



World Health
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Community-based mental health services in the _____ WHO South-East Asia Region _____





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Foreword

Historically, mental health care has been synonymous with institutionalization. However, as our understanding of mental health has evolved, so too must our methods of care. Today, we recognize the shortcomings of isolating individuals in large facilities, and the need for a more holistic and community-driven approach.

The transition to community-based care is beneficial for both individuals and society at large. It allows for greater personal autonomy, improved quality of life, and personalized care options.

In community-based settings, individuals have opportunities to regain a sense of independence and engage in social and vocational activities, which can significantly improve their overall well-being. Community-based care also promotes inclusivity and reduces the stigma often associated with mental health issues.

Placing mental health services within the community helps overcome the barriers that often isolate individuals with mental illnesses. When these services are integrated into the fabric of our communities, it also becomes easier for individuals to seek help without fear of judgement or discrimination.

This publication describes a selection of services in our World Health Organization (WHO) South-East Asia Region Member States, and highlights the efforts and dedication of individuals and organizations committed to advancing the cause of mental health within their communities. These interventions range from community-based mental health centres and teams, psychosocial rehabilitation, supported-living programmes and peer-support networks.

Within these pages, there are examples of innovative approaches, insightful strategies and inspiring stories that illustrate the transformative potential of community-based interventions. Such interventions also have ripple effects, influencing societal attitudes, shaping policy agendas, and fostering environments that promote mental well-being.

It is undeniable that the demand for mental health services continues to outstrip available resources, and systemic barriers such as lack of funding and human resources persist. The interventions outlined in these pages can become the basis of addressing such challenges through innovation, collaboration, advocacy, community engagement and informed policies.

It is my hope that this publication will serve as a source of information as well as inspiration, speaking to our hearts and our minds. It is with that synchronization that we will best craft the policies and programmes needed to ensure equity and improved support for those who need it, in the familiarity and comfort of their own communities.



Ms Saima Wazed
Regional Director
WHO South-East Asia



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Abbreviations

CAN MH Lanka Consumer Action Network Mental Health Lanka

DIL Depression in Late Life

mhGAP Mental Health Gap Action Programme

NGO nongovernmental organization

PHQ-9 Patient Health Questionnaire-9

SCARF Schizophrenia Research Foundation

VHV village health volunteers

1

Introduction

Background

Community-based mental health care includes any mental health care that is provided outside of a psychiatric hospital. It is more accessible and acceptable than institutional care, helps prevent human rights violations, and delivers better recovery outcomes for people with mental health conditions when compared with institutional care.

Community-based mental health care recognizes the need for a person-centred, recovery-based approach that ensures that all people have access to a range of services and support, from promotion and prevention to treatment and rehabilitation. At the level of the individual, such services take a person-centred, rights-focused approach to promoting mental well-being, addressing the diverse and complex needs of individuals and families requiring mental health care. This involves a network of services that provide support to address the multiple needs of people with mental health conditions and of caregivers, which cannot be addressed by a single intervention or facility.

Community networks should therefore be coordinated across different levels and sites within and beyond the health sector, according to people's needs throughout the life-course. To do so, community-based services also rely on strong collaborations with local organizations, schools and other community entities to address not only individual mental health needs but also the broader systemic factors contributing to mental health conditions.

By providing mental health support in communities, prevailing societal norms begin to shift, creating an environment in which seeking help is normalized. This encourages more individuals to engage with mental health services. Community-based services also rely on strong collaborations with local organizations, schools and other community entities to address not only individual mental health needs but also the broader systemic factors contributing to mental health conditions. This collaborative approach strengthens community bonds, creating a supportive network that is essential for both prevention and intervention.

Further, community-based mental health services are particularly important during times of crisis, such as in the aftermath of a natural disaster or a global pandemic. They provide timely and localized assistance, catering to the unique needs that emerge during such challenging periods. The WHO South-East Asia Region is particularly vulnerable to natural disasters and effects of climate change, which have a negative impact on the mental health of communities. Evidence is now accumulating to show that the climate crisis impacts mental health in multiple ways.

Countries can design and implement different types of community-based mental health models of care, based on their specific needs and priorities. Traditionally, most efforts in the field of mental

health focus on integration of mental health into primary health care. However, it is essential to expand mental health services beyond primary health care.

Expanding community-based mental health services encompass three main areas, identified in the *World Mental Health Report 2022 (1)*.

- community mental health services – includes community mental health centres and teams, psychosocial rehabilitation, peer support services and supported living services;
- mental health in general health care – includes mental health services provided in primary care, general hospitals and specific programmes such as maternal health; and
- mental health beyond the health sector – encompasses services in non-health settings, such as in schools, and social sector programmes such as provision of benefits and child protection.

Countries can design and implement different types of community-based mental health models of care, based on their specific needs and priorities. Traditionally, most efforts in mental health focus on integration of mental health into primary health care. However, there is need to expand community-based mental health services outside primary health care. These services are described in subsequent sections.

Therefore, the establishment of a network comprising multiple services, each equipped with multidisciplinary teams and distinct functions, is a fundamental component of community-based mental health services. This document gives examples of services already in existence in the Region.

Regional action

In 2022, the Member States of WHO South-East Asia Region committed to promote and facilitate access to community-based mental health services through the adoption of the *Paro Declaration on universal access to people-centred mental health care and services (2)*.

The adoption of this declaration was followed by the *Mental health action plan for the WHO South-East Asia Region 2023–2030 (3)*, which has four main objectives. Under Objective 2 – Provide comprehensive, integrated and responsive mental health and social care services in community-based settings – it provides an extensive menu of options to expand and strengthen community-based mental health services in WHO South-East Asia Region Member States. It also contains indicators to track the progress of the expansion of community-based mental health services:

1. the number of community-based mental health centres that provide care and support options for people with mental health conditions and psychosocial disabilities in the community (e.g. day care centres, rehabilitation centres)¹;
2. the proportion of general hospitals with mental health units; and
3. the number of supported living facilities – both long and short stay.

¹ These centres are intended to provide support outside institutional settings and in proximity to people's homes. The range of support options provided in these centres varies, depending on size, context and links to the overall health system in a country. In the context of this plan, these are not primary health care centres.

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Community-based mental health services

A wide range of services comes under the description community-based mental health services. The following are covered in this report.

- **Community mental health centres and teams** provide a range of mental health services to individuals in the community. These centres offer counselling, therapy, and psychiatric support on an outpatient basis. They focus on promoting mental well-being, preventing mental health crises. They have the potential to provide accessible care and support close to where people live, work closely with non-specialized primary care, and work with the wider network of support in local communities.
- **Mental health units in general hospitals** are designed to address acute mental health crises and provide immediate intervention. Inpatient wards offer short-term admissions for individuals requiring hospital care, while crisis support services provide assistance and counselling to those experiencing acute emotional distress or a mental health emergency. Local acute inpatient care should be available in dedicated wards of general hospitals (preferably not within the same building as other wards or operating theatres). Their role is to provide care for the acutely ill who cannot be managed at home.
- **Psychosocial rehabilitation or intermediate care centres** provide support and treatment for individuals transitioning from acute mental health care to community living. These centres focus on skill-building, rehabilitation, and fostering independence. They offer a structured environment where individuals can receive therapeutic services and learn essential life skills. Intermediate care services are developed at district level close to the community to support ongoing rehabilitation for those who need it. These services can also offer support to people who are unable to return to their family home because they experience enduring problems that necessitate rehabilitation.
- **Supported living facilities and services** provide both short-stay and long-stay facilities and other services. Living facilities offer a supportive residential environment for individuals with mental health conditions who are transitioning from institutional settings to independent living. These homes provide a structured and supervised living arrangement, offering a supportive community and assistance with daily activities to help individuals regain stability and autonomy. Supported living services encompass a variety of community-based supports tailored to individuals with mental health needs. These services may include assistance with daily living activities, vocational training, social integration and ongoing psychosocial support. The goal is to empower individuals to live independently and participate fully in community life. Supported living services are also instrumental in the process of deinstitutionalization of psychiatric hospitals and mental asylums.

- **Day care services** offer a structured and supportive environment for individuals to engage in therapeutic activities during the day. Community-based day care is an important additional component of a local community-based mental health service. These services are designed to enhance social skills, provide vocational training and offer counselling or group therapy sessions. Day care can be the first service component to be established as part of a wider service system.
- **Peer support services and non-professional support** involves individuals with lived experience of mental health conditions, volunteers and non-professional health workers providing guidance, understanding and encouragement to those with mental health conditions. Such initiatives aim to create a non-judgemental and empathetic space where individuals can share their experiences, receive practical advice and build a sense of community. This type of support is valuable in promoting recovery and resilience. The use of non-professional staff, volunteers and peer support workers can help to establish innovative and effective low-cost support.
- Others services can include those offered through primary and secondary health care, specific health programmes such as maternal health, and services offered through the social sector.

Table 1. Community-based mental health services

	<p>Community mental health centres and teams</p>	<ul style="list-style-type: none"> • Allows the provision of a central point of coordination and a range of services for those living with mental conditions close to where they live • Maintains contact with those living with mental conditions who are most unwell • Co-ordinates care between hospitals, primary care, rehabilitation and day care • Works with local social services, NGOs, schools, workplaces, and traditional and faith-based healers
	<p>Psychiatric acute inpatient wards and crisis support centres, mental health units in general hospitals</p>	<ul style="list-style-type: none"> • Provides services for people living with mental health conditions when they cannot be supported safely in the community, for example because they have lost control, are unable to focus, are actively suicidal or exhibit inappropriate or threatening behaviour • Short-term admission until stabilized, with access to and contact with family and friends and the local community mental health staff
	<p>Rehabilitation or intermediate care centres</p>	<ul style="list-style-type: none"> • Support and care for those living with mental health conditions who need extra help and longer periods to recover, such as those who have spent a long time in hospitals or institutions; accommodation for larger groups
	<p>Supported living services, including halfway homes</p>	<ul style="list-style-type: none"> • Provide help for small groups of people to be as independent as they can and support one another • Provide services and shelter for the very small number of people living with mental health conditions who have lost contact with their family or friends or are unable to live with their families for other reasons



Day care

- Provides a service for people living with mental conditions who can continue to live with their families but still require support during the day
- Provides help with livelihood skills
- Provides social contact



Peer and non-professional support

- Provides support for people living with mental health conditions who have recovered, by non-professional staff and volunteers
 - Helps to free up more highly skilled staff to focus on issues that require specialized attention
-

3

Methodology

Step 1: Desk review

A desk review was conducted to obtain a comprehensive list of community-based mental health programmes in Member States of the WHO South-East Asia Region. It followed the scoping review format, using the PRISMA-ScR guidelines (4). Both academic and grey literature published within the last ten years were reviewed. Three primary databases, PubMed/MEDLINE (5), APA PsycInfo (6) and Embase (7) were searched for academic papers. Grey literature included resources from:

1. Google/Google Scholar
2. preprint databases such as PsyArXiv (8) and MedRxiv (9)
3. government websites
4. websites of organizations working in community-based mental health
5. inputs from international experts (for unpublished research)
6. WHO Collaborating Centre network facilitated by the WHO India office.

The main criterion for the inclusion of a programme was that it had to be based in the community; any programme that was primarily hospital-based or non-community-oriented was not included. Services that were concluded before 2010 were omitted.

Table 2. Information gathered during desk review

Core information	Further information
Affiliated organization	Name of the organization
Name of the programme	Name of the community mental health service (CMHS) or programme
Location	Name of the central location from which the CMHS is provided
Rural/urban	Type of setting
Availability in different locations	If the service is available in multiple locations, the other locations where the services are available
Background	Brief background about the programme
Primary classification	Primary mode of service provision
Other classification	Types of service provided
Population serviced	Sub-set of people for whom the programme is designed
Time frame	Date of initiation of programme and, if concluded, the date of conclusion

Referral pathways	The process of referral from one service delivery point to another when required
Evidence	Type of evidence available on the programme
Evaluation	Method and system of evaluation of the programme
Financing	Source of financing
Innovative practices	Some innovative practices (if any) in delivering the service
Questions to be raised	Clarifications required from the implementing agency
Contact	Contact details

Step 2: Key informant interviews

The desk review identified around 70 programmes. The next step involved communicating directly with the organizations to obtain in-depth information on their implemented programmes. The team contacted various organizations, using email addresses obtained from websites and LinkedIn, and some facilitated by the WHO country offices and by previously established connections. The organizations received a survey questionnaire, based on the table above, in order to elicit preliminary information unavailable on the internet. It was distributed as a Google Form with 28 questions.

At the end of the questionnaire, organizations were asked whether they were interested in being contacted further for an in-depth interview based on the information they had provided. Key personnel of the organizations that responded were interviewed to gain insight into their programme's logistics, implementation strategies, challenges, financial costs and key learnings from their experiences. These in-depth interviews were transcribed and synthesized with literature-sourced information.

Disclaimer

This report was prepared primarily to spotlight studies to inspire other similar efforts in the Region. The selection of the case studies was principally guided by the availability of well-documented case studies representing different countries of the Region, and variety in terms of the nature of the programmes, the services offered and the population catered for.

While the best efforts have been made to identify examples of unique and successful models of community-based mental health programmes implemented in the WHO South-East Asia Region when compiling the selection of case studies, we acknowledge that some programmes that deserve to be part of this report may not have been included. This would be due to varied reasons ranging from, but not limited to, the lack of adequate information or verifiable data available in the public domain about the programme, or non-response.

We make no claim that these are the best programmes in the Region, nor that similar well-functioning programmes provided by other organizations do not exist. This report is not based on a systematic review nor on any ranking system.

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Classification of case reports

The case reports contained in this document can be categorized as below, noting that some of the programmes provide services in multiple domains.

Table 3. Classification of case reports

Community mental health centres and teams	<ul style="list-style-type: none"> • Mental Health Gap Action Programme (mhGAP) – integration of mental health in primary health care, National Institute of Mental Health, Ministry of Health and Family Welfare and WHO Country Office, Bangladesh • Telepsychiatry initiative, Schizophrenia Research Foundation (SCARF), India • Diploma in Community Mental Health Care, The Banyan Academy of Leadership in Mental Health (BALM), India • The Inclusion Project, community mental health services, Koshish, Nepal • Community mental health services, Mental Health Strategy and Planning Division, Department of Mental Health, Ministry of Public Health, Thailand
Psychosocial rehabilitation	<ul style="list-style-type: none"> • Programa Asistencia Moras Menta (PAMM), Psychosocial Recovery and Development in East Timor (PRADET) • Thrive – model for employment support for persons living with severe mental health conditions, Parivartan Trust, India • Community Empowerment for Psychosocial Health, Livelihood and Emergency Resilience (CEPLERY), Pusat Rehabilitasi YAKKUM, Indonesia
Supported living	<ul style="list-style-type: none"> • Proshanthi – supported living services and rehabilitation facility, Sajida Foundation, Bangladesh • Kudil (“Gateway to Life”) – short-term residential rehabilitation service, Jaffna, Ministry of Health, Sri Lanka
Peer and non-professional support	<ul style="list-style-type: none"> • Community-based mental health support services for children and youth at risk, Innovation for Wellbeing Foundation (IWF), Bangladesh • Depression in Late Life (DIL) project, psychosocial services for the elderly, Sangath, India • Atmiyata – enabling access to mental health and social care in rural communities, Centre for Mental Health Law and Policy (CMHLP), Indian Law Society, India • The Khushee Mamta (“Happy Motherhood”) Programme, Mata Jai Kaur Maternal and Child Health Centre, India • Lan Pya Kyel – psychosocial support services, Myanmar • The Butterfly Project – community outreach and peer support, Consumer Action Network Mental Health Lanka (CAN MH Lanka), Sri Lanka

5

Case reports

Mental Health Gap Action Programme – integration of mental health in primary health care

Collaboration between the National Institute of Mental Health, Ministry of Health and Family Welfare and WHO Country Office, Bangladesh

Type of setting	Rural
Availability in multiple locations	Yes
Locations where programme operates	Bandarban, Chapainawabganj, Jashore, and Sylhet districts, Bangladesh
Target population	General population
Referral pathways (in/out)	Self-referral, referral through community workers
Classification of service	Community mental health services, clinical care and support, outreach services
Financing	Donor funding
Classification of service provider	Government
Name of the service provider	National Institute of Mental Health, Bangladesh
Current status of programme	Ongoing
Evidence	Grey literature

Programme description

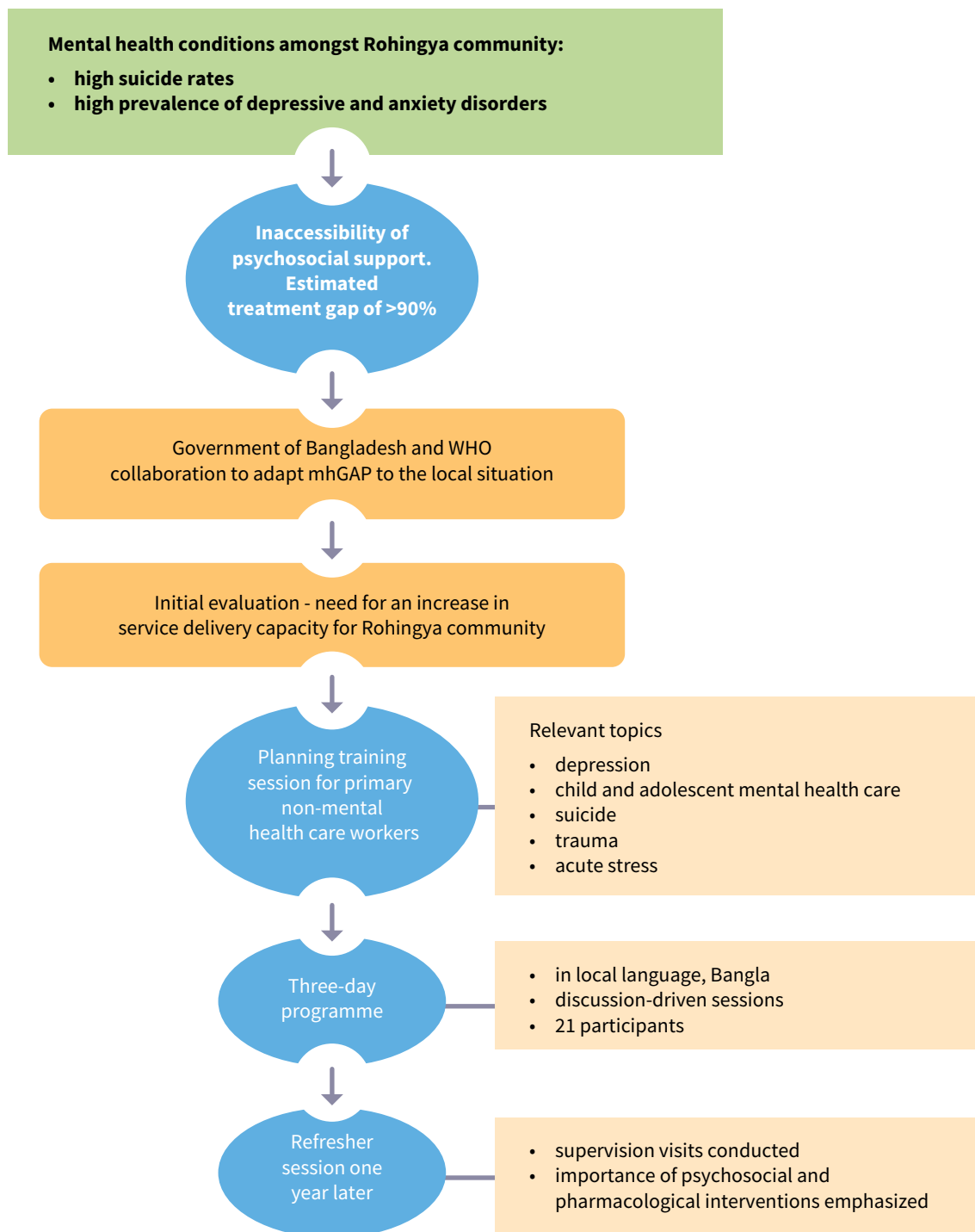
The integration of mental health care in primary care services in the districts of Bandarban, Chapainawabganj, Jashore and Sylhet in Bangladesh is being achieved through a comprehensively planned initiative that has been taking place since 2017. A situational analysis was carried out that indicated a dearth of mental health personnel and resources at the tertiary level and the taluka level, alongside a high prevalence of psychosocial distress in communities in these districts. An investment case study was conducted covering the whole country, which recommended strategies to better allocate resources and finances for mental health care.

Programme operation

Recognizing the reduced mental health service capacity, the Government of Bangladesh

collaborated with WHO to model the existing Mental Health Gap Action Programme (mhGAP) to address the country’s mental health needs through the provision of psychological first aid and services.

Fig. 1. Model of mhGAP



The implementation of mhGAP for displaced Myanmar nationals in Bangladesh proceeded as follows:

- The first step was the training of the mhGAP trainers and supervisors. These trainers facilitated the training of health workers in the selected districts. The priority was to provide for depression, child and adolescent mental health care, suicide, trauma and acute stress. The content of mhGAP was translated and underwent a rigorous process of adaptation to align with the country's context. The process involved collaboration with WHO and local working groups, including consultations with advisory and subcommittee teams. Daily allowances and transport allowances were provided to the health workers during the training process.
- Delivery was mainly through discussion-driven interactions. A refresher training was also held to keep up with recent trends and advancements in mental health. To provide participants with specialized attention, supervision visits were conducted. This was an opportunity for the trainees to work on their skills individually.
- To support this process, provision of tele-mental health services, supportive supervision systems and data recording and reporting systems are being implemented at present.

Impact

Following the contextualized mhGAP training, there was an increase in the capacity of primary health care workers to provide mental health services, and a high demand from practitioners to develop their skills to provide mental health services. This is a good example of collaboration between WHO and the government to strengthen service delivery and response. This initiative is ongoing and is being systematically monitored to assess the service coverages and demand for services.

Learnings

- Strong political commitment for improving mental health and suicide prevention is a significant facilitator in integrating mental health at primary care level.
- Involving media professionals in strengthening the narrative around mental health conditions helps to reduce stigma and improve service seeking.
- Community leaders, religious leaders, teachers and the police department can facilitate the reach to a wider range of groups to enhance mental health literacy.
- Telemedicine and tele-mental health services, when provided in a planned manner, improve services.
- Training in research and data management will further improve the public mental health system in the country.

Additional information

Contact: Dr Helal Uddin Ahmed, President Bangladesh Association for Child & Adolescent Mental Health (BACAMH), Associate Professor Child Adolescent and Family Psychiatry, National Institute of Mental Health (NIMH), Dhaka

Telepsychiatry initiative

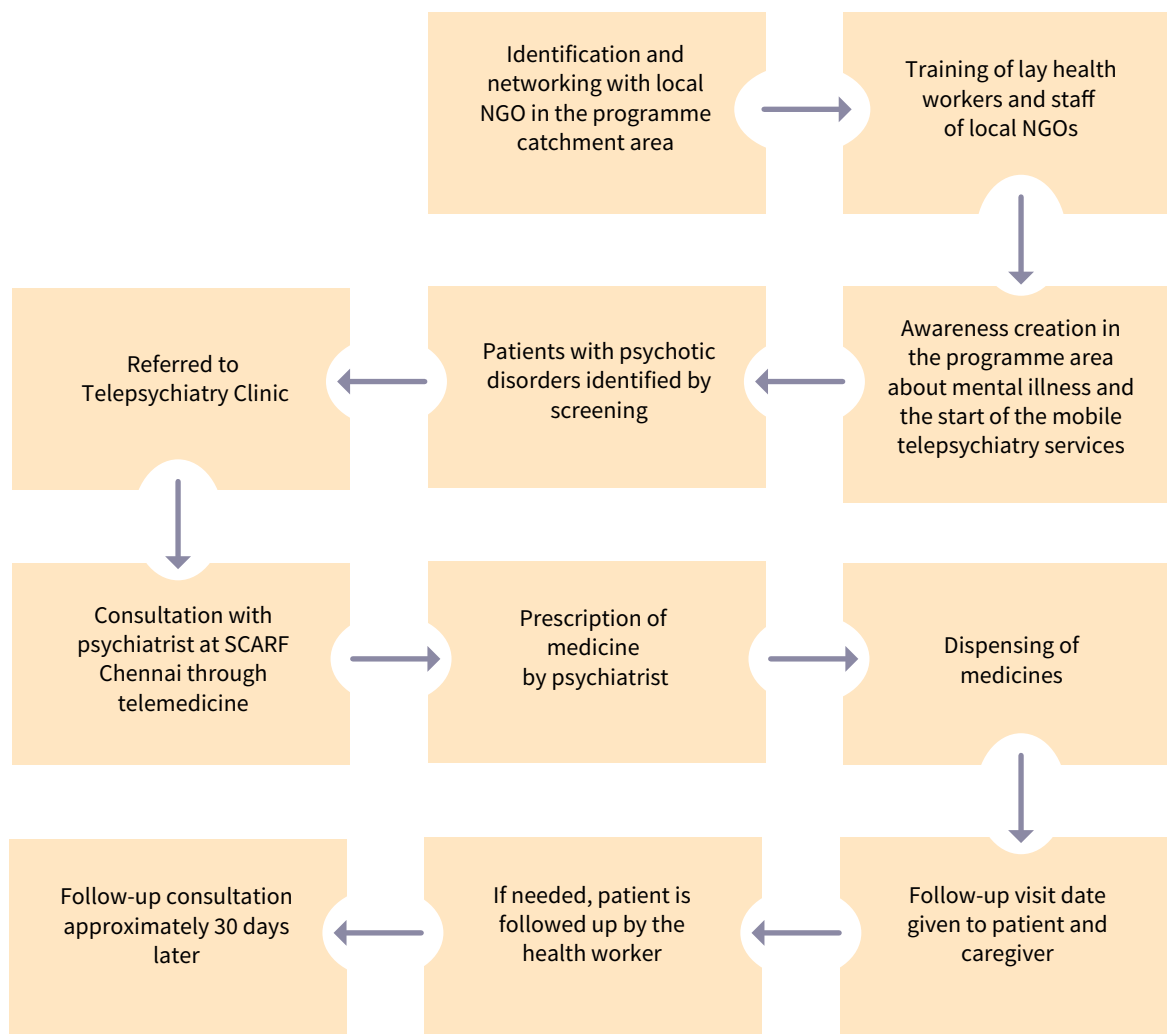
Schizophrenia Research Foundation (SCARF), India

Type of setting	Rural
Availability in multiple locations	Yes
Locations where programme operates	Pudukottai
Target population	3000 people with severe mental conditions in a catchment population of 500 000
Referral pathways	Referrals to the programme: by the trained community health workers/volunteers of the programme Referrals from the programme: to the clinics of the district mental health programme/ local health services for pharmacological management with continued support from health workers/volunteers
Classification of service	Community mental health centres, psychosocial support and rehabilitation services
Financing	External donors
Classification of service provider	NGO/non-profit entity
Current status of programme	The larger STEP programme that started in 2010 is still ongoing; the mobile telepsychiatry component was implemented for the first six years.
Evidence	Published literature and grey literature

Programme description

The aim of SCARF's mobile telepsychiatry innovation was to provide accessible and affordable mental health care services to persons with severe mental conditions in Pudukottai – a rural community without access to mental health care – through the integration of mobile clinics and telemedicine.

Fig. 2. Telepsychiatry programme operation



Programme operation

- Lay health workers and staff of local civil society organization staff were trained in how to raise awareness of mental health, the mobile telepsychiatry unit and identification of those with severe mental health conditions. Those identified were provided with the service through a specially designed bus with a private consultation chamber with video-conferencing equipment.
- Consultation took place between a psychiatrist based at the SCARF office in Chennai and the person seeking services in Pudukottai.
- Prescriptions were sent by the psychiatrist to the telepsychiatry clinic facilitator on the bus and filled by the onboard pharmacy; medication was provided free of charge.
- Structured educational programmes were also conducted for family members by health workers/volunteers of the programme to help them better understand the illness and to enable them to manage it.
- Community volunteers were trained to deliver psychosocial interventions, facilitate self-help groups, link service users and families with social benefit provisions, work with the District Mental Health Programme and public health services, and conduct awareness programmes.

Cost

- Capital costs amounted to approximately 25 000 US dollars (2010) for the creation of infrastructure, which included the hub at Chennai, video-conferencing equipment and the custom-built bus.
- The per capita cost per month was 12 US dollars (2016), which included consultation, medication for a month, one home visit by a health worker and one follow-up/reminder over the phone.

Impact

- The telepsychiatry component of the programme provided care for approximately 3000 people with mental health conditions over five years in Pudukkottai district.
- The programme reduced the mental health gap in the community, with 50% of the untreated individuals in the catchment area accessing and utilizing the telepsychiatry service.
- The reach of the services extended beyond the initially envisioned programme area, with 45% of those accessing the services being from outside the catchment area.
- About 10% of the eligible persons accessed disability benefits compared to 0% earlier.

Learnings

- Ensuring community participation by involving all stakeholders, especially families of people with mental health conditions, community gatekeepers and public health services is essential for reducing treatment gaps.
- To promote service seeking through a tele-mental health system, communities, particularly those in rural areas, should be briefed beforehand to ensure that those seeking the service are comfortable with the process of such a service and its technological nature.
- Home visits are required to assess and manage people experiencing acute episodes and those with more severe conditions, especially in isolated pockets without signal coverage.
- Telepsychiatry facilitates the efficient reallocation of existing resources but does not inherently contribute to the expansion of the overall capacity within the mental health care system.

Additional information

Website: www.scarfindia.org

Videos: <https://www.youtube.com/watch?v=7WeAuDgpfA0>;
https://www.youtube.com/watch?v=Q_OjZudXWjQ

Contact: Mr Kotteswara Rao, Assistant Director of Community Mental Health, SCARF

Diploma in Community Mental Health Care

The Banyan Academy of Leadership in Mental Health (BALM), India

Setting	Urban and rural
Availability in multiple locations	Yes
Locations	India, Bangladesh and Sri Lanka
Target population	Community volunteers and non-specialist health workers
Classification of service	Staff capacity building to deliver community-based mental health services
Financing	Multiple sources such as government funding (CSR) funding, international funding, NGO funding, and grant funding.
Classification of service provider	Nongovernmental organization
Current status of programme	Ongoing
Evidence	Published literature, grey literature

Programme description

The Banyan is a nongovernmental organization that provides comprehensive institutional and community-based mental health services to people experiencing homelessness and poverty in several states of India. Initially, a shelter facility to provide a safe space for homeless women with mental health conditions was established, which was later developed into a temporary recovery space. Upon the users' recovery, The Banyan began facilitating reunions with family members and recognized the crucial role of continuity of care post-reintegration.

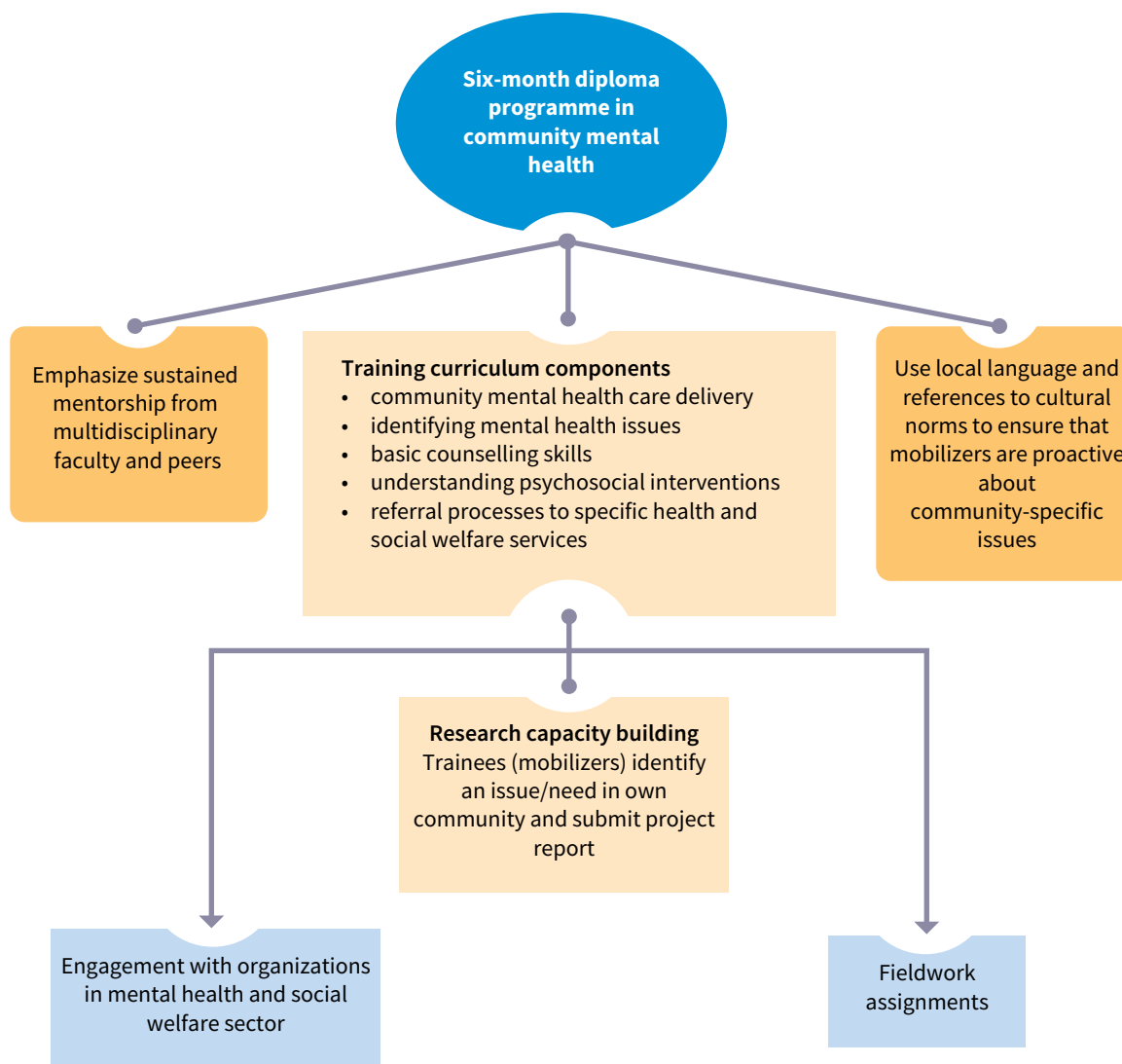
To facilitate continuity of care, the organization piloted socioeconomic interventions such as disability allowances, employment and housing support. The organization offers packages of care delivered by village-level mobilizers supported by clinics connected to primary health centres or community centres across rural and urban areas in five cities in Tamil Nadu, Kerala, Andhra Pradesh, Karnataka and Maharashtra. These mobilizers deliver a range of interventions from counselling to social welfare facilitation to promote better socio-economic outcomes.

The organization developed a curriculum for a diploma programme in community-based mental health services that focuses on five critical domains: understanding self, understanding community, social welfare measures, mental health care, psychosocial intervention skills.

Diploma programme

The flowchart below depicts the framework of the diploma programme:

Fig. 3. Programme for Diploma in Community Mental Health Care



The programme’s structure includes a combination of theoretical and practical learning. Training sessions are held once a week for 25 weeks. At the end of each training session, the faculty assigns fieldwork tasks that cover 18 to 20 hours of work throughout the week to apply the concepts learned in the classroom. To build research capacity, students identify a specific issue or need within their own community and submit a project report.

After completing the diploma, participants receive refresher training once a year. This provides updates on the latest developments in mental health care and helps maintain the knowledge and skills learnt.

The Banyan considers social care as a critical component to improve an individual’s health and well-being. Their training is also provided in activities such as community mapping and information on social welfare schemes that support those with mental health conditions regaining financial autonomy.

Alumni of this programme are involved in community-based mental health work, including raising

awareness about mental health, working with self-help groups and family members, engaging with local leaders, and educating the community about psychosocial health. They also identify individuals at risk of mental health conditions, facilitate support systems, and refer those with mental health conditions to primary health care and clinics with specialized care. The training programme has been expanded to multiple states in India as well as to Bangladesh and Sri Lanka.

Some of the important features of this training programme include:

- personal and professional skill building, sustained supervision and research capacity building of grassroots-level workers;
- emphasis on the bio-psychosocial model to develop and deliver interventions that are suited locally; and
- promoting real-world problem-solving and critical thinking, enabling students to generate new knowledge and innovate within a community based on user-focused participatory practices.

Learnings

- A thorough understanding of the local context is necessary to develop adequate services.
- Co-ownership from the inception improves community involvement. Linking and hiring local resources is also important to the acceptability and sustainability.
- Building capacity of health workers while they are working in the community equips them to provide individualized and context-sensitive interventions.

Additional information

Website: www.thebanyan.org

Contact: Dr K V Kishore Kumar, Director

The Inclusion Project – community mental health services

Koshish, Nepal

Type of setting	Urban and rural
Availability in multiple locations	Yes
Locations	Karnali and Sudurpaschim provinces
Target population	People with mental health conditions and psychosocial disabilities
Referral pathways	Local government
Classification of service	Peer support services
Financing	Donor funding
Classification of service provider	Non-profit organization
Name of the service provider	Koshish
Current status of programme	Active
Evidence	Grey literature

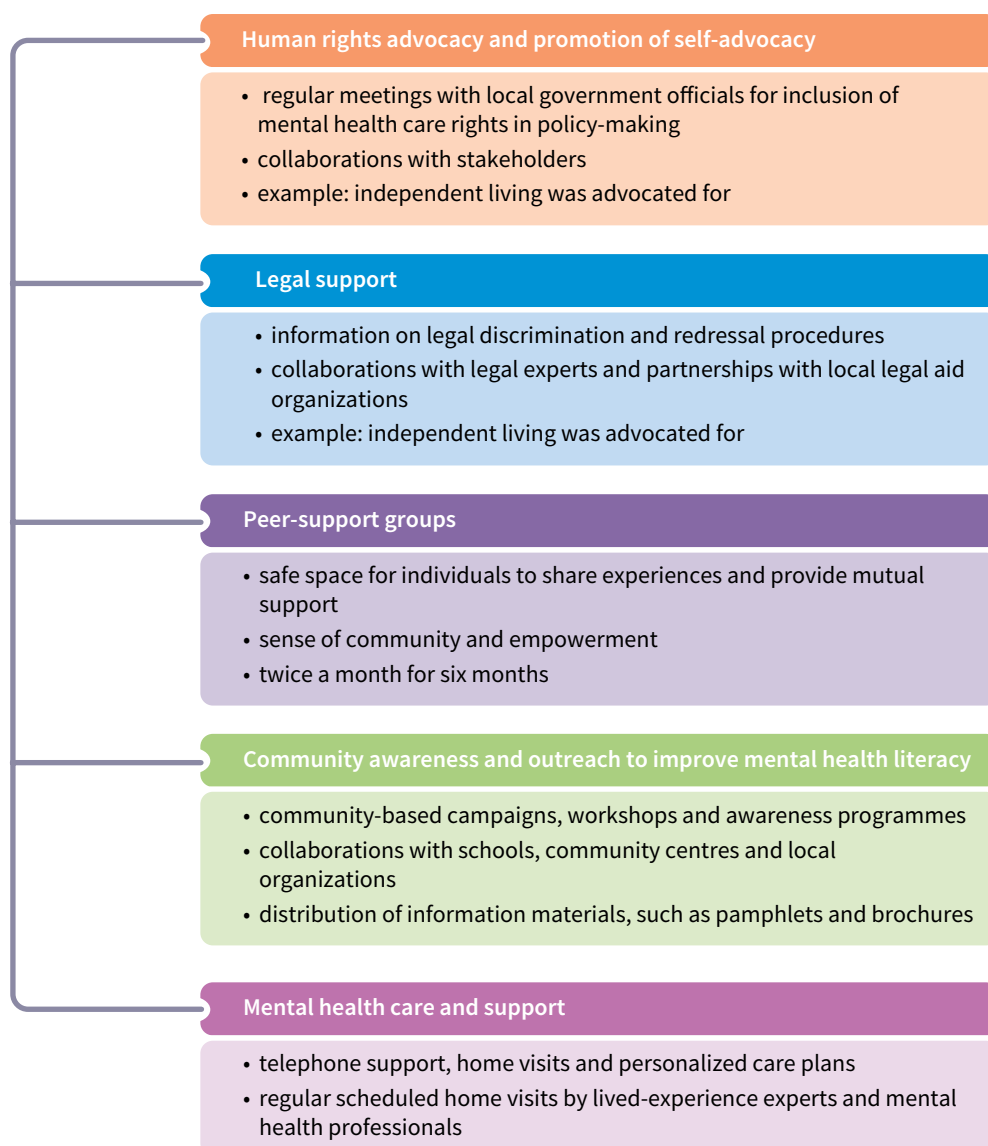
Programme description

The Inclusion Project, set up in Nepal’s Karnali and Sudurpaschim provinces, is spearheaded by Koshish and funded by Felm. Through its innovative strategies and comprehensive approach, the programme has successfully empowered individuals, fostered social inclusion and advocated for systemic changes in Nepal.

Nepal has faced a significant issue when it comes to ensuring that those with long-term mental health conditions are able to exercise their human rights. This project was launched in 2022 to prioritize mental health and psychosocial disabilities in the plans and policies of local governments. The programme aims to create a supportive environment in which individuals with mental health conditions live independently, participate in community life and access social services.

Programme operation

Fig. 4. Services of The Inclusion Project



- Human rights advocacy – The Inclusion Project regularly meets with policy-makers to advocate for the importance of keeping in mind the rights of people with mental health conditions when decisions are made related to communities, legislation and infrastructure. Evidence-based arguments and data are presented to ensure implementation of evidence-informed practices in relation to mental health.
- Legal support – People with mental health conditions or psychosocial disabilities are supported to navigate the legal system. In addition, information on the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD) and existing laws and policies in Nepal, such as the Disability Rights Act, is provided to people with mental health conditions or psychosocial disabilities.

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- Peer support groups – The groups, initially facilitated by staff members with lived experience, work to enhance clients’ coping mechanisms and self-confidence and to provide caregivers and family members guidance and emotional support in accessing community resources.
 - Community awareness and outreach – A wide range of approaches are employed to raise awareness and understanding of mental health.
 - Mental health care and support – Support is provided through telephone support, home visits and personalized care plans. This ensures continuity of care and facilitates sustained recovery.

Impact

In addition to the advocacy activities, this ongoing project supported around 367 individuals and their family members directly, leading to improved mental well-being, increased social inclusion, and a better quality of life. Indirectly, it has reached over 30 000 individuals through awareness campaigns and the fostering of a more supportive and inclusive community.

Learnings

- The meaningful and active involvement of individuals with lived experience is essential for driving policy discussions and policy reform.
- It is imperative to allocate resources to combat discrimination in workplace settings, in community interactions and within the legal system, with a central focus on upholding the human dignity of those with psychosocial disabilities.

Additional information

Website: <https://www.koshishnepal.org/advocacy-awareness-programme-detail/>

Videos: <https://www.youtube.com/@Koshishnepal/videos>

Contact: Matrika Prasad Devkota

Community mental health services

Mental Health Strategy and Planning Division, Department of Mental Health, Ministry of Public Health, Thailand

Type of setting	Urban and rural
Availability in multiple locations	Yes
Locations where programme operates	All provinces
Target population	Individuals facing psychosocial distress
Referral pathways	General hospitals and psychiatric hospitals.
Classification of service provided	Psychosocial support and crisis management
Financing	State health and social sectors, donor funding
Classification of service provider	Government organization
Current status of programme	Active
Evidence	Grey literature (electronic and print formats; e.g. press release, pamphlets, blogs, project/donor reports)

Programme description

Thailand has a dedicated mental health department under the Ministry of Public Health. Apart from crisis services, 13 regional mental health centres have been established. These centres support, coordinate and facilitate local community services to deliver mental health care effectively. The primary aim of this initiative is to establish a functional community that understands the importance of mental health and is well-equipped to care for and rehabilitate those living with mental health issues.

These efforts are funded primarily under universal health coverage and other government schemes. The services provided are based on Thailand's most recent legislative initiative: the 20-year national plan, introduced in 2018.

Crisis services, supported-living services, peer support, vocational assistance, psychosocial rehabilitation and community outreach are provided through community-based mental health services.

Programme operations

- In Thailand, mental health care has been seamlessly integrated into the broader public health system, extending from local communities to regional levels. These services encompass not just psychiatric care and rehabilitation but also initiatives for mental health prevention and promotion: self-care to ensure that individuals are empowered to take agency over their mental health.

-
- Primary mental health care by village health volunteers (VHVs) promotes mental well-being, identifies people with mental health conditions and provides community rehabilitation. Such activities include screening services, access to primary health care physicians, and interactions with VHVs.
 - VHVs are the links between the community and the health sector. They screen people in the community, carry out home visits, follow up on treatment routines and wellbeing post-treatment. After training, volunteers receive on-the-job support through a mobile application.
 - Secondary mental health care ensures that specialized services are accessible to local communities, typically through outpatient facilities, to provide care for people with long-term conditions as well as mental health care for general hospital patients.
 - The reach of mental health care has now extended beyond health care facilities, encompassing schools and community leaders in its stepped holistic approach to mental health support and well-being.

Impact

- During the pandemic, 89.15% of those who requested mental health care received counselling services. A 10-year review showed that the accessibility rate for those suffering from depression has gone from less than 5% to approximately 50%. Direct effects on suicide rates have been observed (communication from Ministry of Public Health, Thailand).
- Those who required professional support were directed to medical professionals, who provided psychosocial support and monitored them for potential relapses.

Learnings

- This model ensures accessibility of services to populations located in more remote areas of Thailand.
- The community-based component prevents the overburdening of both general and specialized hospitals.
- Efforts in building research capacity and competencies is crucial to ensure that there is a systematic documentation of the efforts undertaken at the ground level and that their learnings are incorporated in future implementation.

Programa Asistencia Moras Menta (PAMM) – psychosocial recovery and development

Psychosocial Recovery and Development in East Timor (PRADET)

Type of setting	Urban and rural
Availability in multiple locations	Yes
Locations	Dili, Liquica, Ermera, Maliana, Aileu Ainaro, Baucau
Target population	Vulnerable groups
Referral pathways	Mental health nurses and psychiatric units from PRADET organization
Classification	Psychosocial support and rehabilitation services
Financing	Social sector and donor funding
Classification of service provider	Nongovernmental organization
Name of the service provider	PRADET – Psychosocial Recovery and Development in East Timor
Current status of programme	Active
Evidence	Published literature and grey literature

Programme description

Programa Asistencia Moras Menta (PAMM) is funded by the Psychosocial Recovery and Development in East Timor (PRADET), a nongovernmental organization that provides psychosocial support to those affected by crisis or emergencies.

Programme operation

The services of PAMM have been provided via psychosocial rehabilitation centres. The pilot centre was set up in the PRADET office at Dili Hospital. The function of psychosocial rehabilitation centres is to integrate people with mental health conditions into society. People are referred to the centre by trained local community volunteers. The programme works with mental health care providers and government institutions. Mental health care is provided through a multifaceted approach involving the following:

- mental health education in the community;
- training of health workers in basic mental health care delivery to facilitate the referral process and support clients in accessing and adhering to their medical treatment;
- provision of support for homeless people by connecting them with their families;
- equipping of youth advocates with community-support tools to combat stigma;
- provision of counselling for clients and their families;

-
- provision of medication by Dili Hospital to the psychosocial rehabilitation centres;
 - needs-based home visits made by health workers and the provision of home-based counselling; and
 - facilitation of community reintegration, including skills-based learning, vocational training and support in setting up enterprises.

Family links services

PRADET's services primarily aim to strengthen family and community networks to create awareness of mental health conditions and promote community mental well-being. The Family Links Programme supports PAMM in facilitating information sharing amongst the families of individuals seeking psychosocial support.

To ensure that families of those with mental health conditions stay connected, the organization has facilitated the sharing of phone numbers between participants, enabling ongoing support.

Cost

PAMM is primarily funded by a German NGO, CBMI. It has received further support from the government and runs on a yearly budget of 90 000 – 150 000 US dollars, which covers the range of services.

Learnings

It is necessary to train local volunteers to work in the community to promote mental health and well-being and strengthen referral pathways on mental health, especially during crises such as internal displacement.

Organizing regular family meetings enhances collective knowledge sharing and fosters social connectedness.

Additional Information

Website: <http://www.pradet.org/>

Contact: Nicolau Ximenes, Programme Team Leader

Thrive – model for employment support for persons living with severe mental health conditions

Parivartan Trust, India

Setting	Urban and rural
Availability in multiple locations	Yes
Locations	Satara, Pune and Tezpur
Target population	People with severe mental health conditions
Referral pathways	Referrals from psychiatric and mental health clinics, local governmental institutions
Classification	Psychosocial support and rehabilitation services
Financing	Donor funding
Classification of service provider	Non-profit organization
Current status of programme	Active
Evidence	Grey literature

Programme description

A lack of access to meaningful employment impedes the holistic recovery of people with severe mental health conditions. Employment plays a vital role in reducing stigma and relapse rates. Evidence from high-resource settings suggests that interventions such as individual placement and support help people with serious mental illness gain meaningful employment. However, there is limited observational evidence from low- and middle-income countries (LMICs) on individual placement and support. Parivartan Trust’s Thrive programme in India translates evidence-based interventions into culturally appropriate community-based models. The valued outcomes for this programme include encouraging people with severe mental health conditions to be self-reliant and self-confident and have a higher likelihood of community integration.

Programme operation

Social hierarchies, stigma, awareness among potential employers, availability of social support, and readiness to work critically influence employment rates. The THRIVE model is adapted from the social-ecological model (SEM). It considers the complex interactions among personal, interpersonal, community, and market-related factors influencing employment and income generation for people with psychosocial disabilities.

The team includes one Thrive centre coordinator (psychiatric social worker/trained peer-caregiver worker), a team of volunteer peer-caregiver support workers and a supervising psychiatrist. Individuals with mental health are provided with personalized employment support. Following an assessment, an employment plan is developed to accommodate specific requirements and

objectives. This encompasses enhancing employability by tackling both mental health and job-related aspects.

Employment options include receptionists, delivery persons, office employees and store helpers, fishing, tailoring, packing, and producing paper bags.

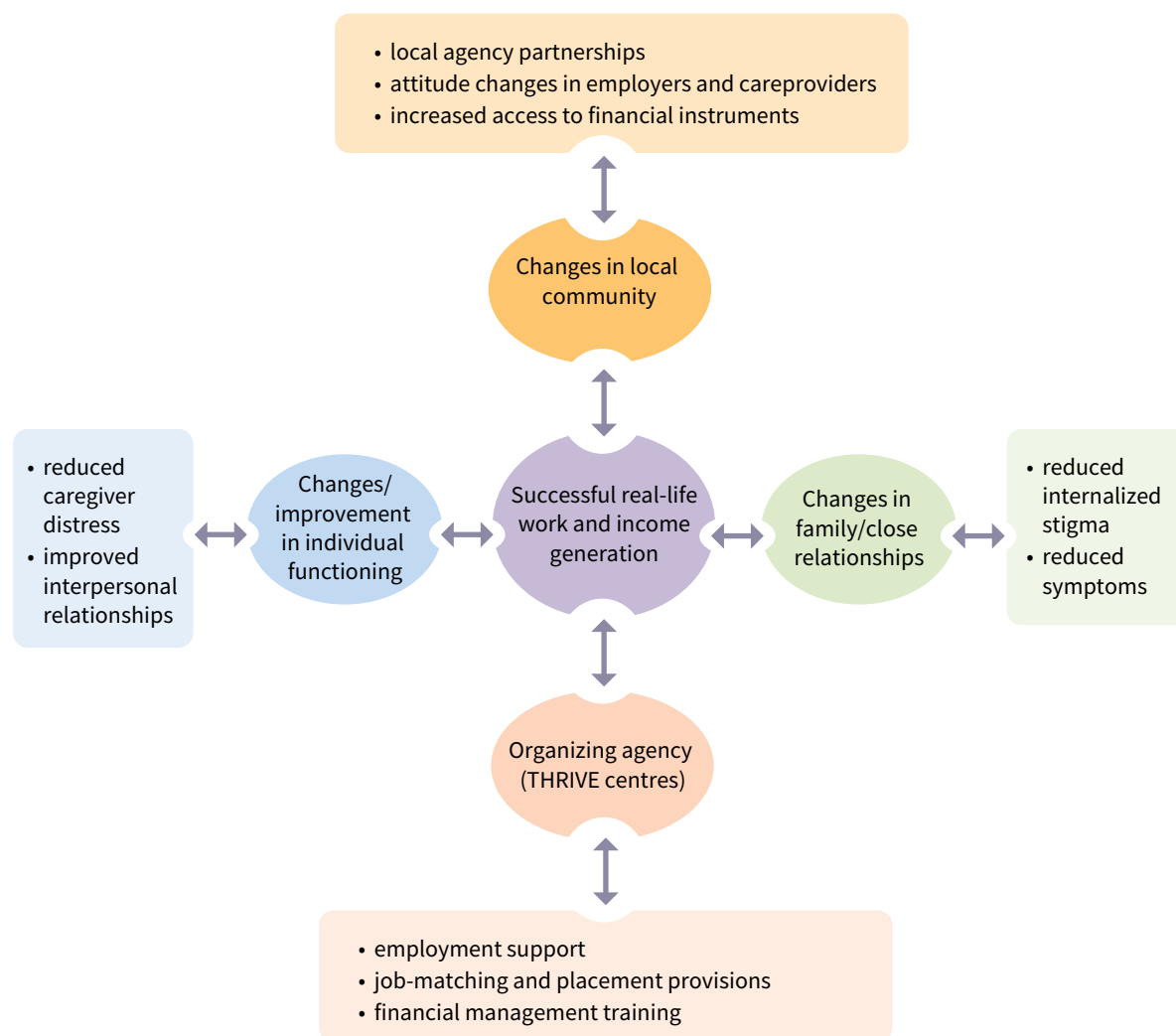
The three types of employment offered under Thrive are:

1. restoring persons with severe mental health conditions to their previous work;
2. collective employment options within the hospital and in the community (including home-based work); and
3. finding new, individualized, job placement options.

Thrive model

This model adopts a multidimensional approach, intervening across four domains: self and social stigma, functioning, interpersonal relationships and caregivers' involvement. Secondly, the importance of local context, including market and community-level factors, are taken into account.

Fig. 5. Thrive model for employment support



Impact

- Parivartan has developed a step-by-step intervention guide, developing employment-related services for patients with severe mental health conditions.
- Around 335 patients and families have been supported by this model.
- Three Kimaya cafes have been established and have functioned for more than five years across three sites: Satara, Pune and Tezpur. They are run by people with mental health conditions, lived experience and also caregivers. The income is shared among them.

Learnings

- Employment is one key requirement of comprehensive community-based care.
- Popular mediums of information dissemination, such as short films, are essential in disseminating the programme results to reach wider audiences.
- In India, individual jobs in formal sectors are scarce, while the informal economy is the largest sector of employment. This limitation opens up the possibility of collective livelihood options.
- Partnering with existing public health services is vital to augment services in the community.

Additional information

Parivartan Trust: <https://parivartantrust.in/>

Contact: Hamid Dabholkar

Community Empowerment for Psychosocial Health, Livelihood and Emergency Resilience (CEPLERY)

Pusat Rehabilitasi YAKKUM, Indonesia

Type of setting	Rural
Availability in multiple locations	No
Locations where programme operates	21 villages across three districts (Sleman, Kulon Progo, and Gunungkidul) of Special Region of Yogyakarta, Indonesia
Target population	People with psychosocial disabilities, caregivers and family members, community mental health volunteers, and organizations of people with disability in three districts
Referral pathways	Health care network
Classification of service provided	Psychosocial rehabilitation services and peer-support services
Financing	Donor funding
Classification of service provider	Nongovernmental organization
Current status of programme	Ongoing
Evidence	Guidebooks and policy paper briefs

Programme description

Community Empowerment for Psychosocial Health, Livelihood and Emergency Resilience (CEPLERY) in Yogyakarta is a community-based mental health rehabilitation project launched in response to the increasing prevalence of mental health conditions amongst people in the Special Region of Yogyakarta. It aims to address the lack of post-discharge rehabilitation in mental health services, as well the stigma experienced by those with mental health conditions and their families.

Programme operation

- This programme operates across 21 rural villages spread across three districts: Sleman, Kulon Progo, and Gunungkidul. It supports the reintegration into the community of people experiencing psychosocial difficulties. Psychoeducation is prioritized in communities to raise awareness on mental health.
- In situations where an individual experiences a relapse or a psychiatric emergency, a system has been established whereby the family, community volunteers, the local government and primary health care centre can work together to efficiently deliver appropriate support.
- Upon the individual's discharge, there are services to monitor their medical, social and occupational needs. Families are educated on the best ways they can support their loved ones.

Impact

The CEPLERY Project has been evaluated by external consultants using a combination of qualitative and quantitative methods, involving stakeholders from various sectors associated with the project. Outcomes show that it has encouraged district governments and civil community organizations to prioritize mental health care development. This underlines the need for better documentation of the processes of this project to facilitate its replication and expansion to other regions.

Learnings

- When community members, religious leaders, staff of local government bodies and staff of existing community-run initiatives are provided with information on how to identify people with mental health conditions and where help is available, identification and management of mental health conditions improve.
- Social rehabilitation and recovery bring social and self-acceptance. Emphasis must be given to reducing internalized stigma among people with psychosocial disabilities, as it hinders individual and collective efforts for change.
- It is important to involve different levels of government – provincial, district and subdistrict – to expand impact and provide visibility and credibility to ground-level work.
- Establishing village self-help groups is an excellent starting point for decentralization of mental health care. It brings together families and individuals to protect those with psychosocial disabilities.

Additional information

Website: <https://pryakkum.org/>

Videos: <https://youtu.be/cCPCZpBKItY>

Contact: Muhammad Aditya, Programme Manager

Proshanti – supported living services and a rehabilitation facility

Sajida Foundation, Bangladesh

Setting	Urban and rural
Availability in multiple locations	Yes
Locations	Habiganj and Manikganj, Bangladesh
Target population	People with chronic mental health conditions
Referral pathways	To and from government health institutions
Classification	Supported living services, with psychosocial support and rehabilitation services
Financing	Out-of-pocket payment
Classification of service provider	Nongovernmental organization
Name of the service provider	Sajida Foundation
Current status of programme	Ongoing
Evidence	Grey literature

Programme description

Sajida Foundation is a nongovernmental organization that embodies the principles of corporate philanthropy in Bangladesh. Its mental health programme focuses on serving the underprivileged, marginalized and underserved members in the community. In October 2022, Sajida Foundation established Proshanti as an initiative to provide supported living services for individuals with mental health conditions, focusing on long-term care and rehabilitation.

Programme operation

Proshanti provides residential facilities in Habiganj and Manikganj, in northeast and central Bangladesh respectively, accommodating up to six people. Separate homes are provided for males and females. Residential facilities consist of rented houses in urban and rural settings.

Care coordinators who are certified in community mental health care, provide basic psychological support and screening, and promote residents' participation in the community. Personal assistants assist clients' engagement in daily activities.

The two-year programme covers different domains that aim to promote independent living, and to integrate people back into the community. Interventions range from counselling sessions to vocational assistance and art-based activities. The programme strives to reflect specific arrangements and requirements requested by the clients and families. Caregivers are key partners in Proshanti homes.

Impact

As of September 2023, the programme had provided assistance to 26 individuals, with 20 residents currently residing in the facilities. The programme utilizes a comprehensive set of evaluation methods, including monthly client progress reports to monitor clinical and household activities, individual client feedback reports for personalized insights, and peer and caregiver feedback reports. Additionally, an annual impact evaluation is conducted to assess the overall effectiveness and outcomes of the programme.

Cost

The programme runs on out-of-pocket expenditures, with a monthly fee of approximately 20 000 Bangladeshi taka (approximately 180 US dollars). The monthly fee covers house rent, personal assistant costs, basic needs, treatment, food, hygiene and recreation.

Staff and training

- Proshanti currently employs 16 full-time staff members, with a multidisciplinary team of experienced professionals involved in the project's functioning.
- Multidisciplinary teams include a project manager, psychologist, occupational therapist, care coordinator, and personal assistants.
- The care coordinator undergoes a six-month certificate course in community mental health care, while the personal assistant receives training in mental health first aid. Further capacity building is tailored to individual needs through ongoing assessments.

Learnings

- Proshanti emphasizes the importance of, and utilizes, evidence-based methods when implementing and scaling up their integrative, community-based care programme.
- By offering a six-month diploma to community members who are willing to take on the roles of non-specialized clinical assistants and operational managers they aim to build capacity within the community.
- Creating a supportive and non-stigmatizing environment for those seeking help, and ensuring their rights and autonomy are respected, is one of the key objectives of the Proshanti approach.

Additional information

Website: <https://www.sajidafoundation.org/>

Contact: Rubina Jahan

Kudil (“Gateway to Life”) – short-term residential rehabilitation service

Jaffna, Ministry of Health Sri Lanka

Setting	Rural
Availability in multiple locations	No
Target population	People facing mental health issues
Referral pathways	Referral by psychiatrists and mental health workers. Follow-up care through nearest mental health clinic. Kudil staff provides continuous support and follow up
Classification of service provided	Supported living service
Financing	State health sector
Classification of service provider	Government
Current status	Active
Evidence	Booklet released in 2017 (The Hut: In the first decade)

Programme description

Psychiatric units in general hospitals and outpatient clinics were the primary mental health service providers in Northern Sri Lanka. Kudil (“Gateway to Life”) was the first community-based psychiatric rehabilitation centre in the country, established in 2007.

It is a centre where people with mental health conditions can reside and recover in a supportive, structured environment. Initially, Kudil functioned through rented homes within communities in Jaffna. Subsequently, the initiative was relocated near the Base Hospital Tellipalai, which also provides Kudil’s residents with medical care.

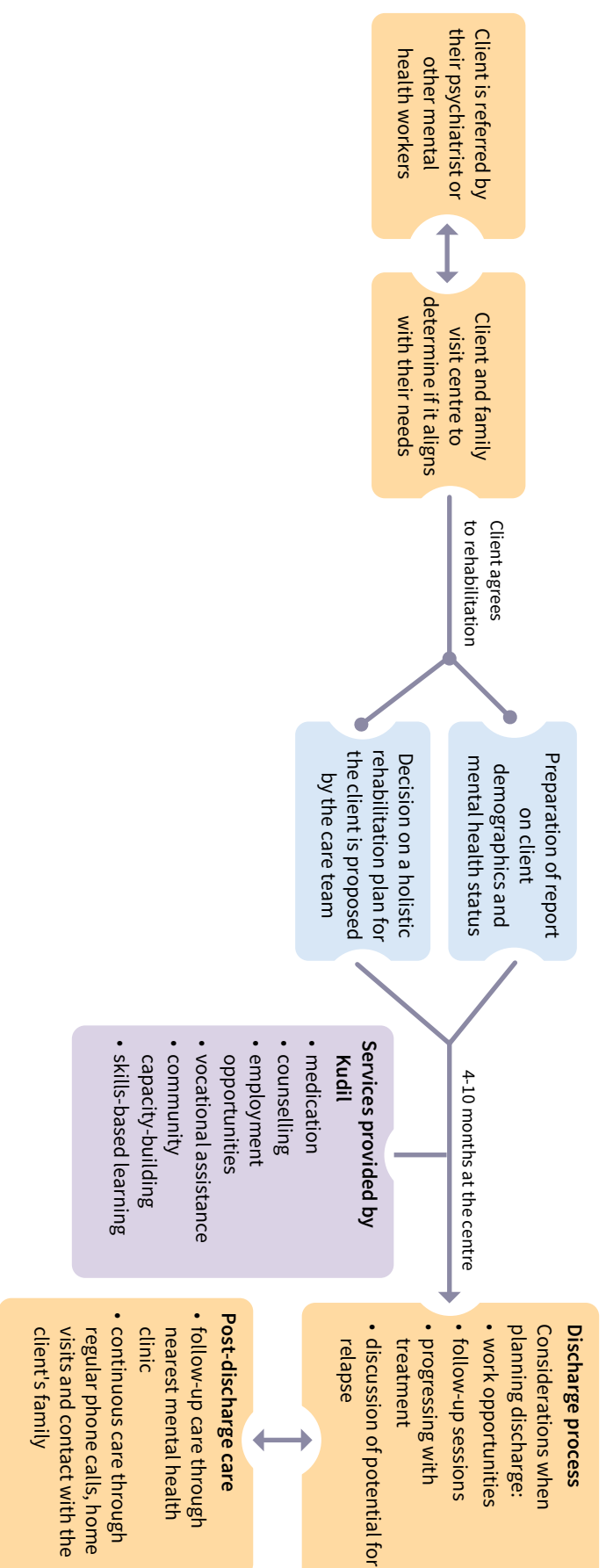
The service area of Kudil can accommodate a maximum of 18 residents and their family members, who are allowed to stay in Kudil for a period of about six months and be part of the rehabilitation process.

The service has nine full-time staff members (rehabilitation workers) and four or five part-time professionals. A consultant psychiatrist provides the overall technical supervision. Volunteers are recruited from the government and trained to provide community-based mental health interventions.

Programme operations

As the chart below shows, Kudil offers services that involve the client and family from the beginning of the process. It focuses on building needs-based care plans and considers the readiness of the client to be an important factor in sustained recovery. The services offered by Kudil are both pharmacological and non-pharmacological. The latter includes learning and vocational assistance. There is a structured process for discharge and follow-up, and for the involvement with clients and their families.

Fig. 6. The progress of the client through Kudil



Impact

Approximately 400 individuals and their families have benefited from the services offered by Kudil over the past 10 years.

Learnings

- Community-based interventions and residential facilities are less stigmatizing than psychiatric hospital-based services.
- When providing community-based mental health services it is important that there are ongoing strategies established to ensure staff well-being and prevent burnout.

Additional information

Contacts: Dr S Sivayokan – Consultant Psychiatrist and Senior Lecturer, Teaching Hospital Jaffna,
Dr A Ketheswaran – Regional Director of Health Services, Jaffna

Community-based mental health support services for children and youth at risk

Innovation for Wellbeing Foundation (IWF), Bangladesh

Type of setting	Urban and rural
Availability in multiple locations	Yes
Locations	Jashore District, two sub-districts in Bagerhat (Sadar Upazila and Rampal Upazila) and three locations in Dhaka (Dhaka Khilgaon and Uttar Badda and Bauniabadh)
Target population	Individuals aged five to 30 years who are either at risk of developing or are already living with mental health conditions, their families, LGBTQ community
Referral pathways	<ul style="list-style-type: none">• By teachers, community health care providers, student peer leaders, caregivers, and traditional healers• Through mental health camps• Mobile phone application
Classification of service provided	Psychosocial and peer support services
Financing	Donor funding
Classification of service provider	Nongovernmental organization
Name of the service provider	Innovation for Wellbeing Foundation (IWF)
Current status of programme	Ongoing
Evidence	Grey literature

Programme description

Innovation for Wellbeing Foundation (IWF) was established in 2015 for promoting mental health equity for all. IWF has been implementing a community-based mental health programme since June 2020. This organization provides an internationally accredited mental health first aid training programme in the Jashore and Dhaka areas. It works to establish a mental health care pathway by engaging policy-makers, local government, service providers, civil society organizations, media, academic institutions, religious leaders and people with lived experience of a mental health condition and psychosocial disability.

Programme operation

1. Baseline assessment – The project began with a comprehensive baseline survey and a mental health needs assessment.
2. Capacity building:
 - Specific training is provided to caregivers, on the rights of children and youth facing mental health challenges.

-
- School teachers and School Management Committee members receive orientation on mental health to better support the well-being of young people.
 - Teachers undergo a comprehensive two-day mental health first aid training programme to ensure a better understanding of adolescent mental health development, non-judgemental listening to students' emotional needs, and provision of appropriate guidance and referrals for professional help. This focuses on improving the relationship between teachers and students, and on fostering a more supportive and empathetic learning environment.
3. Student empowerment – awareness and peer support
 - Student peer support groups have been established and trained to provide emotional support to their peers and promote mental health awareness.
 - The project organizes art, literature and sports activities to facilitate conversations about mental health and self-care.
 - Health camps are organized with the participation of psychiatrists and clinical psychologists. These camps screen children and young people, followed by psychoeducation and counselling sessions. They are regularly followed up through home visits, schools and phone calls.
 - The project ensures accessibility for individuals with physical and psychosocial disabilities by constructing ramps and accessible toilets in various facilities.
 4. Strengthening social services
 - Social service providers underwent training to ensure the safety and well-being of children, youth and vulnerable adults facing mental health challenges.
 - Collaborative efforts with the Department of Social Services ensured that individuals with psychosocial disabilities received government allowances during the COVID-19 pandemic.
 - In collaboration with the Department of Women and Children's Affairs, the project prioritized youth empowerment by facilitating vocational training, offering financial support through loans and seed money for small businesses, and creating pathways for youth to access employment opportunities. This approach aimed to provide meaningful support to youth with physical and psychosocial disabilities.
 5. Nationwide service mapping – This identified mental health service providers based on service types and geographical locations. A digital mental health service directory was developed. Service providers, including teachers, health and social service providers, and local government officials were oriented on how to effectively use this directory for referrals.
 6. Knowledge sharing – Dissemination meetings were organized to share learnings with a wider audience, including policy-makers and mental health programme implementers to strengthen services.

Staff

The organization's staff includes an Executive Director, a Director of Programmes, a Programme Coordinator, Accounts Officer and a Field Organizer.

Impact

The initiative reached over 10 000 people in the age group five to 30 years. Seven peer support groups with a total of 70 members were established, and a Mental Health Wellbeing Forum with 16 members was formed, based in Jessore. IWF conducts pre- and post-testing of the mental health first aid training through a structured training evaluation form to assess knowledge, attitude, skills and confidence and the quality of the training programme.

Cost

The programme has received 9 500 590 Bangladeshi taka in donor funding, which is provided by the UK-based charity Comic Relief.

Learnings

- Mental health first aid training is effective in improving mental health literacy and interactions with those at risk and those with mental health conditions, when provided to community clinic service providers, community leaders and religious leaders and teachers.
- Children and young people who need help are often not identified. Once identified, there is a need for a sustained process to assist them.
- To enhance employability, the unique challenges faced by each individual should be taken into account. This support should be extended to their families, enabling them to acquire the necessary skills for economic self-sufficiency.
- Collaboration with government and nongovernmental organizations, with the support of the media, is an essential requirement for engagement of different stakeholders.

Additional information

Facebook: <https://www.facebook.com/iwellbeingbd>

YouTube: <https://www.youtube.com/@innovationforwellbeingfoun7294/featured>

Website: <https://iwellbeing.org/>

Contact: Monira Rahman

Depression in Late Life project

Psychosocial services for the elderly, Sangath, India

Type of setting	Urban and rural
Availability in multiple locations	No
Location	Goa, India
Target population	People above 60 years
Referral pathways	From rural health centres and communities
Classification of service	Psychosocial support
Financing	Donor funding
Classification of service provider	Nongovernmental organization
Current status of programme	Completed
Evidence	Published literature

Programme description

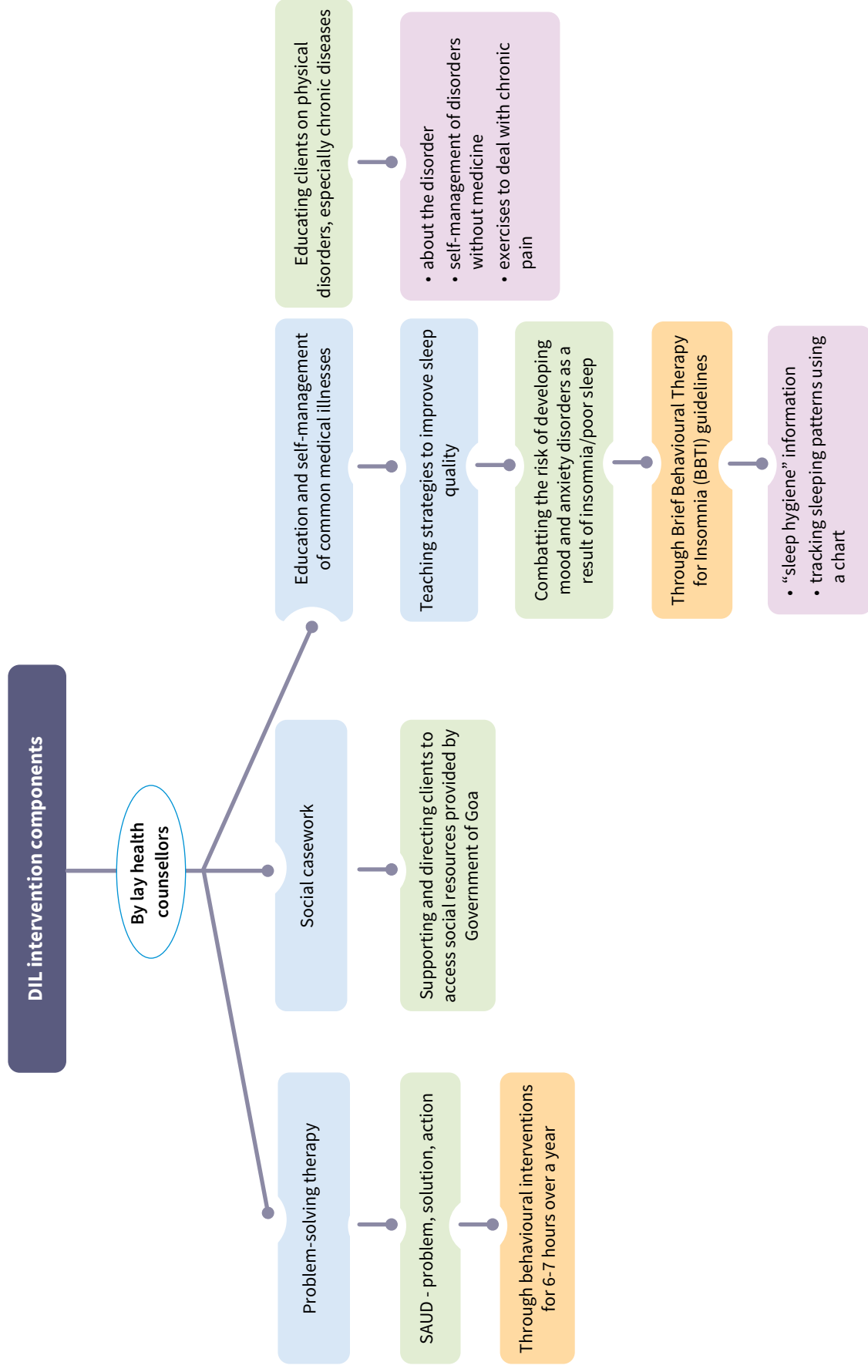
Sangath, a non-profit organization in Goa, India, works to improve mental health by empowering the community through holistic interventions. The Depression in Late Life (DIL) project aimed to develop and adapt a feasible and scalable intervention based on problem-solving therapy to prevent depression in later life. It also explored how lay health counsellors could deliver psychosocial interventions in the community.

Programme operation

The intervention was delivered by lay health counsellors, who facilitated better coping and improving the self-management of common, co-occurring medical conditions. They also supported participants to obtain social and financial services available for older adults in Goa. This intervention was adapted from problem-solving therapy in primary care and brief behavioural treatment for insomnia to support active problem-solving skills and improve sleep quality.

The intervention sessions were 30 to 40 minutes in duration, and were provided at places convenient to participants (usually in their home or in a social or religious centre) for six sessions that spanned six to 10 weeks. Two booster sessions were given at month 7 and 10.

Fig. 7. Depression in Late Life programme



Recruitment was extended to the subcentres under the rural health centre and directly from the community to achieve the targeted enrolment. During community screening, research staff visited every house in the community to identify participants eligible for the trial. The researchers used standardized tools to evaluate the symptoms of depression and anxiety in respondents. Those enrolled in the programme were mildly symptomatic persons without any current mental illness that warranted other active treatment (e.g. antidepressant medication).

Impact

Around 180 individuals received the intervention. Evaluation conducted by independent researchers showed lower incident episodes of depression among them. The significant impact of DIL derives from its novel focus on prevention of mental health conditions in later life and its use of lay health counsellors.

Learnings

- Service users or beneficiaries should be consulted from the inception stage up until completion of any mental health intervention or programme to ensure success.
- Devising larger visual aids with realistic and cultural depictions (including the use of digital tools) promotes engagement.
- Addressing daily stressors and providing support to obtain local service improves outcomes.
- The quality of trainings can be enhanced by introducing self, peer and supervisor rating systems.

Additional information

Papers: <https://doi.org/10.1080/16549716.2017.1420300>

Contact: Dr Amit Dias

Atmiyata – enabling access to mental health and social care in rural communities

Centre for Mental Health Law and Policy (CMHLP), Indian Law Society, India

Type of setting	Urban and rural
Availability in multiple locations	Yes
Locations	Mehsana, Sabarkantha, Patan (Gujarat), Chandrapur (Maharashtra), Darlaghat (Himachal Pradesh), Roorkee (Uttarakhand), Bhatapara (Chhattisgarh), Bangalore (Karnataka), New Delhi
Target population	Adult population with mental health conditions
Referral pathways	Mental health services, helplines, services for domestic violence
Classification	Community outreach, peer support
Financing	Donor funding
Classification of service provider	Non-profit organization
Current status of programme	Ongoing
Evidence	Published literature in peer-reviewed journals

Programme description

Atmiyata is an evidence-based, low-cost, community-led intervention focused on improving access to mental health care and social care in rural India by training community volunteers (e.g. former teachers, community leaders, etc.) to identify and provide primary support and evidence-based counselling to persons experiencing distress or common mental health conditions.

It assists people with common mental health conditions to lead productive and healthy lives and break the vicious cycle of poverty and mental ill-health. The intervention is built on empathy and volunteerism, providing a scalable and sustainable path to increase demand and reduce service gaps in mental health care in low-resourced settings.

Programme operation

The intervention employs a stepped care approach, using community-based volunteers who are trained, mentored and supervised to conduct four activities:

1. identify persons with common mental health conditions and provide four to six sessions of counselling;
2. raise community awareness by showing four films on a smartphone to very small groups of community members (three or four) on social determinants of mental health;
3. make referrals of persons with severe mental health conditions to public mental health services when required; and

4. enable access to social care benefits to increase financial stability.

The intervention is community-led, with the volunteers based at the village-level to provide ongoing care and support to people with mental health conditions. Services are provided at people's doorsteps, free of cost. Volunteers are usually members of the community with a basic level of education, including teachers and shopkeepers. The volunteers are trained to identify those with common and severe mental health conditions.

The volunteers will conduct between four and six counselling sessions and refer those with more serious mental health care needs to specialized services. In both instances, the volunteers will continue to provide support where needed. Some of the volunteers will provide practical assistance by accompanying those needing further help to hospitals. This programme uses a smartphone application, uploaded to the smartphones provided to the volunteers (Champions) to document their work, which includes the number of counselling sessions, referrals made, and the provision of access to social entitlements in the community.

Atmiyata leverages the State governments' funding for mental health specialized services in district hospitals, and to implement the District Mental Health Programme. They work in collaboration with the Department of Health, Government of Gujarat, district hospitals and panchayat members. A functional and responsive health system at the state and district level is an important enabling factor for Atmiyata to effectively bridge the treatment gap.

Staff

By August 2023, the number of volunteers within the Atmiyata programme was around 850, with an estimated number of 1800 expected by the following year. For every district, with a population of approximately 1 million adults, in 550 villages, there are five core team members from the Centre for Mental Health Law and Policy, one project manager and 17 community facilitators.

Cost

The implementation of Atmiyata in rural districts comprising approximately 500 villages, with a total adult population of 1 million, is estimated to cost around 500 000 US dollars over a three-year period.

Impact

Over the course of a year, Atmiyata reached out to approximately 25 000 individuals in one rural district, which consisted of around 500 villages and 0.8 million adults.

A stepped-wedge cluster randomized controlled trial was used to assess the effectiveness of delivery of psychosocial interventions across 645 villages in Mehsana district of Gujarat, India between April 2017 and August 2019. The primary outcome was an improvement in depression and/or anxiety symptoms quality of life, functioning and social participation, measured by standardized instruments. Generalized linear mixed-effects models were used to assess the independent effect of the intervention.

Learnings

- The adaptation of evidence-based practices in rural communities can be achieved through local contextualization.
- Integrating day-to-day monitoring and supervision practices to support the volunteers helps in enhancing quality of implementation.

Additional Information

Atmiyata project: <https://cmhlp.org/projects/atmiyata/>

Community-based mental health services using a rights-based approach: <https://www.who.int/news-room/feature-stories/detail/community-based-mental-health-services-using-a-rights-based-approach>

Contact: Ms Jasmine Kalha, Co-lead, Atmiyata
Dr Kaustubh Joag, Co-lead, Atmiyata

The Khushee Mamta (“Happy Motherhood”) Programme

Mata Jai Kaur Maternal and Child Health Centre India

Setting	Rural
Availability in multiple locations	Yes
Locations	Village 35BB, Padampur, Sri Ganganagar, Rajasthan and serves a catchment area of 558 villages and rural towns around village 35BB, constituting a population of about 80 000 women of childbearing age
Target population	Women in perinatal period suffering from common mental health conditions (depression and anxiety), suicidal ideation and gender-based violence
Referral pathways	Women at the household and village level are screened and referred based on PHQ-9 scores and screening protocols for psychosis and suicidal ideation
Classification of service provided	Peer support services
Financing	Donor funding
Classification of service provider	Nongovernmental organization
Current status of programme	Ongoing
Evidence	Grey literature

Programme description

Perinatal depression is a rising public health concern which has long-lasting negative consequences. The Khushee Mamta (“Happy Motherhood”) Programme is a community-based perinatal mental health intervention carried out in the city of Sri Ganganagar in Rajasthan, India. It is based on the WHO Thinking Healthy Programme, which provides low-intensity psychological interventions that reduce the burden of depression in mothers.

This evidence-based intervention is appropriate in low-resourced settings and deploys peer volunteers to support mothers. It integrates evidence-based cognitive and behavioural techniques with a focus on reducing symptoms of depression, improving maternal well-being and providing education about child development.

Programme operation

The Khushee Mamta programme recruits and trains local women as counsellors to provide a culturally adapted package of care based on principles of cognitive behavioural therapy (CBT) for women who screen positive for depression during pre- and post-partum periods. The programme identifies potential allies who express an interest in volunteering in the community and involves them in the delivery of the intervention.

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- **Training:** The counsellors are trained to provide guidance and support on a wide range of topics, including wellness promotion, fostering positive thinking, enhancing child health and nutrition, and nurturing positive parenting skills. They are also trained in skills such as active listening and rapport building, while ensuring trust and confidentiality is maintained. In parallel to individual counselling sessions, peer counsellors organize group sessions for families.
 - **Assessment and referral:** The programme employs a stepped collaborative-care model, which involves screening for depression among women at the village level covering each household. A screening protocol was established, involving the in-person administration of the Patient Health Questionnaire-9 (PHQ-9) through door-to-door visits. People with severe depression, with symptoms of psychosis and self-harm, are referred to a specialist in the local hospital.
 - **Delivery of interventions:** The Thinking Health Programme aims to alleviate depression symptoms, enhance the overall mental health of expectant and postpartum mothers, and provide educational resources and support to women and families. Even though the programme doesn't actively address gender-based violence, the Khushee Mamta programme incorporated interventions that target gender-based violence, men's health, couple's therapy, and substance-abuse interventions, as they were found to be prevalent and unaddressed in communities.

The number of sessions varies, with each woman and family receiving between 12 and 27 sessions. The counsellors maintain regular contact with the woman and their families even after the initial counselling sessions are completed. Follow-up calls or home visits are conducted to assess progress, address any emerging concerns, and reinforce the knowledge and skills acquired during the counselling sessions.

Staff

Trained counsellors engage with women, offering guidance on prenatal and postnatal care, child nutrition, and family planning. As the programme expands, experienced counsellors may transition into the role of trainers, sharing their expertise with new staff members. Supervisors, who are maternal and child health professionals, oversee the programme. They monitor counsellor performance, conduct evaluations, and make strategic decisions to ensure the programme's success. This staffing structure ensures that mothers and children receive essential health care support, that new staff members are adequately trained, and that the programme maintains high standards of care.

Cost

The budget of the pilot phase of the programme was estimated to be 100 000 Canadian dollars.

Impact

The programme has screened more than 2 000 women and enrolled more than 200 in counselling sessions. In the pilot phase of the programme, a mixed-methods implementation evaluation was employed using lay counsellors and service recipient interviews, focus group discussions, and surveys. The target is to reach over 5 000 screenings and 500 enrolments over the next two years.

Learnings

- The concerns and issues of the target group should be addressed to provide comprehensive care. The programme seeks to find ways to integrate gender-based violence and substance-use prevention to support women and families who may be experiencing such issues or are at risk in the community.
- Addressing factors that improve mental well-being, such as improving social connectedness, empowerment and safety, contributes to improving the programme outcomes.
- A sustained funding environment and interest from donors (individual, government, and research grants), and the long-term presence of the organization in the field before the implementation of the Khushee Mamta programme have been enabling factors for its success.
- Building positive relationships and involving local health officials and teachers helps in reducing resistance or reluctance from the individual or the families to engage in the intervention as they have a high social standing within the community.

Additional information

Website: <http://www.matajaikaur.org>

Videos: https://www.youtube.com/watch?v=N_scDeitgF8

Contact: Aneel Singh Brar, Co-Founder and Executive Director, Mata Jai Kaur

Lan Pya Kyel – psychosocial support services

Myanmar

Type of setting	Urban and rural
Availability in multiple locations	Yes
Locations	Hopin, Yangon, Muse and nearby regions
Target population	Female sex workers, men who have sex with men and transgender persons at risk of HIV and people living with HIV and AIDS in Myanmar
Referral pathways	From the community visits and community awareness programmes. Where further support is necessary, clients referred to more equipped and specialized services.
Classification of service	Psychosocial support services
Financing	Donor funding
Classification of service provider	Non-profit organization
Current status of programme	Active
Evidence	Grey literature

Programme description

Lan Pya Kyel (LPK) seeks to improve access to health care support services for female sex workers, men who have sex with men, transgender persons at risk of HIV and people living with HIV and AIDS in Myanmar. Its services cover medical support, sex education, community outreach and mental health care. The activities are implemented through community clinics, through a community-led model. LPK recruits most of its workers from the community.

Programme operation

LPK has 200 staff and 190 peer volunteers. Mental health professionals supervise the volunteers. People are contacted through outreach services within the community, including beauty and massage parlours and social media platform. Volunteers recruit people through community visits. Community volunteers are also trained to identify people in distress and refer them to the LPK clinic for professional support.

Those enrolled in the programme are referred to counsellors who screen them for anxiety, depression, trauma, and general mental well-being. Those requiring support receive two sessions of counselling, based on Problem Management Plus, and learn relaxation techniques. Efforts are made also to strengthen social support. Following these sessions, a reassessment is conducted. Helplines are available for people experiencing stress or in a crisis.

In addition, HIV/AIDS and TB testing and treatment service are provided. Community awareness

and outreach on HIV/AIDS, sexual health and mental health is provided using digital platforms, social media and educational sessions.

Learnings

- Focusing on making the interactions brief, sustains the engagement and reduces dropout in the target group.
- Promotion and awareness activities play a major role in reaching out to marginalized communities. Digital media and links with relevant public figures have the potential to reduce stigma.

Additional information

Website: <https://www.lanpyakyel.org/>

Contact: Nang Phyu Phyu Aung

The Butterfly Project – community outreach and peer support

Consumer Action Network Mental Health Lanka, Sri Lanka

Type of setting	Urban and rural
Availability in multiple locations	Yes
Locations where programme operates	12 of the 24 districts of Sri Lanka
Target population	People with lived experiences, their families and related service providers
Referral pathways	Self-referrals following promotion campaigns, through local consumer organizations, through mental health services
Classification of service provided	Community outreach and peer support
Financing	Donor funding
Classification of service provider	Non-profit consumer organization
Current status of programme	Active
Evidence	Grey literature

Programme description

Consumer Action Network Mental Health Lanka (CAN MH Lanka) is a non-profit organization operating in both urban and rural areas in Sri Lanka that supports people with psychosocial vulnerabilities. CAN MH Lanka works closely with consumer networks. People who have lived experiences and their caregivers can connect and work with CAN MH Lanka. The strength of the organization is its volunteer network. A vast network of consumers, carers, professionals and students volunteer their time and resources for the organization.

Several innovative projects have been implemented since CAN MH Lanka's establishment, 10 years ago, one of which is The Butterfly Project. This is an outreach initiative that engages political leaders, state officials, educators, law enforcement authorities, corporate sector organizations, school children and the general public every year on World Mental Health Day. It primarily distributes educational materials to raise awareness about mental health and disability, whilst using the butterfly to symbolize the beauty and uniqueness of each person's mind.

Programme operation

- The Butterfly Project catalyses conversations about mental health. For this project, the organization, with a team of people with lived experience, carers and motivated changemakers, engages with around 65 consumer organizations. The management of the campaign is carried out by an advisory board comprising mental health professionals, sector experts and people with mental health conditions
- This project put the organization on the map as a service that actively advocates for the humane

and equal treatment of people with disabilities, voting rights and for budgetary allocations for disability issues. The project also contained sensitization efforts on suicide prevention and improving mental well-being among high-risk groups.

- With the campaign serving as an entry point for new members, the organization's ground-level services have been designed to cater to the individual needs of people. These include community outreach programmes, peer-support initiatives, and hospital-based services. When residential care is needed, the organization connects people to supported-living services or specialized housing options.

Impact

This project marked the beginning of awareness campaigns across 12 of the 24 districts of Sri Lanka, where school children, employees of local government organizations, and the general public received education on mental health. CAN MH Lanka, BasicNeeds, Voluntary Services Overseas (VSO), WHO and the Mental Health Directorate of the Ministry of Health carried out a comprehensive institutional strengthening programme (2007–2017) covering about 30 consumer organizations nationwide. This has boosted their activism and actions in the community and participation in district, provincial and national-level interventions.

Cost

The Butterfly Project's annual budget of 3000 US dollars covers education sessions, advocacy campaigns, and street dramas. Costs vary, depending on partnerships and funding sources, with some years being more budget-friendly due to collaborations, while others require more substantial funding from external organizations.

Learnings

- Working closely with the cross-disability network in Sri Lanka for advocacy and campaigning has proven effective and sustainable throughout the years.
- Sharing life experiences is an important aspect of preventing suicide, advocating for rights and reducing social stigma.

Additional information

Website: <https://canmhlanka.org.lk/>

Contact: Pradeep Gunarathne (National Organizer)

6

Key messages

- Extensive efforts are being made in countries of the WHO South-East Asia Region into shifting the functions of mental health services from more- to less-specialized health workers. The examples described in this report highlight the transformative potential of grassroots collaboration in bridging the gap between service providers and local communities.
- Consistent and active engagement with the community is key to the overall process of delivering community-based care. Addressing the perceived needs of the community has a catalytic role in the sustainability of these initiatives. The programmes are further strengthened through incorporation of culturally appropriate narratives, practices and rituals that make them more acceptable and relevant within the community.
- There have been many successful examples of partnership building across disciplines and of agencies facilitating community-based mental health services across the Region through maternal health clinics, social welfare departments, etc. This illustrates how the existing community-based mental health services across the Region are integrating social components to promote overall community well-being.
- It has been observed in many countries that employing the existing health workforce and/or volunteers results in better uptake of mental health services because there is an established rapport and relationship of trust.
- There is an increased interest and effort across the Region to include family members and caregivers in treatment and recovery plans. This improves the responsiveness of mental health services and is central to reducing stigma by fostering a collaborative atmosphere that promotes the well-being and recovery of the individual. This collaborative effort builds synergies and fosters a supportive network around the person needing support.
- Many programmes have expanded their reach and incorporated new dimensions into their work, notably addressing social determinants that exert significant influences on community-based mental health.
- Some services have extended their reach by incorporating digital technologies in the continuum of care provision – from planning to service delivery.
- Services have also diversified into areas such as research, documentation and training, with a specific focus on informing effective and efficient mental health programmes and policies.
- Given their proximity to the communities, nongovernmental organizations and civil society organizations in the Region are well placed to identify and address evolving needs and perceptions of the community. Their efforts to influence policies and programmes at the state and national levels should be supported, as it involves the development of locally relevant models with the potential of upscaling to the national level.

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- Collaboration between the public sector and donor agencies has become increasingly pivotal for achieving wider implementation and sustainability of community-based mental health services.
 - The barriers identified include inadequate funding to sustain the quality of services, increased turnover of trained health workers, and the presence of divergent local and political objectives, which impedes service provision.

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