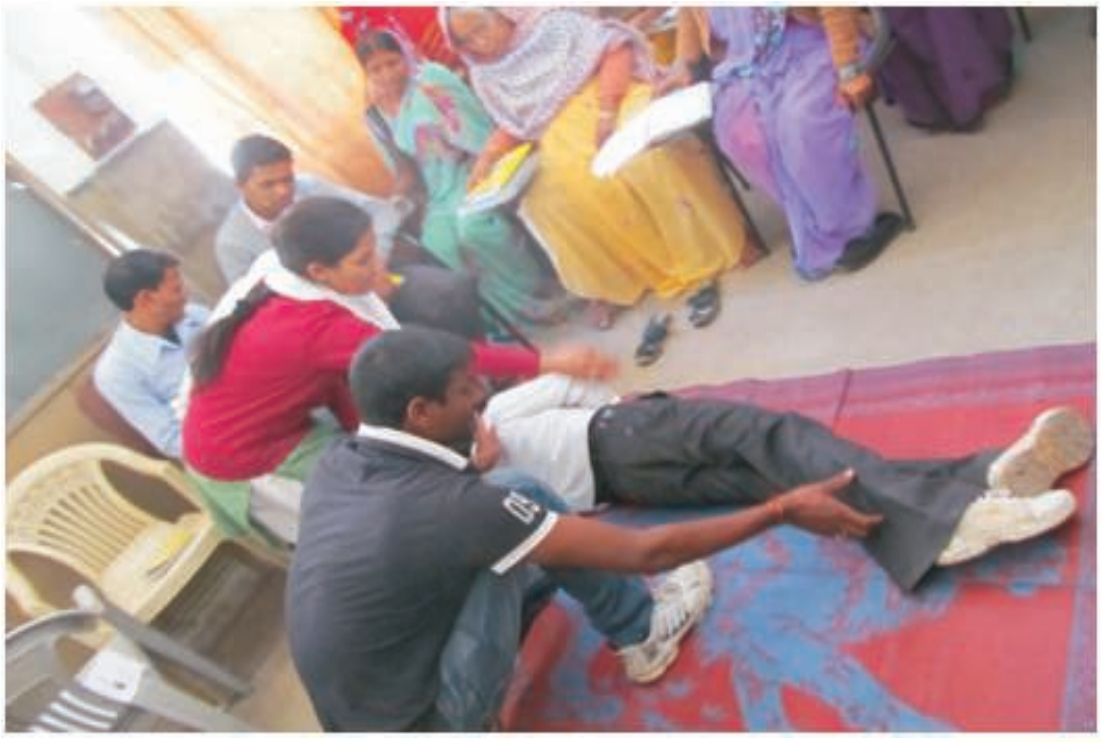
"Documentation" and "Administrative work" were identified as areas to be reviewed to obtain insights on the pressure points that the CHWs experience while performing these activities and possible steps that can be taken to mitigate the same.

6. Developing workforce capacity for integrating mental health services in general health care programs at Mirzapur:

The JMSP at Mirzapur was implemented by integrating mental health treatments within existing general and reproductive health programs and with non-specialist health care providers. The two primary care physicians have developed competency in the use of psychotropic medication in a step by step manner. First, when the basic diagnoses were being discussed, they were separately sensitized to understand the organic/substance induced/functional disorder differences in the 'SMD' category, they learnt to differentiate bipolar disorder from schizophrenia in the 'CMD' category, they learnt the reactive/endogenous distinction, which helps them decide if medicines are required at all, or the person should only receive counseling Secondly, they have successfully learnt how to match the medicines to the condition, two medications each from the antipsychotic, antidepressant,

benzodiazepine and mood stabilizer groups were used. Initially, the drug choice, dosing, titration and side effect monitoring were demonstrated on site visits, with follow up discussed over phone or on repeat visits to that site. At present, they are able to make accurate diagnosis (within this framework), select appropriate drugs (or decide to not medicate), and manage side effects.

In addition, there are a team of12 Intervention Facilitators who form the core middle level team involved in all financial as well as non-financial aspects of the project management like initiating, planning, executing and quality control. All such IFs were also systematically trained and they not only restrict themselves to the camps or medical vans but go door to door with CHW in each of the program villages. As they have been intensively trained in providing Primary Health Care services as well as all aspects of Mental Health, they are able to do a holistic need assessment of the people, be it their physical or mental health or any other social aspect and provide intervention accordingly. The IFs are now skilled in the screening and identification of patients, preparation of individualized care plans, and referral to medical treatments if required, counseling regarding disease, medicine adherence and side effect of medicine and follow up.



The competence of this team has also ensured that all other programs of the RKMHoS are now influenced by a mental health perspective which has been well accepted across programs and is now increasingly seen as an essential component of any further health related work.

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Manasrang

(Colours of the Mind)

Manasrang is a novel method of using various art forms in a culturally sensitive manner to support the recovery of people with mental health problems. Manasrang also serves as a support group for peers and caregivers. Other than this, Manasrang methods can also be usefully employed for effective community engagement, creating awareness, workforce training as well as improving the communication skills of health care workers.

It uses various forms of expressive art such as drama, songs, dance, puppet shows, picture storytelling, group discussions, etc. to help people regain and/ or learn new skills such as self-care, activities of daily living, interpersonal and social skills; create greater awareness of illness and its impact on their lives; enhances ability to effect changes to behaviour and manage ones emotions and greater ability to cope with stress in positive ways. These skills in turn help them to become more effective members of their families and in gaining and maintaining employment. This leads to greater acceptance into mainstream society and reduction in stigma

and discrimination. Consequently, the persons feeling of self-worth and efficacy improve.

Manasrang group has been running at Satara for a year. Over this period we have noticed significant improvements in self-care, social skills, self-esteem, confidence levels of patients; a few patients have managed to gain employment after several years of being at home, others have managed to leave the house after years of being unable to. Families too have noticed improvements in interpersonal relationships, self-care, contributing to household chores.

Other than its therapeutic role and role as a support group for caregivers, Manasrang has also been used for community engagement to create sensitization about mental illnesses, their impact on lives and treatment possibilities. Our experience of working with rural communities is that this medium of communication is well received and culturally acceptable. An example of this is the large number of awareness posters that have been inspired by the Manasrang groups which were made available for public viewing recently in Pune to wide appreciation. Three such posters are attached below for illustrative purposes.

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मानसिक आरोग्य प्रबोधनाकरिता **मानसरंग** प्रकल्प

फीट येणे हा मेंदूचा आजार
वेळीच घ्या डॉक्टरांचा उपचार

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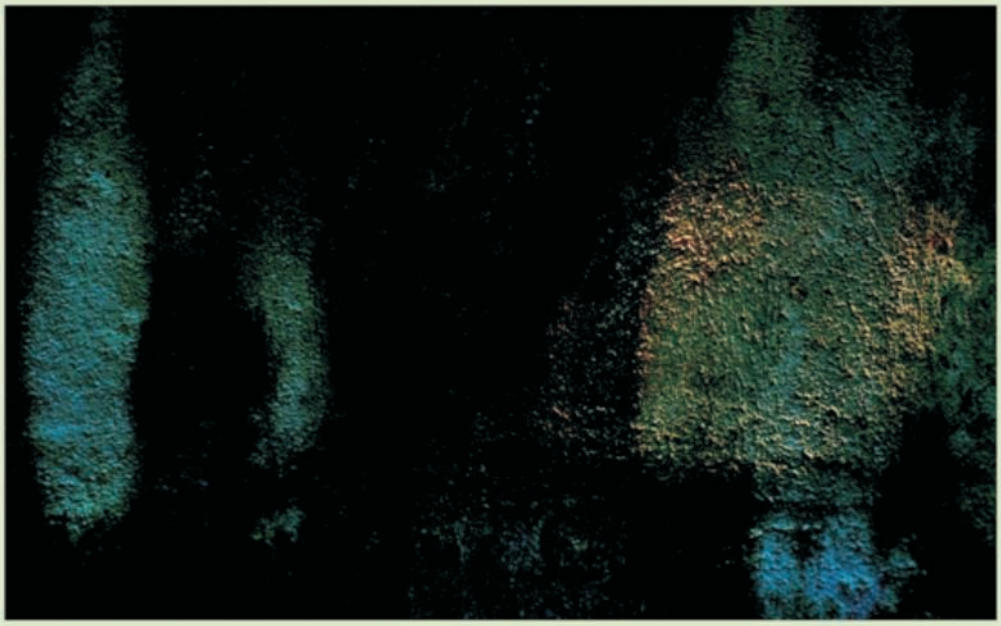
मानसिक आरोग्य प्रबोधनाकरिता **मानसरंग** प्रकल्प



आत्महत्येचे विचार मनात येता त्वरित येऊन डॉक्टरांना भेटा

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मानसिक आरोग्य प्रबोधनाकरिता **मानसरंग** प्रकल्प

नको बाबा,नको बुवा व्यसनमुक्तीसाठी औषधोपचारच हवा

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Evaluation

The pilot phase of the Jan Man Swasth Programme (JMSP) was designed to translate evidence based treatments into real life community based mental health programs and to evaluate whether this was feasible, acceptable and created positive impact. In essence, the JMSP was intended to reduce the large gap 'treatment gap' in mental health care in India through the delivery of evidence based interventions to persons with prevalent selected (priority) mental disorders- severe mental disorders, (SMDs), common mental disorders (CMDs) like depression and anxiety and for people with convulsive epilepsy.

In addition, to understand the effect modification of individual sites in implementing structured interventions in a diverse country like India, the JMSP was designed as a multi site program with six implementation partners across India. The teams at each site have been implementing the JMSP for people with SMDs, CMDs and epilepsy for periods of more than two years; at this time, we feel that the interventions have been rolled out for sufficient period of time to merit an evaluation.

A comprehensive evaluation of the JMSP is an essential component of the whole program. Within the methodological and resource constraints, the planned evaluation will bring together information related to the scale, fidelity and quality of the program across the sites through collated process indicators, outputs and by tracking of the intervention delivery for individuals enrolled in the program.

In addition, a systematic survey was planned to assess the degree to which the program has managed to achieve its stated objectives from the perspective of persons with mental disorders and their family members. The specific objectives of this evaluation exercise are to understand from service users whether the various components of the interventions were:

- accessible
- affordable

- acceptable
- of adequate quality- comprehensive continuous and participatory
- effective in improving their problems and lives

Settings:

The evaluation exercise is being carried out across four of the six field based implementing sites- Ashadeep and ANT in Assam, the Rama Krishna Mission (RKM) in Varanasi, UP and Parivartan in Maharashtra.

Method:

To understand if the JMSP has achieved its stated objectives from the perspective of service users, a set of quantitative information was collected about the individual patient and family's views regarding:

i) systemic factors such as ease of access of mental health services, their acceptability, affordability and continuity of care, and

ii) the service delivery factors such as quality and satisfaction with services.

Sample selection and interview:

Of the total number of persons with mental disorders enrolled in the program at each site, for this evaluation, a proportion were randomly selected by the Central Data Manager from the unique ID numbers available in the central database for each disorder. Semi- structured interviews were then conducted with the randomly selected person with mental disorder and their key family member as a dyad. Thus, at each site, the sample will include respondents from two groups:

- Persons who are in treatment and a paired family member who have been adherent to the treatment for a minimum pre-set duration (depending upon what is considered optimum for the disorder- see below in Table 3) and those who have successfully completed treatment and have had a planned discharge from the program
- Patients who have dropped out from the program and a paired family member

Table 3: Sample for the endline evaluation:

Disorder type	Engaged (in treatment for preset minimum duration and/or planned discharge)	Disengaged / drop -out	Family
CMD - mild	20% (min treatment duration =1 month)	20%	10% of engaged and disengaged groups
CMD mod/severe	20% (min treatment durati on = 3 months)	20%	10% of engaged and disengaged groups
SMD	20% (min treatment duration = 6 months)	20%	10% of engaged and disengaged groups
Epilepsy	20% (min treatment duration 6 months)	20%	10% of engaged and disengaged groups

Data collection will be conducted at each site by the implementing teams headed by the Master Trainers who will receive dedicated training by the Secretariat.

Data collection tools:

- Consent forms for persons with mental disorders and their paired family member
- A purpose designed Program Evaluation Questionnaire was used to record the responses of persons with mental disorders and their primary caregivers. The Questionnaires have been developed for different respondent groups to elicit relevant information for the evaluation. This will be refined and adapted based on the experience in the field after an initial pilot with small groups of respondents. In addition, the Questionnaires will be translated in the local languages for each site.

The questionnaires included items to explore the following themes:

- **Service delivery:** Ease of access, acceptability and affordability of services, continuity of care providers

- **Quality of Service:** Collaborative treatment planning based on needs, quality of explanation about illness
- **Satisfaction with Services:** Experiences in meeting health workers, doctors, experience with medication use, treatment benefits, help in other areas of life like addressing social difficulties, getting back to work
- **Perceived gaps in services**

Steps for data collection

After the list of respondents was finalized through random selection by the Central Data Manager, the respondents were met either at their home or at the local health facility by the researcher to obtain informed consent for participation in data collection. Once consent was provided, the researcher then conducted a face to face interview the patient and their family members using the Program Evaluation Questionnaire.

Data management

A database was created in MS Excel and data entered by the partner organization and checked by the data manager for errors. Quantitative data will be used chiefly for descriptive purposes, so simple analysis of frequencies will be performed and graphs generated in MS Excel. Ethical issues:

Prior to any data collection from respondents, the researchers will obtain written informed consent from both persons with mental disorders and their family members. The researchers will provide the written informed sheet and explain clearly to all potential respondents the purpose of the data collection, that no personal identification will be possible from their responses and that refusal to participate will not interfere in any way with any care being provided. In addition, respondents will be clearly told that there are likely to be limited individual gains from providing the information sought and that the anonymised data will be made public in efforts to improve services locally, regionally and in the country. Once all queries have been answered, persons with mental disorders and their paired family

member will both be asked to sign the informed consent form if they are willing to participate. In case that either the person or the caregiver in the dyad choose not to participate, the interview will be terminated and no data will be collected from the respondent who had agreed. In case either of them are not able to read the contents of the information sheet, standard procedures for obtaining informed consent will be followed. The consent forms and the plans for the evaluation has been reviewed by the Advisory Group and found to be appropriate for use in a program evaluation context.

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External review of the JMSP

An independent external review of the JMSP was commissioned by the Tata Trusts which was conducted by a three member team comprising of Mr Keshav Desiraju (Chair), Dr Lakshmi Vijaykumar and Dr Sushma Mehrotra. As part of the evaluation, the team of external reviewers met with the Principal Applicant and Clinical Lead at Chennai and then visited all six sites between January- February, 2016. The final report of the evaluation was submitted to the Trusts in March 2016 and a copy of this was made available to Parivartan and the partner sites.

Overall, the review concluded that the pilot phase of the JMSP had made considerable progress towards realizing the stated objectives of the program, while also pointing out that there were specific areas where further improvements could be made. The reviewers recommended that the JMSP be consolidated at all sites, include suicide prevention in the program ambit, be expanded in more geographies and, for Parivartan, to be positioned as a national resource centre for community mental health that would work closely with the government to enable the scaling up of services for people with mental disorders.

The Trusts, in turn, asked Parivartan as the Secretariat, to compile the responses to the observations made in the review. This was discussed in a specially convened meeting of all partner organizational heads on 29/04/2016 and subsequently submitted to the Tata Trusts

Results

The JMSP was implemented primarily to respond to the treatment gap for priority mental disorders by implementing an evidence based and structured community based intervention for individuals and their families, the local health systems and the community.

The JMSP has till date been implemented for a total population of 460,000 persons across the sites. A total of 6163 persons have been contacted till the end of November, 2016 after screening by the CHWs or after being referred to the program by health staff or by members of the local community; 3762 (61%) such persons were enrolled in the program after obtaining their informed consent. The rates of enrolment are highest for those with epilepsy, followed by those with severe mental disorders and, at 52%, the lowest for people with common mental disorders. The large gap between screening or referralfrom other sources and enrolment in people with CMDs was mostly due to the a priori cut off score set on the screening instrument- the General Health Questionnaire or the GHQ-12. The details of the numbers of people with SMDs, CMDs and convulsive epilepsy who were enrolled and followed up across the sites are described in Appendix 1. Of those enrolled in the program, the dropout rates were the highest for those with epilepsy with people with CMDs and SMDs having comparable rates of dropout. In addition, 46.8% of those enrolled with CMDs completed their treatments and were discharged from the program while around 22% of the cohort with SMDs and epilepsy could also be discharged in a planned manner after their needs had been adequately met. There were also significant differences between the sites in terms of the treatment coverage, the rates of referrals, enrolment and rates of adherence with treatments.

There were a total of 39 deaths in the cohort with three of them being due to completed suicide with 47 episodes of hospitalization due to relapse of mental health problems or physical health concerns. Another key element of the intervention was the provision of stepped care treatments for people with mental disorders across the sites. There is again wide variation in the distribution pattern or spread of the stepped care treatments across the sites which is discussed at some length below. Finally, as shown in Appendix 2, a significant effort was made across the sites in community engagement activities with a variety of stakeholders in the local communities.

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Implications

By dint of the design, implementation and monitoring, the JMSP provides very important information in relation to the implementation of evidence based community mental health programs in the country. The data clearly demonstrates the need for such interventions and that community mental health programs are feasible to deliver, are safe and largely acceptable to people with mental disorders and their families. The JMSP also provides detailed information about treatment coverage for three priority mental disorders and that stepped care treatments can be implemented for treating people with these disorders efficiently and in congruence with their needs.

The JMSP also demonstrates the powerful mediating influence of sites in the actual implementation of a common structured intervention. Pending further detailed analysis of the factors that specifically contribute to the observed between site differences, there are two clear themes that emerge. Firstly, there are a set of baseline factors like the geographical location, socio economic adversity of the local community and the extent of availability of health services that seem to have a moderating influence on some of the emergent patterns of intervention delivery. Secondly, there are some program related factors like the stability of the senior members of the teams, the engagement of ASHA workers formally in the workforce, the availability of the psychiatrist and mentors and the degree of engagement with the public health system that seemed to mediate the outcomes of the intervention.

As described in the good practices section of the report, the community engagement process has led to the successful development of innovative and culturally sensitive methods, the development of peer and caregiver support and advocacy groups at all sites, examples of highly productive partnerships with traditional and public health systems, access to work and livelihoods opportunities

and a greater understanding and supportive social milieu in relation to attitudes towards mental illnesses at the sites. Very importantly, the engagement process has enabled the development of a constructive dialogue with local communities around issues of mental health and brought mental health out of the shadows.

Finally, the JMSP has developed and field tested a number of important components of delivering high quality community mental health services that are of use across the country. These include a set of materials and a new competency based training methodology for the range of non-specialist workforce necessary to scale up services, detailed intervention delivery guides for community health workers for three of the most common priority mental disorders in the country, documentation requirements and a robust data management system to provide ongoing monitoring inputs and evaluation, collaborations with the public health system as well as effective community engagement tools and methods.

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Conclusion

The JMSP is an important initiative for expanding the accessibility and acceptability of high quality community mental health services in India. The program has reached out to a very large number of persons with three priority mental disorders in a systematic manner and reduced the treatment gap in the catchment areas in collaboration with local communities, governments and people who have been closely involved with the program. The JMSP also provides a detailed template and methodology of how such programs can be implemented across multiple settings and identifies some critical moderating and mediating influences that determine how such interventions behave across diverse sites. With the accumulated experience, the JMSP can contribute substantially to the efforts underway to strengthen the capacity of health systems to incorporate mental health care and thus make such treatments more widely available across local communities, regions and the country. Finally, the program has enabled the creation of expertise within highly credible community based organizations across different parts of India who can provide the leadership for further expansion of community programs within and outside of their program implementation areas in the future.

Acknowledgements

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The Jan Man Swasth program is a large collaborative effort across multiple locations and would simply not have been possible without the combined efforts of many organizations and individuals. First and foremost, we are indebted to all persons with mental health problems and their families for their willingness to engage in the program and for giving us an opportunity to share in their journeys of recovery.

We are very grateful to the Advisory Board chaired by Professor Mohan Isaac, and comprised of Professor Mathew Varghese and Professor Prabha Chandra from NIMHANS, Bengaluru, Dr. Thara at SCARF, Chennai, Professor Mohan Gupte, Dr. Mohan Agashe and Mr. Bakshi- all from Pune for their generous support, guidance and time, in spite of their many other commitments. We would also like to place on record our deep appreciation to the members of the External Review team- Mr. Keshav Desiraju, Dr. Lakshmi Vijaykumar and Dr. Sushma Mehrotra for their detailed evaluation of the JMSP that was extremely useful for all organizations and teams.

It is our pleasure to acknowledge the many individual contributions of all team members, mentors and consultants across the sites who have been involved since the beginning of the program. Without their commitment, hard work and passion, the JMSP would not have been possible to implement. The team at the Secretariat also deserves special praise and mention for their leadership in managing such a complex program with multiple organizations relatively smoothly and in a highly collaborative manner.

We are also very thankful to the Tata Trusts for generously facilitating and supporting the program and, in particular to Tasneem Raja and Sandeep Chavan for

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their close involvement throughout the course of the program. It has been an absolute privilege to work with all the organizations involved in implementing the program- Ashadeep, the Ant, FRCH, Jan Chetna Manch, the Ramakrishna Mission Home of Service, ASHWINI and Parivartanand for the wonderful collegiate relationship and support provided at all times by Mukul Goswami, Jennifer and Sunil Kaul, Swami Varisthananda, Nerges Mistry, Lindsay Barnes and Shyla.

We are also very grateful to Mr. Atul Pethe and Mr. Raju Inamdar for their enthusiasm and sustained passion in introducing the Manasrang component of the intervention. In this context, we also wish to acknowledge the fantastic contribution of Mr. Jayant Joshi and Mr Kumar Gokhale in interpreting the slogans generated by peers and caregivers into a set of outstanding posters. We were also very lucky to have the support and appreciation of Professor Helen Hermann from the University of Melbourne and the incumbent president of the World Psychiatry Association for the public launch of the Manasrang performance and posters at Pune.

We would also like to gratefully acknowledge the support from Swasth India while developing the IT enabled data management system. We would like to formally place on record our deep appreciation for the vital contributions of many individuals in the public health and local government systems, local community agencies and the general members of all local communities for collectively working towards making mental health care a socially sanctioned and positively endorsed activity, out from the shadows.

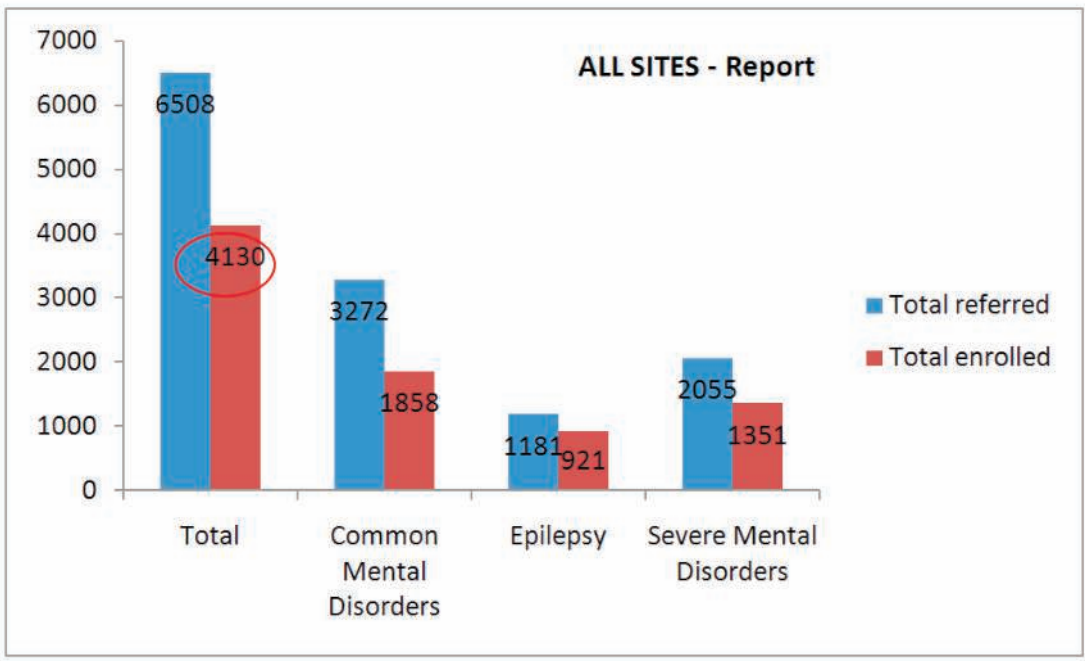
Finally, we wish to gratefully acknowledge the unwavering support of the trustees and staff of the Parivartan Trust while negotiating the many complexities involved in implementing the program.

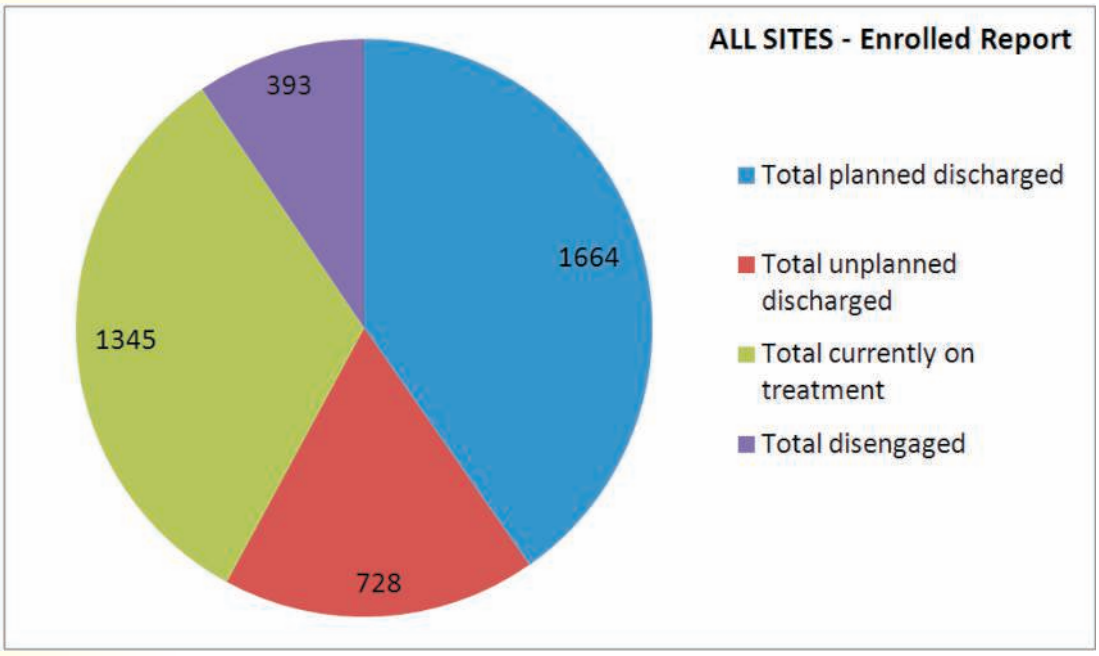
Appendix I

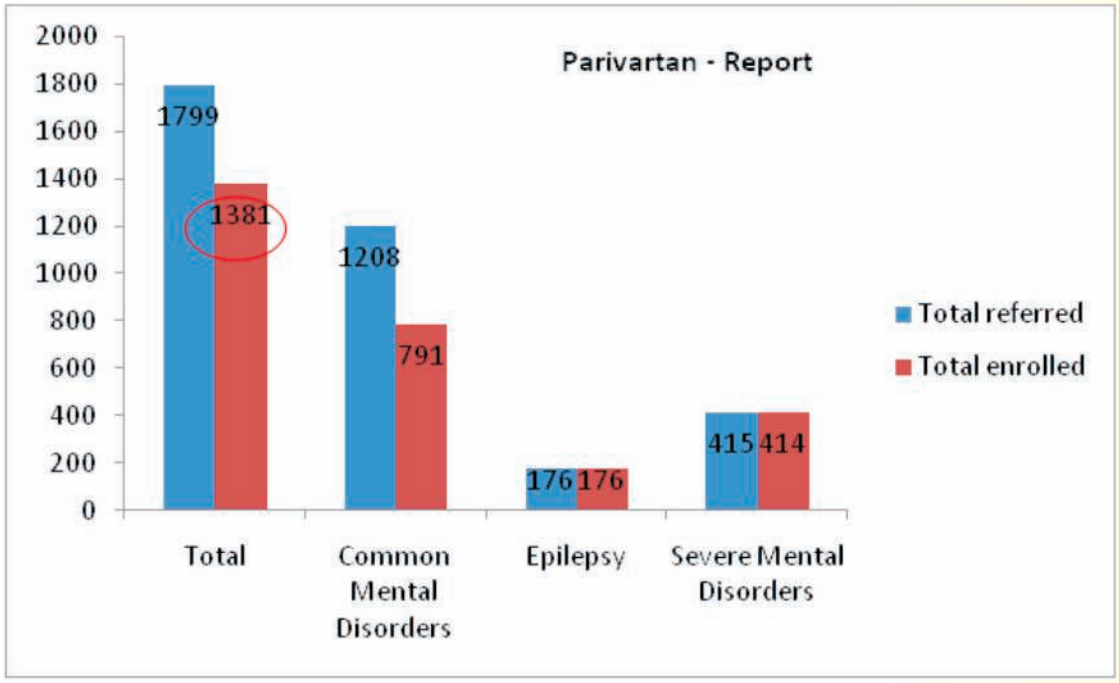
R 1- JMSP PROGRAM INDICATORS REPORT : 0 36

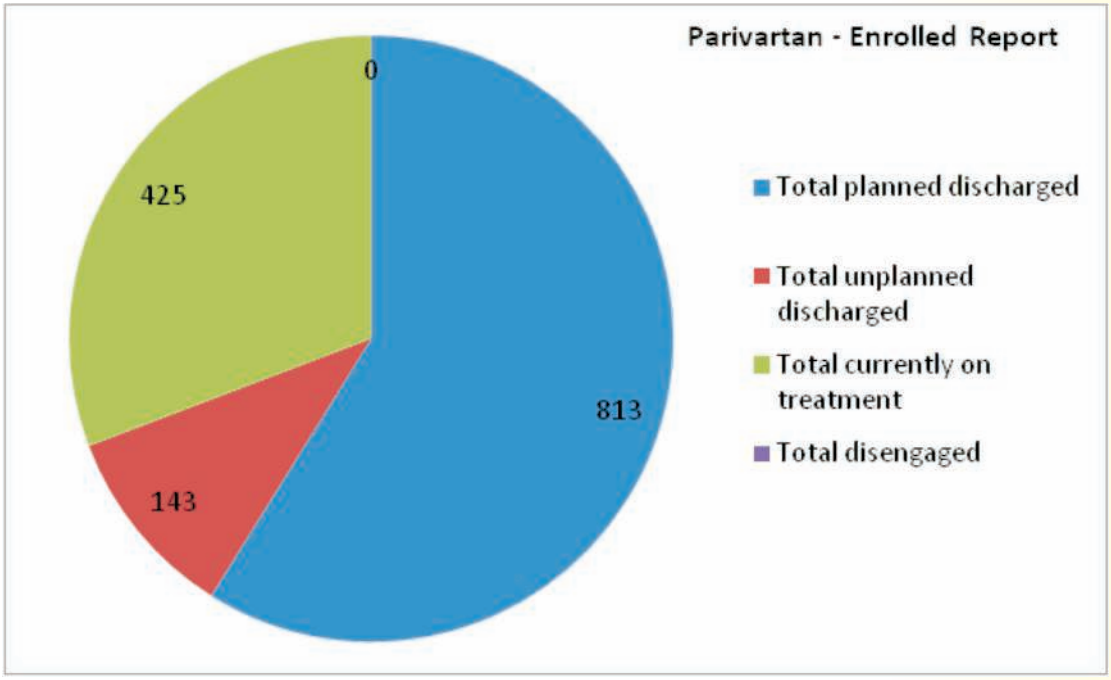
#Graph 1 represents Total referred and Total enrolled by disorder & total

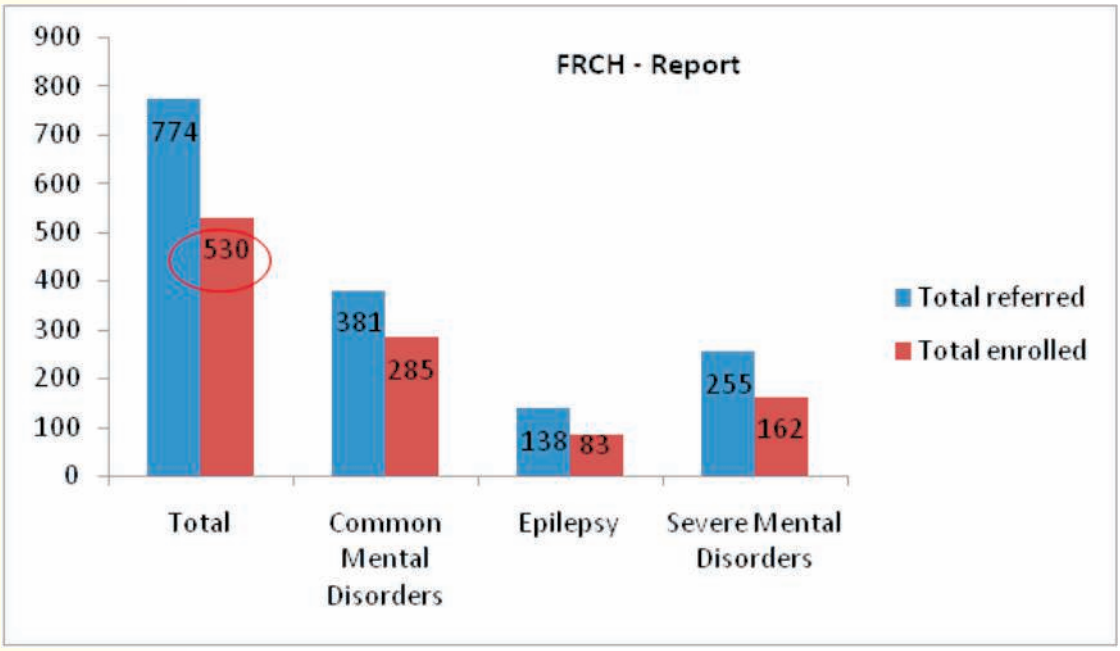
Graph 2 represents Intervention status of total enrolled (number circled in red in graph 1)

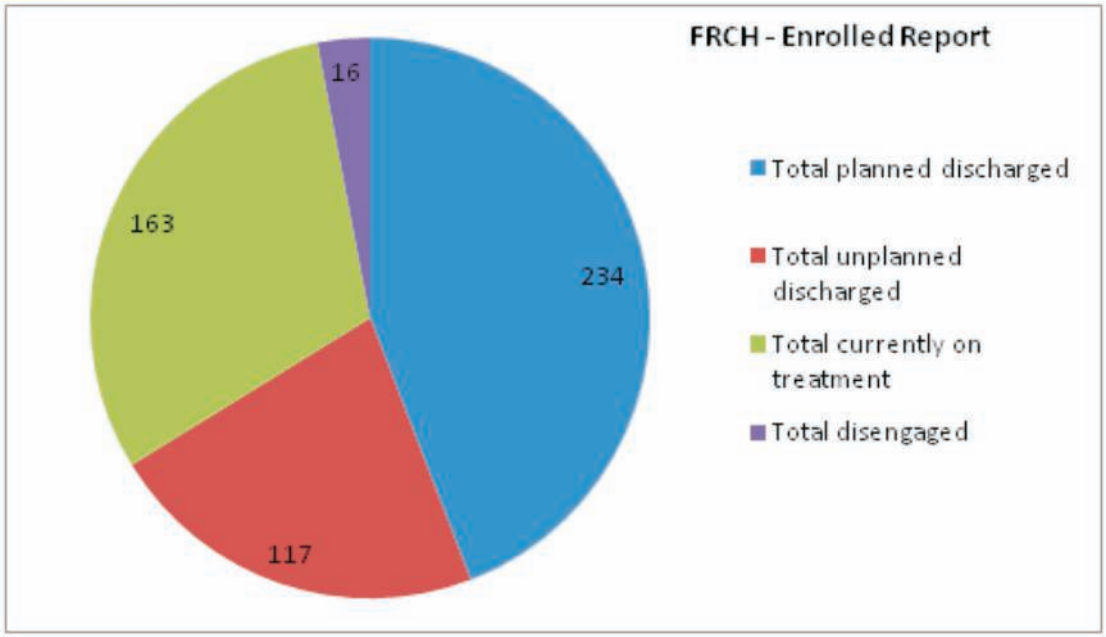





Parivartan - Report
2000
1800
1600
1400
1200
1000
800
600
400
200
0
1799
1381
1208
791
176
176
415
414
Total
Common Mental Disorders
Epilepsy
Severe Mental Disorders
Total referred
Total enrolled


Parivartan - Enrolled Report
0
425
813
143
Total planned discharged
Total unplanned discharged
Total currently on treatment
Total disengaged


FRCH - Report
900
800
700
600
500
400
300
200
100
0
774
530
381
285
138
83
255
162
Total
Common Mental Disorders
Epilepsy
Severe Mental Disorders
Total referred
Total enrolled


FRCH - Enrolled Report
16
163
234
117
Total planned discharged
Total unplanned discharged
Total currently on treatment
Total disengaged

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Appendix II

Organization	Disorder	Total referred	Total enrolled	% enrolled of those total referred
ANT	**Total**	**1035**	**479**	**46.3%**
	Common Mental Disorders	271	95	**35.1%**
	Epilepsy	243	132	**54.3%**
	Severe Mental Disorders	521	252	**48.4%**
Ashadeep	**Total**	**1490**	**632**	**42.4%**
	Common Mental Disorders	851	157	**18.4%**
	Epilepsy	248	176	**71.0%**
	Severe Mental Disorders	391	299	**76.5%**
FRCH	**Total**	**774**	**530**	**68.5%**
	Common Mental Disorders	381	285	**74.8%**
	Epilepsy	138	83	**60.1%**
	Severe Mental Disorders	255	162	**63.5%**
JCM	**Total**	**696**	**446**	**64.1%**
	Common Mental Disorders	270	242	**89.6%**
	Epilepsy	162	146	**90.1%**
	Severe Mental Disorders	264	58	**22.0%**
Parivartan	**Total**	**1799**	**1381**	**76.8%**
	Common Mental Disorders	1208	791	**65.5%**
	Epilepsy	176	176	**100.0%**
	Severe Mental Disorders	415	414	**99.8%**
RKM	**Total**	**714**	**662**	**92.7%**
	Common Mental Disorders	291	288	**99.0%**
	Epilepsy	214	208	**97.2%**
	Severe Mental Disorders	209	166	**79.4%**
Grand Total	**Total**	**6508**	**4130**	**63.5%**
	Common Mental Disorders	3272	1858	**56.8%**
	Epilepsy	1181	921	**78.0%**
	Severe Mental Disorders	2055	1351	**65.7%**

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Total planned discharged	Total unplanned discharged	Total currently on treatment	% on treatment of those total enrolled	Total disengaged	% disengaged of those total enrolled	Total Population covered
158	**71**	**229**	**47.8%**	**21**	**4.4%**	**68,000**
46	16	28	**29.5%**	5	**5.3%**	
25	16	84	**63.6%**	7	**5.3%**	
87	39	117	**46.4%**	9	**3.6%**	
306	**230**	**96**	**15.2%**	**0**	**0.0%**	**111,000**
95	59	3	**1.9%**	0	**0.0%**	
91	63	22	**12.5%**	0	**0.0%**	
120	108	71	**23.7%**	0	**0.0%**	
234	**117**	**163**	**30.8%**	**16**	**3.0%**	**55,000**
199	57	20	**7.0%**	9	**3.2%**	
18	16	48	**57.8%**	1	**1.2%**	
17	44	95	**58.6%**	6	**3.7%**	
55	**75**	**110**	**24.7%**	**206**	**46.2%**	**60,000**
36	40	52	**21.5%**	114	**47.1%**	
0	33	40	**27.4%**	73	**50.0%**	
19	2	18	**31.0%**	19	**32.8%**	
813	**143**	**425**	**30.8%**	**0**	**0.0%**	**100,000**
529	64	198	**25.0%**	0	**0.0%**	
117	14	45	**25.6%**	0	**0.0%**	
167	65	182	**44.0%**	0	**0.0%**	
98	**92**	**322**	**48.6%**	**150**	**22.7%**	**66,000**
65	42	126	**43.8%**	55	**19.1%**	
21	34	119	**57.2%**	34	**16.3%**	
12	16	77	**46.4%**	61	**36.7%**	
1664	**728**	**1345**	**32.6%**	**393**	**9.5%**	**460,000**
970	278	427	**23.0%**	183	**9.8%**	
272	176	358	**38.9%**	115	**12.5%**	
422	274	560	**41.5%**	95	**7.0%**	

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