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The roles of primary-level health workers in delivering mental healthcare in India

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Thesis submitted in accordance with the requirements for the degree of Doctor of Philosophy, University of London

January 2015

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Funded by the Wellcome Trust (Clinical PhD Programme)
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Abstract

This research explored the history, effectiveness and feasibility of primary-level health workers (PHWs) in delivering care for mental, neurological and substance use (MNS) disorders in India, to better inform the organisation and delivery of mental health services at primary care and community levels.

This thesis examined evidence for the effectiveness of PHWs in mental healthcare in low- and middle-income countries (LMICs) (Cochrane review – 38 included studies), and then focused on India. Seventeen oral history interviews described the experiences of integrating mental healthcare into primary care and 72 case-studies explored government and non-governmental models of PHW-delivered mental healthcare initiatives and their human resources.

PHWs can be effective in delivering care for MNS disorders in LMICs. The case studies identified heterogeneous collaborative care models in India, most of which were delivered through community- rather than government- primary care. Other models (training and referral) which have less evidence for effectiveness were more widespread, and included the government model which was perceived as having ‘failed’. A new model was identified: community outreach services which were specialist-led but PHW-delivered.

LHWs and care managers seemed more feasible and appropriate care managers than PHC doctors across models and provided more holistic psychosocial support. Specialists were valuable for PHWs’ and care managers’ training and ongoing support. Barriers to mental health care integration are discussed.

Future research priorities are to assess whether variations of collaborative models are similarly effective to those described in HICs and whether these are feasible and effective if implemented at scale. Priorities for improving the DMHP would be to consider deploying care managers and LHWs and reorient as well as incentivise specialists to support them. Better inter-sectoral collaborations, health system strengthening and technical support at central- and state-government levels may improve leadership, implementation and evaluation of mental healthcare integration into primary care across India.
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I would like to express my heartfelt gratitude to all the participants who dedicated their time and energy to the oral history interviews and the case-studies. Your contributions have been invaluable and it was a pleasure and inspiration working with you. This research would not have been possible without my excellent co-researchers, Meera S.M. and Sarah Ghani, data entry person, Manjula Nagesh and transcribers.

I would not have completed the thesis writing without my family’s loving support in looking after my children: Lance (my husband), Nivie and Wouter (my parents), Carole and James (my parents-in-law) and Andrew, Caroline and Nina (my brother and his family). You all have my deepest gratitude.
# Table of contents

**DECLARATION OF THE CANDIDATE** 1  
**ABSTRACT** 2  
**ACKNOWLEDGEMENTS** 3  
**LIST OF FIGURES** 10  
**LIST OF TABLES** 12  
**LIST OF BOXES AND PANELS** 14  
**CONTRIBUTORS TO THE WORK PRESENTED IN THIS THESIS** 15  
**ABBREVIATIONS** 18  

## INTRODUCTION AND RATIONALE

**Chapter 1 General introduction: why the use of primary-level health workers?** 21  
1.1 The current burden of mental illness worldwide 22  
1.1.1 Defining mental, neurological and substance-abuse disorders 22  
1.1.2 The burden of MNS disorders 23  
1.2 Barriers and strategies to reduce the treatment gap 24  
1.3 Delivering mental healthcare in LMICs 25  
1.3.1 Health systems in LMICs 25  
1.3.2 The scope of mental health services 27  
1.3.3 Primary mental healthcare 28  
1.3.4 Models of mental healthcare delivery 29  
1.3.5 Human resources 32  
1.3.6 Evidence for PHWs in mental healthcare 33  
1.3.6.1 Evidence of effectiveness 33  
1.3.6.2 Evidence of acceptability and feasibility of task-sharing 34  
1.4 Statement of the problem in India 34  
1.4.1 Epidemiology of MNS disorders in India 34  
1.4.2 Health and mental healthcare systems in India 35  
1.4.2.1 The primary healthcare system 35
1.4.2.2 Mental services, policies and financial resources in India

1.4.2.2.1 History, development and distribution of mental health services
1.4.2.2.2 A shortage of specialist human resources: a major barrier to mental healthcare
1.4.2.2.3 A mix of models of healthcare delivery
1.4.2.2.4 The integration of mental healthcare into primary care

1.5 References

Chapter 2: Human resources for mental health care: current situation and strategies for action (research paper 1)

Chapter 3: Research rationale and methodological approach

3.1 Rationale for this research
3.2 Aims and objectives
3.3 Study design and description of data collection methods
3.4 References

DATA CHAPTERS

Chapter 4: The effectiveness of NSHWS in delivering mental healthcare in low- and middle-income countries: a systematic review (research paper 2)

Chapter 5: The development of mental health services within primary care in India: learning from oral history (research paper 3)

Chapter 6: Human resources and models of mental healthcare integration into primary and community care in India: an exploration of 72 programmes (research paper 4)

6.1 Abstract
6.2 Introduction
6.3 Methods
6.3.1 Study setting
6.3.2 Sampling
6.3.3 Data collection
6.3.4 Data analysis

Nadja van Ginneken Thesis Page 5
6.4 Results

6.4.1 Overview of programmes and their human resources

6.4.1.1 Types of programmes

6.4.1.2 Types of human resources

6.4.2 Models of mental healthcare delivery and their human resources

6.4.2.1 Collaborative care

6.4.2.2 Non-collaborative care models

6.4.2.2.1 Education and training

6.4.2.2.2 Replacement, referral and raising awareness

6.4.2.2.3 Community outreach models in specialist programmes

6.5 Discussion

6.5.1 Are the models used appropriate?

6.5.2 Are the human resources used appropriate?

6.5.2.1 PHWs

6.5.2.2 Care coordination

6.5.2.3 Specialist support

6.5.3 Study Limitations

6.5.3.1 Limitations of scope

6.5.3.2 Sampling limitations

6.5.3.3 Data collection limitations

6.5.3.4 Data analysis limitations

6.5.4 Future research priorities

6.5.5 Implications for practice

6.6 Conclusion

6.7 References

DISCUSSION AND CONCLUSIONS

Chapter 7: Discussion and conclusions

7.1 Summary and triangulation of findings

7.1.1 Effectiveness and cost-effectiveness of PHWs in LMICs and India
7.1.2 Models of PHW-delivered mental healthcare in primary care in India

7.1.3 The roles of human resources within these models

7.1.4 Barriers to integrating mental healthcare into primary care
   7.1.4.1 Paucity of specialist and primary care human resources
   7.1.4.2 A weak primary healthcare system
   7.1.4.3 PHWs’ lack of motivation and skills in the government sector
   7.1.4.4 Poor accessibility to government DMHP care provision
   7.1.4.5 Political and governance barriers
   7.1.4.6 Inadequate integration with health system strengthening

7.2 Limitations and reflection of the study’s contribution
   7.2.1 Selection bias
   7.2.2 Responder bias
   7.2.3 Observer bias
   7.2.4 The limitations and opportunities of a mixed methods design
   7.2.5 Limitations of the generalisability and the scope of these findings

7.3 Implications for future research
   7.3.1 Research on the feasibility and impact of scaling up collaborative care
   7.3.2 Comparative effectiveness of different PHW-delivered models of mental healthcare
   7.3.3 Evaluation of methods for training and supervision of PHWs

7.4 Implications for policy and practice
   7.4.1 Deployment of care managers and LHWs
   7.4.2 Integrating mental health with established health system strengthening programmes
7.4.3 Engagement of civil society

7.4.4 Providing technical support for better leadership, implementation and evaluation

7.5 Conclusions

7.6 References

APPENDICES

Appendix 1: Chapter 2 webappendix

Table 1: Summary of evidence on the effect of taskshifting on patients’ and caregivers’ outcomes

Table 2: Summary of evidence on evaluation of training programmes for workforce capacity

Appendix 2: Ethics approvals

2a. London School of Hygiene and Tropical Medicine ethics approval
2b. Sangath Institutional Review Board ethics approval

Appendix 3: Oral history (chapter 5) consent process and data collection tool

3a. Information sheet for informed consent
3b. Consent form
3c. In-depth interview guide

Appendix 4: Case studies’ (chapter 6) consent process and data collection tools

4a. Information sheet (in-depth case studies)
4b. Information sheet (shorter case studies)
4c. Consent form (in-depth case studies)
4d. Consent form (shorter case studies)
4e. Hindi information sheet and consent form (shorter case studies)
4f. Kannada information sheets and consent forms (in-depth and shorter case studies)
4g. Data collection tools (in-depth case studies)
4h. Data collection tools (shorter case studies)

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5c. Copyright permission for chapter 4  
5d. Copyright permission for chapter 5  

Appendix 6: Further contents of the systematic review (chapter 4)  
Appendix 1: Search strategies  
Appendix 2. Adapted CHEC criteria list  
Appendix 3: Other economic studies of relevance but not included  
Appendix 4: Description of studies not included in meta-analyses  

Appendix 7: Supplementary tables for chapter 6  
Supplementary table 1: Characteristics of collaborative care programmes  
Supplementary table 2: Characteristics of education and training programmes  
Supplementary table 3: Characteristics of replacement and referral programmes  
Supplementary table 4: Characteristics of community outreach programmes
List of figures

Chapter 1
Figure 1.1: The elements of scaling up 26
Figure 1.2: WHO service organisation pyramid for an optimal mix of services for mental health 27
Figure 1.3: Models of mental health care in primary care 30
Figure 1.4: Five levels of integration of specialist and primary care 31
Figure 1.5: NRHM structure 37

Chapter 2
Figure 1: Human resources for mental health per 100 000 population, by country income group 55
Figure 2: Median change from Atlas 2005 to Atlas2011 in number of psychiatrists per 100 000 population, by country income group 56

Chapter 3
Figure 3.1: Framework of methods and research questions 68

Chapter 4
Figure 1: Study flow diagram 92
Figure 2: Risk of bias graph: review authors’ judgments about each risk of bias item presented as percentages across all included studies 94
Figure 3: Risk of bias summary: review authors’ judgments about each risk of bias for each included study 95
Figure 4: Forest plot of comparison 1: NSHW-led psychological interventions versus usual care in treating CMDs in adults (RCTs), outcome 1.1: Prevalence of depression (adults) (completers) 98
Figure 5: Forest plot of comparison 1: NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), outcome 1.6: Severity of common mental disorder symptoms (includes anxiety and depression) 99
Figure 6: Forest plot of comparison 2: Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), outcome 2.1: Prevalence of common mental disorders (completers combined) all facilities and in public and private facilities 101
Figure 7: Forest plot of comparison 2: Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), outcome 2.2: Severity of symptoms of common mental disorders (completers combined) in all facilities and in public and private facilities

Figure 8: Forest plot of comparison 3: NSHWs versus usual care in treating maternal depression (RCTs), outcome 3.1: Severity of symptoms in treating maternal depression

Figure 9: Forest plot of comparison 5: NSHW-led psychological interventions versus usual care in treating adults with post-traumatic stress disorder (RCT and NRCT), outcome 5.1: Prevalence of post-traumatic stress disorder (PTSD)

Figure 10: Forest plot of comparison 5: NSHW-led psychological interventions versus usual care in treating adults with PTSD (RCT and NRCT), outcome 5.2: Severity of PTSD symptoms (N = completers)

Figure 11: Forest plot of comparison 6: NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), outcome 6.1: Severity of behavioural problems (patient)

Figure 12: Forest plot of comparison 6: NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), outcome 6.5: Carer burden

Figure 13: Forest plot of comparison 7: NSHW-led brief alcohol interventions versus usual care for adults with alcohol-use disorders (RCTs), outcome 7.1: Amount of alcohol consumed (MDs)

Figure 14: Forest plot of comparison 9: NSHWs/OPHRs versus usual care in conducting interventions for children with PTSD (RCTs), outcome 9.3: Severity of PTSD symptoms – teacher-led interventions (children) (MDs)

Chapter 6

Figure 6.1: Location of the 72 programmes
List of tables

Chapter 2
Table 1: Median number of health professionals per 100 000 population in Atlas 2001, Atlas 2005 and Atlas 2011, by country income group 56
Table 2: Estimated supply and shortage of mental health workers per 100 000 population and total scale-up costs (wage bill) to eliminate shortage of mental health workers in 58 countries of low and middle income in 2005, by country income group 56

Chapter 3
Table 3.1: How the methodology addresses the objectives 69

Chapter 4
Summary of findings for the main comparison 83
Additional summary of findings
1. What are the effects of a collaborative care model (NSHW plus specialist supervision) for mental health care in adults with common mental disorders in low- and middle-income countries? 113
2. What are the effects of NSHW-led interventions for treating maternal depression in low- and middle-income countries? 115
3. What are the effects of NSHWs compared with specialists in treating depression for mental health care in low- and middle-income countries? 117
4. What are the effects of NSHWs compared with usual mental health care in low- and middle-income countries for data from an NRCT in adults with PTSD? 118
5. What are the effects of NSHW-led care in improving dementia patients’ and carers’ outcomes for mental health care in low- and middle-income countries? 120
6. What are the effects of NSHWs in delivering brief alcohol interventions in RCTs for alcohol-use disorders? 122
7. What are the effects of NSHWs/OPHRs conducting interventions for children with PTSD from RCTs in low- and middle-income countries? 123

Additional tables
Table 1: Definitions 137
Table 2: Risk of bias of economic studies – CHEC list criteria 140
Table 3: Outcomes of studies not assigned to meta-analyses 140
Table 14: Summary of costs and resource use from included studies 144
Table 15: Agreements and disagreements with related reviews 144

Chapter 5
Table 1: Participants characteristics 154
Table 2: History of mental health care integration within the Indian health system 156
Table 3: Mental Health Policy Group key recommendations 164

Chapter 6
Table 6.1 Summary of programme characteristics by model 181
Table 6.2: Roles of PHWs, coordinators and specialists by model 184
### List of boxes and panels

**Chapter 1**

Box 1.1: MNS disorders covered in this research  

22

**Chapter 2**

Panel 1: Case example from Sri Lanka  

57

Panel 2: Case example from India  

58

Panel 3: Case example from Aceh, Indonesia  

60
## Contributors to the work presented in this thesis

<table>
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EPOC: Effectiveness for Practice and Organisation of Care; DELIVER: Delivering mEntal heAlth care in India Via non-specialist hEalth woRkers; LSHTM: London School of Hygiene and Tropical Medicine; NIMHANS: National Institute for Mental Health and NeuroSciences; UCL: University C London; WHO: World Health Organisation
Abbreviations

‘The ant’: partner organisation of Ashadeep
AllIMH: All India Institute of Mental Health
AllIMS: All India Institute of Medical Sciences
ANM: auxiliary nurse midwife
ASHA: accredited social health activist
BALM: The Banyan Academy in Leadership in Mental Health
BAMS: Bachelor of Ayurveda, Medicine and Surgery
BRICS: Brazil, Russia, India, China, South Africa
CBA: controlled before and after study
CBO: community based organisation
CBR: community-based rehabilitation
CBT: cognitive behavioural therapy
CHAD: Department of Community Health, Christian Medical College Vellore
CHEC: Consensus on Health Economic Criteria
CI: confidence interval
CMDs: common mental disorders
CMHP: community mental health programme
CMHS: community mental health services
COPSI: Care for people with Schizophrenia in India
C-RCT: cluster randomised controlled trial
CT: Chellamuthu Trust
DMHP: District Mental Health Programme
EPOC: Effective Practice and Organisation of Care (Cochrane group)
E&T: education and training
FPA: Family Planning Association
GASS: Grameen Abhyudaya Seva Samasthe
GOI: Government of India
GP: general practitioner
HICs: high income countries
ICC: intracluster correlation coefficient
ICD-10: international classification of disorders (10th version)
IIAHS: Indian Institute of Allied Health Sciences
IPT: interpersonal therapy
ITS: interrupted time series study
ITT: intention to treat analysis
LHW: lay health worker
LICs: low income countries
LMICs: low- and middle- income countries
MCD : mean change difference
MD: mental disorder
MD (in Cochrane review): mean difference
MDT: multidisciplinary team
MH: mental health
MHAT: Mental Health Action Trust
MICP: Malappuram Initiative in Community Psychiatry
MNS: mental neurological and substance use
MSW: medical social worker
NBJK: Nav Bharat Jagrath Kendra
NCDs: non-communicable diseases
NET: narrative exposure therapy
NGO: non-governmental organisation
NIMHANS: National Institute for Mental Health and NeuroSciences
NMHP: National Mental Health Programme
NRHM: National Rural Health Mission
NRCT: non-randomised controlled trial
NSHW: non-specialist health worker
OPHR: other professional with health roles
PACT: Saarthak reintegration project for people recovering from severe mental illness
PHC: Primary healthcare
PHW: primary-level health worker
PSW: psychiatric social worker
PTSD: post-traumatic stress disorder
RCT: randomised controlled trial
RFS: Richmond Fellowship Society
R&R: replacement and referral
SCARF: Schizophrenia Research Foundation
SD: standard deviation
SHG: self-help group
SMDs: severe mental disorders
SMD (in Cochrane review): standardised mean difference
SW: social worker
TTK: T.T.K. Ranganathan Trust Clinical Research Foundation
UMHP: urban mental health program
VOLCOM: Volunteers for Community Mental Health
WHO: World Health Organisation
Chapter 1

General introduction: Why the use of primary-level health workers?
The introduction starts with describing the burden of mental, neurological and substance use disorders worldwide (1.1). It follows with a description of health and mental health models and human resources and their effectiveness in low-and middle-income countries (LMICs) (1.2 and 1.3). Finally it situates the burden of mental neurological and substance use (MNS) disorders and health system and human resource issues within India (1.4).

1.1 The current burden of mental illness worldwide

1.1.1 Defining mental, neurological and substance-abuse disorders

Mental neurological and substance use (MNS) disorders (Box 1.1) are sometimes dealt with together because they can co-exist (such as neurological consequences of alcohol or drug abuse). In the context of limited health service resources in LMICs, they are often addressed by the same health sector.

Box 1.1: MNS disorders covered in this research (ICD10 categories) (based on ICD-10 criteria (WHO, 2007a; Patel, 2003))

1. Common mental disorders
Mild to moderate mood/ affective disorders (F32-38)
Neurotic, stress-related and somatoform disorders (F40-49)
Behavioural syndromes associated with physiological disturbances and physical factors (F50-59)

2. Severe mental disorders
Schizophrenia, schizotypal and delusional disorders (F20-F29)
Bipolar affective disorder (F31)
Severe depressive episode with or without psychosis (F32.2, F32.3)

3. Neuropsychiatric disorders
Organic, including symptomatic, mental disorders (F1-9)
Mental retardation (F70-79)
Epilepsy (G40)

4. Disorders caused by substance abuse
Mental and behavioural disorders due to psychoactive substance use (F10-19)
Mental disorders are characterised by a combination of abnormal thoughts, emotions, behaviour and relationships with others. These disorders, if left untreated, lead to disability and social exclusion (WHO, 2008a). Though the concept of mental disorder is universal, its expression can differ individually and culturally. Treatment choices for mental disorders also vary according to medical and cultural paradigms (Kleinman et al., 2006).

1.1.2 The burden of MNS disorders

The global burden of MNS disorders is high. The latest global burden of disease estimates have shown that mental, behavioural and neuropsychiatric disorders all feature in the top 30 causes of all years lived with disability, the highest contributors being major depression (ranked second), anxiety (ranked seventh) and substance-use disorders (ranked twelfth) (Vos et al., 2012). The worldwide contribution of major depressive disorders to the loss of disability-adjusted life years (DALYs) has increased by 37% from 1990 to 2010 and is predicted to rise further (Murray et al., 2012; Prince et al., 2007). Furthermore, self inflicted injuries and alcohol-related disorders are likely to increase in the ranking of disease burden due to the decline in communicable diseases and because of a predicted increase in war and violence. The disease burden due to Alzheimer's disease is also increasing, linked to the demographic transition towards an ageing population (Vos et al., 2012). The lifetime risk of a severe mental disorder or epilepsy remains stable between 1 and 4% (Patel et al., 2007c; Saha et al., 2005). The impact of mental disorders spans beyond the affected individual's mental health. For example maternal mental disorders impact on child mortality, morbidity, growth and development (Rahman et al., 2013).

The economic effect of MNS illnesses on individuals, families, health services and social costs is substantial (WHO, 2003a). MNS disorders affect productivity and quality of life (Bloom et al., 2011). Data remain sparse on the macro-economic costs for LMIC settings (Hu, 2006). However, high direct costs are incurred in countries such as India where health spending is met largely through private, as opposed to public, spending and where health insurance and employer-met health payments are insubstantial (Patel et al., 2007b). High indirect costs are also incurred due to informal care-giving.
and lost work opportunities, as well as due to untreated disorders and their associated disability (Chisholm et al., 2000; WHO, 2003a).

1.2 Barriers and strategies to reduce the treatment gap

The gap between those who could benefit from MNS health interventions and those who receive such care is very large (WHO, 2008a; WHO, 2010); in LMICs up to 90% of people needing care do not receive it (Demyttenaere et al., 2004; Saxena et al., 2007). This is despite the existence of a range of cost-effective interventions in mental health care (Patel et al., 2007a; WHO, 2010).

Major barriers to closing the treatment gap are the huge scarcity of skilled human resources, as well as large inequities and inefficiencies in resource allocation and the significant stigma associated with psychiatric illness (Saxena et al., 2007). This thesis focuses on the specific issue of human resources and their use in rural areas. The first research paper (chapter 2) presents the worldwide mental health human resource shortage figures, and changes to these over a 10 year period (2001 to 2011). The prevalence of psychiatrists and psychiatric nurses is much lower in LMICs (the median number of psychiatrists is 172 times lower in low-income countries than in high-income countries (HICs)). The article also reviews strategies for increasing human resources which involves sharing tasks with primary level health workers (PHWs) and educating mental health service providers. To remove shortages in human resources for mental health, overarching issues need to be addressed: scaling-up costs, recruitment, management of attrition and leadership (Kakuma et al., 2011).

To help overcome these barriers, the World Health Organisation (WHO) have initiated a Mental Health Gap Action Programme which sets clear comprehensive activities and programmes for scaling-up care for mental, neurological and substance use disorders (WHO, 2008a). Within this are firm recommendations and guidelines to integrate the use of PHWs, as well as a manual to help build their skills in mental healthcare (WHO, 2010).
1.3 Delivering mental healthcare in LMICs

1.3.1 Health systems in LMICs

Many health systems in LMICs have difficulties providing a successful wide-scale accessible and affordable delivery of health services. Common barriers to this are one or several of the following: good leadership, effective management, realistic financing arrangements, national ownership and technical innovation; by contrast the presence of these characteristics are common attributes of successful programmes (Medlin et al., 2006). As a consequence, health professionals trained in these countries tend to favour working in the private sector which is more lucrative and less bureaucratic.

Government health services have widely adopted the model of decentralisation in an attempt to proved better services. Decentralisation is a health reform strategy promoted worldwide in the 1980s following the Alma Ata declaration and the desire for better and locally-adapted healthcare services (Mills, 1994). Decentralisation involves the transfer of workload, management and political decision-making powers from central to peripheral levels (Munga et al., 2009; Rondinelli et al., 1983). Curative and preventive services are provided in line with national health policy and local needs through a tiered system of care: (i) primary care: the first level of contact with formal health services;¹ (ii) secondary care (referral general hospitals), (iii) tertiary level care (specialist centres) (Gorgen et al., 2004).

In addition, the health system may be composed of horizontal or integrated care (general health services which bring together inputs, delivery, management and organisation of health care), and vertical programmes (disease-specific packages of care which may be delivered within or parallel to primary care often executed directed or supervised wholly or to a great extent by a specialist service using dedicated health workers) (Gorgen et al., 2004; Atun et al., 2008).

¹ Services provided at community level or at PHC clinics (on their own or attached to hospital settings, provided they have no specialist input, apart from supervision)
Most health services are also constantly changing and becoming more complex, partly because of an ongoing desire to make more healthcare accessible. Scaling up interventions or services is the process of increasing coverage of health interventions that have been shown to be successful on a small scale, accompanied by an increase in resources (WHO, 2001) (see figure 1.1). It may involve creating broader access to general services (horizontal programmes), broadening access to specific innovations or services (vertical programmes) or integrating specific interventions into existing services (a combination of vertical and horizontal integration sometimes called diagonal integration). However, scaling-up can be hampered by the same weaknesses that affect health systems: weak policy, poor health service infrastructure, lack of community utilisation and the shortage of healthcare workers (Travis et al., 2004; WHO, 2006; Hanson et al., 2003). In addition, not only do models first have to be shown to be effective on a small scale, but also it is difficult to evaluate what impact scaling up interventions has on health outcomes (Mangham and Hanson, 2010). In spite of this complexity, a limited number of scaled-up health and financing initiatives have been shown to be successful (Levine et al., 2004). It is therefore relevant to think about scaling up in the context of mental health services.

Figure 1.1: The elements of scaling up based on (Simmons and Shiffman, 2007)
The next section discusses what place mental healthcare has within the health system in LMICs.

1.3.2 The scope of mental health services

A balance of community- and hospital-based services and better organisation and cooperation of services between general and mental health sectors have been advocated as part of the task-shifting (also called task-sharing, defined in more detail below) strategy and to achieve effective comprehensive mental healthcare (Thornicroft and Tansella, 2004; WHO, 1975). Mental healthcare is delivered at each tiered level of the decentralised health system and may be more or less integrated or vertically provided at primary care level. A visual representation of these tiers as applied to mental healthcare is represented by the WHO pyramid (figure 1.2) (WHO, 2008a).

Figure 1.2: WHO service organisation pyramid for an optimal mix of services for mental health (WHO-WONCA, 2008)
The top of the pyramid corresponds to tertiary specialist care, the second level down includes secondary care delivered in hospitals (psychiatric care in general hospitals) and in the community (community mental health services). The bottom sections of the pyramid are where non-specialist providers/PHWs usually are involved: primary care and community care. They often are the levels which identify mental illness, and may provide preliminary treatment or care and/or follow up. They also encourage self care of patients and carers. Informal care may also include other types of health care accessed often by a large proportion of people, such as indigenous medicines, religious healing and other types of healing.

1.3.3 Primary mental healthcare

The integration of mental health services into general health services is a key strategy worldwide and has been shown to reduce stigma, address personnel shortages, and encourage early identification of mental disorders (WHO, 2003b). Comprehensive and integrated service delivery is a core value of primary healthcare (PHC) (WHO, 2008b).

The use of formal government-run primary care is an obvious model for implementing PHW-delivered mental health care as it uses existing nationwide resources which are cheaper than highly skilled specialist resources. The WHO defines primary mental healthcare as “mental health services that are integrated into formal general health care at a primary care level [...] provided by primary care workers who are skilled, able and supported to provide mental healthcare services” including “first-line interventions that are provided as an integral part of general healthcare” (WHO-WONCA, 2008).

However few LMICs have adequate mental health policies or implementation strategies to collaborate with general healthcare delivery. Also many LMICs’ primary care systems function poorly: they have high rates of staff attrition, those who are there are overburdened, and often there are poor mechanisms for monitoring, evaluation and support. Funding shortages, inadequate infrastructure and poor training compound the issue of inadequate care. Several LMICs also implement what is known as selective primary care: a minimal package of certain interventions only (such as maternal and child health and some crucial vertical programmes like tuberculosis
and polio eradication). When faced with these limitations, it is then inappropriate to expect such a system to take on mental healthcare without profound changes to and strengthening of the system itself (Atun et al., 2008). Indeed many programmes bypass primary care and have direct links with communities.

Within LMICs, other platforms of healthcare delivery outside formal primary care are present which have developed as a consequence of a poor government healthcare structure, such as NGO-delivered community healthcare, private for-profit care, or health interventions delivered in non-health settings (such as schools, or within development projects). This study therefore adopted the broader Alma Ata definition of primary healthcare which “is the first level of contact of individuals, the family and community with the national health system [...]. It involves, in addition to the health sector, all related sectors and aspects of national and community development, and demands the coordinated efforts of all those sectors” (WHO/UNICEF, 1978). This, according to figure 1.2, encompasses not just formal primary care but also community and self care.

1.3.4 Models of mental healthcare delivery

In practice the levels of mental health care delivery described in the WHO pyramid (figure 1.2) do not necessarily function simply as a referral system or as a stepped care model from the bottom to the top of the pyramid. Certain services may function independently and just get referred to from other sectors, such as long stay facilities/residential care, or acute psychiatric treatment facilities in specialist or general hospitals. However many of these levels may interact with each other under various guises and with different levels of intensity. They may simply be co-located but not involve primary care, such as having ambulatory psychiatric care (outreach clinics by a psychiatric team) (Thornicroft and Tansella, 2004). They may on the other hand engage primary care or community level providers: for example psychiatric services may train and supervise primary care delivery of mental healthcare, or some community mental health services may bypass primary care and deliver interventions at community level through locally trained lay health workers (LHWs).
The latter forms of collaboration have been described particularly in the literature in HICs. Several models have been developed to think about collaborative care. Within this thesis we refer to two, which were most relevant to our material: the Bower model and the Milbank report model. Both these models provide different frameworks for exploring collaborations between specialist and non-specialist care. The Bower framework is an established framework for analysing the level of engagement, collaboration and integration between mental health specialists and primary care workers (Bower, 2011; Bower and Gilbody, 2005) (figure 1.3).

**Figure 1.3: Models of mental health care in primary care based on (Bower and Gilbody, 2005)**

This framework describes four levels of integration of depression care within primary care in HICs, ranging from relatively more PHW responsibility to relatively more specialist responsibility for mental healthcare:

1. Training and education: Aims to make primary care practitioners independent in managing basic mental health conditions through training provision only.
2. Consultation liaison: As above but also involves an ongoing educational relationship with a specialist (for example through joint case discussions) to make the primary practitioner more independent and confident in providing mental health care and reduce the frequency of referrals to specialist care.
3. Collaborative care: Also known as the chronic care model, this has an additional workforce member (a “care manager”) with mental healthcare
responsibilities and who acts as a ‘link’ between the patient, the primary care practitioner and the specialist.

4. Replacement and referral: Health workers are trained to identify and refer suspected cases to the mental health professional, who retains the main responsibility of care.

Another way of describing collaboration is according to how integrated the PHW and specialist services are in terms of service delivery, as described in the Milbank report (figure 1.4). This framework explains how at one end of the spectrum, specialist and PHW structures work in completely separate facilities and communicate sporadically (minimal collaboration), whereas at the other end of the spectrum there may be a completely integrated system where specialists and PHWs are part of the same service, i.e. mental healthcare is part of regular primary care (fully integrated). In between are lesser or greater degrees of integration: basic collaboration (where specialists and primary care services are either collaborating at a distance or are collocated), and close collaboration, which implies some shared systems of care where specialist and primary care services are either partially integrated or fully integrated. They further explain that different degrees of integration are needed depending on the patient’s physical and mental needs: a patient with low requirements of mental care would be best served in primary care setting, whereas those with high mental care requirements would need both primary and specialist care settings. Integrated care would be valuable for this group of patients (Collins et al., 2010).

Figure 1.4: Five levels of integration of specialist and primary care based on (Collins et al., 2010)

![Collaboration Continuum Diagram](image)

These frameworks have been formulated to describe models of collaboration in HICs. How much this applies to LMIC models remains to be determined.
1.3.5 Human resources

As this study covers both primary and community-level healthcare, we sought an appropriate term to encompass all non-specialists with mental healthcare duties. At the beginning of the study, we called these health workers non-specialist health workers (NSHWs). However several interviewees and programme founders within our study found the negative term ‘non-specialist’ demeaning. We therefore chose a new term which we have referred to already above: primary-level health workers (PHWs). Both these terms will appear in different publications in this thesis but both include the following health workers:

- professionals (those without specialist mental health training) (doctors, nursing staff, social workers and other allied health professionals)

- non-professional cadres (such as LHWs) who do not have tertiary paraprofessional or professional training, but perform a broad range of paid or voluntary healthcare delivery and often work at community level (Lewin et al., 2010). This category does not include caregivers who care only for one person (or a select group of people) with mental illness and who are not used in a broader healthcare context.

PHWs have been part of WHO’s global primary healthcare strategy since 1975 as an attempt to overcome specialised human resource shortages and to improve access to services (Lewin et al., 2008; WHO/UNICEF, 1978). The task-shifting model mentioned above, aims to delegate appropriate tasks to less specialised workers, requiring many new resources (WHO, 2007b). Task-shifting extends existing cadres’ roles or creates new competency-based cadres (Celletti et al., 2010). Task-sharing is the preferred term in this thesis as it implies the need for teams of specialists and non-specialists, whereby roles are shared across the team and where specialists support PHWs to deliver shifted roles. Task-shifting has a connotation that specialists are only substituted by non-specialists (Dawson et al., 2014).
It has been suggested that PHWs can deliver equally effective and acceptable general healthcare (Lewin et al., 2008; Babigumira et al., 2009; Bellanger and Or, 2008; Evans et al., 2009; Loubiere et al., 2009; Lewin et al., 2010), though there are doubts about their sustainability (Walt and Gilson, 1990; Bhutta et al., 2010). Task-sharing seems to be more successful within systems that have sufficient checks and balances at work and appropriate work legislation (WHO, 2007b). It also necessitates adequate support for PHWs which is why this study also explores the roles of specialists, coordinators, managers and programme founders. Specialists include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses and other mental health professionals.

1.3.6 Evidence for PHWs in mental healthcare

1.3.6.1 Evidence of effectiveness

The evidence from randomised and non-randomised trials for clinical outcomes is published in the second paper: the Cochrane review (chapter 4). PHWs and other professionals such as teachers, have some promising benefits in improving outcomes for general and perinatal depression, PTSD, alcohol-use disorders, and patient- and carer-outcomes for dementia.

Other evidence measures processes, not outcomes. Post-training questionnaires suggest knowledge acquisition improved attitudes and referral rates amongst multipurpose workers (MPWs - a type of CHW in India) - (Nagarajaiah et al., 1987) and initiation of screening/educational activities by PHC doctors (Narayana Reddy et al., 1987; Sriram et al., 1990b; Nagarajaiah et al., 1994b; Isaac et al., 1982; Nagarajaiah et al., 1994a; Sriram et al., 1990a). However conflicting research shows PHWs have been ineffective at delivering mental healthcare: low recognition rates of depression/ anxiety by PHC doctors (Patel, 1996), inadequate use of antidepressants (Patel and Andrade, 2003), and the frequent use of ineffective medications such as vitamin injections (Linden et al., 1999).
1.3.6.2  **Evidence of acceptability and feasibility of task-sharing**

A recent systematic review found that despite task-sharing being widely adopted following evidence of effectiveness, task-sharing could overcome human resources shortages in LMICs without several factors being addressed. PHWs experienced distress and were demoralised; they were uncertain about their levels of competence; they were poorly accepted by other healthcare professionals, and were unsatisfied with their remuneration or incentives. Despite some limitations (included studies had small sample sizes and acceptability and feasibility were secondary outcomes), the review argues that increased investment in mental health, particularly regarding improving training and supervision, remuneration, management and accountability, is essential to overcome these barriers (Padmanathan and De Silva, 2013). A further study in five countries (Ethiopia, India, Nepal, South Africa and Uganda) published since this review has argued for similar changes to improve acceptability and feasibility of task-sharing, however also emphasises increasing the numbers of human resources and better access to medications (Mendenhall et al., 2014).

1.4  **Statement of the problem in India**

1.4.1  **Epidemiology of MNS disorders in India**

Though prevalence rates of mental disorders are lower in India than the USA or Africa, they are substantially higher when compared with other Asian countries (Ganguli, 2000; Math et al., 2007). The lower rates in the Indian population may be due to underreporting due to stigma and under-diagnosis of two common mental disorders and substance abuse, two major contributors to mental disease burden in India and worldwide (Math et al., 2007; Math and Srinivasaraju, 2010). It has been postulated this may also reflect better coping skills, lifestyle factors, social support, cultural factors or genetic reasons though none of these have been subjected to rigorous examination (Math and Srinivasaraju, 2010). Mental health however contributes very substantially to the public health burden in India. Recent census data revealed that suicide accounts for 3% of all deaths over the age of 15 years, which occur predominantly in women 15 to 29 years old, which means suicide has now overtaken
maternal mortality as a cause of death in women of child-bearing age in India (Patel et al., 2012). Substance-abuse is also a widespread problem in India.

1.4.2 Health and mental healthcare systems in India

1.4.2.1 The primary healthcare system

Much effort has been put into developing a vast health infrastructure to promote social development through improving health status (Khandelwal et al., 2004) particularly since 1946, when the Government of India appointed a Health Survey and Development Committee, headed by Sir Joseph Bhore. Their report (Bhore, 1946) which was never fully implemented (Bhatia, 1993), suggested preventative and curative services as well as social and infrastructure development to improve health.

India’s current health strategy is based on the decentralised primary care approach proposed in India’s 1983 National Health Plan which focused solely on medical treatment rather than addressing the wider remits of healthcare. In fact, until recently the Indian primary health system could be described as selective primary care, that is a minimal package of cost-effective medical interventions which are brought together as a cluster: the focus of primary care has been to address primarily maternal and child health, as well as TB and other infection treatment and control programmes. The number of national health programmes implemented at primary care level has now expanded to 13, and mental healthcare is one of them.

There are various challenges to the primary care system. Firstly, in spite of its large network throughout India there has been poor commitment to developing it to make it a fully functional structure. Secondly, throughout the years, various initiatives to train rural lay health workforce emerged:

- village health workers and auxiliary nurse midwives (ANMs) (mid 1960s)
- multipurpose workers (MPWs) (1970s) retrained disease control programme staff
- community health volunteers, health guides and dais (traditional birth attendants) in the 1970-80s.
Poor commitment and funding to these programmes lead to their demise. Further Five Year Plans (1980-90s) also failed to improve infrastructure of health services and sanitary conditions.

The current Indian health system now faces several ongoing challenges:

- Continuing poor financial and implementation commitments to the entire Indian health strategy. Only 5.2% of India’s total annual government spending budget is spent on healthcare, over 70% of which is out of pocket (Khandelwal et al., 2004).

- Primary care services remain poor and inequitable with only 20-30% of the population having access to these services (Sibbald, 2008). In terms of infrastructure, there are currently about 23,000 primary health centres, 130,000 sub-centres and 150,000 health-care institutions. However these are often far from communities (for example more than 10 km away). There are also problems of drug supply availability (IIPS, 2006).

- There are persistent gaps in manpower and infrastructure at PHC level and absenteeism of health staff at PHC level (GOI, 2009a). 18% of primary health centres are without a doctor. The number of allopathic doctors, nurses, and midwives (11.9 per 10,000 people) is about half the WHO benchmark of 25.4 workers per 10,000 population, and is about a quarter if one takes those with valid qualifications (Rao et al., 2009).

- The absenteeism and the multiple requirements of the national health programmes (both of clinical and administrative report-writing duties) have led to overburdening primary care staff.

- Insufficient transparency and community ownership is present (GOI, 2009b).

- There are few inter-sectoral linkages of primary care with vertical health programmes (such as the mental health programme) and costs are escalating due to the expansion of the primary care network and inflation (Khandelwal et al., 2004).

The above issues have lead to poor quality of care in many areas, with subsequent underutilisation of primary health centres (Gupte, 1993; Nair et al., 2004). In fact
private and informal sectors of healthcare in India have remained primary providers. 70% of health workers are employed by the private sector (80% of allopathic doctors and 50% of nurses and midwives) (Rao et al., 2009). Given the weaknesses of the public sector the private sector has continued to grow significantly (Bhatia, 1993). Private inpatient and outpatient care was utilised by 40% of rural and urban populations in 1986, whereas 25 years later, in 2012, it had increased to nearly 70% (IMS, 2013). Unfortunately the private sector remains unmonitored and unaudited despite some glaring malpractices (Antia, 1993; Bhat, 1993).

In response to a dysfunctional and selective primary care system, a nation-wide ambitious National Rural Health Mission (NRHM) strategy was implemented in 2005 advocating for integrated community care and ensuring action on a range of social determinants of health (such as sanitation, education, nutrition, gender equality etc) (GOI, 2005) (Figure 1.5).

Figure 1.5: NRHM structure, based on (GOI, 2009b)
The NRHM is the largest public health programme India has ever had. Since its inception, improvements have been noticed: from increased usage of primary health centres, to capacity building, with much greater numbers of community based workers, partly achieved through public-private partnerships (GOI, 2008; Rao et al., 2011; GOI, 2009b). In addition to improving the training for existing health assistants, a new community-based human resource, the ‘Accredited Social Health Activist’ (ASHA) was created to improve rural access to services with 690,000 trained so far. Furthermore, though currently still controversial and not widespread, the NRHM are experimenting with medical education programmes to train rural medical practitioners (a new cadre currently only utilised in two states). The NRHM has been successful in increasing the number of community resources: the auxiliary nurse midwives (ANMs) who are lay graduate women with 1 year training, and ASHAs (not necessarily literate, with 1 month training). However the NRHM evaluation after its first 5 years revealed their targets had not been met. The rates of immunisations, antenatal and postnatal checks and institutional deliveries slightly improved but were still low (less than 50%), and the distance to facilities has hardly changed particularly in some of the most deprived states in the North and North-East of India (GOI, 2011a).

In addition, since 2011, in the 12th Five-Year Plan (5 yearly strategy plan for spending the national budget) India committed to attain universal health coverage by 2022 so that the aim for health for all (pledged 60 years ago) is met: that all Indian citizens will have access to “affordable, accountable, appropriate health services of assured quality as well as public health services addressing the wider determinants of health, with the government as a guarantor and enabler, although not necessarily the only provider of health and related services” (GOI, 2011b). The 12th Five Year Plan aims to capitalise existing schemes, such as the NRHM and several other programmes such as 1/ the Janani Suraksha Yojana, launched in 2005 to promote institutional deliveries through providing financial incentives to expectant mothers; 2/ the Rashtriya Swasthya Bima Yojna scheme (2007) to provide insurance coverage in hospitals to families below the poverty line; and 3/ the Jan Aushadhi programme (2008): a public-private partnership scheme to provide generic affordable medicines and surgical equipment through pharmacies in every district (Reddy et al., 2011).
Though they remain controversial because of the concern that government sector will start to rely on private healthcare, private public partnerships are developing at different input levels: some help with health system functioning (offering health system strengthening mechanisms), and others are geared towards healthcare provision (offering specialist services brought to primary care). Many of these currently remain unevaluated.

1.4.2.2 Mental services, policies and financial resources in India

1.4.2.2.1 History, development and distribution of mental health services

India has been ahead of most LMICs in setting up mental health services (Weiss et al., 2001). In 1982 a National Mental Health Programme (NMHP) was initiated, to promote community mental healthcare through an inter-sectoral approach (Murthy, 2005). Part of the strategy was to integrate mental healthcare into the existing primary care structure, training existing primary health centre staff to diagnose and treat mental disorders, supervised by district level mental health specialists, through task-shifting. In 1996 the district model for mental healthcare, the District Mental Health Programme (DMHP), was initiated (Agarwal, 2005) and was modelled on a community programme set up in Bellary district in Northern Karnataka. This programme – which is no longer functional - is still upheld as a model for the DMHP (Kapur, 2005). The history of primary mental health services’ development and policy is detailed in the third research paper (chapter 5).

Evaluations have shown that India is far off track for DMHP coverage (123 out of 664 districts) (GOI, 2014; WHO, 2011). In addition, despite the NMHP having structured recommendations within each five-year plan for increasing the accessibility, affordability, adaptability and acceptability of its mental health services, India still does not have a mental health policy. A current policy is however currently being created.

As with general healthcare, a majority of India’s mental healthcare is provided by the private for profit sector. This sector has grown in the post-independence era, also to fill a vacuum of mental health services due to the dearth of government mental services. This sector remains still relatively inaccessible to a rural population: 33% work
in large state capitals. However, 67% of private psychiatrists work in towns (though only 7% of these practice in district towns in rural areas) (Kala, 2005). Some private psychiatrists, particularly those linked to NGOs or academic institutions, may visit rural areas to provide outreach care. Unfortunately, this sector, as other private health sectors, is financially and clinically unregulated and expenditure on private consultations leads to catastrophic expenditure for many families in the absence of insurance systems (Khandelwal et al., 2004).

1.4.2.2 A shortage of specialist human resources: a major barrier to mental healthcare

In India, the treatment gap is large: no more than 10% of those who need mental healthcare receive it (Murthy, 2005). Several factors have been elicited: insufficient, inaccessible and unaffordable services and structures, the stigma attached to mental disorders preventing people from seeking care, and a lack of political support. Amongst one of the most important barriers to mental healthcare delivery however is the shortage of specialist human resources (Khandelwal et al., 2004). There are barely 4000 psychiatrists for a population of 1.2 billion. Most are located in the private sector and in major cities. There is also a 40-60 fold deficit in the number of clinical psychologists, social workers, and nurses (WHO, 2011). This shows a shortfall of a factor of 200 compared to the coverage of mental health specialists expected in a HIC.

1.4.2.3 A mix of models of mental healthcare delivery

There are several private and public institutions and facilities for the delivery of psychiatric care. Government-run mental healthcare provision is focused on secondary and tertiary care hospital settings, and involved in primary care (the DMHP programme) through training PHC doctors and more recently the community-level health workers, the ANM and ASHA.

Active and innovative models of mental healthcare have grown from the voluntary sector which may have potential for scaling up (Patel and Thara, 2003). These include half-way homes (most of which are run by NGOs), and also many models of community-delivered mental healthcare which bypass primary care. These include programmes where psychiatric services have direct links to community-level workers.
and also a range of groups set up by users or carers to provide self-help and support (Thara et al., 2004).

In addition, patients often seek folk-healing, religious treatments in places of worship (Hindu, Muslim and Christian), and indigenous medicine (Ayurveda, Unani and Siddha) are widely utilised as is yoga for mental disorders (Thara et al., 2004). These have little evidence as yet in Western medical scientific thought partly because these have not been interrogated comprehensively, though some evidence suggest they may have some benefits (Raghuram et al., 2002; Murthy, 1998). However policy makers have not encouraged its integration. More details of these models will be found in the fourth research paper (chapter 6).

1.4.2.2.4 The integration of mental healthcare into primary care

The barriers to the integration of mental healthcare into primary care in LMICs (see above) also apply to India. There are several health system issues which are particularly problematic in India: poor access to medications in some areas, little acceptability and utilisation of health services due to people’s mistrust and bad experiences of these services and inadequate funding. In addition, primary care human resources are expected to deliver mental healthcare: too few primary care workers, inadequate training and support to take on mental health roles, and poor remuneration. These issues are at the core of the problems also associated with trying to achieve universal health coverage in India (Sengupta, 2013). These barriers hinder using the primary care structure as a reliable and effective method of delivering mental healthcare (GOI, 2009b).

Not only does primary care need strengthening but so do the mental health support structures. The DMHP has not built sufficient capacity to fulfil its objective of integrating mental health into primary care. Their strategy has been to retain a cheap (but unfortunately not evidence-based) intervention to provide training to PHC doctors in mental healthcare with no support system in place for them apart from a referral system. Inter-sectoral linkages are also poorly developed. The DMHP operates in relative isolation from the NRHM despite primary mental healthcare being a core feature.
Because universal health coverage is one of the main health delivery priorities in India, the delivery of mental healthcare should be thought with this in mind. Recommendations will need to focus on the feasibility of integrating mental healthcare in a way which is feasible and sustainable for universal coverage. This study will therefore explore some of the questions regarding the integration of mental healthcare within a universal healthcare delivery mechanism. For example should mental healthcare be fully integrated into primary care, ie using only existing human resources, or should it feature as a partial integration, perhaps with a new cadre either solely for mental health or a chronic disease/non-communicable disease worker (Beaglehole et al., 2008).

Chapter 2 is the first research paper that provides further background information to complement this introduction: a situational analysis of human resources for mental health worldwide. We then describe the rationale for this research, as well as its aims, objectives and a justification of a mixed methods approach (chapter 3). The following three chapters are results papers from this thesis. Chapter 4 is a systematic review of the effectiveness of PHWs in delivering care for MNS disorders in LMICs. Chapter 5 describes the development of mental health services in India using an oral history approach. Chapter 6 explores and compares the models of mental healthcare delivery and their human resources in 72 programmes across India using a case-study approach. Chapter 7 summarises and triangulates these findings and provides implications for research and practice.
1.5 References


Padmanathan, P. & De Silva, M. J. (2013) The acceptability and feasibility of task-sharing for mental healthcare in low and middle income countries: A systematic review. Social Science & Medicine, 97(0), 82-86.


Chapter 2

Human resources for mental health care: current situation and strategies for action

(research paper 1)
RESEARCH PAPER COVER SHEET

PLEASE NOTE THAT A COVER SHEET MUST BE COMPLETED FOR EACH RESEARCH PAPER INCLUDED IN A THESIS.

SECTION A – Student Details

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<td>Principal Supervisor</td>
<td>Vikram Patel</td>
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<tr>
<td>Thesis Title</td>
<td>The roles of primary-level health workers in delivering mental healthcare in India</td>
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If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

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<td>If the work was published prior to registration for your research degree, give a brief rationale for its inclusion</td>
<td>Was the work subject to academic peer review?</td>
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*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

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<td>Stage of publication</td>
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SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

I contributed to the systematic reviews methodology, search strategy, identification of papers, data extraction and synthesis. I was the lead author for the Indian case study (panel 2) which was informed by my oral history research. I commented on drafts of the paper.
Introduction

“At the heart of each and every health system, the workforce is central to advancing health”

The World Health Report 2006 focused global attention on the shortage of health workers. Many countries of low and middle income face a health workforce crisis, and the scarcity of human resources and training is similarly overwhelming for mental health.1–3 Practical guidelines to assist policy makers, health planners, and educators to address shortfalls in human resources for mental health are available,4–6 efforts are increasing to focus on this issue; and evidence from countries of low and middle income is emerging that will have many implications for policy on human resources for mental health.

The mental health workforce described in this report includes three groups of individuals. The first is composed of specialist workers, such as psychiatrists, neurologists, psychiatric nurses, psychologists, mental health social workers, and occupational therapists. The second group is formed of non-specialist health workers, such as doctors, nurses and lay health workers, affected individuals, and caregivers. In the third group, other professionals are included, such as teachers and community-level workers.

Here, we discuss the current status and needs of human resources for mental health. We also review available evidence about actions and strategies to strengthen human resources for mental health in low-income and middle-income countries, with the objective to inform development of policies in this area.

Identification of data sources

Evidence of the current status of human resources for mental health was obtained from WHO’s 2011 Mental Health Atlas.7 WHO has been gathering data on mental health resources approximately every 5 years since 2000 from almost all countries of the world.1,3,8 The latest data were published in 2011 and were obtained with a questionnaire containing standard definitions for all variables, from 183 countries covering 99–3% of the world’s population. Median change scores were calculated to assess the alteration in the number of psychiatrists per 100 000 population from Atlas 2005 to Atlas 2011.9 Information on estimated need and shortages of psychiatrists, psychosocial care providers, effective leadership and management of human resources for mental health will be essential to address key challenges such as mobilisation of financial resources, recruitment, and retention, and equitable distribution of the workforce.
and nurses in mental health settings in 58 low-income and middle-income countries was obtained from a large study published by WHO.\(^1\) The computations were based on 2005 data available from the 2005 WHO Assessment Instrument for Health Systems (WHO-AIMS) and the 2004 WHO Global Burden of Disease Report for the 58 countries. We are not aware of any other data sources that are comparable to these in scope and coverage.

We searched Medline and PubMed to identify peer-reviewed publications from 1990 to December, 2010, on effectiveness of mental health care and training for various service providers. Our search methodology incorporated three validated strategies to capture publications related to “health services and policy” and “mental health” in “LMICs [low-income and middle-income countries]\(^{9,12–15}\) combined with selected index-text and free-text terms relating to non-specialist health workers and mental health. We also hand-searched relevant journals (Human Resources for Health, Bulletin of the World Health Organization, Health Research in Policy and Systems, and International Journal of Mental Health Systems) and scanned reference lists of relevant publications and websites of pertinent organisations (eg, WHO, Global Forum for Health Research).

We included studies that assessed the effectiveness of mental health care interventions delivered by specialist and non-specialist workers for detection, treatment, and prevention of mental disorders; and training on workforce capacity. Studies eligible for our report included randomised controlled trials and non-randomised trials (such as controlled clinical trials, controlled before-and-after studies, and interrupted time-series studies). For detection of mental disorders, cross-sectional studies in which diagnoses made by non-specialist health workers were compared directly with those made by specialists were also eligible for inclusion. Studies taking place in areas of conflict were excluded. No language restrictions were made.

Finally, we developed brief case examples from three countries—Sri Lanka, India, and Indonesia—to show how shortages in human resources for mental health are being addressed in these settings. To gain an historical perspective on mental health care in India, mental health experts and senior bureaucrats were interviewed by one of us (NvG; details available on request).

**Current state of human resources for mental health**

Figure 1 shows the median number of human resources for mental health reported in Atlas 2011,\(^9\) separated by income groups of countries. Globally, nurses were the largest workforce category in the mental health system, with a median of 4·95 nurses per 100 000 population, followed by psychiatrists (1·27 per 100 000 population). Although numbers of psychologists and social workers were much smaller, occupational therapists were especially rare, with not one occupational therapist working in the mental health system in at least 50% of low-income countries. Psychiatrists were far more prevalent in high-income countries, with the median number 17 times greater than in low-income countries.

Figure 2 and table 1 show changes in human resources for mental health over the years. Between Atlas 2005 and Atlas 2011,\(^3\) the median change in number of psychiatrists was greatest in high-income countries, with a median increase of 0·65 per 100 000 population, whereas in low-income countries the number fell by 0·01 per 100 000 population.

The estimated total number of mental health care workers needed in the 58 countries of low and middle income in 2005 was 362 000, representing 22·3 workers per 100 000 population in low-income countries and 26·7 workers per 100 000 in middle-income countries, comprising 6% psychiatrists, 54% nurses in mental health settings, and 41% psychosocial care providers. These data reflect an overall shortage of 239 052 mental health workers (17·3 workers per 100 000 population in low-income countries and 14·9 per 100 000 population in middle-income countries; table 2). Based on this result, a shortage of 1·18 million mental health workers was reported for all 144 countries of low and middle income. Almost all countries of low and middle income face shortages in at least one of the three categories of workers. The largest shortages were seen in Vietnam, with 1·70 psychiatrists and 11·52 psychosocial health providers per 100 000, and in Uruguay, with 22·20 nurses per 100 000. All low-income countries and about two-thirds of middle-income countries had far fewer mental health workers to deliver a core set of mental health interventions than were needed.
Strategies for increasing human resources for mental health

Task shifting

Task shifting (also known as task sharing), defined as “delegating tasks to existing or new cadres with either less training or narrowly tailored training”, is an essential response to shortages in human resources for mental health. This process can entail: employment of mental health care providers in different sectors; intersectoral collaborations with other professionals, such as teachers and prison staff, to strengthen mental health awareness, detection of mental disorders, referrals, and service delivery; or both of these.

With our literature search, we retrieved 63 studies on strategies for increasing human resources for mental health, of which 42 evaluated interventions with respect to patient or caregiver outcomes (webappendix pp 1–7) and 24 evaluated training according to staff performance outcomes (webappendix pp 8–11). Three studies addressed both. 23 reports were from south Asia, 13 from Africa, ten from Latin America and the Caribbean, five from the Middle East, five from China, four from Turkey, two from east Asia, and one from Russia. Most studies were quasi-experimental in design, and 20 were randomised or cluster-randomised controlled trials.

The need for mental health specialists, particularly psychiatrists and neurologists, will continue even if task shifting is implemented extensively. Existing evidence shows that the roles of these specialists can change, with clinical roles focused on complex psychiatric cases and diagnoses whereas less complex cases can be managed by trained non-specialist health workers. Mid-level mental health workers (eg, medical officers for mental health) have also helped to reach rural areas where psychiatrists are typically unavailable (panel 1).

Psychosocial workers also have an important role. In India, social workers have facilitated support groups for

![Figure 2: Median change from Atlas 2005 to Atlas 2011 in number of psychiatrists per 100,000 population, by country income group](image)

### Table 1: Median number of health professionals per 100,000 population in Atlas 2001, Atlas 2005, and Atlas 2011, by country income group

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrists</th>
<th>Nurses*</th>
<th>Psychologists</th>
<th>Social workers</th>
<th>Occupational therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income</td>
<td>0.06</td>
<td>0.05</td>
<td>0.05</td>
<td>0.16</td>
<td>0.16</td>
</tr>
<tr>
<td>Lower middle</td>
<td>0.90</td>
<td>0.05</td>
<td>0.54</td>
<td>1.00</td>
<td>1.05</td>
</tr>
<tr>
<td>Upper middle</td>
<td>2.40</td>
<td>2.70</td>
<td>2.03</td>
<td>5.70</td>
<td>5.35</td>
</tr>
<tr>
<td>High</td>
<td>9.00</td>
<td>10.50</td>
<td>8.59</td>
<td>33.50</td>
<td>32.95</td>
</tr>
<tr>
<td>World</td>
<td>1.00</td>
<td>1.20</td>
<td>1.27</td>
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</tr>
<tr>
<td>Number</td>
<td>182</td>
<td>183</td>
<td>178</td>
<td>164</td>
<td>172</td>
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</tbody>
</table>

Data are from references 3, 9, and 10. *Defined as psychiatric nurses in Atlas 2005 and as nurses in a mental health setting (broader) in Atlas 2011.

### Table 2: Estimated supply and shortage of mental health workers per 100,000 population and total scale-up costs (wage bill) to eliminate shortage of mental health workers in 58 countries of low and middle income in 2005, by country income group

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrists</th>
<th>Nurses</th>
<th>Psychosocial health providers</th>
<th>Total full-time employed staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Supply</td>
<td>Shortage</td>
<td>Wage bill (x1000 US$)</td>
<td>Supply</td>
</tr>
<tr>
<td>Low income</td>
<td>0.26</td>
<td>1.04</td>
<td>48,588</td>
<td>0.15</td>
</tr>
<tr>
<td>Middle income</td>
<td>2.15</td>
<td>0.46</td>
<td>31,845</td>
<td>5.70</td>
</tr>
<tr>
<td>Both low and</td>
<td>1.18</td>
<td>0.76</td>
<td>80,433</td>
<td>5.42</td>
</tr>
<tr>
<td>middle income</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Data are population-weighted averages from reference 11.
Panel 1: Case example from Sri Lanka

Out-migration of psychiatrists from Sri Lanka is greater than for most other countries of low and middle income. In 2007, 25 psychiatrists were working in Sri Lanka for a population of 20 million, whereas 142 Sri Lankan-trained psychiatrists were working in the UK, the USA, Australia, and New Zealand.18 The shortage of psychiatrists was the main impetus for creation of a new category of specialist mental health worker—namely, medical officers of mental health—and establishment of a 1-year diploma in psychiatry for doctors working in mental health settings. Medical officers of mental health receive 3 months’ specialist training in psychiatry and provide psychiatric outpatient and community outreach mental health services from primary care health clinics, enabling very good geographic coverage for basic mental health services. In areas where no psychiatrist is working, graduates of the diploma in psychiatry programme are able to support less well-trained workers in mental and general health and take responsibility for heading newly created acute psychiatric inpatient units in district general hospitals.

The devastation and widespread occurrence of mental disorders in communities affected by the 2004 Indian Ocean tsunami motivated creation of a new category of community mental health worker—namely, the community support officer. These workers were established initially as community volunteers receiving small monetary incentives to provide social support and psychological first aid and to identify people in need of additional mental health services, under the supervision of mental health professionals. They have contributed to detection and referral of affected individuals, and they provide support in the community, such as facilitation of treatment adherence.

Findings of a study in three districts in the southern province of Sri Lanka (Minas H; unpublished) showed that community support officers had referred more than half of all inpatients, and this proportion rose to 75% in areas where no psychiatric services had previously existed. During the month of the study, 128 community support officers (in addition to other duties) were case-managing more than 1500 people with mental disorders in the community. More than 80% of patients remained involved with the service and adhered to treatment. Referral sources included family members (40%), friends (21%), and the affected individual (15%). Community support officers were well connected with and managed by the primary health care system, had regular meetings with staff from this system, and were technically accountable to the medical officer of mental health. All districts had developed a highly organised system of coordination at the primary health care level.

People who use mental health services can provide similar support to others, share personal experiences, and participate in self-help and mutual aid initiatives.59–61 Although some organisations for mental health provide psychoeducation and skill-building sessions to affected individuals and their families for home-based care, self-help, and entrepreneurship (Kleintjes S, Groote Schuur Hospital, Cape Town, South Africa; personal communication), no rigorous evaluations have been done of their effect in countries of low and middle income. The role of affected individuals and caregivers needs to be better investigated, assessed, and, possibly, expanded.

Nadja van Ginneken Thesis Page 57

www.thelancet.com  Published online October 17, 2011  DOI:10.1016/S0140-6736(11)61093-3
Panel 2: Case example from India

India, with a population in excess of 1·1 billion, faces enormous challenges with respect to provision of mental health care. Integration of mental health into general health care, and training of general doctors in mental health, has been implemented since 1961, but community-based care was not introduced until 1982 in the national mental health programme.5 Primary care doctors were trained, a mental health primary care model was developed (based on the 1985–90 Bellary model),6 and a district mental health programme was launched in four districts in 1997. However, state government targets to train 20% of all doctors with a 2-week programme over 5 years have not been achieved. The district mental health programme is currently in operation in only 123 of 640 districts, and total coverage is anticipated to be achieved by 2017. Even then, there will be an insufficient number of psychiatrists to meet the requirements of the district mental health programme model.

The national mental health programme also lacks adequate guidance and leadership. No mental health policy existed before the programme, and the 1987 Mental Health Act (which established the central and state mental health authorities) has been largely non-functional. Experts have identified apathy, an absence of leadership, and issues of political power (at state and government level) as relevant barriers to development of mental health policy and legislation to support the expansion of human resources for mental health.

Governmental funding for mental health has risen substantially in the past decade. In the 10th national plan (2002–07), US$22 million (100 crores) was allocated to the national mental health programme, mainly to upgrade psychiatric hospitals and psychiatric facilities in general hospitals and medical colleges; funding rose tenfold in the 11th 5-year plan (2007–12). The current training infrastructure produces about 320 psychiatrists, 50 clinical psychologists, 25 psychiatric social workers, and 185 psychiatric nurses annually—too few for effective care in the country. The national mental health programme and private-sector focus has remained on specialist mental health services, and allocated budgets have been spent largely on boosting numbers of specialists, by supporting medical colleges, and by introducing additional seats in all the psychiatric specialties. Less progress has been made in developing non-specialist health workers. Bureaucrats and experts suggest specialists have augmented managerial and supervisory responsibilities towards a greatly expanded non-specialist workforce, but they warn that psychiatrists (in government and the private sector) are resistant to taking on managerial roles (van Ginneken, unpublished). Current service provision by non-specialists is—according to these experts—of poor quality, and they suggest improving the training with less didactic initial training and regular ongoing formal and informal training. They also suggest assessing the feasibility and effect of care provided by non-specialists. Four key challenges exist for the government.

- Delays in efforts to increase significantly the numbers of specialist and non-specialist mental health-care providers.
- Little partnership with other government organisations to improve access to health care (eg, national rural health mission).
- Absence of mental health policy. Both national and district mental health programmes, for all their shortcomings, have been driven by the Government of India, with comparatively little interest by state governments. Responses to Supreme Court directives have, unfortunately, adopted outdated models of mental hospitals.
- Insufficient capacity to use available funds effectively. Barriers include excessive bureaucracy and scant interest by programme planners and the public health system.

Collaboration between government and non-governmental organisations and private practitioners could help to achieve greater and more diverse human resources for mental health. The Karuna Trust in Karnataka, Ashagram in Guwahati, and The Banyan in Chennai have shown the feasibility of delivering community-based mental health care outside the public primary care setting, using lay health workers and families.

For more on The Banyan see http://www.thebanyan.org

Education of mental health service providers

Ongoing development of a workforce with appropriate skills is essential to strengthen human resources for mental health. Training should be relevant to the mental health needs of the population and include in-service training (ie, continuing education) and strengthening of institutional capacity to implement training programmes effectively. However, training programmes for psychiatrists are present in only 55% of low-income countries, 69% of countries of lower middle income, and 60% of those of upper middle income.3 Approaches to psychiatric education also vary across countries.3–5 In Nigeria, a specialist training programme in psychiatry has been in place for more than 25 years, yet only half of the country’s tertiary mental health facilities have enough psychiatrists to provide accredited training.5

Training of non-specialist health workers also needs scaling up. We noted in our review of published work that overall short-term training by specialist mental health professionals with ongoing monitoring and supervision can improve confidence, detection, treatment, and treatment adherence of individuals with mental disorders and reduce caregiver burden. Our findings were less convincing for detection of neurological conditions.5,6 The sustainability of knowledge and skills gained remains uncertain, and further examination of effective supervision and mentorship is needed.
Scale-up costs to remove shortages in human resources for mental health

The annual wage bill to eliminate shortages in human resources for mental health in countries of low and middle income will be considerable. Not including costs for training or improvement of facilities needed, the estimated bill was about US$814 million in 2005 ($894 million in 2009): $80 million for psychiatrists, $420 million for nurses in mental health settings, and $314 million for psychosocial care providers (table 2). The highest cost estimates were in Nigeria for all workforce categories: $14-8 million for psychiatrists, $49-6 million for nurses, and $53-7 million for psychosocial health providers, a total of $118-2 million.

Mobility of financial resources to develop human resources for mental health is one of the biggest challenges for development of effective mental health systems. All countries of low and middle income have inadequate funding for mental health. Cost-effectiveness studies for scaling-up of non-specialist health workers are scarce, and further studies are necessary to inform planning of human resources for mental health.

Strategic changes in payment systems are as important as financing in bringing about system change. For example, increasing the role of psychiatrists as supervisor and trainer and boosting the number of other mental health workers will need payment arrangements that recognise these changed roles. These alterations will also be important for shifting of practice from institutions to community services.

Recruitment

Negative attitudes of health professionals is an important challenge to overcome, and even when training programmes are available, very few students are choosing a career in psychiatry. In Kenya, medical students were surveyed on their attitudes towards psychiatry. Although almost 75% of respondents had overall favourable attitudes, only 14% would consider psychiatry as a career choice. In Brazil, primary health care providers detect mental disorders of their clientele but believe that diagnosis and treatment should remain the responsibility of mental health specialists. Misconceptions about mental disorders, fear, perceived low status of mental health professionals, and inadequate training contribute to the reluctance of many health workers to provide mental health care in Ghana, South Africa, Uganda, and Zambia. Educational interventions for primary care professionals improve attitudes towards mental illness, and similar strategies for medical students to increase recruitment need further investigation.

Management of attrition

Emigration of mental health professionals from countries of low and middle income, and rural-to-urban migration, seriously constrain development of human resources for mental health. Professional isolation and better training and career opportunities are key reasons for emigration. The UK, the USA, New Zealand, and Australia employ almost 9000 psychiatrists from India, the Philippines, Pakistan, Bangladesh, Nigeria, Egypt, and Sri Lanka. Without this migration, many source countries would have more than double (in some cases five to eight times) the number of psychiatrists per 100 000 population.

Establishment of local training programmes is especially important to reduce the likelihood of out-migration. International collaborations have been an important strategy in scaling-up of human resources for mental health. By providing training in Ethiopia, the number of psychiatrists rose from 11 to 34 between 2003 and 2009. The success of the initiative has led to its expansion to cover 14 different health programmes (Toronto Addis Ababa Academic Collaboration).

Retention and equitable distribution of human resources for mental health remain a challenge. Innovative financial incentive strategies, institutional capacity building that promotes career development, opportunities to receive and provide mentorship, and favourable workplace conditions are areas that need to be strengthened to minimise attrition.

Leadership

Effective leadership is judged necessary for scaling-up of the mental health workforce, but little evidence exists that addresses this issue adequately. The case example from India highlights the result of poor leadership when funding for mental health was increased substantially (panel 2). The University of Melbourne has been running an international mental health leadership programme since 2001. This 4-week course provides training in mental health policy and systems, mental health workforce, and mental health and human rights for researchers, psychiatrists, mental health professionals, and decision makers. Shorter 2-week leadership courses have been developed subsequently in Indonesia, India, and Nigeria. Anecdotal evidence suggests that the courses and ongoing support for alumni have a positive effect in their home countries (panel 3).

Concluding remarks

Human resources for mental health continue to be grossly inadequate in most countries of low and middle income. The shortage is likely to worsen unless substantial investments are made to train a wider range of mental health workers in much higher numbers. Task shifting seems to be an effective and feasible approach but it too will entail substantial investment, innovative thinking, and effective leadership.

Here, we have shown examples of innovative and effective strategies to expand mental health services to primary care settings and into the community. The variability in roles of different mental health workers across settings highlights the importance of focusing on a
likely to facilitate scaling-up of mental health care in low- 
tunities will be vital to minimise attrition.

A key component of the recommendations was to build a comprehensive mental health system. In subsequent months, a model of community-focused mental health services was agreed.

Psychiatric morbidity was already high in Aceh as a result of the long-running military conflict, but it rose after the tsunami. Among the major impediments to development of a mental health system was the scarcity of human resources for mental health. The 250-bed mental hospital in Banda Aceh was the only mental health service for a population of 4 million people. The hospital was staffed by psychiatrists and general nurses, with no nurses trained in mental health, psychologists, or other mental health specialists. Primary care doctors working in the well developed (though seriously damaged) primary health-care system had no training in psychiatry. Only patients with psychotic disorders were recognised as suffering from a mental disorder and were referred to the mental hospital for treatment. Psychiatric drugs were largely unavailable in primary health-care centres. Expansion of human resources for mental health was identified as a key strategy for building up a community-focused mental health system for the province. The strategy entailed development and delivery of short-course psychiatric training for primary care doctors (who were then designated as GP+), more extensive training for nurses who would then function as community mental health nurses, and recruitment, training, and support of village mental health volunteers.

In 2005, five psychiatrists were working in the mental hospital in Banda Aceh, and no other mental health professionals were present in the province. In 2009, nine psychiatrists, 27 psychologists, 628 community mental health nurses (of whom 94 were supervisors and trainers), and 5961 village mental health volunteers were working in 923 of Aceh’s villages (Minas H; unpublished).

The approach taken to strengthen human resources for mental health in Aceh has been consistent with WHO’s health-workforce framework developed in the World Health Report 2006. A provincial mental health policy is in place, and several districts have developed a district mental health policy. Data for the mental health workforce have improved steadily, although a good deal more work needs to be done to develop a workforce data system that would be adequate for planning, recruitment, deployment, and further skill development for workers. 13 of 23 districts have an identified budget for mental health, and all 23 districts employ community mental health nurses through the core district health budget and provide support for the extensive village volunteers programme. Education and training has been a major part of the strategy for development of the provincial mental health system. In partnership with Gadjah Mada University (Yogyakarta), the Syah Kuala University in Banda Aceh has established a clinical psychology training programme and is attracting many Acehnese students. Training and support for village mental health volunteers has seen rapid growth in the number of these essential community-level workers.

A key area of continuing deficiency is the scarcity of an Aceh-based training programme for psychiatrists, although several psychiatric residents are about to graduate in 2011 from training programmes in other parts of Indonesia. The provincial and district governments of Aceh, continuously supported by the Indonesian Ministry of Health, have shown exemplary leadership in their sustained commitment to development of the most comprehensive community-based mental health system in Indonesia. Many of the key people involved in building up the Acehnese mental health system have received training from the international mental health leadership programme based in Melbourne, Australia. The whole enterprise of building a community-based mental health system, and a community mental health workforce, has been a series of partnerships including: provincial and district governments of Aceh; the Indonesian Ministry of Health; Acehnese, other Indonesian, and international universities; UN agencies, including WHO, UNICEF, and the International Organization for Migration; and local and international non-governmental organisations.

Panel 3: Case example from Aceh, Indonesia

The province of Aceh, Indonesia, had been embroiled in decades of military conflict when, on Dec 26, 2004, it was struck by the Indian Ocean earthquake and tsunami. 11 coastal districts were devastated. The death toll was estimated at more than 160 000, with more than 500 000 people displaced. All forms of physical and social infrastructure, including the health system in the capital Banda Aceh and the affected districts, were thrown into chaos. International response was swift and a massive influx of assistance, money, and technical expertise took place.

Immediately after the tsunami, the Ministry of Health asked WHO for assistance in preparing a mental health response to the disaster. WHO’s recommendations were adopted in full by the Ministry of Health as the mental health plan for Aceh in 2005. A key component of the recommendations was to build a comprehensive mental health system. In subsequent months, a model of community-focused mental health services was agreed.

Involvement of a broad set of workforce categories is likely to facilitate scaling-up of mental health care in low-income and middle-income countries. The specific skill-mix rather than a staff-mix approach to increase human resources for mental health. Training programmes will need to be accompanied by effective supervision to maintain skills, and ongoing career development opportunities will be vital to minimise attrition.

Future directions

Global efforts to address widespread shortages in the health workforce have entailed development of a technical framework to assist governments and health managers to

For more on the international mental health leadership programme see http://www.cimb.unimelb.edu.au/pdp/imhlp
work on and implement a comprehensive strategy to achieve an effective and sustainable health workforce.\(^1\) The Human Resources for Health Action Framework,\(^2\) which consists of six interconnected components necessary in human resource development (policy, health workforce management, finance, education, partnerships, and leadership), could provide a useful approach to address shortages in human resources for mental health.

Skilled health management and support workers, who comprise up to a third of the health workforce, are vital for overseeing the implementation of strategic directions while policy makers manage resource allocation and monitor targets and outcomes. Managers and support workers are responsible for planning and implementation of human resources for health, management of the work environment and conditions, information systems for human resources for health, workforce performance, and staff retention. Greater investments in health management capacity will be an important component for increasing human resources for mental health.

Additional evidence is needed of the effectiveness and cost-effectiveness of task shifting for identification and management of mental disorders by non-specialist health workers. Information and data are also needed on training requirements and application of newly acquired knowledge and skills in everyday practice. Evidence of the effectiveness of involvement of affected individuals or caregivers in service delivery and a better understanding of push and pull factors for migration of mental health specialists are both needed for effective planning of human resources for mental health.

Stronger intersectoral collaborations than we have at present will also contribute to reduction of the shortage in human resources for mental health, and this area must be investigated further.\(^7\) With our literature search, we retrieved only one study that looked at the effect of training school teachers for raising mental health awareness among school children, parents, and neighbours.\(^8\) We did not identify with our search any studies assessing the role of community resources, such as traditional or alternative care providers. This issue needs careful investigation since, in many countries of low and middle income, alternative care is generally sought before care from a mental health specialist or primary care practitioner.

Despite emerging evidence on mental health systems in low-income and middle-income countries, development and evaluation of human resources for mental health are difficult and complex tasks that will continue to pose substantial challenges in the coming years. A systemic approach is needed, with interdisciplinary and multi-sectoral collaborations and strong partnerships between government ministries, researchers, non-governmental organisations, health professionals, affected individuals or caregivers, and communities, if important long-term gains are to be made. Adequate attention to these aspects is essential to achieve the objective of scaling-up of care for people with mental disorders.

**Contributors**

All authors contributed ideas for the report and helped to write the paper.

**Conflicts of interest**

We declare that we have no conflicts of interest.

**Acknowledgments**

Nirupama Yechoor assisted with analysis of data from Mental Health Atlas and prepared the figures used in this paper.

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Chapter 3

Research rationale and methodological approach
3.1 Rationale for this research

This proposal fills several gaps of knowledge:

- Little analysis or description of Indian models of primary-level health worker (PHW)-delivered mental healthcare exists (Cohen, 2003; Murthy, 2008) nor PHWs’ or specialists’ tasks and roles within these models.
- An historical understanding of primary mental healthcare development in India
- Policy makers’ and implementers’ opinions on the future of mental health services

A better understanding of current programmes models and human resources set within an historical context would provide policy makers with an analysis of what innovations and ideas have potential at scale for major changes to rural mental healthcare provision. This would therefore inform policy development on appropriate implementation and sustainability of scaling up community mental health services using PHWs in India. This research may also highlight opportunities for the convergence of the National Rural Health Mission (NRHM) and National Mental Health Programme (NMHP) in terms of policy and practice.

Given the issues with the public health system, this study sets out to explore not just the government primary healthcare (PHC) structure but also the alternatives that are available across India within the non-governmental organisation (NGO) sector in particular. This research focuses on PHW-delivered mental healthcare in both the government and non-governmental sector, and how these services may interact with other specialists or specialist services. We excluded private-for-profit organisations as the profit-making business model aims to maximise profits which may become more important than healthcare provision itself. The not-for-profit NGO sector on the other hand may also sell goods and services but the purpose of which is to provide income to cover their activities’ costs (Green and Matthias, 1996). As with the government sector, the NGO sector retains its main focus on healthcare provision. We also excluded the non-allopathic treatment sectors (healers, religious treatments, other
medical traditions) to remain focused on the care that can be offered by the Western medical tradition.

The description and analysis of PHWs will be contextualised within current health systems’ challenges. The above models of mental healthcare delivery at primary and community care level will also be analysed in terms of their level of integration with the general health system, i.e. to what extent these programmes are vertical/ separate specialist-led services or function within general health services. Also we will describe to what extend these models are similar or not to those in HIC (as described in section 1.2.4 above).

Within the mental health field in low- and middle- income countries (LMICs), notably also in India, several programmes and experts have requested existing models to be scaled-up. Part of this study’s purpose is thus also to discuss different models of PHW-delivered mental healthcare in light of their feasibility for scaling-up.

### 3.2 Aims and objectives

The research hypothesis is that PHWs can be effective in delivering mental healthcare. The aim of this research was to explore the history, effectiveness and feasibility of PHW-delivered mental healthcare in remote areas in India, to better inform the process of health system organisation and delivery of mental health services at primary care and community levels.

The proposed project examines global evidence for effectiveness of PHWs in mental healthcare, then focuses on India, as an example of a LMIC with government and non-governemental primary and community mental healthcare initiatives.

Objectives:

1. Review the effectiveness of PHWs in primary and community mental healthcare in LMICs (Cochrane review – chapters 2 and 3).

2. Explore the history and development of mental healthcare within primary care in India (oral history paper – chapter 5).
3. Describe and compare current Indian models of PHW-delivered mental healthcare and characteristics and roles assigned to their specialist and non-specialist workforce (Human resources and models – chapter 6)

4. Assess the effectiveness and feasibility of integrating mental healthcare within the primary and community health systems in India (discussion).

**Effectiveness** is defined as the ability of PHWs to produce a desired result in terms of patient- and service-related outcomes. This research also proposes to look at the efficacy (the effectiveness in clinical trial settings) through the systematic review (Fox-Rushby and Cairns, 2005).

**Feasibility** is defined as something that is possible and practical to achieve, within the limitations or resources that are currently or could be made available in that setting (New Oxford Dictionary of English, 2010). This study explores available resources, historical context, and acceptability (such as political will or cultural factors) in assessing the feasibility of PHW-delivered mental healthcare.

### 3.3 Study design and description of data collection methods

Details of each method (systematic review, oral history and qualitative methods) are presented in the three main papers. In this section, we outline the rationale for a mixed methods approach and the method for drawing together the information from these three perspectives to reach the conclusions presented in the discussion.

To address the research objectives, quantitative, historical and qualitative methods drew on several data sources (figure 3.1). Mixed-methods research is recommended for exploring complex interventions (Campbell et al., 2000; Campbell et al., 2007). Mental health interventions are often complex as they require multiple independent and interdependent components and multidisciplinary staff to address clinical care and social support.
Figure 3.1: Framework of methods and research questions

1. QUANTITATIVE COCHRAN SYSTEMATIC REVIEW (38 studies, chapter 4)
   - What is the effectiveness of PHWs in mental healthcare provision in LMICs?

2. ORAL HISTORIES OF FORMER AND CURRENT MENTAL HEALTH PLANNERS AND IMPLEMENTERS IN INDIA (1947-NOW) (17 interviews, chapter 5)
   - What are the origins of the District Mental Health Programme (DMHP) and how has it evolved?
   - What are the reasons for the current DMHP failures and achievements?
   - How have PHWs roles evolved?

3. QUALITATIVE CASE STUDIES IN INDIA (chapter 6)
   - In-depth case studies of DMHP PHC-based mental health services in Karnataka (South India) (2 case studies: interviews, observation, documentary analysis)
     - What mental health roles do PHWs have in PHCs?
     - What roles do specialists and coordinators play in the context of community mental health services?
     - What is the sustainability of this model and its human resources?
   - Shorter case studies in governmental and NGO programmes across India (70 case studies: interviews, site visits, documentary analysis)
     - What are the models of delivery of mental health services using PHWs in India?
     - What types of PHWs, specialists and coordinators are used and what are their roles?
     - What is the scalability and feasibility of these models and human resources within the DMHP?

GOALS (chapter 7)
- Answer main research questions: What are the feasible and effective models of mental healthcare provision involving PHWs in India?
- PHW roles within these models
- Provide recommendations to inform policy and existing community/primary care initiatives.
Table 3.1 is a synthesis of how each method addresses the objectives. The systematic review aimed to cover a global quantitative summary of effectiveness of PHWs in an attempt to see what was generalisable beyond context, though quantitative aggregated data lacked applicability to specific contexts. Thus, the qualitative case studies broadened our understanding of the realities of the existing community mental healthcare delivery by PHWs. They also questioned the ‘why’ of certain organisational or infrastructural realities, and of PHWs’ and specialists’ roles. This study contextualised and drew out issues that impact upon efficacy. The data analysis drew out the tensions and challenges between the local and global findings of PHWs’ roles in mental healthcare.

The historical work enhanced the analysis of current programmes through providing a better understanding of the historical context. The use of multiple methods also offered rigorous identification of all relevant data. The history interviews also highlighted important projects worth including in the qualitative analysis.

### Table 3.1: How the methodology addresses the objectives

<table>
<thead>
<tr>
<th>Objectives (objective number)</th>
<th>Systematic review</th>
<th>Historical analysis</th>
<th>Case studies</th>
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<td>Effectiveness of PHW interventions (1)</td>
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<td>Feasibility of PHW interventions (1)</td>
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<td>2*</td>
<td>1*</td>
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<td>Current PHW roles and models (3)</td>
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<td>1*</td>
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<tr>
<td>Policy implications (4)</td>
<td>2*</td>
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</tbody>
</table>

1*: primary source; 2*: secondary source
As outlined in figure 3.1., the qualitative data aimed to describe models of mental healthcare delivery and health workers roles with two separate methods to allow for both breadth (shorter case studies – i.e. semi-structured interviews and site visits) but also depth of understanding (in depth longer case studies which included observation of health workers and other staff). All case study data were collected, coded and analysed side-by-side. Comparing and cross-checking these data to constantly test emerging hypotheses increased the credibility and validity of emerging patterns or conflicts between programmes (Bernard, 2006).

The process of triangulating primary material in India (oral histories and case studies which both involved triangulating interviews, and documentary analysis, and in addition observations for case studies) and quantitative data from trials in LMICs provided more data reliability because it allowed the researcher to check whether similar interpretations were achieved through different angles and perspectives of data collection. Multiple methods also provided greater opportunities for information saturation, and thus richness in identifying the potential barriers and solutions to scaling-up PHWs in mental healthcare. Triangulating this data also helped draw out the feasibility and acceptability of potential models of PHW-delivered mental healthcare at country level (India). The discussion therefore drew together these materials to discuss what factors within PHW models of mental healthcare delivery may or may not be generalisable to be implemented at local, national or international levels. We looked for conceptual generalisability (such as issues of acceptability, what seems to influence better delivery of care etc) rather than generalisability of context or fact (such as exact number of health workers, specifics of training programmes etc) as the latter would require multiple in-depth quantitative evaluations and pilot studies for scalability (Green and Thorogood, 2004). Conceptual generalisability was an essential preliminary step to deciding which concepts or elements of models are important before the specifics of models are framed for testing at scale. Within this endeavour we also assessed the transferability of findings, to draw out which elements were context-specific and which may be more widely applicable.
This research got ethical approval from the London School of Hygiene, Sangath and the Indian Medical Research Council (appendix 2). Appendices 3 and 4 provide the consent forms, information sheets and data collection tools for chapters 5 and 6. Appendix 5 provides the permissions from copyright holders to use manuscripts and images in the thesis.
3.4 References


Chapter 4

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries

(research paper 2)
RESEARCH PAPER COVER SHEET

PLEASE NOTE THAT A COVER SHEET MUST BE COMPLETED FOR EACH RESEARCH PAPER INCLUDED IN A THESIS.

SECTION A – Student Details

<table>
<thead>
<tr>
<th>Student</th>
<th>Nadja van Ginneken</th>
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<td>Vikram Patel</td>
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<tr>
<td>Thesis Title</td>
<td>The roles of primary-level health workers in delivering mental healthcare in India</td>
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If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

<table>
<thead>
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<table>
<thead>
<tr>
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</tr>
<tr>
<td>Stage of publication</td>
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SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

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<thead>
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<tr>
<td>I conceived the review, led the protocol development, was the main contributor to extracting data and assessed risk of bias (and checked all), performed the statistical analysis and GRADE assessments and wrote the final version. The other authors contributions are listed in the Cochrane review.</td>
<td></td>
</tr>
</tbody>
</table>
Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)


This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in The Cochrane Library 2013, Issue 11

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TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEADER</td>
<td>1</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>1</td>
</tr>
<tr>
<td>PLAIN LANGUAGE SUMMARY</td>
<td>2</td>
</tr>
<tr>
<td>SUMMARY OF FINDINGS FOR THE MAIN COMPARISON</td>
<td>4</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>6</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>7</td>
</tr>
<tr>
<td>METHODS</td>
<td>7</td>
</tr>
<tr>
<td>RESULTS</td>
<td>12</td>
</tr>
<tr>
<td>Figure 1</td>
<td>13</td>
</tr>
<tr>
<td>Figure 2</td>
<td>15</td>
</tr>
<tr>
<td>Figure 3</td>
<td>16</td>
</tr>
<tr>
<td>Figure 4</td>
<td>19</td>
</tr>
<tr>
<td>Figure 5</td>
<td>20</td>
</tr>
<tr>
<td>Figure 6</td>
<td>22</td>
</tr>
<tr>
<td>Figure 7</td>
<td>23</td>
</tr>
<tr>
<td>Figure 8</td>
<td>25</td>
</tr>
<tr>
<td>Figure 9</td>
<td>27</td>
</tr>
<tr>
<td>Figure 10</td>
<td>28</td>
</tr>
<tr>
<td>Figure 11</td>
<td>29</td>
</tr>
<tr>
<td>Figure 12</td>
<td>29</td>
</tr>
<tr>
<td>Figure 13</td>
<td>30</td>
</tr>
<tr>
<td>Figure 14</td>
<td>32</td>
</tr>
<tr>
<td>ADDITIONAL SUMMARY OF FINDINGS</td>
<td>33</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>46</td>
</tr>
<tr>
<td>AUTHORS’ CONCLUSIONS</td>
<td>48</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>49</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>49</td>
</tr>
<tr>
<td>CHARACTERISTICS OF STUDIES</td>
<td>71</td>
</tr>
<tr>
<td><strong>Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)</strong></td>
<td></td>
</tr>
<tr>
<td>REFERENCES <em>refs to excluded studies and awaiting assessment not included in this thesis</em></td>
<td>232</td>
</tr>
<tr>
<td>REFERENCES <em>not included in this thesis</em></td>
<td>232</td>
</tr>
<tr>
<td>DATA AND ANALYSES</td>
<td>232</td>
</tr>
<tr>
<td>Analysis 1.1. Comparison 1 NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), Outcome 1 Prevalence of depression (completers)</td>
<td>242</td>
</tr>
<tr>
<td>Analysis 1.2. Comparison 1 NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), Outcome 2 Prevalence of depression (ITT sensitivity analysis - assumption non-completers depressed)</td>
<td>243</td>
</tr>
<tr>
<td>Analysis 1.3. Comparison 1 NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), Outcome 3 Prevalence of depression (ITT sensitivity analysis - assumption non-completers not depressed)</td>
<td>244</td>
</tr>
<tr>
<td>Analysis 1.4. Comparison 1 NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), Outcome 4 Prevalence of depression (ITT sensitivity analysis - worse-case scenario intervention group depressed; control group not depressed)</td>
<td>245</td>
</tr>
<tr>
<td>Analysis 1.5. Comparison 1 NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), Outcome 5 Prevalence of depression (ITT sensitivity analysis - best-case scenario: intervention group not depressed; control group all depressed)</td>
<td>246</td>
</tr>
<tr>
<td>Analysis 1.6. Comparison 1 NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), Outcome 6 Severity of common mental disorder symptoms (includes anxiety and depression)</td>
<td>247</td>
</tr>
<tr>
<td>Analysis 1.7. Comparison 1 NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), Outcome 7 Functional impairment/disability in common mental disorders</td>
<td>248</td>
</tr>
<tr>
<td>Analysis 2.1. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 1 Prevalence of common mental disorders (CMDs - includes anxiety and depression) (completers-combined) all facilities and in public and private facilities</td>
<td>250</td>
</tr>
</tbody>
</table>

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)
Copyright © 2013 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
Analysis 2.2. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 2 Severity of symptoms of CMDs (completers-combined) in all facilities and in public and private facilities. ................................................ 252
Analysis 2.3. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 3 Functional impairment/disability in CMD (completers-combined) all facilities and in public and private facilities (SMD). ................................................ 254
Analysis 2.4. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 4 Suicide attempt for those with CMDs all facilities and in public/private facilities (completers). ................................................ 256
Analysis 2.5. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 5 Prevalence of CMDs (only Patel - sensitivity analysis (SA)) (completers) all facilities and in public and private facilities. ................................................ 258
Analysis 2.6. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 6 Severity of symptoms in CMD (only Patel and Jenkins (SA)) in all facilities and in public and private facilities. ................................................ 259
Analysis 2.7. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 7 Prevalence of depression (completers) (SA) all facilities and in public and private facilities. ................................................ 261
Analysis 2.8. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 8 Severity of symptoms of depression (SA) in all facilities and in public and private facilities. ................................................ 263
Analysis 2.9. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 9 Functional impairment/disability in CMD (SA) all facilities and in public and private facilities (SMD). ................................................ 265
Analysis 2.10. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 10 Functional impairment/disability in CMD (SA) all facilities and in public and private facilities (MD). ................................................ 267
Analysis 2.11. Comparison 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), Outcome 11 Functional impairment/disability in depression (SA) all facilities and in public and private facilities. ................................................ 269
Analysis 3.1. Comparison 3 NSHWs versus usual care in treating maternal depression (RCTs), Outcome 1 Severity of symptoms in treating maternal depression. ................................................ 271
Analysis 4.1. Comparison 4 NSHWs versus specialists in treating depression in adults (controlled before-and-after studies), Outcome 1 Severity of depression short term (2 months post intervention). ................................................ 272
Analysis 4.2. Comparison 4 NSHWs versus specialists in treating depression in adults (controlled before-and-after studies), Outcome 2 Frequency of adverse events. ................................................ 272
Analysis 4.3. Comparison 4 NSHWs versus specialists in treating depression in adults (controlled before-and-after studies), Outcome 3 Number of days spent in hospital. ................................................ 273
Analysis 4.4. Comparison 4 NSHWs versus specialists in treating depression in adults (controlled before-and-after studies), Outcome 4 Number of days spent on sick leave. ................................................ 274
Analysis 5.2. Comparison 5 NSHW-led psychological interventions versus usual care in treating adults with post-traumatic stress disorder (RCT and NRCT), Outcome 2 Severity of PTSD symptoms. ................................................ 276
Analysis 5.3. Comparison 5 NSHW-led psychological interventions versus usual care in treating adults with post-traumatic stress disorder (RCT and NRCT), Outcome 3 Severity of depression. ................................................ 277
Analysis 6.1. Comparison 6 NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), Outcome 1 Severity of behavioural problem (patient). ................................................ 278
Analysis 6.2. Comparison 6 NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), Outcome 2 Patient functional ability. ................................................ 278
Analysis 6.3. Comparison 6 NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), Outcome 3 Patient quality of life. ................................................ 279
Analysis 6.4. Comparison 6 NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), Outcome 4 Carer mental health status. 280
Analysis 6.5. Comparison 6 NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), Outcome 5 Carer burden. 280
Analysis 6.6. Comparison 6 NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), Outcome 6 Carer distress. 281
Analysis 6.7. Comparison 6 NSHWs versus usual care in improving dementia patients’ and carers’ outcomes (RCTs), Outcome 7 Carer quality of life. 282
Analysis 7.1. Comparison 7 NSHW-led brief alcohol interventions versus usual care for adults with alcohol-use disorders (RCTs), Outcome 1 Amount of alcohol consumed (MD). 282
Analysis 7.2. Comparison 7 NSHW-led brief alcohol interventions versus usual care for adults with alcohol-use disorders (RCTs), Outcome 2 Frequency of binge drinking. 283
Analysis 7.3. Comparison 7 NSHW-led brief alcohol interventions versus usual care for adults with alcohol-use disorders (RCTs), Outcome 3 Adverse consequences. 284
Analysis 8.1. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 1 Severity of PTSD symptoms - teacher/LHW-led interventions (SMDs). 285
Analysis 8.2. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 2 Severity of PTSD symptoms - classroom-based LHW interventions (MCDs). 286
Analysis 8.3. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 3 Severity of PTSD symptoms - classroom-based LHW interventions - boys/girls. 287
Analysis 8.4. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 4 Severity of depressive symptoms - teacher/LHW-led interventions (SMDs). 288
Analysis 8.5. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 5 Severity of depressive symptoms - classroom-based LHW interventions (MCDs). 289
Analysis 8.6. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 6 Severity of depressive symptoms (MCDs) Tol 2012 boys/girls. 290
Analysis 8.7. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 7 Severity of anxiety symptoms - classroom-based intervention (within 6 months post intervention). 291
Analysis 8.8. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 8 Severity of anxiety symptoms - classroom-based intervention - boys/girls. 292
Analysis 8.9. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 9 Functional impairment teacher/LHW-led interventions. 293
Analysis 8.10. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 10 Functional impairment LHW-led - classroom-based intervention. 294
Analysis 8.11. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 11 Functional impairment - classroom-based LHW intervention - boys/girls. 295
Additional tables 295
Appendices 327
What’s new 365
Contributions of authors 365
Declarations of interest 366
Sources of support 366
Differences between protocol and review 366

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)
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Nadja van Ginneken Thesis Page 79
Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries

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ABSTRACT

Background

Many people with mental, neurological and substance-use disorders (MNS) do not receive health care. Non-specialist health workers (NSHWs) and other professionals with health roles (OPHRs) are a key strategy for closing the treatment gap.

Objectives

To assess the effect of NSHWs and OPHRs delivering MNS interventions in primary and community health care in low- and middle-income countries.

Search methods

We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (including the Cochrane Effective Practice and Organisation of Care (EPOC) Group Specialised Register) (searched 21 June 2012); MEDLINE, OvidSP; MEDLINE In Process & Other Non-Indexed Citations, OvidSP; EMBASE, OvidSP (searched 15 June 2012); CINAHL, EBSCOhost; PsycINFO, OvidSP (searched 18 and 19 June 2012); World Health Organization (WHO) Global Health Library (searched 29 June 2012); LILACS; the International Clinical Trials Registry Platform (WHO); OpenGrey; the metaRegister of Controlled Trials (searched 8 and 9 August 2012); Science Citation Index and Social Sciences Citation Index (ISI Web of Knowledge) (searched 2 October 2012) and reference lists, without language or date restrictions. We contacted authors for additional studies.

Selection criteria

Randomised and non-randomised controlled trials, controlled before-and-after studies and interrupted-time-series studies of NSHWs/OPHR-delivered interventions in primary/community health care in low- and middle-income countries, and intended to improve...
outcomes in people with MNS disorders and in their carers. We defined an NSHW as any professional health worker (e.g. doctors, nurses and social workers) or lay health worker without specialised training in MNS disorders. OPHRs included people outside the health sector (only teachers in this review).

Data collection and analysis

Review authors double screened, double data-extracted and assessed risk of bias using standard formats. We grouped studies with similar interventions together. Where feasible, we combined data to obtain an overall estimate of effect.

Main results

The 38 included studies were from seven low- and 15 middle-income countries. Twenty-two studies used lay health workers, and most addressed depression or post-traumatic stress disorder (PTSD). The review shows that the use of NSHWs, compared with usual healthcare services: 1. may increase the number of adults who recover from depression or anxiety, or both, two to six months after treatment (prevalence of depression: risk ratio (RR) 0.30, 95% confidence interval (CI) 0.14 to 0.64; low-quality evidence); 2. may slightly reduce symptoms for mothers with perinatal depression (severity of depressive symptoms: standardised mean difference (SMD) -0.42, 95% CI -0.58 to -0.26; low-quality evidence); 3. may slightly reduce the symptoms of adults with PTSD (severity of PTSD symptoms: SMD -0.36, 95% CI -0.67 to -0.05; low-quality evidence); 4. probably slightly improves the symptoms of people with dementia (severity of behavioural symptoms: SMD -0.26, 95% CI -0.60 to 0.08; moderate-quality evidence); 5. probably improves/slightly improves the mental well-being, burden and distress of carers of people with dementia (carer burden: SMD -0.50, 95% CI -0.84 to -0.15; moderate-quality evidence); 6. may decrease the amount of alcohol consumed by people with alcohol-use disorders (drinks/drinking day in last 7 to 30 days: mean difference -1.68, 95% CI -2.79 to -0.57; low-quality evidence).

It is uncertain whether lay health workers or teachers reduce PTSD symptoms among children. There were insufficient data to draw conclusions about the cost-effectiveness of using NSHWs or teachers, or about their impact on people with other MNS conditions. In addition, very few studies measured adverse effects of NSHW-led care - such effects could impact on the appropriateness and quality of care.

Authors’ conclusions

Overall, NSHWs and teachers have some promising benefits in improving people’s outcomes for general and perinatal depression, PTSD and alcohol-use disorders, and patient- and carer-outcomes for dementia. However, this evidence is mostly low or very low quality, and for some issues no evidence is available. Therefore, we cannot make conclusions about which specific NSHW-led interventions are more effective.

PLAIN LANGUAGE SUMMARY

The effect of non-specialist health workers on people with mental, neurological and substance-abuse disorders in developing countries

Background

In developing countries, most people with mental, neurological and substance-abuse (MNS) disorders do not receive adequate care mainly because of a lack of mental health professionals. Non-specialist health workers, but also other professionals with health roles, such as teachers, may therefore have an important role to play in delivering MNS health care.

Researchers in The Cochrane Collaboration carried out a review of the effects of using non-specialist health workers or other professionals with health roles to help people with MNS disorders in developing countries. After searching for all relevant studies in scientific databases, they found 38 studies published before October 2012. Their findings are summarised below.

What is a non-specialist health worker?

Any type of health worker (like a doctor, nurse or lay health worker) who is not a specialist in mental health or neurology but who may have had some training in these fields. We also looked at teachers, as they can be particularly important in the care of children and youths.

What the research says

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)
The studies in this review were from 22 developing countries. In most studies, lay health workers delivered the mental health care, and addressed depression or anxiety (or both), or post-traumatic stress disorder. The review shows that the use of non-specialist health workers, compared with usual healthcare services:

- may increase the number of **adults who recover from depression or anxiety (or both)** two to six months after treatment;
- may slightly reduce symptoms for **mothers with depression**;
- may slightly reduce the symptoms of **adults with post-traumatic stress disorder** (non-specialists and teachers were used in one study);
- probably slightly improves the symptoms of **people with dementia**;
- probably improves/slightly improves the mental well-being, burden and distress of **carers of people with dementia**;
- may decrease the quantity of alcohol consumed by **problem drinkers**.

It is uncertain whether lay health workers or teachers reduce **post-traumatic stress disorder symptoms among children**. There were too few studies to draw any conclusions about the cost-effectiveness of using non-specialist health workers or teachers, or about their impact on people with other MNS conditions such as epilepsy, schizophrenia, and alcohol and drug abuse problems. In addition, very few studies measured unintended consequences of non-specialist health worker-led care - such effects could impact on the appropriateness and quality of care.

**Quality of the evidence**

Overall, non-specialist health workers and teachers have some promising benefits in improving people’s outcomes for general and perinatal depression, post-traumatic stress disorder and alcohol-use disorders, and patient and carer outcomes for dementia. However, this evidence is of low or very low quality in some areas, and for some issues no evidence is available. Therefore, we cannot make conclusions about which specific interventions using non-specialist health workers to help people with MNS disorders are more effective.
**SUMMARY OF FINDINGS FOR THE MAIN COMPARISON**

What are the effects of NSHW-led psychological interventions for treating depression in adults in low- and middle-income countries?

**Patient or population:** Adults with depression  
**Settings:** Low- and middle-income countries (Taiwan, Pakistan, Uganda)  
**Intervention:** NSHWs conducting psychological interventions  
**Comparison:** Usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Effect estimate (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assumed risk</td>
<td>Corresponding risk</td>
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<tr>
<td>Usual care</td>
<td>300 per 1000</td>
<td>91 per 1000</td>
<td>RR 0.30 (0.14 to 0.64)</td>
<td>1082 (3 studies)</td>
<td>⊕⊕⃝⃝ low2,3</td>
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<tr>
<td>NSHWs</td>
<td>Prevalence of depression (adults), short term (0-8 weeks) measured using various depression rating scales1</td>
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*The basis for the assumed risk is the mean control group risk across studies for pooled results and the control group risk for single studies. The corresponding risk (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).  
CI: confidence interval; DSM: Diagnostic and Statistical Manual of Mental Disorders; NSHW: non-specialist health worker; RCT: randomised controlled trial; RR: risk ratio.

**GRADE Working Group grades of evidence**  
**High quality:** Further research is very unlikely to change our confidence in the estimate of effect.  
**Moderate quality:** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.  
**Low quality:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.  
**Very low quality:** We are very uncertain about the estimate.

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1 Bolton 2003 C-RCT Uganda: DSM-IV criteria A, C and E; Rahman 2008 CRCT Pakistan: Hamilton Depression Rating scale; Chen 2000 RCT Taiwan: Taiwanese Beck Depression Inventory.  
2 Serious study limitations: Two of the three studies were at risk of bias. Bolton 2003 C-RCT Uganda was judged unclear for allocation concealment, and quasi-randomisation of individuals within clusters (though randomisation was in clusters) could have introduced bias; Chen 2000 RCT Taiwan was unclear for sequence generation and allocation concealment, all outcomes were self reported, there was
possible contamination and the dropout rate after randomisation was high, with no analysis of differences in dropouts versus non-dropouts. These two studies contributed 62% of the weight in the pooled analysis. Downgraded by 1.

Serious inconsistency: $I^2$ was 81%. However, the inconsistency related to the magnitude of benefit favouring collaborative care rather than in the direction of effect. Downgraded by 1.
BACKGROUND

Description of the condition

The global burden of mental, neurological and substance-abuse (MNS) illnesses is high. The latest global burden of disease estimates have shown that mental, behavioural and neuropsychiatric disorders all feature in the top 30 causes of all years lived with disability, the highest contributors being major depression (ranked second), anxiety (ranked seventh) and substance-use disorders (ranked twelfth) (Vos 2012). The contribution of major depressive disorders to worldwide disability-adjusted life years (DALYs) has increased by 37% from 1990 to 2010 and is predicted to rise further (Murray 2012; Prince 2007). Furthermore, self-inflicted injuries and alcohol-related disorders are likely to increase in the ranking of disease burden due to the decline in communicable diseases and because of a predicted increase in war and violence. The disease burden due to Alzheimer’s disease is also increasing, linked to the demographic transition towards an ageing population (Vos 2012).

These illnesses also come with substantial economic costs. One recent report on the global economic burden of non-communicable diseases (NCDs) suggests that by the early 2030s, mental health conditions alone will account for the loss of an additional USD16.1 trillion with dramatic impact on productivity and quality of life (Bloom 2011). Data remain poor on the macro-economic costs for low- and middle-income country (LMIC) settings (Hu 2006). However, the economic and social costs for individuals and families are substantial. High direct costs are incurred in countries where health spending is met largely through private, as opposed to public, spending and where health insurance and employer-met health payments are insubstantial (Patel 2007a). High indirect costs are also incurred due to informal care-giving and lost work opportunities, as well as due to untreated disorders and their associated disability (Chisholm 2000a; WHO 2003a).

The gap between those who could benefit from MNS health interventions and those who receive such care is very large (WHO 2008; WHO 2010); in LMICs up to 90% of people needing care do not receive it (Demyttenaere 2004; Saxena 2007). This is despite the existence of a range of cost-effective interventions in mental health care (Patel 2007b; WHO 2010). Major barriers to closing the treatment gap are the huge scarcity of skilled human resources, large inequities in resource distribution and utilisation, and the significant stigma associated with psychiatric illness (Saxena 2007). Some papers have advocated for scaling up evidence-based services and for the task-shifting of mental health interventions to non-specialists as key strategies for closing the treatment gap (Jacob 2007; lancet 2007; Patel 2007b; Prince 2007; Saraceno 2007; Saxena 2007).

Description of the intervention

Non-specialist health workers (NSHWs) are first-level providers who have received general rather than specialist mental health training. Cadres included are professionals (doctors, nurses and other general paraprofessionals) and non-professionals (such as lay providers). NSHWs do not include, for example, psychiatrists, neurologists, psychologists, psychiatric nurses or mental health social workers. Other professionals with health roles (OPHRs), such as teachers and community-level workers, are a further human resource used in delivering mental health care and are also included in this review. These OHPRs have an important role, particularly in the promotion of mental health and the detection of mental disorders (Patel 2007b; Patel 2008b;WHO 2003b). NSHWs and OPHRs have been used in various services, including those delivered by governmental, private and non-governmental organisations (NGOs) in clinics, half-way homes and communities. They have been involved in a variety of activities and roles, including detecting, diagnosing, treating and preventing common and severe mental disorders, epilepsy and mental retardation. Their roles differ according to their level of training. For example, lay health workers (LHW) have been involved in supporting carers, befriending, ensuring adherence and in detection of mental health problems (Chatterjee 2003; Dias 2008 RCT India; Rahman 2008 CRCT Pakistan). Nurses, social workers and lay workers may also take on follow-up or educational/promotional roles (Araya 2003 RCT Chile; Chatterjee 2003; Patel 2008b). In addition, doctors with general mental health training have been involved in the identification, diagnosis, treatment and referral of complex cases (Murthy 1987; Patel 2008b; Saxena 2007).

How the intervention might work

In many LMICs, training and retaining sufficient numbers of specialists is not feasible in the near future. It is, therefore, important in these settings to consider options for expanding access to mental health services. The use of NSHWs, who are far more numerous and affordable than specialists, is one such option that is of high relevance to LMICs.

Training these NSHWs to deliver MNS interventions may be a way of expanding provision of mental health services as well as making these services more accessible to communities. It has been suggested that interventions that rely on NSHWs could deliver general health and mental health interventions that are at least as effective and acceptable as those delivered by specialist health workers (Chatterjee 2003; Lewin 2008; McKenzie 2004; Thornicroft 2004; WHO 2001; Wiley-Exley 2007). In addition, NSHW interventions often have lower up-front costs compared with reliance on professional specialist health workers. However, it is possible that these savings may be cancelled out by higher downstream resource use (Chisholm 2000a), and this review will, therefore, include data on the costs and cost-effectiveness of NSHW...
interventions. The review is limited to LMICs where the need for NSHWs is greater than in high-income settings. The prevalence of psychiatrists and psychiatric nurses is much lower in LMICs (the median number of psychiatrists is 172 times lower in low-income countries (LICs) than high-income countries (HICs) (Kakuma 2011; Mental Health Atlas 2011)) and the organisation and resourcing of mental health services is poorer. These differences in the organisation of mental health services between LMICs and HICs, with poorer countries having little or no mental health service structures in primary care or the community, means that the problem of providing mental health care is different in such settings. NSHWs may need to work with little or no support from specialist mental health services and fewer options for referral. Consequently, NSHWs interventions might be expected to function differently in many LMICs compared with HICs.

Why it is important to do this review
The continuing shortage of specialist human resources for health in LMICs has made the need to involve non-specialists in MNS healthcare provision more urgent. Reliable evidence is needed on the effectiveness of NSHWs and OPHRs in scaling up mental health interventions, including for the detection, treatment and rehabilitation of MNS disorders. This systematic review will provide the evidence needed to inform policy development for the sustainable scaling up of mental health services in LMICs (Cohen 2003; Murthy 2008).
The intention of this review is to examine which non-specialised cadres of healthcare providers can effectively deliver different aspects of treatment interventions.

OBJECTIVES
To assess the effectiveness of the delivery of mental, neurological and substance abuse (MNS) interventions by non-specialist health workers (NSHWs) and other professionals with health roles (OPHRs) in LMICs. This includes the effects on patient and health delivery outcomes of NSHWs and OPHRs:

- delivering acute MNS interventions;
- delivering long-term follow-up and rehabilitation for people with MNS disorders;
- detecting MNS disorders.

For each of these areas, we have also examined the impacts of delivery by NSHWs and OPHRs on the resource use and costs associated with MNS healthcare provision in LMICs.

METHODS

Criteria for considering studies for this review

Types of studies
We included randomised controlled trials (RCT), non-randomised controlled trials (NRCT), controlled before-and-after (CBA) studies and interrupted time series (ITS) studies. We only included CBAs with at least two control sites and two intervention sites. We included controlled and non-controlled ITS that had at least three time points before the intervention and three time points after the intervention (as per the Cochrane Effective Practice and Organisation of Care (EPOC) review group criteria) (Ballini 2010). We only included studies conducted in LMICs, as defined by the World Bank.

We also included economic studies conducted as part of included effectiveness studies. We considered full economic evaluations (cost-effectiveness analyses, cost-utility analyses or cost-benefit analyses), cost analyses or comparative resource utilisation studies. We extracted and reported only cost and resource usage outcomes from these studies.

Types of participants
We included children (aged below 18 years) or adults with any MNS seeking first-level care/primary care or who were detected in the community in LMICs. Additionally we included carers of people with MNS disorders (i.e. any relative or friend of any age who defined themselves as a key supporter to a person with an MNS disorder) as some interventions may be directed at the carers rather than at patients themselves - for example interventions to alleviate carer burden.

(See Table 1 for further definitions of participants, ‘LMIC’ and ‘primary care’.)

Types of interventions
Clinical (medical and psychological) and service interventions delivered in primary care or the community by NSHWs or OPHRs, and intended to improve MNS disorders were included (see Table 1 for definitions of OPHR and NSHW and types of interventions). We did not include social interventions (such as income generation or general social support) if the trial did not also include a specific MNS intervention.

We included interventions delivered for any MNS disorder. Acute interventions delivered by NSHWs/OPHRs could include various forms of psychotherapy or pharmacological treatment. Long-term interventions delivered by NSHWs/OPHRs could include roles in follow-up or rehabilitation of people with chronic severe mental
disorders, and roles in detecting and dealing with relapse/recurrence, compliance issues, side effects of treatment or psychosocial problems.

We considered the following comparisons:
- provision of MNS care by NSHWs/OPHRs with some MNS care training compared with usual/no care;
- provision of MNS care by NSHWs/OPHRs trained and supervised in MNS care (i.e. the highest level of training for NSHWs) compared with mental health specialists in primary care and the community;
- provision of MNS care by NSHWs/OPHRs with some MNS care training compared with non-trained NSHWs/OPHRs.

We included studies where a specialist teaches NSHW/OPHRs about psychiatric illness and its management. The only interventions of this type that we excluded were those where there were no patient outcomes (i.e. where they only assessed knowledge or attitude changes, such as pre-post training interventions).

We included studies that considered the effect of detection, screening or case-finding of MNS disorders by NSHWs or OPHRs on subsequent patient and health provider outcomes, compared with NSHWs/OPHRs not actively detecting cases, or where specialists did the detection.

The identification methods used by NSHWs could include ‘naturalistic’ detection (i.e. detection in the course of a routine clinical consultation), or detection using a validated screening/detection tool (e.g. in the context of a trial). We did not examine diagnostic accuracy between these NSHWs and specialists, as this was likely to be confounded by the screening/detection tools used. Therefore, it would be difficult to differentiate between the effect of the screening tool and the skills of the health worker (specialist or non-specialist).

**Types of outcome measures**

We organised these outcomes into categories drawing on the Cochrane Consumers and Communication Review Group's outcome taxonomy (La Trobe 2008), and consultation with co-reviewers and service users from the Movement for Global Mental Health discussion board. Where studies reported more than one measure for each relevant outcome, we abstracted the primary or main measure (as defined by the study authors). We separately documented the other measures used, as necessary.

We grouped outcomes into two sets of time points:
- up to six months post intervention (to detect illness recovery/symptom reduction);
- six to 12 months post intervention (which indicates medium- to long-term avoidance of recurrence and chronicity).

For depression and other common mental disorders, we did not group results up to three months post intervention. This time point would normally elicit whether the length of a depressive episode would be shortened compared with spontaneous recovery (which occurs for 50% of people with depression at three months after treatment initiation and for 65% of people with depression at six months) (Spijker 2002). However, most of these studies had very variable lengths of interventions (zero to 18 months) and it was difficult to ascertain how long the depression had been present when treatment started (we could assume that people who have not recovered naturally within three months seek help). Pooled results up to three months post intervention would, therefore, not reflect whether the intervention shortened recovery from depression to less than or equal to a spontaneous recovery.

**Primary outcomes**

1. Improvement of symptoms (e.g. level of anxiety, depression, psychosis).
2. Psychosocial functioning and impairment (e.g. levels of self esteem, perception of coping, level of dependency, self care ability).
3. Quality of life outcomes (including disability).

We changed the definitions of outcomes 2 and 3 during our analysis from those stated in the protocol, as many scales measured both impairment and functioning and were considered part of the same spectrum. Quality of life outcomes were deemed different from outcomes related to psychosocial functioning as the former encompass a summary of many other aspects of life in addition to psychosocial functioning.

For the detection component of the review, we aimed to consider the outcomes for the patient, the carer, the health provider, or a combination of these people, not the accuracy of diagnosis among NSHWs, compared with specialists, as this is likely to be confounded by the screening/detection tools used. Therefore, it would be difficult to differentiate between the effect of the screening tool and the skills of the health worker (specialist or non-specialist).

We did not base inclusion decisions on whether a reference or validated standard measure (either a screening instrument or psychiatric assessment) had been used in studies to differentiate between those correctly and incorrectly diagnosed by NSHWs, but this featured as part of the assessment of the quality of evidence (within study limitations).

**Secondary outcomes**

1. For studies evaluating the detection of mental disorders and the delivery of acute and chronic mental health interventions

**Patient/carer-oriented outcomes and societal outcomes**

- Patient or carer satisfaction and involvement in decision-making processes.
Health provider and service delivery related outcomes

• Measures of changes in management (such as referral rates, prescribing patterns and appropriateness).
• Measures of health worker behaviour (such as improvement in knowledge/skills, attitude/acceptability, retention rates, absenteeism).
• Measures of service delivery change (such as number of supervision sessions, effect on other health services provided).

2. For studies of costs and resource use

We considered:
• direct and indirect costs to the patient and health services (including opportunity costs);
• resource use (such as the patient's lost productivity, and health service personnel's time allocated/number of consultations).

The economic outcome measures considered were informed by the training material of, and discussion with, the Campbell & Cochrane Economics Methods Group (CCEMG 2010). We included only measures related to resource use and costs in this review. We recognise that costs and resource use are intertwined but divided the outcomes in this way to make it clear which outcomes we intended to assess.

Search methods for identification of studies

Electronic searches

We searched the following electronic databases for primary studies:
• the Cochrane Central Register of Controlled Trials (CENTRAL) 2012, Issue 6 (including the Cochrane EPOC Group Specialised Register (searched 21 June 2012);
• MEDLINE, 1946 to June week 1 2012, OvidSP (searched 15 June 2012);
• MEDLINE In-Process & Other Non-Indexed Citations 14 June 2012, OvidSP (searched 15 June 2012);
• EMBASE, 1980 to 2012 week 23, OvidSP (searched 15 June 2012);
• CINAHL (Cumulative Index to Nursing and Allied Health Literature), 1980 to 19 June 2012, EBSCOhost (searched 19 June 12);
• PsycINFO, 1806 to June week 2 2012, OvidSP (searched 18 June 2012);
• Latin American and Caribbean Health Sciences database (LILACS), Virtual Health Library (VHL) (searched 9 August 2012);
• WHO Global Health Library (World Health Organization Library Information System (WHOLIS), AIM (AFRRO), IMEMR (EMRO), IMSEAR (SEARO, WPRIM, WPRO) (searched 29 June 2012);
• Science Citation Index and Social Sciences Citation Index, ISI Web of Knowledge (searched 2 October 2012).

The EPOC Trials Search Co-ordinator (TSC) (Marit Johansen), in consultation with the authors, developed the search strategies. Search strategies were comprised of keywords and controlled vocabulary terms (selected index terms and free-text terms relating to NSHWs and mental health).

We applied no language limits. We searched all databases from database start date to date of search.

We used a combination of two methodology search filters to limit retrieval to appropriate study designs: a modified version of the Cochrane Highly Sensitive Search Strategy (sensitivity- and precision-maximising version - 2008 revision) to identify RCTs (cf. Cochrane Handbook for Systematic Reviews of Interventions Section 6.4d); and an EPOC methodology filter to identify NRCT designs.

Searching other resources

Grey Literature


Trial Registries

• metaRegister of Controlled Trials (mRCT) (www.controlled-trials.com/mrct/) (searched 8 August 2012).
• International Clinical Trials Registry Platform (ICTRP), WHO (apps.who.int/trialsearch/) (searched 9 August 2012).

We also searched:
• the reference lists of existing reviews (De Vet 2008);
• other grey literature (unpublished material), through contacting experts;
• conducted cited reference searches for all included studies in ISI Web of Knowledge.

We did not search for economic analyses. We retrieved potentially eligible economic analyses when screening records generated from
the various searches reported above, but only selected those performed alongside identified effects studies. We contacted the authors of all included effects studies for information on any published or unpublished economic studies related to their trials. We also scanned the reference lists of eligible trials and economic analyses (where these were reported separately to the eligible trials), and other related reviews and papers, for further eligible studies. See Appendix 1 for all search strategies used.

Data collection and analysis

Selection of studies
Four review authors (NvG, GR, MSM, JP) and a Chinese researcher for the Chinese included study double-screened all records obtained from the searches. We retrieved full-text copies of all articles identified as potentially relevant by at least one review author. Two review authors checked each full paper for inclusion criteria. We resolved disagreements on inclusion by discussion. If no agreement was reached, we asked a third review author to make an independent assessment (SL). Where appropriate, we contacted the study authors for further information.

Data extraction and management
Five review authors (NvG, GR, MSM, JP, PT) and the Chinese and Spanish researchers independently extracted descriptive and outcome data for each paper using an adapted version of the EPOC data collection checklist. Two review authors together or by one and cross-checked by another (except the Chinese paper, which relied on one researcher’s data extraction only) extracted data. Review authors obtained any missing data by contacting trial authors. Review authors entered the final agreed descriptive extracted data into the relevant tables of characteristics in Review Manager 5 (RevMan 2012). One review author (NvG) entered the checked outcome data into Review Manager 5 for meta-analysis and this was checked by PT (RevMan 2012).

We extracted the following information for all included studies, in the form that this was reported in the original text:

- details of the intervention; the type and length of each of the clinical, psychosocial and service interventions; a full description of cadre(s) of NSHW/OPHRs consulting with the patient, including details of their training and supervision/support; and the length, frequency and type of intervention delivered by each NSHW/OPHR; description of the specialist providing care (type, experience, training in using reference standard);
- participants: a full description of the participants (sex, age, socioeconomic status, ethnicity), including details of the MNS condition being treated;
- setting: country; type of health service (e.g. government funded, NGO, etc.), organisation of the primary care and specialist services; specialist outreach or generalist;
- results: organised into patient, provider and process outcomes (see above).

Assessment of risk of bias in included studies
Five review authors (NvG, GR, MSM, JP, PT) and the Chinese researcher working in pairs independently assessed each study for risk of bias. NvG and PT independently checked assessments for all studies. We followed the Cochrane EPOC group format (Ballini 2010) (which follows the Cochrane Collaboration approach (Higgins 2009)) to assess risk of bias for each of the study designs (RCT, CBA, NRCT, ITS). For two of the EPOC risk of bias criteria, we did the following:

- divided detection bias into two categories, assessing whether subjective (requiring a judgement, such as clinical improvement) and objective outcomes (such as number of hospitalised days, etc.) were assessed blindly;
- assessed attrition bias for two types of outcome: efficacy outcomes and safety outcomes (e.g. adverse events and unintended consequences).

For economic studies, we adapted the Consensus on Health Economic Criteria (CHEC) criteria list (see Appendix 2) to include an extra question on the sources of data used, and we excluded some questions that were already covered as part of the main risk of bias assessment described above.

We incorporated risk of bias assessments by generating ‘Risk of bias’ summary graphs and figures using Review Manager 5 (RevMan 2012).

Measures of treatment effect

Measures of intervention effect regarding clinical (medical and psychological) and service interventions

For dichotomous outcomes, we used risk ratios (RR). For continuous outcomes, we used the mean difference (MD), standardised mean difference (SMD) or mean change difference (MCD). We expressed all effect estimates with their 95% confidence intervals (CI). For SMDs, we used the Cochrane Handbook for Systematic Reviews of Interventions to interpret their clinical relevance: 0.2 represented a small effect, 0.5 a moderate effect, and 0.8 a large effect (Cohen 1988). We attempted to establish minimally important differences per outcome (as suggested in Guyatt 2013) but this was not possible due to the wide variety of instruments used.

Measures of effect of detection of MNS disorders interventions

We aimed to report the effects of detection of MNS disorders by NSHWs or OPHRs by assessing patient outcomes, looking at the proportion of patients who recovered or improved over a specific length of time as described in the included studies. We
aimed to measure health worker outcomes by examining changes in prescribing rates, referral rates and treatment initiation rates.

Unit of analysis issues
Where possible, we re-analysed studies that randomised or allocated clusters (patients, health professionals, healthcare settings or geographical areas) but did not account for clustering in their analysis (Ukoumunne 1999). We adjusted the results for clustering by multiplying the standard errors of the estimates by the square root of the design effect where the design effect is calculated as \( \text{DEff} = 1 + (M - 1) \times \text{ICC} \), where \( M \) is the mean cluster size and ICC is the intracluster correlation coefficient. All of the included studies reported the ICCs that we needed.

We combined the adjusted measures of effects of cluster-randomised trials with the results of non-cluster trials, if it was possible to adjust adequately the results of the cluster trials. There were too few studies per meta-analysis to perform sensitivity analyses comparing the effects estimates with and without the inclusion of the cluster trials.

We contacted authors when we needed additional information for the analysis.

Dealing with missing data
For missing or unclear information, we contacted the study investigators for clarification or additional information. We were able to access all required authors for the purpose of statistical information. Some remaining missing information on the qualitative description of the interventions that we did not get despite several attempts at following up with study authors, is highlighted in the Characteristics of included studies tables. To reduce the risk of overly positive answers, we use open-ended questions (as recommended in the Cochrane Handbook for Systematic Reviews of Interventions, Higgins 2009).

Where possible, we extracted data to allow an intention-to-treat (ITT) analysis in which all randomised participants were analysed in the groups to which they were originally assigned. If ITT data were not present, where possible, we did a full ITT analysis where we considered four scenarios in which the people reassigned to the control and intervention groups either had the condition or not. For studies that reported continuous data but did not report standard deviations, we either calculated these from other available data such as standard errors, or imputed these using the methods suggested in Higgins 2009. We did not make any assumptions about loss to follow-up for continuous data and we analysed results for those who completed the trial.

Assessment of heterogeneity
We first made a qualitative assessment of the extent to which the studies assessing a particular comparison where similar to one another. This included an assessment of the settings, the interventions, the participants and outcomes to determine whether meta-analysis was appropriate. We obtained an initial visual overview of statistical heterogeneity through scrutinising the forest plots, looking at the overlap between CIs around the estimate for each included study. To quantify the inconsistency across studies, and thus the impact of heterogeneity on the meta-analysis, we used the \( I^2 \) statistic, and defined an \( I^2 \) greater than 50% as indicative of substantial heterogeneity. We then considered these assessments when interpreting the results of a pooled analysis: the importance of an observed \( I^2 \) was interpreted in light of 1. the magnitude and direction of effects and, 2. the strength of evidence for heterogeneity (e.g. a CI for the \( I^2 \), or the \( P \) value from the Chi\(^2 \) test).

Assessment of reporting biases
To reduce possible publication bias, we employed strategies to search for and include relevant unpublished studies. These strategies included searching the grey literature and prospective trial registration databases to overcome time-lag bias. We used funnel plots for the outcomes with more than four studies to visualise whether there was asymmetry. None of them showed asymmetry. We performed no statistical testing for funnel plot asymmetry as none of the pooled outcomes included more than 10 studies.

Data synthesis
We grouped the studies for comparison by type of disorders (common mental disorders, severe mental disorders, neurological and substance-abuse disorders); by mix of healthcare providers (NSHW-led, collaborative, NSHWs and OPHRs); and by types of community intervention (pharmacological, non-pharmacological and mixed approach). We did this as these categories fit with current models of service delivery in LMICs.

The number of comparisons was larger than anticipated at the protocol stage and we have outlined each comparison in the results section below. For each comparison (groups of disorders), we created tables of summary statistics according to study designs (RCTs, NRCTs and CBAs). These tables included study design, baseline and follow-up summary statistics, effect estimates and their statistical significance. We used forest plots to display the data graphically.

Where the outcomes assessed and the settings and interventions were very diverse (as agreed by at least two review authors), we did not consider it appropriate to combine the results quantitatively. For these results, we have presented a descriptive summary of data. For all data syntheses, we used the generic inverse-variance model of analysis as this allows the analysis of continuous and dichotomous data and allows clustered and non-clustered data to be combined. We based the choice of whether to use a fixed-effect or random-effects model on the extent to which studies were similar, or homogeneous, based on their PICOS characteristics (population, intervention, comparators, outcomes and settings). No studies were homogeneous enough to apply the fixed-effect model.
We reported the results separately for RCTs and for NRCTs. No ITS studies were included in the review. We used effect estimates adjusted for confounding (baseline differences in control and intervention groups) where possible, and used the methods described in Reeves 2009 to guide data synthesis.

Economic data

We conducted all the elements of the economics component of this review according to current guidance on the use of economics methods in the preparation and maintenance of Cochrane reviews (Shemilt 2009). We classified the included economic evaluations based on an established system (Drummond 2005). We summarised the characteristics and results of included economic evaluations using additional tables, supplemented by a narrative summary that compared and evaluated methods used and principal results between studies.

We displayed resource use and cost data in a table, along with unit cost data (where available). A unit cost was defined as the cost of each specific resource input calculated by multiplying the measured number of units (quantities) of an item of resource use (e.g. the number of hours of time provided by a senior teacher) by an applicable unit cost (e.g. the salary cost of one hour of senior teacher time). We reported the currency and price year applicable to measures of costs and unit costs in each original study. Measures of costs are highly likely to vary across and within study settings, and over time. This is the product of variations in the underlying quantities of resource use and variations in the underlying unit costs.

Because the data on resource use and costs were very heterogeneous, meta-analysis was not appropriate and we presented the findings narratively. We discussed the limitations of this approach below.

Subgroup analysis and investigation of heterogeneity

Within each comparison, the following subgroups were considered: by category of health worker (professionals: e.g. doctors, nurses), OPHRs and non-professionals (LHWs); by types of community intervention (e.g. collaborative versus psychological interventions in comparison 3); and by setting (government versus non-government). We were not able to perform subgroup analyses to check if the intervention effect varied with different population characteristics as the number of included studies for each comparison was not sufficient. Where applicable, we have described subgroup differences narratively under Main results.

For random-effects meta-analyses, we used the formal Chi² test and I² statistic for subgroup differences in RevMan 2012 to detect statistically significant subgroup differences.
Figure 1. Study flow diagram.

12,545 records identified through database searching

16 additional records identified through other sources

11,825 records after duplicates removed

11,825 records screened

11,086 records excluded based on abstracts

701 full-text articles excluded:
- 11 ongoing studies
- 17 awaiting classification
- 239 excluded with relevance to this review (reasons listed in Characteristics of Excluded Studies)
- 348 excluded (several inclusion criteria not met or not relevant)

739 full-text articles assessed for eligibility

38 studies included in qualitative synthesis (total of 55 with supporting references)
3 of these 38 contain economic data

31 studies included in quantitative synthesis (meta-analysis)
Included studies

Study design

Of the 38 included studies, 17 were RCTs, 10 were cluster RCTs, nine were CBA studies and two were NRCTs. Analysis was by ITT in eight studies (Bolton 2007 RCT Uganda; Ertl 2011 RCT Uganda; Hirani 2010 CRCT Pakistan; Jenkins 2012 C-RCT Kenya; Jordans 2010 C-RCT Nepal; Tiwari 2010 RCT China; Tol 2008 C-RCT Indonesia; Tol 2012 C-RCT Sri Lanka), and was unclear in one (Neuner 2008 NRCT Uganda). It was not possible to do an ITT for the remaining studies (see Dealing with missing data).

Setting

Fifteen included studies were conducted in seven LICs: Burundi (one study), Kenya (two studies), Nepal (one study), Pakistan (three studies), Rwanda (two studies), Sri Lanka (two studies) and Uganda (four studies). Twenty-three studies were from 15 middle-income countries: Argentina (one study), Bosnia (one study), Chile (three studies), China (three studies), Hungary (one study), India (two studies), Indonesia (two studies), Jamaica (one study), Kosovo (one study), Malaysia (one study), Palestinian Territories (two studies), Russia (one study), Thailand (two studies), Turkey (one study) and Vietnam (one study). These LIC and middle-income country assignments are based on the World Bank’s classification of countries by gross national income per capita in 2010. In this section, as well as following sections (participants, interventions, etc.), the numbers when added up may exceed 38 due to double counting. There were 16 studies from rural, 23 from urban and five from refugee camp settings. Most interventions were delivered in community groups/centres (11 studies). Others were delivered at home (nine studies), in primary healthcare (PHC) centres (eight studies), in schools (seven studies) and in other health clinics (three centres).

Participants

Twenty-seven studies included adults. Of the studies including children, 10 included children up to the age of 12 years, and eight focused on adolescents (aged 12 to 17 years). Most studies covered common mental disorders (18 included depression, anxiety, maternal depression) and PTSD (12 studies). See ‘Effects of interventions’ for details of these by analysis groups.

Interventions

NSHWs and OPHRs: various cadres were used: LHWs (22 studies), doctors (nine studies), nurses (six studies), teachers (six studies) and social workers (three studies). The educational level of the LHWs was poorly documented, but of the 15 studies that did specify this, eight selected LHWs with a minimum of secondary school education, three used illiterate LHWs and three included LHWs who had primary school education and who were or were not literate. Remuneration was generally poorly described. The training and supervision of these providers are described in detail under ‘Effects of interventions’.

Interventions: many studies combined different types of interventions. The eight interventions providing pharmacotherapy also provided follow-up to check adherence, the effect of medication and side effects (provided by a LHW (four studies), a nurse/clinical officer (one study), a social worker (one study) or a doctor (two studies). Twenty-five studies had some form of psychosocial intervention (which included psycho-education, various support and general counselling/cop ing skills interventions and stimulation programmes for children). Sixteen studies used specific psychological interventions on their own or as part of a collaborative care model (e.g. cognitive behavioural therapy (CBT), interpersonal therapy (IPT), motivational interviewing). One study evaluated economic skills building as a second arm to the trial, which were expected to have an effect on mental health outcomes. No studies examined detection by NSHWs or OPHRs and none reported health worker outcomes. More details on these are provided under ‘Effects of interventions’.

Economic studies

Three economic studies were conducted alongside included RCTs (Araya 2003 RCT Chile; Jordans 2011 (which is linked to Tol 2008 C-RCT Indonesia; Tol 2012 C-RCT Sri Lanka) and Zambori 2002 CBA Hungary). One further study noted that the financial burden and severity of schizophrenia decreased marginally for both intervention and control groups, but did not reach statistical significance; however, it did not measure costs (Paranthaman 2010 CBA Malaysia). In addition, one study mentioned they had collected cost data but results were not yet available before the end of the search period (Patel 2010 C-RCT India). This was subsequently published (Buttorff 2012). We aim to include these data in a future update.

Excluded studies

We excluded 701 studies, of which 289 were of interest to this area of study but did not fulfill all inclusion criteria. These 289
studies, together with their reasons for exclusion, are documented in Characteristics of excluded studies. Thirteen studies that included economic data on MNS conditions, but were not linked to studies included in this review, are reviewed in Appendix 3.

Risk of bias in included studies

The most often identified biases across studies were allocation concealment, random sequence generation, reliability of primary outcomes and blinding of outcome assessment (Figure 2; Figure 3).

Figure 2. Risk of bias graph: review authors’ judgements about each risk of bias item presented as percentages across all included studies.
Figure 3. Risk of bias summary: review authors' judgements about each risk of bias item for each included study.
Allocation

Only 13 of the 38 included studies met the ‘low risk of bias’ criteria for allocation concealment. Of the remaining studies, 13 explicitly did not conceal allocation (of which 10 were not RCTs). For 12 studies, the risk of bias was unclear due to poor reporting. Eleven studies did not utilise randomised sequence generation. One RCT was also at high risk of bias with regard to allocation sequence generation because they had a combination of random and non-random sequence generation (Sutcliffe2009RCT Thailand). Several studies did not have similar subjective or objective outcome measurements (such as numbers of days in hospital) at baseline between the two arms (subjective outcomes: seven unclear and 10 not similar; objective outcomes: five unclear and five not similar) or did not have similar baseline characteristics (seven not similar and three unclear). The studies in which two or three of the baseline characteristics were not similar included the following CBA studies (Loughry 2006 CBA Palest; Lyketsos1999CBA Argentina; Paranthaman2010CBAMalaysia; Thabet 2005 CBA Palestine; Zambori 2002 CBA Hungary), and RCTs (Li 1989 RCT China; Sutcliffe2009RCT Thailand).

Blinding

We divided the blinding domain into blinding of participants and personnel, and blinding of outcome assessment. All studies reported blinding of outcome assessment, one study did not blind participants/personnel (Neuner 2008 NRCT Uganda), and for four studies it was unclear if participants/personnel were blinded (Dybdahl 2001 RCT Bosnia; Ertl 2011 RCT Uganda; Loughry 2006 CBA Palest; Lyketsos1999CBA Argentina).

Incomplete outcome data

We considered incomplete outcome data separately for efficacy and for adverse outcomes. For most studies, outcome data were complete. However, for six studies, this was unclear and seven had incomplete outcome data. Twenty-two studies did not clearly report whether they had data on adverse outcomes, and an additional four studies stated explicitly that they had not collected adverse outcome data (or we obtained this information from the authors). This made analysis of adverse outcomes difficult for most comparisons.

Selective reporting

For 26 of the 38 studies, there appeared to be no selective reporting, based on the outcomes listed in the methods section of these papers, and from contacting authors where there was doubt. In only one study was it clear that there had been selective reporting (Dias 2008 RCT India). In 11 studies, this was not clear (see Characteristics of included studies tables).

Other potential sources of bias

Risk of contamination was quite common among both RCTs and CBA studies. We assessed six studies as unclear because insufficient information was available regarding whether contamination across groups was likely and conclusive information on this from the authors could not be obtained (Chen 2000 RCT Taiwan; Dias 2008 RCT India; Dybdahl 2001 RCT Bosnia; Gavrilova 2009 RCT Russia; Hirani 2010 CRCT Pakistan; Li 1989 RCT China). We assessed an additional six studies as being at high risk of contamination (Araya 2003 RCT Chile; Berger2009 CRCT SriLanka; Bolton 2007 RCT Uganda; Loughry 2006 CBA Palest; Neuner 2008 NRCT Uganda; Sutcliffe2009RCT Thailand).

For a number of studies, it was not clear whether the primary outcome measures were reliable: in 11 studies, these measures were not validated in the study context; and we assessed an additional six studies as ‘unclear’ because insufficient information was available on the validity of the measures. Other sources of bias that were detected included:

- the control and intervention arms potentially delivering interventions that were too similar, as mentioned by the authors (Sutcliffe2009RCT Thailand);
- high likelihood of confounding: for example, due to incentives being provided to patients (Brown 2009 CBA Rwanda), or a teetotal religious festival occurring between baseline and follow-up that may have had a greater impact on alcohol consumption than the motivational interviewing intervention in Noknoy 2010 RCT Thailand.

Economic studies - risk of bias assessment with the adapted CHEC list criteria

All studies had significant risks of bias (Table 2), although we considered no study at high risk of bias on more than seven of the 23 adapted CHEC list criteria. The risk of biases identified were potentially important for the interpretation of costing, such as not discounting costs (Araya 2003 RCT Chile; Jordans 2011), not including the appropriate costs or outcomes and not valuing some outcomes appropriately.

Effects of interventions

See: Summary of findings for the main comparison NSHW-led psychological interventions compared with usual care in treating depression in adults in low- and middle-income countries (RCTs); Summary of findings 2 Collaborative care model (NSHWs
plus specialist) compared with usual care in treating common mental disorders in adults (RCTs); Summary of findings 3 NSHWs compared with usual care for treating maternal depression (RCTs); Summary of findings 4 NSHWs compared with specialists in treating depression in adults (RCTs); Summary of findings 5 NSHW-led psychological interventions compared with usual care in treating adults with PTSD (RCTs); Summary of findings 6 NSHWs compared with usual care in improving dementia patients' and carers' outcomes in middle-income countries (RCTs); Summary of findings 7 NSHW-led brief alcohol interventions compared with usual care for adults with alcohol-use disorders (RCTs); Summary of findings 8 NSHWs/OPHRs compared with usual care in conducting interventions for children with post-traumatic stress disorder and depression (RCTs)

This review covered a wide range of NSHWs delivering a wide range of healthcare interventions for a variety of MNS disorders. However, no MNS detection studies were found that reported patient outcomes. We grouped studies by MNS disorders as different interventions and roles of NSHWs will in particular differ between severe and common mental disorders. These broad groups have, in turn, been subdivided into types of interventions that made clinical sense to group together (e.g. studies on depression have been divided into those involving collaborative care, where NSHWs are only one aspect of a complex intervention, and those involving psychological interventions provided by just one type of NSHW). We have further grouped studies by study design, and according to their comparator group (usual care or specialist care).

We performed meta-analyses for eight groupings covering common mental disorders, PTSD, dementia and alcohol abuse. All analyses include the primary outcomes specified for this review, and some secondary outcomes. Below are the meta-analysis groupings that we have reported:

1. NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs);
2. collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs and cluster RCTs);
3. NSHWs versus usual care in treating maternal depression (RCTs);
4. NSHWs versus specialist care in treating common mental disorders (CBA studies);
5. NSHWs versus usual care in delivering PTSD interventions to adults (RCTs);
6. NSHWs versus usual care in improving dementia patients' and carers' outcomes (RCTs);
7. NSHW-led brief alcohol interventions versus usual care in delivering interventions to adults with alcohol-use disorders (RCTs);
8. NSHWs/OPHRs versus usual care in delivering interventions for children with PTSD and depression (RCTs).

We could not pool the remaining studies, as they were individual studies of different disorders (severe mental disorders, epilepsy, drug abuse and child mental disorders other than PTSD and depression). We reported the results of these studies narratively in the text and in Table 3.

Comparison 1. Non-specialist health workers-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs)

Setting: we identified seven studies from four countries: China (two studies) (Chen 2000 RCT Taiwan; Tiwari 2010 RCT China), Jamaica (one study) (Baker-H 2005 CRCT Jamaica), Pakistan (three studies) (Ali 2003 RCT Pakistan; Hirani 2010 CRCT Pakistan; Rahman 2008 CRCT Pakistan), and Uganda (one study) (Bolton 2003 C-RCT Uganda). Interventions were delivered in urban settings (Ali 2003 RCT Pakistan; Baker-H 2005 CRCT Jamaica; Chen 2000 RCT Taiwan; Hirani 2010 CRCT Pakistan), rural settings (Bolton 2003 C-RCT Uganda; Rahman 2008 CRCT Pakistan), and both (Tiwari 2010 RCT China). Participants: participants were mostly from deprived backgrounds, though those in Ali (2003) were lower middle class and those in Chen (2000) were split equally between high-, middle- and low-income groups. Six studies included only women with depression (Ali 2003 RCT Pakistan; Hirani 2010 CRCT Pakistan; Tiwari 2010 RCT China), or perinatal depression (Baker-H 2005 CRCT Jamaica; Rahman 2008 CRCT Pakistan). Studies including women tended to exclude adult women over the age of 50 years.

Intervention: NSHWs: there were four LHW-led interventions (Ali 2003 RCT Pakistan; Baker-H 2005 CRCT Jamaica; Bolton 2003 C-RCT Uganda; Hirani 2010 CRCT Pakistan). The LHWs in these studies all had primary or no education, and some had high school or further education (Bolton 2003 C-RCT Uganda; Rahman 2008 CRCT Pakistan). The group also includes one nurse-led (Chen 2000 RCT Taiwan), and one social worker-led (Tiwari 2010 RCT China), intervention. Most of the NSHWs were women, though Bolton had sex-specific health workers for sex-specific groups. In two studies, the NSHWs were employed by the government (Baker-H 2005 CRCT Jamaica; Rahman 2008 CRCT Pakistan), and the others were salaried or volunteers within NGOs.

Training duration and intensity very varied from three days (Hirani 2010 CRCT Pakistan), to four weeks (Baker-H 2005 CRCT Jamaica). Though information was often incomplete, most studies that reported the content of the training had a mixture of didactic and practical training. Supervision was highly varied in terms of organisation and intensity from ad-hoc checking (Ali 2003 RCT Pakistan; Tiwari 2010 RCT China), to structured meetings every two weeks (Baker-H 2005 CRCT Jamaica). All training and supervision was done by the principal investigators or specialists (psychiatrists and psychol-
ogists), or both.

**Description of interventions:** LHWs provided psychological interventions: CBT-like problem solving (Ali 2003 RCT Pakistan; Rahman 2008 CRCT Pakistan), and group interpersonal therapy (G-IPT) (Bolton 2003 C-RCT Uganda). LHWs also provided general counselling and economic skills building in one study (Hirani 2010 CRCT Pakistan). In two trials, non-medical professionals delivered psychosocial counselling and problem solving (Chen 2000 RCT Taiwan; Tiwari 2010 RCT China). Interventions were delivered in community centres or groups (Baker-H 2005 CRCT Jamaica; Bolton 2003 C-RCT Uganda; Hirani 2010 CRCT Pakistan; Tiwari 2010 RCT China), in healthcare settings (Chen 2000 RCT Taiwan), and in homes (Ali 2003 RCT Pakistan; Rahman 2008 CRCT Pakistan).

Interventions varied in duration (30 to 120 minutes), in frequency (weekly to monthly, often with increasing intervals between sessions, e.g. Rahman 2008 CRCT Pakistan), and in total time (one month (Chen 2000 RCT Taiwan) to one year (Baker-H 2005 CRCT Jamaica)). Three interventions included manuals for training and for conducting the intervention (Baker-H 2005 CRCT Jamaica; Bolton 2003 C-RCT Uganda; Rahman 2008 CRCT Pakistan).

Comparison groups included usual care without the addition of a NSHW (Ali 2003 RCT Pakistan; Bolton 2003 C-RCT Uganda; Hirani 2010 CRCT Pakistan), or usual care where the NSHW was already present but was not trained to deliver the intervention (Baker-H 2005 CRCT Jamaica; Chen 2000 RCT Taiwan; Rahman 2008 CRCT Pakistan; Tiwari 2010 RCT China).

**Results**

1. **Prevalence of depression**

LHW-led psychological interventions may reduce depression prevalence within six months (RR 0.30, 95% CI 0.14 to 0.64, 3 studies, 1082 participants) but this evidence was of low quality due to heterogeneity (I² = 81%; P value = 0.005) and selection bias (Summary of findings for the main comparison) (Bolton 2003 C-RCT Uganda; Chen 2000 RCT Taiwan; Rahman 2008 CRCT Pakistan). ITT analyses (looking at the four possible scenarios where re-assigned participants are either assigned with improved outcomes or not) showed that these results varied from RR 0.20 (95% CI 0.09 to 0.45) to RR 1.11 (95% CI 0.56 to 2.21) indicating uncertainty of this result. Chen (2000) and Bolton (2003) varied widely through these four scenarios from favouring NSHW to favouring usual care, probably because of their relatively small sample size and large dropout rate. Rahman (2008) was least susceptible to change in figures, indicating possibly more reliable results (Figure 4).

![Figure 4. Forest plot of comparison: 1 NSHW-led psychological interventions versus usual care in treating CMDs in adults (RCTs), outcome: 1.1 Prevalence of depression (adults) (completers).](image-url)

2. **Severity of common mental disorder symptoms (including anxiety and depression)**

Seven studies reported severity of common mental disorder symptoms (including anxiety and depression). LHW-led psychological interventions (Ali 2003 RCT Pakistan; Bolton 2003 C-RCT Uganda; Hirani 2010 CRCT Pakistan; Rahman 2008 CRCT Pakistan), were pooled with nurse and social worker-led interventions (Chen 2000 RCT Taiwan; Tiwari 2010 RCT China). It is uncertain whether these interventions lead to appreciable clinical benefit in common mental disorder symptom severity at six months post-intervention, because despite an apparent clinical appreciable benefit (SMD -0.75, 95% CI -1.29 to -0.21, 1470 participants), the evidence was of very low quality due to high

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**Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)**

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heterogeneity ($I^2 = 94%$; $P$ value $< 0.00001$) and selection bias. (Note that a small clinically appreciable benefit was set at SMD $< 0.2$, and a moderate benefit at SMD of 0.5 to 0.8) (Cohen 1988) Table 4). One study, Bolton 2003, was an outlier (possibly because their LHWs performed single-sex group interventions). When this study was excluded the heterogeneity reduced and suggested LHWs may have a clinically appreciable benefit (SMD -0.42, 95% CI -0.53 to -0.30, low-quality evidence).

Two studies suggested that there is probably a reduction in depression symptom severity at eight to 12 months post intervention (SMD -0.47, 95% CI -0.60 to -0.34, moderate-quality evidence) (Figure 5) (Baker-H 2005 CRCT Jamaica; Rahman 2008 CRCT Pakistan).

Figure 5. Forest plot of comparison: 1 NSHW-led psychological interventions versus usual care in treating common mental disorders in adults (RCTs), outcome: 1.6 Severity of common mental disorder symptoms (includes anxiety and depression).

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>NSHW led care</th>
<th>Usual care</th>
<th>Std. Mean Difference</th>
<th>Std. Error</th>
<th>IV, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 2003 RCT Pakistan (1)</td>
<td>-0.5084 0.1626</td>
<td>70</td>
<td>91</td>
<td>17.92</td>
<td>-0.61 [-0.93, -0.29]</td>
</tr>
<tr>
<td>Bolton 2003 C-RCT Uganda (2)</td>
<td>-2.955 0.1699</td>
<td>103</td>
<td>113</td>
<td>17.58</td>
<td>-2.05 [-2.39, -1.72]</td>
</tr>
<tr>
<td>Chen 2006 RCT Taiwan (3)</td>
<td>-9.712 0.2689</td>
<td>30</td>
<td>32</td>
<td>19.22</td>
<td>-7.71 [-11.23, -4.19]</td>
</tr>
<tr>
<td>Hirani 2010 CRCT Pakistan (4)</td>
<td>-0.2756 0.5423</td>
<td>7</td>
<td>8</td>
<td>11.90</td>
<td>-0.38 [-1.34, 0.67]</td>
</tr>
<tr>
<td>Rahman 2008 CRCT Pakistan (5)</td>
<td>-0.3866 0.0706</td>
<td>410</td>
<td>420</td>
<td>18.59</td>
<td>0.10 [-0.05, 0.25]</td>
</tr>
<tr>
<td>Tiwari 2010 RCT China (6)</td>
<td>-0.396 0.1423</td>
<td>100</td>
<td>100</td>
<td>18.29</td>
<td>0.31 [0.44, 0.09]</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td>-0.478 0.8716</td>
<td>720</td>
<td>742</td>
<td>100.00</td>
<td>-0.75 [-1.29, -0.21]</td>
</tr>
</tbody>
</table>

Test for overall effect $Z = 2.21$ ($P = 0.027$)

1.6.2 Medium term (≥ 1 year)

Baker-H 2005 CRCT Jamaica (7) | -0.4087 0.1809 | 64 | 61 | 13.55 | -0.41 [-0.78, -0.04] |

Rahman 2008 CRCT Pakistan (6) | -0.4529 0.0719 | 413 | 420 | 18.14 | -0.46 [-0.82, -0.10] |

Subtotal (95% CI) | -0.478 0.8716 | 767 | 742 | 100.00 | -0.75 [-1.29, -0.21] |

Test for overall effect $Z = 2.08$ ($P = 0.00001$)

One CBA study, Brown 2009 CBA Rwanda's intervention of adult mentoring of youths who were heads of households, showed no difference in depression symptom severity at two years (see Table 2). Two CBA studies performed in rural post-conflict areas suggested it is uncertain whether LHW- and OPHR-led interventions decrease the severity of common mental disorder symptoms (SMD -0.32, 95% CI -0.60 to -0.04, very-low-quality evidence) (Bass 2012 CBA Indonesia; Scholte 2011 CBA Rwanda). See Characteristics of included studies and Table 5 for more details.

3. Functional impairment of adults with common mental disorders

Four studies assessed functional impairment of which three were LHW-led interventions (Bolton 2003 C-RCT Uganda; Hirani 2010 CRCT Pakistan; Rahman 2008 CRCT Pakistan), and one was social worker-led (Tiwari 2010 RCT China). It is uncertain whether these interventions lead to a reduction in functional impairment within zero to six months of interventions (SMD -0.33, 95% CI -0.80 to 0.13, 4 studies, 1243 participants, very-low-quality evidence due to very serious risk of bias, inconsistency and imprecision). Findings from a CBA study assessing a similar LHW non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)
intervention suggested that it is uncertain whether this reduces functional impairment (Bass 2012 CBA Indonesia).

However, LHW-led interventions probably reduce functional impairment of patients with common mental disorders in the medium term (12 months) (SMD -0.56, 95% CI -0.70 to -0.42, 1 study, 798 participants, moderate-quality evidence). The improvement at 12 but not six months may suggest that it takes longer for functional recovery.

**Comparison 2. Collaborative care model (non-specialist health workers plus specialist) versus usual care in treating common mental disorders (including depression and anxiety) (RCTs)**

Setting: we identified five studies from Chile (Araya 2003 RCT Chile; Fritsch 2007 RCT Chile; Rojas 2007 RCT Chile), India (Patel 2010 C-RCT India), and Kenya (Jenkins 2012 C-RCT Kenya). Both Patel (2010) and Jenkins (2012) were interventions located in a combination of urban and rural settings. The Chilean trials were conducted in deprived urban areas. All trials were conducted in government-funded PHC facilities. The Patel trial presented combined and separate results for government- and privately funded facilities.

Participants: In all studies, participants were adults (over 16 (Jenkins 2012 C-RCT Kenya) and over 17 (Patel 2010 C-RCT India) years; over 18 years for other studies) with common mental disorders (including anxiety or depression, or both) or just depression. Araya (2003), Fritsch (2007) and Rojas (2007) included only women. Most participants were of low socioeconomic status.

Interventions: Types of NSHWs: these collaborative care models involved existing PHC staff, including private and government PHC doctors (Araya 2003 RCT Chile; Fritsch 2007 RCT Chile; Jenkins 2012 C-RCT Kenya; Patel 2010 C-RCT India; Rojas 2007 RCT Chile), non-medical professional staff (nurses, social workers, midwives) (Araya 2003 RCT Chile; Jenkins 2012 C-RCT Kenya; Rojas 2007 RCT Chile), and LHWs (Fritsch 2007 RCT Chile; Patel 2010 C-RCT India; Rojas 2007 RCT Chile).

Training and supervision of NSHWs: doctors received four to six hours of training in all studies (except for Jenkins 2012) where it was not specified how many hours frontline staff received. LHWs training varied from two to two months. Those with longer training (Patel 2010) were expected to deliver a wider range of services. In all studies, NSHWs received some supervision (weekly to monthly/ad hoc) though those in Jenkins (2012) received no supervision and had poor medication supply.

Description of interventions: collaborative care models involved a multidisciplinary team consisting of one or several NSHWs and specialists. Doctors and nurses in Jenkins (2012) diagnosed patients, provided medical treatment and follow-up/referral as per the existing government health delivery model. Araya (2003), Rojas (2007) and Patel (2010) used a stepped care intervention where doctors prescribed antidepressants and provided usual physical care and referred if there was high suicide risk. Jenkins’ (2012) PHCs had poor medication supply. LHWs and non-medical professionals provided several services such as psychoeducation, medication adherence/follow-up (in person or by telephone) and IPT (Araya 2003 RCT Chile; Fritsch 2007 RCT Chile; Patel 2010 C-RCT India; Rojas 2007 RCT Chile). The intensity of these interventions varied from ad hoc (Fritsch 2007 RCT Chile; Jenkins 2012 C-RCT Kenya; Patel 2010 C-RCT India) to eight weekly psychoeducation sessions (Rojas 2007 RCT Chile). Comparison groups were the same settings where NSHWs did not receive training/supervision (Araya 2003 RCT Chile; Fritsch 2007 RCT Chile; Jenkins 2012 C-RCT Kenya; Rojas 2007 RCT Chile), and same settings without the addition of a lay counsellor, and where current staff received a training manual (enhanced usual care) (Patel 2010 C-RCT India).

**Results**

The primary analysis performed was of prevalence, severity and functional impairment of common mental disorders. Where trials only reported depression scores, these were combined within the common mental disorder analysis (including both anxiety and depression). Data reported at six months post intervention (if available) were chosen to represent the medium-term time point, otherwise an earlier time point (zero to five months) was combined.

### 1. Prevalence of common mental disorders

Three studies reported prevalence of CMDs (CMD scores: Patel 2010 C-RCT India; depression scores: Araya 2003 RCT Chile; Patel 2010 C-RCT India; Rojas 2007 RCT Chile). Across all facilities (private and government), the use of NSHWs may reduce the prevalence of CMDs within two to six months (RR 0.63, 95% CI 0.44 to 0.90, 2380 participants, low quality of evidence due to serious study limitations and inconsistency (I² = 79%; P value = 0.001) (Figure 6; Summary of findings 2). For government facilities only (where data from Patel 2010 C-RCT India was substituted for just the government health facilities data), the effect size was similar (RR 0.57, 95% CI 0.42 to 0.78, 1528 participants, low-quality evidence). There is probably no reduction in prevalence at 12 months in ‘all facilities’ (RR 0.95, 95% CI 0.68 to 1.33, 1 study, 2009 participants, moderate-quality evidence due to imprecision) or in government facilities alone (RR 0.72, 95% CI 0.39 to 1.34, 1 study, 1104 participants; low-quality evidence due to very serious imprecision).
We conducted a sensitivity analysis to analyse CMD scores and depression scores separately. This revealed very similar results (depression: RR 0.61, 95% CI 0.40 to 0.94, 3 studies, 1092 participants, low-quality evidence; CMD: RR 0.80, 95% CI 0.61 to 1.05, 1 study, 1961 participants, moderate-quality evidence).

2. Severity of common mental disorders

Severity of CMDs was measured in five studies (CMD scores: Jenkins 2012 C-RCT Kenya; Patel 2010 C-RCT India, depression scores: Araya 2003 RCT Chile; Frisch 2007 RCT Chile; Patel 2010 C-RCT India; Rojas 2007 RCT Chile). It is uncertain whether collaborative care reduces the severity of CMDs in the short term (two to six months) despite a statistically significant small benefit (SMD -0.31, 95% CI -0.56 to -0.06, 5 studies, 3604 participants, very-low-quality evidence due to serious study limitations, serious inconsistency (I² = 91%; P value < 0.00001), and serious indirectness) (note that a small clinically appreciable benefit was set at SMD < 0.2) (Cohen 1988) (Table 6). Government facilities analysis shows a similar magnitude of effect (SMD -0.32, 95% CI -0.58 to -0.07, very-low-quality evidence). There is probably no medium term (12 months) reduction in CMD symptom

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Log(Risk Ratio)</th>
<th>Collab care Total</th>
<th>Enhanced usual care Total</th>
<th>Risk Ratio IV, Random, 95% CI</th>
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<tr>
<td>2.1.1 All facilities short term (within 6 months post intervention)</td>
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<tr>
<td>Araya 2003 RCT Chile (4)</td>
<td>-0.855</td>
<td>104</td>
<td>104</td>
<td>0.43 [0.21, 0.89]</td>
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<tr>
<td>Patel 2010 C-RCT India (1)</td>
<td>-0.223</td>
<td>549</td>
<td>549</td>
<td>0.80 [0.61 to 1.05]</td>
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<tr>
<td>Rojas 2007 RCT Chile (2)</td>
<td>-0.241</td>
<td>110</td>
<td>110</td>
<td>0.71 [0.56, 0.90]</td>
</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td>0.69 [0.44, 0.98]</td>
</tr>
<tr>
<td>Heterogeneity: Tau² = 0.06; Chisq: 9.48, df = 2 (P = 0.0099, I² = 79%)</td>
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<tr>
<td>Test for overall effect: Z = 2.57 (P = 0.01)</td>
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<tr>
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<td>2.1.2 Public facilities short term (within 6 months post intervention) (subgroup)</td>
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<tr>
<td>Araya 2003 RCT Chile (4)</td>
<td>-0.855</td>
<td>104</td>
<td>104</td>
<td>0.43 [0.21, 0.89]</td>
</tr>
<tr>
<td>Patel 2010 C-RCT India (1)</td>
<td>-0.223</td>
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<tr>
<td>2.1.3 Private facilities short term (within 6 months post intervention) (subgroup)</td>
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<tr>
<td>Patel 2010 C-RCT India (1)</td>
<td>0.133</td>
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<td>359</td>
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<tr>
<td>Subtotal (95% CI)</td>
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<td>1.12 [0.68, 1.84]</td>
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<td>Test for overall effect: Z = 0.45 (P = 0.65)</td>
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<tr>
<td>2.1.4 All facilities medium term (at 1 year post intervention)</td>
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<tr>
<td>Patel 2010 C-RCT India (1)</td>
<td>-0.551</td>
<td>731</td>
<td>731</td>
<td>0.55 [0.36, 0.80]</td>
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<tr>
<td>Subtotal (95% CI)</td>
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<tr>
<td>Test for overall effect: Z = 1.04 (P = 0.30)</td>
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<th>Risk Ratio IV, Random, 95% CI</th>
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<tr>
<td>2.1.5 Public facilities medium term (at 1 year post intervention) (subgroup)</td>
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<tr>
<td>Patel 2010 C-RCT India (1)</td>
<td>-0.328</td>
<td>540</td>
<td>540</td>
<td>0.72 [0.56, 0.93]</td>
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<tr>
<td>Subtotal (95% CI)</td>
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<td>0.72 [0.56, 0.93]</td>
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<td>Heterogeneity: Not applicable</td>
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<tr>
<td>Test for overall effect: Z = 1.52 (P = 0.13)</td>
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<tr>
<td>2.1.6 Private facilities at 1 year post intervention</td>
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<tr>
<td>Patel 2010 C-RCT India (1)</td>
<td>0.231</td>
<td>387</td>
<td>387</td>
<td>1.25 [0.76, 2.06]</td>
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<tr>
<td>Subtotal (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td>1.25 [0.76, 2.06]</td>
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<tr>
<td>Heterogeneity: Not applicable</td>
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<tr>
<td>Test for overall effect: Z = 0.83 (P = 0.30)</td>
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(1) Collab: model for persistent recurrent depression; I-PDSS: scores 6 (recovered) at 6 months, transformed to fit with Patel prevalence model - no recovered
(2) stepped care for CMDs: CID-R; 6 month prevalence of CMDs adjusted RR
(3) stepped care for postnatal depression: N of patients with EPDS 6 point reduction 3 months post-partum - no recovery (6 months post baseline) pre of prevalence (total - no recovery)
(4) stepped care for postnatal depression: CID-R: scores 6 (recovered) at 6 months, transformed to fit with Patel prevalence by doing total - no recovery
(5) stepped care for CMDs: CID-R; 6 month prevalence of CMDs adjusted RR
(6) stepped care for CMDs: CID-R: numbers and totals for CMDs; adjusted RR for non-recovered completers
(7) stepped care for CMDs: CID-R: adjusted RR for non-recovered completers
(8) stepped care for CMDs: CID-R: adjusted RR for non-recovered completers
(9) stepped care for CMDs: CID-R: adjusted RR for non-recovered completers
(10) stepped care for CMDs: CID-R: adjusted RR for non-recovered completers
(11) stepped care for CMDs: CID-R: adjusted RR for non-recovered completers
(12) stepped care for CMDs: CID-R: adjusted RR for non-recovered completers

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)
severity (SMD -0.03, 95% CI -0.12 to 0.06, 1 study, 1905 participants, moderate-quality evidence) (Figure 7), possibly due to recurrence of depression at this point in time.

Figure 7. Forest plot of comparison: 2 Collaborative care model (NSHWs plus specialist) versus usual care in treating common mental disorders (RCTs), outcome: 2.2 Severity of symptoms of common mental disorders (completers combined) in all facilities and in public and private facilities.
The Araya trial results were an outlier for this outcome, with a much larger effect size reported (although with the same direction of effect). This may be because it was the only trial measuring major depression (moderate to severe depression). Other trials included mild depression in their inclusion criteria. This would explain the larger effect size as there is strong evidence that baseline severity of depression is a predictor of the effectiveness of depression treatments (Kirsch 2008). In a sensitivity analysis in which Araya was excluded, the reduction in symptoms no longer showed appreciable benefit (SMD -0.10, 95% CI -0.17 to -0.03, 3394 participants, low-quality evidence) and the results were consistent across studies (I² = 0%; P value = 0.39).

We conducted a sensitivity analysis to analyse CMD scores and depression scores separately. CMD scores suggested collaborative care models probably do not result in a clinically appreciable reduction in the severity of CMDs in either the short term (two to six months) (SMD -0.07, 95% CI -0.15 to 0, 2 studies, 2889 participants, moderate-quality evidence due to serious indirectness) or the medium term (one year). The short-term findings are inconsistent with the above prevalence findings. Possible explanations may be that the tools used to assess severity, particularly General Health Questionnaire (GHQ)-12 in Jenkins, may not be appropriate for assessing severity, and that the sample size is smaller in this comparison, thereby giving a less precise estimate. In addition, CMDs could include many milder symptoms of anxiety and depression whereas depression scales would identify patients with more moderate to severe symptoms. The effect of the intervention would be expected to have a greater impact on those with more symptoms (Kirsch 2008).

We could not examine the difference between outcomes for government and private facilities for the severity of CMDs due to limited data.

3. Functional impairment and disability in adults with common mental disorders

Five studies (CMD scores: Jenkins 2012 C-RCT Kenya; Patel 2010 C-RCT India; depression scores: Araya 2003 RCT Chile; Fritsch 2007 RCT Chile; Rojas 2007 RCT Chile) reported functional impairment and disability in adults with CMD. Collaborative care probably does not reduce functional impairment over 12 months (SMD -0.02, 95% CI 0.11 to 0.07, 1 study, moderate-quality evidence).

It is uncertain whether collaborative care reduces functional impairment in CMDs at six months (SMD -0.22, 95% CI -0.44 to -0.01, very-low-quality evidence because of serious risk of bias, serious inconsistency (I² = 87%; P value < 0.00001) and serious indirectness).

The Araya trial results were outliers for this outcome, with a much larger effect size reported (although with the same direction of effect). As above, this may because included patients had more severe symptoms and, therefore, more likely to respond to an intervention. In a sensitivity analysis in which Araya was excluded, there was no longer any appreciable clinical benefit for reducing functional impairment (SMD -0.05, 95% CI -0.12 to -0.02, 3394 participants) but the results were now consistent (I² = 0%; P value = 0.40). At 12 months, there was no difference in functional impairment scores with collaborative or with usual care (SMD -0.02, 95% CI -0.12 to 0.15, 1 study, moderate-quality evidence).

We conducted a sensitivity analysis to analyse CMD scores and depression scores separately. Depression scores were similar or no different but again showed very-low-quality evidence. CMD scores on their own suggested no reduction in functional impairment in people with CMDs at six months (SMD -0.03, 95% CI -0.1 to 0.04, 2889 participants, high-quality evidence) or at 12 months (one study).

Patel’s study was the only study to report disability days. This showed that, over 12 months, collaborative care probably reduces the number of days of no or reduced work in the last month by 4.43 days (MD -4.43 days, 95% CI -8.37 to -0.48, moderate-quality evidence) in government facilities but seems to have no reduction in disability days in private facilities (MD 0.78 days, 95% CI -2.25 to 3.82).

4. Suicide attempts in adults with common mental disorders

Only one study reported suicide attempts in adults with CMDs (Patel 2010 C-RCT India). There was no difference in suicide attempts for those diagnosed with CMDs at one year (RR 0.56, 95% CI 0.24 to 1.32, 1905 participants) and within two to six months. The quality of evidence was low due to very serious imprecision.

Comparison 3. Non-specialist health workers versus usual care in treating maternal depression (RCTs)

This group of studies combined RCTs that were also included above as part of the ‘NSHW-led’ and ‘collaborative’ intervention comparisons and that assessed perinatal depression outcomes.

Setting: we identified four studies, which were conducted in urban settings in Chile (Rojas 2007 RCT Chile), Jamaica (Baker-H 2005 CRCT Jamaican), and Taiwan (Chen 2000 RCT Taiwan), and rural settings in Pakistan (Rahman 2008 CRCT Pakistan).

Participants: the trials recruited mothers at different times from the third trimester of pregnancy (Rahman 2008 CRCT Pakistan), up to 13 months’ postpartum (Baker-H 2005 CRCT Jamaican). Participants in all of the trials were generally from lower socioeconomic backgrounds, except for Chen (2000) where there was an equal distribution of participants across all socioeconomic groups.

Interventions: NSHWs: these were mainly existing government employees or aides, including doctors, midwives and LHWs (Rojas 2007 RCT Chile), nurses (Chen 2000 RCT Taiwan), and LHWs (Baker-H 2005 CRCT Jamaican; Rahman 2008 CRCT Pakistan). In Baker-Henningham (2005), LHW training was much more intensive than in Rahman (2008) though in both studies LHWs also received refresher training. In Rojas (2007), the midwives only...
were given an eight-hour training session (other cadres’ training was not specified). In all of the trials, weekly to monthly supervision was provided, apart from Chen (2000), where this was not specified.

Description of interventions: interventions were delivered at home (Baker-H 2005 CRCT Jamaica), in the community (Rahman 2008 CRCT Pakistan), in postnatal wards (Chen 2000 RCT Taiwan), and PHC clinics (Rojas 2007 RCT Chile). Interventions ranged from collaborative care (Rojas 2007 RCT Chile), to CBT-like intervention (Rahman 2008 CRCT Pakistan), to general adapted counselling (Baker-H 2005 CRCT Jamaica; Chen 2000 RCT Taiwan). They varied in intensity from four weeks (Chen 2000 RCT Taiwan), to weekly home visits over 12 months (Baker-H 2005 CRCT Jamaica).

Comparison groups from all four studies included usual care (existing NSHWs without training).

Results

1. Severity of maternal depressive symptoms

There was high-quality evidence that NSHW interventions improved the severity of perinatal depressive symptoms (SMD within three months: -0.50, 95% CI -0.63 to -0.36, 2 studies), and moderate-quality evidence that collaborative interventions slightly improved perinatal depressive symptoms within two to six months (SMD -0.22, 95% CI -0.48 to 0.04, 1 study). LHW interventions may have slightly improved perinatal depressive symptoms at 12 months (SMD -0.41, 95% CI -0.76 to -0.06, 1 study, low-quality evidence) (Table 7). A meta-analysis including all four studies showed that these interventions may have slightly reduced the severity of perinatal depressive symptoms (SMD -0.42, 95% CI -0.58 to -0.26, low-quality evidence due to very serious risk of bias). Results were similar if only the three short-term studies were combined (SMD -0.42, 95% CI -0.65 to -0.20). The statistical heterogeneity was low ($I^2 = 29\%$; $P_{value} = 0.24$) (Figure 8; Summary of findings 3).

Figure 8. Forest plot of comparison: 3 NSHWs versus usual care in treating maternal depression (RCTs), outcome: 3.1 Severity of symptoms in treating maternal depression.

Comparison 4. Non-specialist health workers versus specialist care in treating common mental disorders (controlled before-and-after studies)

Setting: two CBA studies compared NSHWs (primary care doctors/general practitioners (GPs)) to 'gold standard' care (psychiatrists) for pharmacotherapy. These were designed as equivalence studies and were conducted in urban settings in Argentina (Lyketsos1999CBA Argentina) and Hungary (Zambori 2002 CBA Hungary).

Participants: Adults with common mental disorders (anxiety and depression) (Zambori 2002 CBA Hungary), and major depressive disorder (Lyketsos1999CBA Argentina).

Interventions: NSHWs: GPs in Lyketsos (1999) received half a...
day of training and ad hoc supervision from support staff. GPs in Zambori (2002) did not receive either training or supervision in the context of the trial.

Description of interventions: the GPs provided usual care for depression (prescribing medications, supportive therapy and referring). In Lyketsos (1999), both GPs and control group psychiatrists were given a protocol for prescribing antidepressants.

Results

We could not combine any outcomes. Below is a summary of the studies.

1. Severity of depression

It is uncertain whether GPs are equivalent to specialists in delivering pharmacotherapy for depression (MD -0.90, 95% CI -1.20 to -0.60, 1 study, Lyketsos1999CBA Argentina) as the quality of evidence was very low (CBA study and very serious risk of bias) (Summary of findings 4).

2. Adverse events

It is uncertain whether GPs are equivalent to specialists when adverse events get reported (RR 0.85, 95% CI 0.67 to 1.07, 1 study, Lyketsos1999CBA Argentina) as the quality of evidence was very low (Table 8).

3. Number of days spent at hospital and on sick leave

It is uncertain whether GPs were equivalent to specialists in the number of days spent at hospital (MD -1.79 days, 95% CI -3.59 to 0.01 in favour of NSHWs) and on sick leave (MD 14.63 days, 95% CI -0.75 to 30.02, 1 study, Zambori 2002 CBA Hungary) as the quality of evidence was very low (very serious risk of bias and imprecision).

Comparison 5. Non-specialist health workers/other professionals with health roles-led psychological interventions versus usual care in delivering post-traumatic stress disorder interventions to adults (RCTs and NRCT)

Setting: we identified three studies, where participants lived in internally displaced camps (Dybdahl 2001 RCT Bosnia; Yeomans 2010 RCT Burundi) and refugee settlements (Neuner 2008 NRCT Uganda).

Participants: adults of both sexes who were diagnosed with PTSD, or with symptoms suggesting PTSD in mothers (Dybdahl 2001 RCT Bosnia).

Interventions: NSHWs/OPHRs: in Neuner (2008), LHWs with secondary school education were trained for six weeks in two counselling techniques (NET - narrative exposure therapy, a psychological therapy, and general trauma counselling), which they delivered in different sessions. In Yeomans (2010), the LHWs had experience in trauma workshop facilitation (so only were given one-day training to adapt the workshop delivery) but little formal education. In Dybdahl (2001), preschool teachers were trained during a five-day workshop that used a range of group, role play and lecture teaching methods. There was intensive supervision in Neuner (2008) and Dybdahl (2001) (not specified in Yeomans (2010)).

Description of interventions: duration: Neuner and Yeomans interventions had four to six sessions (but at different intervals) whereas Dybdahl’s intervention consisted of weekly sessions for five months (20 sessions). Content: three studies’ interventions were manualised (Neuner - NET, Yeomans (both arms), Dybdahl). Neuner’s non-manualised trauma counselling, Yeomans workshop with counselling and Dybdahl’s interventions were similar (problem solving and coping strategies, interpersonal skills, relaxation techniques and healing through reconciling communities, psychoeducation (and childcare in Dybdahl)). Neuner’s first intervention was a psychological therapy NET.

Neuner and Dybdahl’s comparison groups were usual care (without any LHWs, and in Dybdahl they received free medical care). Yeomans’ comparison group was usual care (with LHWs without training for this intervention).

Results

1. Prevalence of post-traumatic stress disorder symptoms

Neuner’s (2008) LHW-led interventions may have reduced the prevalence of PTSD symptoms (NET intervention: RR 0.48, 95% CI 0.27 to 0.85; trauma counselling: RR 0.55, 95% CI 0.33 to 0.93; 1 study, low-quality evidence) (Figure 9).
Figure 9. Forest plot of comparison: 5 NSHW-led psychological interventions versus usual care in treating adults with post-traumatic stress disorder (RCT and NRCT), outcome: 5.1 Prevalence of post-traumatic stress disorder (PTSD).

2. Severity of post-traumatic stress disorder symptoms

We pooled the three interventions that were most similar to each other (see description above). At assessment between two and six months post-intervention, teacher/LHW interventions may have slightly improved PTSD symptoms (SMD -0.36, 95% CI -0.67 to -0.05, 3 studies, 223 participants, I² = 22%, P value = 0.02, low-quality evidence) (Summary of findings 5). As Neuner and Yeomans had two intervention arms, we also combined these results in four ways (Neuner NET + Yeomans no psychoeducation; Neuner NET + Yeomans psychoeducation; Neuner - trauma counselling + Yeomans no psychoeducation; Neuner - trauma counselling + Yeomans psychoeducation). The results were very similar, ranging from SMD -0.31, 95% CI -0.58 to -0.04 (Dybdahl + Neuner NET + Yeomans psychoeducation) to SMD -0.41, 95% CI -0.72 to -0.11 (Dybdahl + Neuner NET + Yeomans no psychoeducation) (Figure 10; Table 9).
A sensitivity analysis excluding Neuner (2008) (as it uses quasi-randomisation) showed a lower effect size and imprecision in the first comparison (SMD -0.22, 95% CI -0.54 to 0.10, 2 studies, 151 participants, I² = 0%, P value = 0.03), with similar results for the other comparisons using the other intervention arms. A subgroup analysis excluding Dybdahl, which was teacher-led, and therefore retaining only LHWs suggested a slightly higher magnitude of effect (SMD -0.47, 95% CI -0.90 to -0.05, 2 studies, 148 participants, I² = 34%, P value = 0.03).

3. Severity of depressive symptoms

LHW-led psychological interventions may not have reduced depression severity (SMD -0.07, 95% CI -0.36 to 0.22, 1 study, both arms had similar results, 76 participants, I² = 0%, P value = 0.03), with similar results for the other comparisons using the other intervention arms. A subgroup analysis excluding Dybdahl, which was teacher-led, and therefore retaining only LHWs suggested a slightly higher magnitude of effect (SMD -0.47, 95% CI -0.90 to -0.05, 2 studies, 148 participants, I² = 34%, P value = 0.03).

Comparison 6. Non-specialist health workers versus usual care in improving dementia patients' and carers' outcomes (RCTs)

Setting: we found two studies, which were conducted in urban areas in India (Dias 2008 RCT India), and Russia (Gavrilova 2009 RCT Russia).

Participants: the interventions were directed at carers of people with dementia. The carers were generally aged between 50 and 60 years and had varying economic backgrounds.

Interventions: NSHWs: Dias 2008 RCT India used two types of LHWs (home care advisors and lay counsellors) trained intensively for one week whereas Gavrilova 2009 RCT Russia used newly qualified doctors trained for two days to deliver the intervention. The LHWs were supervised every two weeks by a specialist. The supervision provided to the doctors was not described.

Description of interventions: in both studies brief carer interventions were conducted, based on a larger 10/66 dementia initiative (Prince 2004). However, Gavrilova (2009) organised a short training package for carers only, whereas Dias (2008) implemented a collaborative care package (LHWs undertook psychoeducation, counselling and followed up on treatment effects during home visits).

Results

1. Patient outcomes

At six months post intervention, NSHW-led carer interventions for dementia probably led to slightly improved patient outcomes (including severity of behavioural symptoms (SMD -0.26, 95% CI -0.60 to 0.08, 2 studies) (Figure 11; Summary of findings 6), quality of life (MD -0.43, 95% CI -0.98 to 0.12, 1 study), and functional impairment (MD -0.24, 95% CI -0.67 to 0.20, 1 study) (moderate-quality evidence) (Table 10)).
2. Carer outcomes

NSHWs probably improved/slightly improved carer outcomes, including burden (SMD -0.50, 95% CI -0.84 to -0.15) (Figure 12), mental health status (SMD -0.42, 95% CI -0.76 to -0.08) and distress (SMD -0.47, 95% CI -0.82 to -0.13) (moderate-quality evidence). NSHWs probably led to little or no difference in carer quality of life. The study authors suggested that this result, which is out of keeping with the other carer outcomes, may be due to a type 2 error because the study was not statistically powered to detect differences of this size in the quality of life outcome.

Comparison 7. Non-specialist health worker-led brief alcohol interventions versus usual care for people with alcohol-use disorders

Setting: we found two studies from rural Thailand (Noknoy 2010 RCT Thailand), and urban Kenya (Papas 2011 RCT Kenya). Participants: adults with hazardous use of alcohol (AUDIT score ≥ 8) from primary care settings (Thailand) and patients (AUDIT score > 3) enrolled at a human immunodeficiency virus (HIV) clinic in Kenya. Patients with alcohol dependency were excluded in Noknoy (2010).

Interventions: NSHW: nurses in primary care clinics (Noknoy 2010 RCT Thailand), and LHWs (Papas 2011 RCT Kenya). Training ranged from six hours (Thai nurses) to 175 hours (Kenyan LHWs). Thai nurses received no specific supervision whereas the Kenyan LHWs received 300 hours, weekly monitoring and telephone supervision in the later stages of the trial.

Description of interventions: Noknoy’s (2010) intervention was motivational enhancement therapy (MET), Papas’s (2011) was a CBT intervention. The comparison group was usual care. In Noknoy (2010), these were existing nurses without intervention training, and in Papas (2011), these were existing nurses without intervention training, and in Papas's study, the usual care group received no specific structured intervention.
Results

1. Amount of alcohol consumed and frequency of binge drinking

At three to six months, NSHW-led interventions for alcohol-use problems may reduce the amount of alcohol consumed (MD - 1.68 drinks/day, 95% CI -2.79 to -0.57, 2 studies, low-quality evidence) and may reduce the frequency of binge drinking (MD - 0.50, 95% CI -1.14 to 0.14, 1 study, low-quality evidence due to risk of bias and imprecision) (Figure 13; Summary of findings 7).

Figure 13. Forest plot of comparison: 7 NSHW-led brief alcohol interventions versus usual care for adults with alcohol-use disorders (RCTs), outcome: 7.1 Amount of alcohol consumed (MD).

2. Adverse consequences

NSHW interventions for alcohol problems may not reduce road traffic accidents (RR 0.36, 95% CI 0.12 to 1.08, 1 study, 92 participants, low-quality evidence due to sparse data, study limitations and serious imprecision). It is uncertain whether these interventions increase withdrawal symptoms (RR 2.67, 95% CI 0.29 to 24.37, 1 study, 68 participants, very-low-quality evidence due to sparse data, study limitations and very serious imprecision) (Table 11).

Comparison 8. Non-specialist health workers/other professionals with health roles versus usual care in delivering interventions for children with post-traumatic stress disorder and depression (RCTs)

Setting: we identified eight studies, which were conducted in internally displaced people camps in Bosnia (Dybdahl 2001 RCT Bosnia), Indonesia (Tol 2008 C-RCT Indonesia), Kosovo (Gordon 2008 RCT Kosovo), Nepal (Jordans 2010 C-RCT Nepal), Sri Lanka (Berger2009 CRCT Sri Lanka; Tol 2012 C-RCT Sri Lanka), and Uganda (Bolton 2007 RCT Uganda; Ertl 2011 RCT Uganda). Most studies were undertaken in post-conflict or peri-conflict settings, except for Berger (2009), which followed a natural disaster. The settings were rural/semi-rural (Bolton 2007 RCT Uganda; Gordon 2008 RCT Kosovo; Jordans 2010 C-RCT Nepal; Tol 2008 C-RCT Indonesia), urban (Berger2009 CRCT Sri Lanka; Dybdahl 2001 RCT Bosnia), or urban and rural (Ertl 2011 RCT Uganda; Tol 2012 C-RCT Sri Lanka).

Participants: children with PTSD diagnoses or symptoms were included. Some also had depressive and anxiety symptoms, or conduct problems, or a combination. The ages of the children varied from five to six years (Dybdahl 2001 RCT Bosnia), to adolescents aged 14 to 18 years (Bolton 2007 RCT Uganda; Gordon 2008 RCT Kosovo). One study included child soldiers aged 12 to 25 years (Ertl 2011 RCT Uganda). Most children came from low-resource backgrounds.

Interventions: NSHWs: five studies used LHWs (of both sexes) and had manual-based training for their respective interventions (Bolton 2007 RCT Uganda; Ertl 2011 RCT Uganda; Jordans 2010 C-RCT Nepal; Tol 2008 C-RCT Indonesia; Tol 2012 C-RCT Sri Lanka).
Sri Lanka). Supervision varied from being regular (Jordans 2010 C-RCT Nepal; Tol 2008 C-RCT Indonesia; Tol 2012 C-RCT Sri Lanka) to intensive (e.g. case discussions of their treatment sessions and their notes) (Ertl 2011 RCT Uganda).

OPHRs: three studies used existing high school or preschool teachers (Berger 2009 CRCT Sri Lanka; Dybdahl 2001 RCT Bosnia; Gordon 2008 RCT Kosovo), who were given an additional three-day (Berger 2009 CRCT Sri Lanka) to 10-day (Gordon 2008 RCT Kosovo) intensive training by researchers. Supervision was weekly (Berger 2009 CRCT Sri Lanka; Dybdahl 2001 RCT Bosnia), or regularly (Gordon 2008 RCT Kosovo), by mental health professionals. There was no information on training for Dybdahl (2001).

Description of interventions: all interventions were delivered to groups in schools except for two in community groups (Bolton 2007 RCT Uganda; Dybdahl 2001 RCT Bosnia), and one in child soldiers in their home (Ertl 2011 RCT Uganda). All interventions were targeted at children except Dybdahl (2001) where the target group was mothers. Group interventions varied from 12 to 20 sessions spread over five weeks to five months. Jordans (2010), Tol (2008) and Tol (2012) had the same manual-based, classroom-room-based intervention (CBI). This intervention included elements of creative-expressive therapy, co-operative play and CBT. Berger (2009), Dybdahl (2001) and Ertl (2000) were similar psychosocial/psychological interventions (psychoeducation, group activities, coping skills training) though Ertl (2000) had two arms: NET and academic catch up. Bolton (2007) was a three-armed trial, comparing two LHW interventions (G-IPT and creative play) delivered to single-sex groups. Gordon (2008) used slightly different psychosocial techniques (imaginative mind-body techniques, meditation, etc.).

Results

1. Severity of post-traumatic stress disorder symptoms

Because of differences in outcome measures for short-term outcomes (MCDs could not be combined with MD), we present these outcomes separately. We followed this approach for all outcomes in this comparison.

In the short term (< six months post intervention), despite a large apparent clinical benefit (SMD -0.89, 95% CI -1.49 to -0.30, 3 studies (including Ertl's first intervention arm: NET - a psychological therapy), 298 participants), it is uncertain whether LHWs and teachers reduce the severity of PTSD symptoms due to very-low-quality evidence (very serious study limitations and serious inconsistency I² = 78%; P value = 0.003) (Figure 14; Summary of findings 8). Results were similar if Ertl's second intervention arm (academic catch-up - assisting children with their academic activities only) was combined (SMD -0.85, 95% CI -1.52 to -0.19, 295 participants, I² = 82%; P value = 0.003). In a planned subgroup analysis, interventions led by teachers were analysed separately to attempt to reduce heterogeneity (Berger 2009 CRCT Sri Lanka; Dybdahl 2001 RCT Bosnia). However, it was still uncertain whether teacher-led interventions may reduce the severity of PTSD symptoms (SMD -1.20, 95% CI -1.52 to -0.88, 2 studies, 244 participants, I² = 0%; P value = 0.64) because of very-low-quality evidence (serious study limitations and imprecision due to sparse data).
It is uncertain whether LHW-led CBI reduce PTSD symptoms (MCD -0.56, 95% CI -2.82 to 1.70, very-low-quality evidence due to very serious risk of bias, heterogeneity (I² = 82%; P value = 0.004) and serious imprecision). In one study (Tol 2012 C-RCT Sri Lanka), PTSD symptoms improved in girls in the control group (not in the intervention group), but there was no difference for boys (Analysis 8.3).

At 11 months, one study (Ertl 2000) suggested that NET or academic catch-up interventions probably does not reduce PTSD severity (SMD -0.45, 95% CI -0.99 to 0.10, 1 study, 53 participants, moderate-quality evidence due to serious imprecision and sparse data) (Figure 14: Table 12).

Two CBA studies also assessed teacher-led interventions for children with PTSD (aged six to 17 years) from displaced populations (Thabet 2005 CBA Palestine short term - two months; Wolmer 2005 CBA Turkey long term - three years post intervention). It is uncertain whether these interventions reduced PTSD severity (SMD -0.10, 95% CI -0.34 to 0.14, 329 participants, very-low-quality evidence) (Table 13).

2. Severity of depression symptoms

In the short term (< six months), interventions delivered by either teachers or LHWs may slightly reduce depressive symptoms compared with usual care (SMD -0.23, 95% CI -0.45 to -0.22, 4 studies, 504 participants, low-quality evidence due to very serious study limitations) (Table 12). However, LHW-led CBI may have led to little or no difference in the severity of depression symptoms compared with usual care (MCD -0.18, 95% CI -0.33 to -0.03, low-quality evidence). In one CBA study, it was uncertain if interventions delivered by teachers reduced depressive symptoms (SMD -0.12, 95% CI -0.63 to 0.40) (Thabet 2005 CBA Palestine; very-low-quality evidence; Table 13).

In the medium term (11 months post intervention), LHW-led interventions may not have reduced depressive symptoms (SMD 0.02, 95% CI -0.52 to 0.56, 1 study, 53 participants, low-quality evidence due to very serious imprecision). Similarly, Loughry 2006 CBA Palestine’s study, a LHW-led intervention for displaced children with PTSD, suggested that the effects are uncertain (SMD -0.27, 95% CI -0.50 to -0.04, very-low-quality evidence).

3. Severity of anxiety symptoms

It is uncertain whether LHW-led CBI reduced anxiety severity in children compared with usual care (MCD -0.34, 95% CI -0.75 to 0.07, 3 studies, very-low-quality evidence due to selection bias and imprecision). Tol 2012 C-RCT Sri Lanka undertook a subgroup analysis by sex that showed there may be little or no difference for boys (MCD -0.63, 95% CI -1.23 to -0.03, 245 participants, low-quality evidence).
4. Functional impairment

In the short term (< six months), LHW/teacher-led interventions probably reduce functional impairment (SMD -0.61, 95% CI -1.13 to -0.08, 2 studies, 220 participants, moderate-quality evidence due to serious study limitations) (Analysis 8.9) and LHW-led CBI (MCD -0.81, 95% CI -1.48 to -0.13, 3 studies, 1092 participants) may have reduced functional impairment (low-quality evidence due to very serious study limitations) (Analysis 8.10). At 11 months, Ertl's LHW-led NET group probably also reduced functional impairment (SMD -0.69, 95% CI -1.25 to -0.14, 1 study, 53 participants, moderate-quality evidence due to serious imprecision).

Outcomes of studies not assigned to the above comparisons

The individual studies that could not be pooled are fully described in the Characteristics of included studies tables and their outcomes are summarised in Table 3 and Appendix 4.

These studies included the following comparisons:
1. NSHW versus usual care (life skills training) in improving drug abuse outcomes (RCT);
2. NSHWs versus usual care for treating schizophrenia (CBA study);
3. NSHWs versus specialist care in treating epilepsy (equivalence trial RCT);
4. OPHRs versus usual care in delivering a psychosocial/activities intervention for parents of children with intellectual disabilities (RCT).

Economic studies

Although literature is emerging on the effectiveness of NSHWs in delivering mental health services, very limited data are available on the unit costs and resource requirements. This is mainly due to the difficulties associated with conducting economic analyses, time lags from inputs to outcomes and many confounding variables. Table 14 shows the data from the three included studies that reported cost effectiveness or costs in relation to the care of depression in adults and PTSD in children. These studies underline the feasibility and potential cost effectiveness of NSHWs in providing mental health care, and report costs related to absenteeism and healthcare utilisation. However, all of the studies had significant risks of bias that cast doubt on the accuracy and reliability of these data. Not all relevant alternatives and costs (such as productivity loss) were considered or reported, some costs relied on estimates, future costs were not discounted properly and chosen time horizons were less than one year in Araya.
**ADDITIONAL SUMMARY OF FINDINGS**

What are the effects of a collaborative care model (NSHW plus specialist supervision) for mental health care in adults with common mental disorders low- and middle-income countries?

**Patient or population:** Adults (≥ 18 years) with CMDs (includes anxiety or depression, or both)

**Settings:** Middle-income countries (Chile, India)

**Intervention:** Collaborative care model (NSHW plus specialist supervision)

**Comparison:** Enhanced usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Effect estimate (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assumed risk</td>
<td>Corresponding risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of CMDs, short term (2-6 months) measured using various CMD/depression rating scales</td>
<td>205 per 1000</td>
<td>140 per 1000</td>
<td>RR 0.63 (0.44 to 0.90)</td>
<td>2380 (3 studies)</td>
<td>⊕⊕⃝⃝ low(^1)</td>
</tr>
</tbody>
</table>

\(^1\) The basis for the assumed risk is the mean control group risk across studies for pooled results and the control group risk for single studies. The corresponding risk (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: confidence interval; CIS: Clinical Interview Schedule; CMD: common mental disorder; EPDS: Edinburgh Postnatal Depression Scale; GP: general practitioner; HDRS: Hamilton Depression Rating Scale; ICD: International Classification of Diseases; NSHW: non-specialist health worker; RCT: randomised controlled trial; RR: risk ratio.
<table>
<thead>
<tr>
<th>GRADE Working Group grades of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High quality:</strong> Further research is very unlikely to change our confidence in the estimate of effect.</td>
</tr>
<tr>
<td><strong>Moderate quality:</strong> Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.</td>
</tr>
<tr>
<td><strong>Low quality:</strong> Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.</td>
</tr>
<tr>
<td><strong>Very low quality:</strong> We are very uncertain about the estimate.</td>
</tr>
</tbody>
</table>

1. Araya 2003 RCT Chile: HDRS; Patel 2010 C-RCT India: CIS-R generated ICD-10 diagnosis for CMD; Rojas 2007 RCT Chile: EPDS with a 6-point reduction in score indicating recovery.

2. Serious study limitations: In Araya 2003 RCT Chile, GPs provided both intervention and control treatments, so there was a high risk of contamination. Downgraded by 1.

3. Serious inconsistency: $I^2$ was 79% with Araya 2003 RCT Chile clearly an outlier, contributing to this unexplained inconsistency. However, the inconsistency related to the magnitude of benefit favouring collaborative care rather than in the direction of effect. Downgraded by 1.
### What are the effects of NSHW-led interventions for treating maternal depression in low- and middle-income countries?

**Patient or population:** Adult women with maternal depression  
**Settings:** Low- and middle-income countries (Chile, Jamaica, Pakistan, Taiwan)  
**Intervention:** NSHW-led interventions  
**Comparison:** Usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Estimate effect (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severity of symptoms of perinatal depression, (short and medium term: 0-12 months)</strong> measured using various depression rating scales</td>
<td>The mean severity of symptoms of perinatal depression - medium term with NSHW-led interventions was 0.42 standard deviations lower (0.58 to 0.26 lower)</td>
<td>SMD -0.42 (-0.58 to -0.26)</td>
<td>1213 (4 studies)</td>
<td>⊕⊕⃝⃝ low&lt;sup&gt;1,3&lt;/sup&gt;</td>
<td>Note that a small clinically appreciable benefit was set at SMD &lt; 0.2, and a moderate benefit at SMD of 0.5 to 0.8 (Cohen 1988)</td>
</tr>
</tbody>
</table>

*The basis for the assumed risk is the mean control group risk across studies for pooled results and the control group risk for single studies. The corresponding risk (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

BDI: Becks Depression Inventory; CES-D: Center for Epidemiologic Studies Depression Scale; CI: confidence interval; EPDS: Edinburgh Postnatal Depression Scale; HDRS: Hamilton Depression Rating Scale; NSHW: non-specialist health worker; RCT: randomised controlled trial; SMD: standardised mean difference.

**GRADE Working Group grades of evidence**

**High quality:** Further research is very unlikely to change our confidence in the estimate of effect.  
**Moderate quality:** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.  
**Low quality:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.  
**Very low quality:** We are very uncertain about the estimate.

---

<sup>1</sup> Baker-H 2005 CRCT Jamaica CES-D; Chen 2000 RCT Taiwan Taiwanese BDI; Rahman 2008 CRCT Pakistan; HDRS; Rojas 2007 RCT Chile: EPDS.
Serious study limitations: Baker-H 2005 CRCT Jamaica; Chen 2000 RCT Taiwan has study limitations and together contributed 24% weight to the pooled estimates. Removal of these trials altered the results to favour NSHW-led interventions strongly. Downgraded by 1.

Serious imprecision: The 95% CI of the SMD indicated appreciable and non-appreciable benefit for NSHW-led interventions. Downgraded by 1.
What are the effects of NSHWs compared with specialists in treating depression for mental health care in low- and middle-income countries?

**Patient or population:** Adults with depression  
**Settings:** Middle-income countries (Hungary and Argentina)  
**Intervention:** NSHWs providing pharmacological intervention  
**Comparison:** Specialists providing pharmacological intervention

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed risk</td>
<td>Corresponding risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialists</td>
<td>NSHWs</td>
<td>MD -0.90 (-1.20 to -0.60)</td>
<td>768</td>
<td>☞ΟΟΟΟ very low1,2</td>
<td>Note that a small clinically appreciable benefit was set at SMD &lt; 0.2, and a moderate benefit at SMD of 0.5 to 0.8 (Cohen 1988)</td>
</tr>
<tr>
<td>Severity of depression, short term (0-56 days)</td>
<td>The mean score (SD) on the HDRS was 9.6 (2.1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>measured using HDRS</td>
<td>The mean severity of depression - short term (2 months post intervention) in the NSHW group was 0.9 lower (1.2 to 0.6 lower)</td>
<td></td>
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<tr>
<td>Follow-up: 56 days</td>
<td></td>
<td></td>
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</table>

*The basis for the assumed risk is the risk in the control group. The corresponding risk (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CBA: controlled before-and-after; CI: confidence interval; HDRS: Hamilton Depression Rating Scale; MD: mean difference; NSHW: non-specialist health worker; RR: risk ratio; SD: standard difference; SMD: standardised mean difference.

GRADE Working Group grades of evidence

**High quality:** Further research is very unlikely to change our confidence in the estimate of effect.

**Moderate quality:** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

**Low quality:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

**Very low quality:** We are very uncertain about the estimate.

1 Very serious study limitations: Lyketsos1999CBA Argentina was a CBA study so selection bias was likely. There was a risk of contamination and outcome assessments were done by same physicians doing the intervention. Downgraded by 2.

2 Serious imprecision: The MD on the HDRS was <1 point and this is not clinically a meaningful difference on the HDRS; and the 95% CI of the MD indicated only non-appreciable benefits with NSHW intervention versus specialist intervention. However, the data came from only one study, so estimate is imprecise. Downgraded by 1.
What are the effects of NSHWs compared with usual mental health care in low- and middle-income countries for data from an NRCT in adults with PTSD?

**Patient or population:** Adults with PTSD  
**Settings:** Low- and middle-income countries (Bosnia, Burundi, Uganda)  
**Intervention:** NSHWs and OPHRs delivering psychological interventions (narrative exposure therapy, trauma counselling and workshops with psychoeducation)  
**Comparison:** Usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of PTSD symptoms in LHW/teacher-led psychological interventions (trauma counselling, workshop with psychoeducation, mother intervention) in the short term (2 weeks to 6 months) measured using various PTSD symptom scales (^1)</td>
<td>The mean severity of PTSD with psychological interventions in the short term (within 6 months post-intervention) was 0.36 standard deviations lower (0.67 to 0.05 lower)</td>
<td>SMD -0.36 (-0.67 to -0.05)</td>
<td>223 (3 studies)</td>
<td>⊕⊕⃝⃝ low(^{2,3})</td>
<td></td>
</tr>
</tbody>
</table>

*The basis for the **assumed risk** is the median control group risk or mean control group risk across studies for pooled estimates and the control group risk for single studies. The **corresponding risk** (and its 95% CI) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI). CI: confidence interval; LHW: lay health workers; NRCT: non-randomised controlled trial; NSHW: non-specialist health worker; OPHR: other professionals with health roles; PTSD: post-traumatic stress disorder; SMD: standardised mean difference.

GRADE Working Group grades of evidence

**High quality:** Further research is very unlikely to change our confidence in the estimate of effect.

**Moderate quality:** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

**Low quality:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

**Very low quality:** We are very uncertain about the estimate.

2 Serious study limitations: Neuner 2008 NRCT Uganda no allocation concealment, randomisation had no sequence generation. High dropout rate and different between groups, different baseline characteristics and likely contamination; Yeomans 2010 RCT Burundi: unvalidated Harvard Trauma Questionnaire in the local context (only validated in Burundi) so may affect reliability of outcomes. Dybdahl 2001 RCT Bosnia: incomplete outcome reporting, Impact of Events Scale not previously validated in this setting. Downgraded by 1.

3 Serious imprecision: The 95% CI of the effect estimates demonstrated appreciable and non-appreciable benefit with NSHW care. Downgraded by 1.
What are the effects of NSHW-led care in improving dementia patients’ and carers’ outcomes for mental health care in low- and middle-income countries?

**Patient or population:** People with dementia and their carers  
**Settings:** Middle-income countries (India, Russia)  
**Intervention:** NSHWs delivering brief intervention  
**Comparison:** Usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimate effect</td>
</tr>
<tr>
<td></td>
<td>(95% CI)</td>
</tr>
<tr>
<td></td>
<td>No of Participants (studies)</td>
</tr>
<tr>
<td></td>
<td>Quality of the evidence (GRADE)</td>
</tr>
<tr>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td><strong>Severity of patient behavioural problems, short term (6 months)</strong></td>
<td>SMD -0.26 (-0.60 to 0.08 lower)</td>
</tr>
<tr>
<td>measured using the behavioural symptom scale (NPI-S)</td>
<td>(2 studies)</td>
</tr>
<tr>
<td></td>
<td>⊕⊕⊕⃝ moderate</td>
</tr>
<tr>
<td></td>
<td>Note that a small clinically appreciable benefit was set at SMD &lt; 0.2, and a moderate benefit at SMD of 0.5-0.8 (Cohen 1988)</td>
</tr>
</tbody>
</table>

*The basis for the assumed risk is the mean control group risk across studies for pooled results and the control group risk for single studies. The corresponding risk (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI). CI: confidence interval; NPI-S: Neuropsychiatric Inventory - Severity; NSHW: non-specialist health worker; RCT: randomised controlled trial; SMD: standardised mean difference.

GRADE Working Group grades of evidence

- **High quality:** Further research is very unlikely to change our confidence in the estimate of effect.
- **Moderate quality:** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
- **Low quality:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
- **Very low quality:** We are very uncertain about the estimate.

1 No serious study limitations: Gavrilova 2009 RCT Russia was unclear whether allocation concealed. Dias 2008 RCT India was at low risk of bias and contributed > 60% of the weight to the pooled estimates. Removal of the former study did not alter the results. Not downgraded.
Serious imprecision: The 95% CI for the pooled estimates indicates appreciable benefit for NSHW care and non-appreciable benefit for usual care. Downgraded by 1.
**What are the effects of NSHWs in delivering brief alcohol interventions in RCTs for alcohol-use disorders?**

**Patient or population:** People with alcohol-use disorders  
**Settings:** Low- and middle-income countries (Thailand, Kenya)  
**Intervention:** NSHWs in delivering brief alcohol interventions  
**Comparison:** Usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Assumed risk</strong></td>
<td><strong>Corresponding risk</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Usual care</strong></td>
<td><strong>NSHWs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of alcohol consumed, short term (3-6 months) measured using the number of drinks/drinking day (in past week to 30 days)</td>
<td>The mean amount of alcohol consumed in the intervention groups was 1.68 lower (2.79 lower to 0.57 lower)</td>
<td>MD -1.68 (-2.79 to -0.57)</td>
<td>167 (2 studies)</td>
<td>⊕⊕⊕⃝⃝ low</td>
<td>1,2</td>
</tr>
</tbody>
</table>

*The basis for the assumed risk is the mean control group risk across studies for pooled data or the control group risk for individual studies. The corresponding risk (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: confidence interval; MD: mean difference; NSHW: non-specialist health worker; RCT: randomised controlled trial; RR: risk ratio.

**GRADE Working Group grades of evidence**

**High quality:** Further research is very unlikely to change our confidence in the estimate of effect.

**Moderate quality:** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

**Low quality:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

**Very low quality:** We are very uncertain about the estimate.

---

1. Serious study limitations: Noknoy 2010 RCT Thailand: high dropout rate with no information on whether they are different to completers, no validated tools in the setting, so unreliable primary outcomes. Papas 2011 RCT Kenya: unclear about whether the non-blinding of outcome assessors would have impacted on study. Downgraded by 1.

2. Serious imprecision: The 95% CI of the MD in number of drinks indicates marginal benefit and no appreciable benefit with interventions. The sample size was also low. Downgraded by 1.
What are the effects of NSHWs/OPHRs conducting interventions for children with PTSD from RCTs in low- and middle-income countries?

**Patient or population:** Children/adolescents with PTSD and related depressive/anxiety symptoms

**Settings:** Low- and middle-income countries (Bosnia, Kosovo, Sri Lanka)

**Intervention:** NSHWs/OPHRs delivering psychological and psychosocial interventions

**Comparison:** Usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Estimate effect (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumed risk</td>
<td>Corresponding risk</td>
<td>SMD</td>
<td>(studies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usual care</td>
<td>NSHWs/OPHRs</td>
<td>0.89</td>
<td>(-1.49 to -0.30)</td>
<td>298 (3 studies)</td>
<td>☭○○○ very low2,3</td>
</tr>
</tbody>
</table>

Severity of PTSD symptoms in LHW/teacher-led interventions, short term (1-6 months) measured using various PTSD severity of symptom scales1

The mean severity of PTSD symptoms in children in teacher-led intervention groups was 1.2 standard deviations lower (1.52 to 0.88 lower)

**Assumed risk** the mean control group risk across studies for pooled results and the control group risk for single studies. The **corresponding risk** (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: confidence interval; LHW: lay health workers; NSHW: non-specialist health worker; OPHR: other professionals with health roles; PTSD: post-traumatic stress disorder; RCT: randomised controlled trial; SMD: standardised mean difference; UCLA: University of California at Los Angeles.

GRADE Working Group grades of evidence

- **High quality:** Further research is very unlikely to change our confidence in the estimate of effect.
- **Moderate quality:** Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
- **Low quality:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
- **Very low quality:** We are very uncertain about the estimate.

Very serious study limitations: Gordon 2008 RCT Kosovo no allocation concealment, also likely contamination, and no blinding of outcome assessments; Berger 2009 CRCT Sri Lanka no allocation concealment, likely contamination and outcomes not adjusted for clustering. Two of the three trials are at risk of bias and contribute to > 60% weight to the pooled results. Downgraded by 2.

Serious inconsistency: $I^2 = 78\%$. The inconsistency is not related to the direction of effect. Downgraded by 1.
DISCUSSION

Summary of main results

This review identified 38 RCTs and NRCTs and CBA studies evaluating the effectiveness of NSHWs delivering care for MNS disorders in seven LICs and 15 middle-income countries. Twenty-two studies used LHWs, and most addressed depression or PTSD. The diversity of included studies limited meta-analysis to outcomes for eight comparisons. All analyses presented below compare interventions versus usual care.

The review showed that the use of NSHWs, compared with usual healthcare services:

- may increase the number of adults who recover from depression or anxiety (or both) two to six months after treatment (low-quality evidence). At seven to 12 months, LHW-led psychological interventions probably reduced common mental disorder (anxiety and depression) symptoms and functional impairment, but collaborative care interventions (a multidisciplinary team that included one or several NSHWs and specialists) showed little or no effect over the same time period. It is unclear why this effect was lost by 12 months for collaborative care and this may be because of depression recurrence and because of the relatively short duration of the intervention. The intervention may need to carry on longer, even if just as case management, to detect early signs of relapse. There is also insufficient evidence, due to sparse data, to favour LHW-led psychological interventions over collaborative care at this time;
- may slightly reduce symptoms for mothers with perinatal depression symptoms (low-quality evidence);
- may slightly reduce the prevalence and the symptoms of adults with PTSD over six months (low-quality evidence);
- probably slightly improves the symptoms of people with dementia (moderate-quality evidence);
- probably improves/slightly improves the mental well-being, burden and distress of carers of people with dementia (moderate-quality evidence);
- may decrease the amount of alcohol consumed by people with alcohol-use disorders (low-quality evidence).

In children experiencing PTSD, teachers and LHWs:

- probably reduce functional impairment of PTSD-affected children at six and 12 months following the intervention (moderate-quality evidence);
- may have little or no effect on depressive or conduct symptoms (low-quality evidence);
- it is uncertain whether LHWs or teachers reduce PTSD symptoms over six months among children (very-low-quality evidence).

The three studies measuring costs suggested that NSHW interventions may be cost effective for depression and PTSD, but there is insufficient evidence to draw firm conclusions. For other outcomes (including the equivalence CBA studies for NSHWs versus specialists in treating depression), the evidence is insufficient to draw conclusions regarding the effects of NSHWs. There is also insufficient evidence to determine which NSHW training or intervention strategies are likely to be most effective.

Overall completeness and applicability of evidence

This review aimed to assess the effectiveness of NSHWs in delivering care to people with MNS disorders in order to provide guidance to health policy makers in LMICs. Several issues need to be considered when making judgements about the applicability of these findings to large-scale programmes.

Factors related to the type and role of non-specialist health workers

The included studies reported using many different types of NSHWs/OPHRs (some of whom were existing cadres within health services while others were additionally trained resources), particularly for common mental disorders and PTSD. However, there were few studies in each comparison and often information on details of the intervention and training were inadequate. We, therefore, not able to explore the effects of interventions according to different NSHW characteristics (including selection, training, support, incentives or remuneration). We were also not able to explore the independent effect of NSHWs when they were part of complex interventions (such as collaborative care) or the effect of the intensity of the NSHW-led interventions. This information would help guide policymakers to tailor the type of NSHWs and their roles within scaled up programmes appropriately.

Furthermore, the review provides limited data on the effects of task-shifting to NSHWs. Most studies considered NSHWs or OPHRs as an add-on to usual care. Only three studies (Li 1989 RCT China for epilepsy, and Lyketsos1999CBA Argentina; Zambori 2002 CBA Hungary for depression) compared these cadres versus specialists, but these studies were of low quality and data for most outcomes could not be pooled. We, therefore, cannot be certain if task-shifting (with appropriate supervision) to non-specialists leads to equivalent quality of care or results in terms of appropriate care. Furthermore, very few studies measured adverse effects or unintended consequences of NSHW-led care - such effects could impact on the appropriateness and quality of care, and could lead to patient harm.

Interventions

Comparisons of studies were possible by MNS disorder and by broad types of interventions (such as drug treatment and psychological interventions), as well as who delivered them. However, again there were too few studies and substantial intervention variation within these categories, so it was not possible to draw strong
conclusions on what type of intervention was most effective in relation to specific mental health disorders.
None of the included studies addressed the impact of delivering mental health care on other elements of NSHWs’ healthcare roles (e.g. the impact of a mental health intervention on a PHC doctors’ other tasks such as diabetes, or on their working pattern, such as consultation times). One study assessed the impact of a depression intervention on the number of days spent in hospital (i.e. both a patient outcome and a health service outcome) (Zambori 2002 CBA Hungary), but more studies looking at these indirect outcomes or unintended consequences are needed.

Programme delivery
Several issues need to be considered in applying these findings to healthcare delivery systems. First, these are interventions delivered in a research setting where NSHWs are more likely to have been carefully selected; project leaders are more motivated; remuneration may be more available because of research funding; and training, supervision and monitoring are generally much more intensive. These conditions may not be replicable at scale or may not be as effective at scale. Second, the types of study design chosen here were not appropriate or sufficient to inform judgements regarding the sustainability of programmes; alternative study designs, such as longitudinal studies, economic evaluations and qualitative studies, are needed for this.

Third, the elements necessary for assessing the applicability of interventions need to be considered in each setting where decisions on task-sharing or task-shifting are being made (Lavis 2009). These elements include the extent to which these real-life settings resemble those of included studies, such as on-the-ground constraints, health service arrangements, differences in baseline conditions, presence of specific groups who might benefit from the intervention and the availability of routine data.

Fourth, it is important to know the financial burden of such interventions. Few studies reported cost data, which makes it difficult to draw any conclusions on this question.

Quality of the evidence
The review included 38 studies covering a wide range of interventions and settings. For studies included in meta-analyses, the evidence for most outcomes was of low to moderate quality. Risk of bias assessments highlighted concerns regarding insufficient information on sequence generation and allocation concealment; differences in baseline outcome measurements; the reliability of primary outcome measures; and a failure to address incomplete outcome data, particularly safety data, adequately. Several studies were small and were probably underpowered. Where meta-analysis was possible, the results were fairly consistent in showing improvements in favour of NSHW interventions, although for some interventions and outcomes there were important variations in the reported effects that could not be explained.

Some studies assessed large numbers of outcomes, increasing the probability of finding statistically significant differences for some outcomes by chance. Furthermore, the diversity of the psychometric and other outcome measures used made the interpretation of statistically pooled outcome data difficult.

In the update of this review, we will consider RCTs and cluster RCTs only, as we found few NRCTs and CBA studies and no ITS studies. Those NRCTs and CBA studies that were included did not contribute significant additional data to the review.

Potential biases in the review process
NSHWs, and in particularly LHWs, are still currently poorly indexed in the literature. Though we tried covering a broad range of different synonyms for these health workers, it is possible that some studies have been missed. In addition, NSHWs and LHWs do not have standard widely accepted definitions, so some readers may disagree with these definitions or how this review has aggregated different health workers together.

There were too few studies for each comparison to assess publication bias through assessment of asymmetry. However, because many studies reported non-statistically significant results, publication bias is probably unlikely.

Many meta-analyses were performed; therefore, some of the findings may be due to chance. Many pooled results were statistically and clinically heterogeneous, mainly because of the small number of studies and the breadth of geographical, health worker and patient characteristics - these results, therefore, need to be interpreted with caution.

Furthermore, we did not record whether, for NRCTs, the study restricted participant selection or demonstrated balance or matching between intervention and control groups on prognostic factors, or a combination of these. An imbalance of these may act as confounders (such as age, sex, socioeconomic status). However, most of the findings were reported from RCTs, so this is unlikely to have a major impact on the interpretation of our findings.

A further limitation was that trials that did not conduct an ITT analysis were generally not re-analysed or their missing data was not imputed (except for one analysis were we were able to source data: NSHW-led psychological interventions for depression - prevalence of depression). Doing so may have impacted on the estimates of effect.

Agreements and disagreements with other studies or reviews
Several reviews in primary or community mental health care have been conducted but none have focused exclusively on the effectiveness of mental healthcare delivery by a non-specialist workforce.
Reviews have covered alternatives to inpatient care but with a focus on specialist outreach services such as specialist child community services (Shepperd 2009), or community-based rehabilitation (without specifying the workforce) (Robertson 2012). Other studies addressed resource use and primary care provider behaviour with the addition of a mental health resource at primary care level, but did not assess the effect on patient outcomes (Harkness 2009). Certain reviews compared interventions themselves rather than the provider (Abas 2003; Huntley 2012; Wiley-Exley 2007). Seven reviews incorporated aspects of interventions that were included in this review (Boer 2005; Bower 2006; Huntley 2012; Parker 2008; Rahman 2013; Tol 2011; Wolfram 2012). Details of agreements and disagreements with these reviews are presented in Table 15.

**Economic studies**

Appendix 3 describes other relevant economic studies that were not included in this review. The findings of these studies are similar to those of the three studies (Araya 2003 RCT Chile; Jordans 2011; Zambori 2002 CBA Hungary) included in this review, that is, that NSHW interventions seem cost-effective, and that these findings are difficult to generalise due to the different healthcare systems in various countries.

**AUTHORS’ CONCLUSIONS**

**Implications for practice**

Most results from the 38 studies suggest non-specialist health workers (NSHW) delivering mental, neurological and substance-use disorders (MNS) interventions have some impact on patients’ outcomes, though the evidence is overall of low quality. Given the multitude of settings, disorders, interventions and health worker expertise covered in this review, there are still too few studies within each category to draw conclusions on specific intervention characteristics (such as type of health worker, duration of intervention, levels of training and supervision, etc.) that may impact on effectiveness.

The results show that in adults, lay health worker (LHW)-led psychological interventions and collaborative care (a multidisciplinary team with NSHWs and specialists) may increase the number of adults who recover from depression or anxiety, or both, two to six months after treatment (low-quality evidence). At seven to 12 months after treatment, it is uncertain whether the delivery of psychological treatment by LHWs alone is more effective than delivery by non-specialists who are part of a multidisciplinary team (collaborative care). NSHWs may also slightly reduce symptoms for mothers with perinatal depression symptoms (low-quality evidence).

Among the other disorders, NSHWs probably slightly improve the symptoms of people with dementia and the mental well-being, burden and distress of carers of people with dementia (moderate-quality evidence). They may also slightly reduce the symptoms of adults with post-traumatic stress disorder (PTSD) and may decrease the amount of alcohol consumed by people with alcohol-use disorders (low-quality evidence).

It is uncertain whether LHWs or teachers reduce PTSD symptoms among children (very-low-quality evidence). There were insufficient data to draw conclusions about the cost-effectiveness of using NSHWs or teachers, or about their impact on people with other MNS conditions such as epilepsy, schizophrenia, and alcohol and drug abuse problems. There is also insufficient evidence to determine which NSHW training or intervention strategies are likely to be most effective.

**Implications for research**

While this review has identified a large number of studies conducted in low- and middle-income countries (LMICs), a number of important research questions remain. Research recommendations have been subdivided into those for trialists, systematic reviewers and other researchers.

**Trialists**

Trialists need to:

- describe trial interventions better, for example in terms of training, supervision and incentives for NSHWs or other professionals with health roles (OPHRs). This will allow systematic reviewers to identify and compare characteristics that may help to explain the effects of NSHW interventions better;
- conduct trials comparing interventions with different characteristics/types of NSHWs/OPHRs or modes of delivery, to be able to understand the effects of these variations. This is particularly applicable to collaborative care and other complex interventions where there may be several types of specialists and NSHWs, and several types of interventions on offer (such as stepped care);
- compare NSHWs/OPHRs versus specialists to be able to assess the potential for task-shifting;
- include assessments of potential adverse effects or unintended consequences of NSHWs and OPHRs;
- design better quality trials, which includes more rigorous local validation of instruments and agreeing on standard instruments for specific outcomes and disorders to facilitate pooling and comparing data;
- focus on clinical issues that have been poorly addressed to date, including epilepsy and other neurological disorders, severe mental disorders and substance abuse;
- include economic data in their trials, as costs and cost-effectiveness are important information for health planning.
Systematic reviewers
Further systematic reviews, drawing on a range of study designs (such as studies of effects, but also process evaluations, economic evaluations and qualitative work), are needed on:
- factors affecting the sustainability of NSHW/OPHR interventions when scaled up;
- the effectiveness of different approaches to ensure programme sustainability, including the use of different types of incentives and payment systems for NSHWs/OPHRs;
- mechanisms for integrating LHW (subset of NSHW) programmes into the formal health system;
- the equity impacts of these programmes.

Other researchers
Given the very broad range of NSHWs and OPHRs (with considerable variation in their characteristics (training, supervision, etc.), settings, interventions and delivery mechanisms in mental health care), there is a need to develop a comprehensive typology of NSHWs and OPHRs, as well as of the interventions they provide, which would help health planners and future researchers to have more standardised and comparable interventions and situations.

ACKNOWLEDGEMENTS
We thank: Jan Odgaard-Jensen from the Cochrane Effective Practice and Organisation of Care (EPOC) Group in Norway for his statistical guidance and support; Ian Shemilt from the Campbell & Cochrane Economics Methods Group (CCEMG) for extensively reviewing and providing guidance on the development of the economics component of this review; Marit Johansen from the EPOC Norwegian Satellite for her help with compiling the search strategy and to the following people for their help with papers that were not in English: Liu Qin (Chinese), Ji Eun Park (Korean), Oded Horn (Czech), Gerard Urrutia Cuchi (Spanish), Krystyna Hviding (Polish), Claire Glenton (Swedish), Ozren Polasek (Croatian), Ahmet Metin Gulmezoglu (Turkish), Abbas Kasymov (Russian) and Firoze M. (Farsi).

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Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)

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Rahman 2008 CRCT Pakistan * [published data only]


Rojas 2007 RCT Chile * [published data only]

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Alvarado 2011 [published data only]

Anand 2005 [published data only]

Apil 2011 [published data only]

Aravena 2011 [published data only]

Arcel 1995 [published data only]

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Deeks 2009

Demyttenaere 2004

Drummond 2005

Dybdahl 1996

Dybdahl 1999

Foa 2005

Fox 2002

Goldberg 2009

GRADE 2007

Guyatt 2013

Harkan 1997

Higgins 2009

Higgins 2011

Hu 2006

Huntley 2012

Jacob 2007

Jordans 2011

Kakuma 2011

Khamis 2000
Kirsch 2008

La Trobe 2008

Lancet 2007

Laor 2002

Lavis 2009

Lewin 2008

Lewin 2010

Lopes Cardozo 2000

Lucas 2001

Lukumar 2008

Mental Health Atlas 2011

Murray 2012

Murthy 1987

Murthy 2008

Parker 2008

Patel 2003c

Patel 2007a

Patel 2007b

Patel 2007c

Patel 2008a

Patel 2008b
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van Steenbergen-Weijenburg KM, van der Feltz-Cornelis CM, Horn EK, van Marwijk HWJ, Beekman ATF, Ruiter CM, Horn EK, van Marwijk HWJ, Beekman ATF, Ruiter...

Vos 2012

WHO 1997

WHO 2001

WHO 2003a

WHO 2003b

WHO 2008

WHO 2010

Wiley-Exley 2007

Woltmann 2012

* Indicates the major publication for the study.
### Analysis 8.11. Comparison 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs), Outcome 11 Functional impairment - classroom-based LHW intervention - boys/girls.

Review: Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries

Comparison: 8 NSHWs/OPHRs versus usual care in conducting interventions for children with post-traumatic stress and depression (RCTs)

Outcome: 11 Functional impairment - classroom-based LHW intervention - boys/girls

<table>
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<th>Study or subgroup</th>
<th>NSHW/OPHR-led care</th>
<th>Usual care</th>
<th>Mean Difference (SE)</th>
<th>Mean Difference Weight</th>
<th>IV/Random,95% CI</th>
<th>Subtotal (95% CI)</th>
<th>Heterogeneity: not applicable</th>
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<tbody>
<tr>
<td>1 Short term (boys) (within 6 months post intervention)</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Tol 2012 C-RCT Sri Lanka (1)</td>
<td>122</td>
<td>123</td>
<td>-1.19 (0.5312)</td>
<td>68.4%</td>
<td>-1.19 [-2.23, -0.15]</td>
<td></td>
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<tr>
<td>Subtotal (95% CI)</td>
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<td></td>
<td>68.4%</td>
<td>-1.19 [-2.23, -0.15]</td>
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<tr>
<td>2 Short term (girls) (within 6 months post intervention)</td>
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<tr>
<td>Tol 2012 C-RCT Sri Lanka (2)</td>
<td>76</td>
<td>78</td>
<td>-0.40 (0.7823)</td>
<td>31.6%</td>
<td>-0.40 [-1.93, 1.13]</td>
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</tr>
<tr>
<td>Subtotal (95% CI)</td>
<td></td>
<td></td>
<td>31.6%</td>
<td>-0.40 [-1.93, 1.13]</td>
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<td>Test for overall effect: Z = 0.51 (P = 0.61)</td>
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<tr>
<td>Total (95% CI)</td>
<td></td>
<td></td>
<td>100.0%</td>
<td>-0.94 [-1.80, -0.08]</td>
<td></td>
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<tr>
<td>Heterogeneity: Tau² = 0.0; Chi² = 0.70, df = 1 (P = 0.40); I² =0.0%</td>
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<tr>
<td>Test for overall effect: Z = 2.14 (P = 0.032)</td>
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<tr>
<td>Test for subgroup differences: Chi² = 0.70, df = 1 (P = 0.40); I² =0.0%</td>
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</tbody>
</table>

### ADDITIONAL TABLES

**Table 1. Definitions**

<table>
<thead>
<tr>
<th>Adult</th>
<th>Patients who were ≥ 18 years old. However, if some studies had an age range from, for example, 16 years upwards and the majority of participants are over 18 years, we included these study participants as adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and adolescents</td>
<td>Children (from birth to 18 years) were considered as a separate group of participants as they have 1. different patterns of psychopathology/mental disorders; 2. different help-seeking be-</td>
</tr>
</tbody>
</table>
Table 1. Definitions (Continued)

| Mental, neurological and substance-abuse (MNS) disorders | This review included MNS disorders as defined by any criteria within included papers. For the purpose of subgroup analysis, we subcategorised these disorders using the International Classification of Diseases (ICD)-10 criteria for mental and behavioural disorders and epilepsy in adults (the related ICD-10 code is listed in brackets). These categories are most likely to be used in LMIC mental health service delivery, and are based on Patel’s classification (Patel 2003), and the World Health Organization (WHO) MNS disorder categorisation (WHO 2008)

1. Common mental disorders
   - Mild to moderate mood (affective) disorders (F32-38)
   - Neurotic, stress-related and somatoform disorders (F40-49)
   - Behavioural syndromes associated with physiological disturbances and physical factors (F50-59)

2. Severe mental disorders
   - Schizophrenia, schizotypal and delusional disorders (F20-29)
   - Bipolar affective disorder (F31)
   - Severe depressive episode with/without psychosis (F32.2, F32.3)

3. Neuropsychiatric disorders
   - Organic, including symptomatic, mental disorders (includes dementia) (F1-9)
   - Mental retardation (F70-79)
   - Epilepsy (G40)

4. Disorders caused by substance abuse
   - Mental and behavioural disorders due to psychoactive substance use (F10-19)

5. Mental disorders specifically related to childhood/development
   - Conduct disorders
   - Developmental disorders
   - Eating disorders
   - Pervasive developmental disorders

The diagnosis could be made in clinical practice or in the context of the trial

| First level care, primary care and community | First level of contact with formal health services were community-based interventions or primary care interventions (or both), on their own or attached to hospital settings, provided they had no specialist input apart from supervision (modified from Wiley-Exley 2007). This would include individuals with mental illness living in the community and programmes in outpatient clinics or primary care practices. This would not include programmes in hospitals unless the programmes in the hospitals were providing care to outpatients (i.e. generalists in outpatient departments) Community: as mentioned above detection of mental disorders in all age groups were often done outside the health facility, for... |
Table 1. Definitions (Continued)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low- and middle-income country (LMIC)</td>
<td>Any country that has ever been an LMIC, as defined by the World Bank lists of LMICs</td>
</tr>
<tr>
<td>Non-specialist health workers (NSHWs)</td>
<td>Health workers who were not specialised in MNS disorders or have not received in-depth professional specialist training in this clinical area. These included doctors, nurses, auxiliary nurses, lay health workers, as well as allied health personnel such as social workers, occupational therapists. This category did not include professional specialist health workers such as psychiatrists, neurologists, psychiatric nurses or mental health social workers. For inclusion, NSHWs received some training in MNS disorders (in either the control or the intervention group), but this would not constitute a professional category. The authors made a judgement of what constitutes 'some training'. Examples of 'some training' may be an undergraduate module or a short course in mental health</td>
</tr>
<tr>
<td>Other professionals with health roles (OPHRs)</td>
<td>People who were involved as community-level workers but were not within the health sector, as many people, particularly adolescents and young adults, have low contact with health workers. This category included teachers/trainers/support workers from schools and colleges, and other volunteers or workers within community-based networks or non-governmental organisations. These OPHRs have an important role particularly in the promotion of mental health and detection of mental disorders (Patel 2007c; Patel 2008a; WHO 2003a)</td>
</tr>
<tr>
<td></td>
<td>We excluded studies that looked at informal care provided by family members or extended members only to members of his or her own family (i.e. who were unavailable to other members of the community) from this review. As previously highlighted in Lewin's Cochrane review, &quot;these interventions are qualitatively different from other LHW [lay health worker] interventions included in this review given that parents or spouses have an established close relationship with those receiving care which could affect the process and effects of the intervention&quot; (Lewin 2010).</td>
</tr>
<tr>
<td>Clinical interventions</td>
<td>1. Detection (recognition and diagnosis) of illness, including screening</td>
</tr>
<tr>
<td></td>
<td>2. Acute interventions: drug treatment, non-drug treatment/care (such as specific psychological therapies, or interventions with psychosocial components like counselling, psychoeducation, coping skills, etc.), referral</td>
</tr>
<tr>
<td></td>
<td>3. Follow-up, rehabilitation</td>
</tr>
<tr>
<td>Service interventions</td>
<td>These include change in staffing, or change in mechanism of mental health service delivery (e.g. extension of mental health services through camps and such other outreach services, mobile vans, etc.</td>
</tr>
</tbody>
</table>
### Table 1. Definitions (Continued)

### Table 2. Risk of bias economic studies - CHEC list criteria

<table>
<thead>
<tr>
<th>Study</th>
<th>Risk of bias issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Araya 2003 RCT Chile</td>
<td>- time horizon &lt; 1 year</td>
</tr>
<tr>
<td></td>
<td>- a societal perspective would have been more appropriate</td>
</tr>
<tr>
<td></td>
<td>- not all relevant costs reported</td>
</tr>
<tr>
<td></td>
<td>- not all relevant outcomes included (only ambulatory, not hospital)</td>
</tr>
<tr>
<td></td>
<td>- no discounting</td>
</tr>
<tr>
<td>Jordans 2010 C-RCT Nepal</td>
<td>- no discounting</td>
</tr>
<tr>
<td></td>
<td>- no sensitivity analysis</td>
</tr>
<tr>
<td></td>
<td>- not all important variables listed</td>
</tr>
<tr>
<td></td>
<td>- no discussion of ethical/distributional issues</td>
</tr>
<tr>
<td>Zambori 2002 CBA Hungary</td>
<td>- the competing alternatives were not described</td>
</tr>
<tr>
<td></td>
<td>- time horizon at 1 year was not appropriate (needs to be longer)</td>
</tr>
<tr>
<td></td>
<td>- not all relevant outcomes assessed (e.g. effect of treatment on severity, number of healthcare visits to psychiatrist)</td>
</tr>
<tr>
<td></td>
<td>- outcomes not measured appropriately (self reporting meant low response; standard prices used may not reflect actual prices)</td>
</tr>
<tr>
<td></td>
<td>- outcomes not valued (only the short-term outcome)</td>
</tr>
<tr>
<td></td>
<td>- no sensitivity analysis</td>
</tr>
<tr>
<td></td>
<td>- conclusions do not all follow from results</td>
</tr>
</tbody>
</table>

### Table 3. Outcomes of studies not assigned to meta-analyses

<table>
<thead>
<tr>
<th>Study, and outcomes measured and tools</th>
<th>Intervention data [no. of participants]</th>
<th>Control data</th>
<th>Measure of effect (95% CI)</th>
<th>P value</th>
<th>Authors’ conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown 2009 CBA Rwanda (depression in youth)</td>
<td>Mentoring programme by LHW</td>
<td>Usual care</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Severity of depression at 2 years (mean) measured using CID-S</td>
<td>Mean [no. of participants] 23.27 [347]</td>
<td>Mean [no. of participants] 23.28 [345]</td>
<td>-</td>
<td>0.99</td>
<td>Reduction in intervention group but not in control group (at baseline higher score in intervention group). However, the score indicates continuing levels of depression in both groups</td>
</tr>
<tr>
<td>Levels of marginalisation at 2 years (mean) measured</td>
<td>3.35</td>
<td>3.13</td>
<td>-</td>
<td>-</td>
<td>Improved scores in intervention group, which are no different to control group</td>
</tr>
</tbody>
</table>
| Table 3. Outcomes of studies not assigned to meta-analyses  
(Continued) | | | | |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Levels of grief at 2 years (mean) measured using a non-validated 7 point grief scale</td>
<td>3.42</td>
<td>3.38</td>
<td>-</td>
</tr>
<tr>
<td>Baseline lower levels of grief in the control group. No change at the end of the intervention though grief increased in control group and remained stable in the intervention group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Li 1989 RCT China (epilepsy - adults and children)</td>
<td>Village doctors</td>
<td>Psychiatrists</td>
<td>-</td>
</tr>
<tr>
<td>Effective epilepsy control with phenobarbital after 3 months</td>
<td>No. seizures/month [no. of participants] 12 [20]</td>
<td>No. seizures/month [no. of participants] 11 [20]</td>
<td>-</td>
</tr>
<tr>
<td>Total number of adverse events after 3 months</td>
<td>No. events [no. of participants] 19 [20]</td>
<td>No. events [no. of participants] 39 [20]</td>
<td>-</td>
</tr>
<tr>
<td>Paranthaman2010CBAMalaysia (people with schizophrenia and their carers)</td>
<td>Medical assistants/nurses</td>
<td>Usual care</td>
<td>MD (95% CI)</td>
</tr>
<tr>
<td>Carer burden (activities in daily living) (mean) at 6 months. Measured using the Family Burden Interview schedule</td>
<td>Mean (SD) [no. of participants] 9.41 (3.99) [54]</td>
<td>Mean (SD) [no. of participants] 8.93 (4.47)</td>
<td>0.48 (-1.11 to 2.07)</td>
</tr>
<tr>
<td>Carer assistance in daily living severity - ADL at 6 months measured using the Family Burden Interview Schedule</td>
<td>-</td>
<td>-</td>
<td>0.83 (-0.94 to 2.60)</td>
</tr>
<tr>
<td>Re-admission rates</td>
<td>No. (events) [no. of participants] 3 [54]</td>
<td>No. (events) [no. of participants] 5 [55]</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 3. Outcomes of studies not assigned to meta-analyses (Continued)

<table>
<thead>
<tr>
<th>Defaulting from follow-up</th>
<th>No. (events) [no. of participants]</th>
<th>No. (events) [no. of participants]</th>
<th>-</th>
<th>0.03</th>
<th>important improvement in follow-up rate for intervention group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shin 2009 RCT Vietnam</strong></td>
<td><strong>Teacher-led portage programme (OPHRs)</strong></td>
<td><strong>Usual care</strong></td>
<td><strong>MD (95% CI)</strong></td>
<td><strong>P value</strong></td>
<td><strong>Authors’ conclusions</strong></td>
</tr>
<tr>
<td><strong>(children with intellectual disabilities)</strong></td>
<td>Mean (SD) [no. of participants]</td>
<td>Mean (SD) [no. of participants]</td>
<td>-1.40 (-12.93 to 10.13)</td>
<td>0.81</td>
<td>No significant difference for any mental outcomes but some improvement for motor and personal care outcomes if looked at time x effect interaction</td>
</tr>
</tbody>
</table>

| Functional impairment (motor skills) at 6 months (similar at 12 months) measured using the Vineland Adaptive Behaviour Scales | 47.1 (15.5) [16] | 46.3 (18.3) [14] | 0.80 (-11.51 to 13.11) | 0.93 | - |

| Functional impairment (social skills) at 6 months (similar at 12 months) measured using the Vineland Adaptive Behaviour Scales | 55.6 (10.5) [16] | 55.7 (10) [14] | -0.10 (-7.44 to 7.24) | 0.98 | - |

| **Sutcliffe 2009 RCT Thailand** | **Peer educator-led psychoeducation (LHWs)** | **Usual care (life skills training)** | **RR/MD (95% CI)** | **P value** | **Authors’ conclusions** |
| (people with drug abuse disorder) | No. [no. of participants] | No. [no. of participants] | RR 1.01 (0.91 to 1.13) | 0.79 | Randomised peer education, social network intervention and control (social skills training) are both associated with reductions in methamphetamine use and increases in condom use over 12 months among a sample of young Thai people |
| Methamphetamine use at 6 months (similar results at 3, 9 and 12 months) | 272 [442] | 267 [440] | - |

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)

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Table 3. Outcomes of studies not assigned to meta-analyses (Continued)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mean (SD) [no. of participants]</th>
<th>Mean (SD) [no. of participants]</th>
<th>MD [-4.03 to -0.37]</th>
<th>RR [0.60 to 1.07]</th>
<th>SMD [-1.73 to 0.35]</th>
<th>SMD (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery of depressive symptoms at 12 months (index patient) measured using CES-D score</td>
<td>15.7 (9.7) [209]</td>
<td>17.9 (9.3) [206]</td>
<td>-2.20</td>
<td>-0.80</td>
<td>-1.05</td>
<td>-1.05 [-3.20 to 1.11]</td>
</tr>
<tr>
<td>The effect was strongly observed amount intervention index participants compared with both control and network participants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery of depressive symptoms at 12 months (index and network patient combined) measured using CES-D score</td>
<td>[no. of participants] [495]</td>
<td>[no. of participants] [488]</td>
<td>MD -1.05 [-3.20 to 1.11]</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Contrary to expectation, mean and in CES-D score change did not substantially differ between intervention network participants and control network participants. Thus, there is no evidence that the differential intervention effect on depression diffuses to network members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of depression at 12 months (index patient) measured using CES-D score</td>
<td>Events (No.) [no. of participants] [57] [209]</td>
<td>Events (No.) [no. of participants] [70] [206]</td>
<td>RR 0.80 (0.60 to 1.07)</td>
<td>- 0.80 (0.73 to 1.06)</td>
<td>- SMD (95% CI)</td>
<td>- 0.80 (0.73 to 1.06)</td>
</tr>
<tr>
<td>Prevalence of depression at 12 months (index and network patient combined) measured using CES-D score</td>
<td>[no. of participants] [495]</td>
<td>[no. of participants] [488]</td>
<td>RR 0.88 (0.73 to 1.06)</td>
<td>- 0.88 (0.73 to 1.06)</td>
<td>- SMD (95% CI)</td>
<td>- 0.88 (0.73 to 1.06)</td>
</tr>
<tr>
<td>Hirani 2010 CRCT Pakistan (adults with depression, economic skills building intervention arm)</td>
<td>NSHW-led economics skill building n = 9</td>
<td>Usual care n = 8</td>
<td>SMD (95% CI)</td>
<td>- 0.80 (0.73 to 1.06)</td>
<td>- SMD (95% CI)</td>
<td>- 0.80 (0.73 to 1.06)</td>
</tr>
<tr>
<td>This study documents improved self efficacy and employment for women enrolled in economic skill-building compared with general counselling and to control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity of depressive symptoms measured using Beck’s Depression Inventory II</td>
<td>Mean (SD) 20.1 (11.3)</td>
<td>Mean (SD) 27.63 (9.1)</td>
<td>SMD -0.69 (1.73 to 0.35)</td>
<td>- 1.05 (1.73 to 0.35)</td>
<td>- SMD (95% CI)</td>
<td>- 1.05 (1.73 to 0.35)</td>
</tr>
<tr>
<td>Functional impairment measured using the General Self-Efficacy scale</td>
<td>28.7 (6.2)</td>
<td>21.63 (3.8)</td>
<td>SMD -1.29 (-2.41 to -0.16)</td>
<td>- -1.29 (-2.41 to -0.16)</td>
<td>- SMD (95% CI)</td>
<td>- -1.29 (-2.41 to -0.16)</td>
</tr>
</tbody>
</table>

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)
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Nadja van Ginneken Thesis Page 143
Table 14. Summary of costs and resource use from included studies

<table>
<thead>
<tr>
<th>Author/year</th>
<th>Type of economic evaluation</th>
<th>Study population</th>
<th>Intervention</th>
<th>Economic results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Araya 2003 RCT Chile</td>
<td>Cost-effectiveness analysis</td>
<td>Women with depression</td>
<td>Collaborative intervention (doctors, non-medical professionals supervised by psychiatrist) with stepped care, multi-component programme compared with usual care in depressed women in Chile</td>
<td>Incremental cost per person for improved care was USD 37.6 more than usual care. Unit cost to obtain 1 additional depression-free day was USD 0.75</td>
</tr>
<tr>
<td>Jordans 2011</td>
<td>Cost analysis</td>
<td>Children with PTSD (7-15 years)</td>
<td>LHW-led multilayered package (including classroom-based intervention, non-therapeutic resilience groups, psychoeducation and counselling) (data extracted from Sri Lanka and Indonesia as related to Tol 2008 C-RCT Indonesia and Tol 2012 C-RCT Sri Lanka)</td>
<td>Mean cost per user of total package: Indonesia: USD 21.77 (59% of which is human resources cost). Sri Lanka: USD 8.85 (56% of which is human resources cost)</td>
</tr>
<tr>
<td>Zambori 2002 CBA Hungary</td>
<td>Cost analysis</td>
<td>Patients with anxiety and mood disorders</td>
<td>Primary physicians versus psychiatrists in prescribing sertraline in Hungary</td>
<td>Absenteeism reduced from 15.7 to 6.8 days and costs of non-psychiatric prescriptions decreased from USD 138 to USD 91.8 per year. Laboratory costs ranged from USD 6.4 to USD 11.5</td>
</tr>
</tbody>
</table>


Table 15. Agreements and disagreements with related reviews

<table>
<thead>
<tr>
<th>Author/year</th>
<th>Summary of review</th>
<th>Agreements</th>
<th>Disagreements/differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parker 2008</td>
<td>Reviewed consultation liaison in primary care - HICs</td>
<td>-</td>
<td>Our review process did not find any consultation liaison in primary care in LMICs so results cannot be compared</td>
</tr>
</tbody>
</table>

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)  
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<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
<th>Agreement with related reviews</th>
<th>Disagreement with related reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boer 2005</strong></td>
<td>Reviewed paraprofessionals in delivering psychological interventions for anxiety and depression (HIC only)</td>
<td>Included studies were from HICs only, but support our findings that non-professional care is generally equivalent to professional care (this review's equivalent of specialist care), and that non-professional care is better than usual care.</td>
<td>Some of their paraprofessionals would have been classified as specialist health workers in our review.</td>
</tr>
<tr>
<td><strong>Bower 2006</strong></td>
<td>Reviewed the effect of collaborative care models on antidepressant use. All included studies were from HICs except for Araya 2003 RCT Chile</td>
<td>Bower found improvement of antidepressant use, particularly in studies where the case manager had a mental health background, where there was adequate supervision and where there was systematic identification of patients (rather than waiting for a referral).</td>
<td>We were not able to assess, as did Bower, whether lengths of training, supervision or other intervention characteristics modified these outcomes because only 5 studies were included in this comparison.</td>
</tr>
<tr>
<td><strong>Woltmann 2012</strong></td>
<td>Review on collaborative care/chronic care management.</td>
<td>They also found a statistically significant effect on reduction in depression severity among the 14 HIC studies that were included in the meta-analysis (SMD 0.31, 95% CI 0.16 to 0.47) (Araya and Patel's studies were included in the narrative review but did not qualify for their meta-analysis). The authors suggested that collaborative care is of moderate benefit; however, Woltmann has estimated a more conservative value of SMD &gt; 0.5 to show moderate benefit (from the analysis of scales and how to interpret their SMDs). Our meta-analyses of collaborative care models suggested similar improvements in symptoms and recovery from depression or CMDs (same direction of effect, and similar magnitude).</td>
<td>Woltmann's chronic care management had a stricter definition to our collaborative care definition.</td>
</tr>
<tr>
<td><strong>Huntley 2012</strong></td>
<td>Reviewed the effect of CBT and group CBT.</td>
<td>Huntley also found that LHW-led psychological interventions are effective in the short and medium term in reducing symptoms of depression.</td>
<td>Huntley described the effect of CBT and group CBT (rather than the effect of NSHWs).</td>
</tr>
<tr>
<td><strong>Tol 2011</strong></td>
<td>Systematic review on mental health interventions in humanitarian settings.</td>
<td>Tol found similar results to our review for school-based interventions for children with PTSD (i.e. no significant benefit) (an extra study.</td>
<td>This review differed from ours in that it included studies of both NSHWs/OPHRs and specialists, according to our definitions.</td>
</tr>
</tbody>
</table>
Table 15. Agreements and disagreements with related reviews  

(Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Review</th>
<th>Comparison</th>
<th>Agreement with Related Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rahman 2013</td>
<td>Systematic review on interventions for common perinatal mental disorders in women in LMICs</td>
<td>This was similar but a more in-depth review of our perinatal depression pooled comparison, which also looked at LHW-led interventions for mothers with perinatal depression. Their final pooled outcome was similar in magnitude and direction to ours for our perinatal depression category (SMD -0.38, 95% CI -0.56 to -0.21) vs. our findings (SMD -0.42, 95% CI -0.58 to -0.26).</td>
<td>This review differed from ours in that its study's inclusion criteria were broader as it included studies that measured maternal (all perinatal disorders) or child (or both) outcomes even if the intervention was not primarily targeted at these groups. It also reported child outcomes, which ours did not</td>
</tr>
</tbody>
</table>

CBT: cognitive behavioural therapy; CI: confidence interval; CMD: common mental disorders; HIC: high-income country; LHW: lay health worker; LMIC: low- and medium-income countries; NSHW: non-specialist health worker; OPHR: other professionals with health roles; PTSD: post-traumatic stress disorder; SMD: standardised mean difference.

APPENDICES

Appendix 1. Search strategies

CENTRAL

| #1 | MeSH descriptor Allied Health Personnel, this term only |
| #2 | MeSH descriptor Community Health Workers, this term only |
| #3 | MeSH descriptor Nurses’ Aides, this term only |
| #4 | MeSH descriptor Psychiatric Aides, this term only |
| #5 | MeSH descriptor Caregivers, this term only |
CONTRIBUTIONS OF AUTHORS

NvG conceived the review. All authors contributed to the development of the protocol. NvG, PT, GR, MSM, SC and JP extracted data and assessed risk of bias. NvG and PT checked these and did the statistical analysis and GRADE assessments. NvG wrote the final version. All authors commented on and approved the final version.

DECLARATIONS OF INTEREST

NvG, PT, GR, MSM, JP, SC: None known.

VP: A co-author on some of the papers that are included in this study.

SL: An editor for the Cochrane Effective Practice and Organisation of Care Group and the Consumers and Communication Review Group.

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Internal sources

- Christian Medical College, Vellore, India.
  Salary and logistic support for PT

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- Indian Council of Medical Research, India.
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- Wellcome Trust, UK.
  Clinical PhD Fellowship awarded to NvG.
- Wellcome Trust, UK.
  Senior Research Fellowship awarded to VP

DIFFERENCES BETWEEN PROTOCOL AND REVIEW

Authors

Meera SM, Sudha Chandrashekar and Jessica Pian are new authors who helped with data extraction, analysis and writing (SC).

Search strategy

In the review protocol, we planned to search African Indexus Medicus, EurasiaHealth (Eastern European countries) and IndMED (Indian Medlars Centre). This was not done as we felt that the World Health Organization (WHO) trial registry, World Health Organization Library Information System (WHOLIS) and other databases would cover these sources. We did not search the HEED database (as outlined in our protocol) as there were few identified studies. We will perform this search when conducting the next update of this review.
Data extraction and management

- **Settings**: We narrowed down the options to workplace, school, community, PHC clinic and other.
- **Results**: We extracted more details pertaining to outcomes such as whether they were continuous or dichotomous and what the authors’ conclusions were.
- **Screening instruments**: Removed citation details from data extraction.

Assessment of risk of bias

- All based on Cochrane Effective Practice and Organisation of Care (EPOC) criteria, not on the Cochrane Handbook for Systematic Reviews of Interventions.
- We added two extra categories for risk of bias assessment. The detection bias has been divided into two: that of assessing subjective and objective outcomes were assessed blindly. In addition, the attrition bias has been divided into how incomplete or not two types of outcomes are: efficacy outcomes and safety outcomes (e.g. adverse events).
- **Consensus on Health Economic Criteria (CHEC) list criteria**: This was adapted with more questions: 1. Was there a comparison between two more groups receiving different interventions? 2. Is the perspective/viewpoint** of the analysis explicitly stated? If yes, give detail; 3. Are costs measured? If yes, give details of costs measured; 4. Were outcomes measured? If yes, give details of outcomes measured; 5. Were sensitivity analyses undertaken? If yes, give details of forms of sensitivity analyses.

Data synthesis

For NRCTs, we did not record whether the study restricted participant selection or demonstrated balance or matching between intervention and control groups on prognostic factors, or a combination of these. An imbalance of these may act as confounders (such as age, sex, socioeconomic status).

We also did not record whether the study adjusted for confounders or effect modifiers in statistical analyses to quantify the effect size (Reeves 2009). Therefore, we have not entered these into additional tables.

We did not transform ordinal outcomes (such as symptom severity, general psychosocial functioning, levels of dependency in disability and any other outcomes measured on a scale) into binary data (e.g. symptom improvement will become improvement or no improvement) or vice versa as it did not make clinical sense. There were very different scales and many studies that had binary data also pooled continuous data that could be pooled with other similar figures.

**Pooling results**: Though it is generally advised not to pool results if the $I^2$ statistic is more than 50%, we decided to pool outcomes and results that made clinical sense (based on settings, mental illnesses, types of interventions and outcomes measured), rather than rely only pooling those that had an $I^2$ statistic less than 50%.

**Economic outcomes**: There were too few studies to do any conversion of unit costs to 2010 International Dollars (Shemilt 2010), re-estimation of costs, adjustments for currency and price year or perform any further calculations of total costs, or resource use per patient, intervention or health provider.

**Statistical analysis**: We did not perform meta-regression to investigate both the effect of the intervention on the estimates of effects and to investigate the effect of multiple characteristics (regarding setting and the intervention) simultaneously (Deeks 2009), as there were never more than five studies per variable.

**Sensitivity analyses**: We did not perform additional sensitivity analyses that were listed as considered analyses in the protocol:
- based on specific decisions made during the review process, such as how ICCs are imputed for cluster trials;
- based on whether the included cluster RCTs found different estimates of effect to non-cluster trials for specific outcomes, but excluding cluster RCTs;
- based on whether the study reported a validated tool that confirmed the NSHWs diagnostic accuracy;
- if one or more studies reported outcomes using either a continuous scale or a dichotomous scale and in either scenario had been transformed (to dichotomous or continuous variable respectively);
- based on the effect.

For the economic analyses, we also did not perform additional sensitivity analyses, as there were too few studies to make this meaningful.
Subgroup analysis and investigation of heterogeneity

We had initially planned to use non-overlapping CIs to indicate a statistically significant difference in treatment effect between the subgroups, acknowledging that the CIs can overlap to a small degree and the difference could still be statistically significant. However, the implementation in RevMan 2012 of the Chi$^2$ test and $I^2$ statistic for subgroup differences within random-effects meta-analyses meant that this approach was no longer needed.

Definitions

NSHW/OPHR: We excluded certain health workers that we classified as a specialist including those who were not traditionally thought of as specialists by the psychiatry/medical system: for example school counsellors who were trained to exclusively do that and who had a qualification, with or without extra experience and where their sole focus was on child psychology/counselling. We also excluded all healthcare providers within non-biomedical systems (e.g. a yoga master) as we had not searched for these specifically and it was difficult to judge, from our perspective, what constituted for them a mental health intervention.

MNS disorders: We relaxed our criteria for International Classification of Diseases (ICD)-10 diagnoses for inclusion criteria of participants. The reason we did this was that in some studies, the population studied did not have formal diagnoses administered (either because of lack of psychiatrist or because their aim was to look at reduction in symptoms and improvement in psychosocial functioning). Therefore, we included studies where the overwhelming majority of the participants (above 75%) had significant mental health symptoms (such as high scores of depression symptoms or post-trauma symptoms, e.g. Jordans).

Clinical interventions: We decided not to include interventions delivered by people who were not within the medical paradigm (such as faith healers or yoga masters).

Social interventions: We did not include social interventions (initially defined as return to employment/school or general social support) if it was not part of a trial with a specific mental health intervention, as we discovered our search strategy did not address this completely and opened a whole array of studies that we had not considered at the protocol stage (such as income generating activities without a mental health intervention but that may look at mental health outcomes).
Chapter 5

The development of mental health services within primary care in India: learning from oral history

(research paper 3)
RESEARCH PAPER COVER SHEET

PLEASE NOTE THAT A COVER SHEET MUST BE COMPLETED FOR EACH RESEARCH PAPER INCLUDED IN A THESIS.

SECTION A – Student Details

<table>
<thead>
<tr>
<th>Student</th>
<th>Nadja van Ginneken</th>
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<tr>
<td>Principal Supervisor</td>
<td>Vikram Patel</td>
</tr>
<tr>
<td>Thesis Title</td>
<td>The roles of primary-level health workers in delivering mental healthcare in India</td>
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If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

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<th>International Journal of Mental Health Systems</th>
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<td>Was the work subject to academic peer review?</td>
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SECTION C – Prepared for publication, but not yet published

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<td>Stage of publication</td>
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SECTION D – Multi-authored work

| For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary) | I conceived the design of the study and structure of interviews. I conducted all interviews, performed all the analysis and wrote the article which was commented on by my co-supervisors as well as my India-based advisor (Sanjeev Jain). |

Student Signature: [Signature] Date: 3/1/15

Improving health worldwide www.lshtm.ac.uk
The development of mental health services within primary care in India: learning from oral history

Nadja van Ginneken1,2*, Sanjeev Jain3, Vikram Patel1,2 and Virginia Berridge4

Abstract

Background: In India very few of those who need mental health care receive it, despite efforts of the 1982 National Mental Health Programme and its district-level component the District Mental Health Programme (DMHP) to improve mental health care coverage.

Aims: To explore and unpack the political, cultural and other historical reasons for the DMHP’s failures and successes since 1947 (post-independence era), which may highlight issues for today’s current primary mental health care policy and programme.

Methods: Oral history interviews and documentary sourcing were conducted in 2010–11 with policy makers, programme managers and observers who had been active in the creation of the NMHP and DMHP.

Results: The results suggest that the widely held perception that the DMHP has failed is not entirely justified, insofar that major hurdles to the implementation of the plan have impacted on mental health coverage in primary care, rather than faults with the plan itself. These hurdles have been political neglect, inadequate leadership at central, state and district levels, inaccessible funding and improperly implemented delivery of services (including poor training, motivation and retention of staff) at district and community levels.

Conclusion: At this important juncture as the 12th Five Year Plan is in preparation, this historical paper suggests that though the model may be improved, the most important changes would be to encourage central and state governments to implement better technical support, access to funds and to rethink the programme leadership at national, state and district levels.

Keywords: Mental health, History, India, Developing countries, Health policy, Health planning, Primary health care, Health workers

Background

In low- and middle-income countries (LMICs) very few mentally ill people receive mental health care despite available evidence for cost-effective and feasible packages of care [1,2]. The scarcity of specialist human resources, as well as large inequities and inefficiencies in resource allocation are significant reasons why this treatment gap remains [3,4]. Currently available studies from LMICs suggest various primary health care worker (PHWs) cadres (primary level doctors, nurses, lay health workers and other generalist paraprofessionals with no specialisation in mental health) are effective in a range of interventions for mental, neurological and substance abuse disorders [5]. In light of achieving universal health coverage, efforts at a global level and within India have advocated task-sharing and better leadership in scaling-up services [6]. In particular, the WHO Mental Health Gap Action Programme created guidelines for task-sharing mental health interventions with non-specialists [2,4,7].

India was the first post-colonial “non-white” independent country to have mental health reforms. The national mental health programme (NMHP), created three decades ago in 1982, established an integrated approach to mental healthcare...
delivery utilising a specialist and non-specialist workforce. There is a widely held perception that the NMHP failed [8]. Mental healthcare coverage has certainly been limited on both the specialist and the primary care fronts. There are 3600 psychiatrists in India for a population of 1.2 billion [9]. Most are located in the private sector and in major cities. There is a 40–60 fold deficit in the number of clinical psychologists, social workers, and nurses [9]. As for primary mental health care, still only 127 districts of the 626 districts in India have implemented the District Mental Health Programme (DMHP), the district implementation of the NMHP which operationalises mental healthcare integration into primary care. Within these districts not all primary care doctors are trained [10].

The aim of this study is to explore and unpack the political, cultural and other historical reasons for the DMHP's failures and successes since 1947 (post-independence era). At this important juncture, as a 12th Five Year Plan is in preparation, which is the sixth Five Year Plan since the NMHP started, this historical analysis is critical to policy makers when rethinking the current DMHP's implementation.

Methods

The first author (NvG) conducted oral history interviews in 2010–11. This marked the end of a government health planning cycle, the 11th Five Year Plan. Oral histories are in-depth interviews with witnesses to and participants in past events. The method captures individual memories and thus personal and social perspectives on events, which can be crucial in complementing written documentation. It may be the only recording of certain events which have no written evidence. This study interviewed the ‘elite’ (such as civil servants and professionals) to better understand policy and political processes, and the interplay with personalities [11].

To select interviewees, five contacts known to one of the authors (VP) helped identify further participants through snowballing. Of 26 potential interviewees, 17 were purposively selected to represent different perspectives, backgrounds and time periods. They comprised national and regional Indian mental health policy makers, clinical experts and programme implementers, sometimes fitting into multiple categories (see Table 1), who were active between 1975 (when WHO advocated the extension of mental health services) and the present day. These audio-recorded interviews were conducted in English, and followed a narrative of each individual's involvement in mental health policy and programmes in India, what they viewed as current key issues and the future vision for improving mental healthcare in primary care. Informed consent was obtained from all participants.

Written historical material was gathered from literature searches and participants. We relied principally on oral history sources and published materials (Indian newspapers, training manuals, government reports) as has been done in other contemporary history studies [12]. Indian organisations such as mental health institutions, psychiatric societies, or NGOs who were approached have not maintained formal archives. Correspondence and records of formal governmental reviews are not available in the public domain. Many documents had been destroyed from lack of space, or other administrative reasons. Some documents, the author was informed, were retained in various professors’ offices. Through attempts to track these through participants and their contacts, the first author obtained access to some unpublished material such as minutes of meetings, grant reports, unpublished papers, memorabilia related to the organisation’s activities, but not to any administrative records.

The main analysis focussed on the interviews which were transcribed and coded. The codes were analysed within a thematic framework which combined deductive themes (present in the interview guide), as well as inductive themes (identified during the process of coding). Written sources helped to cross check and contextualise emerging data to highlight discrepancies and inconsistencies in interviewees’ memories of events and processes. This methodological triangulation allowed the identification of critical perspectives and emerging themes [13], and identified the important time periods of mental health policy developments.

Themes inductively identified in the analysis matched the existing functional typology of health system policies [14,15]:

1. Delivery arrangements (which services, to whom, by whom, what settings and accessibility, health

### Table 1 Participants characteristics (n = 17)

<table>
<thead>
<tr>
<th>Roles</th>
<th>Numbers*</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical psychiatrists</td>
<td>14</td>
<td>- Six retired</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Eight implemented mental health programmes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Nine advisors/decision makers (state or central government)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Three work within NGOs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- One private psychiatrist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Four now work abroad</td>
</tr>
<tr>
<td>Bureaucrats</td>
<td>7</td>
<td>- Five bureaucrats within the Indian Government</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Two international-level bureaucrats</td>
</tr>
<tr>
<td>Programme implementers</td>
<td>9</td>
<td>- Six NGO programme founders or coordinators, of whom one user-survivor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Four government programme implementers</td>
</tr>
<tr>
<td>Academics</td>
<td>8</td>
<td>- All did research in India</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- One lawyer, seven psychiatrians</td>
</tr>
</tbody>
</table>

*most participants had two or three different roles so numbers do not add up.
information and technology, supplies, quality and safety monitoring mechanisms)
2. Financial arrangements (financing of the programme, funding of clinics for services, remuneration of providers)
3. Governance arrangements (establishments of responsibilities and accountabilities at the levels of policy and professional authorities and consumer/stakeholder involvement in policy decisions)

Ethical approval was gained from the London School of Hygiene and Tropical Medicine, from Sangath, Goa, and from the Indian Medical Research Council. Consent was obtained from all participants.

Results
An overview of the recent milestones of primary mental health care developments in India is presented to set the context for the second section of the results which will explore the reasons for achievements and failures of the DMHP.

A brief overview of phases
The overview starts from Independence of India (1947) to set the full context of primary mental health care developments. This study identified seven key periods (Table 2), which were similar to other NMHP historical reviews [16,17]. These time periods delineated the rise of the NMHP, its fall in the 1990s, and a recent rise of government attention to the NMHP in the 21st century.

1. 1946 to 1975: Creating an Indian system of mental health care

The evolution from asylums to more humanistic mental health institutions began in the 1920s. Significant developments — internationally (psychotropic medicines) and in India (General Hospital Psychiatric Units, more specialists and epidemiological surveys) - contributed to mainstreaming psychiatry as a medical specialty. The post-Independence government focussed mainly on psychiatric training and building hospitals rather than on developing a non-mental health specialist workforce as intended by the Bhore Committee Report, a report set up by the colonial government, headed by Sir Joseph Bhore and advised by a panel of international experts, intended to address the health needs of India in a post-colonial era [21,22]. In the 1950s and 1960s non-mental health specialists were used only in a handful of tertiary care settings (Amritsar, Madras and Calcutta). No formal government plans existed for extending mental health services to the community. However this was a major time for the development of primary care and community health worker services in general [23].

2. 1975 to 1982: piloting models for extending mental health services

The WHO’s study, “Strategies for extending mental health care” [24], instituted primary-level health worker (PHW)-delivered mental health care in seven countries. One site was in Raipur Rani, northern India (1975–81). A similar model was developed in Karnataka, southern India (1976–1986) through the National Institute for Mental Health and Neurosciences (NIMHANS), one of the largest mental institutions in India, and one of the few heavily involved in national mental health planning and implementation. Twenty nine other minor similar models emerged across the country [25].

Inspired by these apparently successful models and by primary care developments (1978 Alma Ata Declaration, primary care in India), a small taskforce committee produced a National Mental Health Programme (NMHP), which was adopted by the Government of India in 1982. The NMHP was initiated to promote community mental healthcare through an intersectoral approach and through integration with primary care by training existing PHWs to diagnose and treat mental disorders. The NMHP programme, though conceived as one plan, evolved in nature and remit according to decisions taken at the beginning of each ensuing Five Year Plan.

3. 1982 to 1990: the NMHP’s first steps

In the early 1980s, NIMHANS identified that their models which operated at PHC level were too resource-intensive for a small catchment area. They therefore piloted a district-level initiative in the Bellary district in Karnataka State (1985–1990) [26]. Simultaneously, the NMHP asked each state to “operationalise a programme in at least one district in their State” [25]. The Bellary model, one of the few operationalised and favourable programmes, was taken up by the government as a national model and has remained the model for primary mental care delivery ever since.

4. 1990 to 1996: Politics, power and the rise of NGOs

The NMHP continued to be hospital-focussed [27]. During these years, the healthcare system in India moved away from the 1982 pro-poor and comprehensive National Health Policy and this development also coincided with a faltering of the comprehensive ideology of Alma Ata. The government reduced the healthcare budgets of the States [28] and this affected mental healthcare. Earlier community mental health models (e.g. Raipur Rani) collapsed and their leaders moved abroad. Few regional centres other than NIMHANS implemented the NMHP, and the programme stagnated.
NGOs thus flourished in order to address the gap in mental healthcare provision [29]. These developed several innovative models, including rehabilitation and advocacy, using an array of non-specialist health workers (such as social workers and users) and bypassing government primary care centres.

5. 1996 to 2002: The human rights agenda and DMHP creation

### Table 2 History of mental health care integration within the Indian health system*

<table>
<thead>
<tr>
<th>Time periods</th>
<th>Date</th>
<th>Health system and political developments</th>
<th>Mental health developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE-INDEPENDENCE</td>
<td>early 20th century</td>
<td>1935 Act: provinces autonomy for Health activities</td>
<td>Growth of mental hospitals, first general hospital psychiatric unit (GHPU)</td>
</tr>
<tr>
<td></td>
<td>1946</td>
<td>Bhore Committee Report</td>
<td></td>
</tr>
<tr>
<td>1. POST-INDEPENDENCE</td>
<td>Aug 1947</td>
<td>Independence of India declared</td>
<td>1950s: Psychotropic medications developed</td>
</tr>
<tr>
<td></td>
<td>1950s</td>
<td>1st Five Year Plan (FYP)</td>
<td>1954: All India Institute of Mental Health (AIIMH) established, Bangalore</td>
</tr>
<tr>
<td></td>
<td>1956</td>
<td>Second FYP. Rs. 225 crore (5%) for health</td>
<td>Late 1950s: concept of ‘family ward’ (Amritsar and CMC); nurse training at AIIMH</td>
</tr>
<tr>
<td></td>
<td>1961</td>
<td>3rd FYP. Rs. 342 (4.3%) for health; Mudaliar Committee Report</td>
<td>1960s: More GHPUs and specialists; psychiatric social worker training in AIIMH</td>
</tr>
<tr>
<td></td>
<td>1969</td>
<td>4th FYP. Rs. 840 crores for health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1973</td>
<td>Medical personnel forced to work in rural areas; Multi Purpose Workers introduced; 1974: 5th FYP. Rs. 796 crores health</td>
<td>1974: NIMHANS replaces AIIMH and the government mental hospital</td>
</tr>
<tr>
<td>2. PILOTING MODELS FOR MH</td>
<td>1975</td>
<td>WHO report on organisation of mental health services; Community Psychiatry Unit created in NIMHANS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1980</td>
<td>6th FYP</td>
<td></td>
</tr>
<tr>
<td>3. NMHP- INITIAL STEPS</td>
<td>1982</td>
<td>National Health Policy</td>
<td>National Mental Health Programme initiated. Budget: 10 million rupees for the first 5 years</td>
</tr>
<tr>
<td></td>
<td>1987</td>
<td></td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>4. POLITICS, POWER and NGOS</td>
<td>1990s</td>
<td></td>
<td>Increasing number of NGOs. E.g.: 1993: Banyan; 1996: Ashadeep, Sangath, GASS; 1999: Bapu Trust</td>
</tr>
<tr>
<td></td>
<td>1992</td>
<td>8th FYP</td>
<td>Community mental health featured on health budget</td>
</tr>
<tr>
<td></td>
<td>1994</td>
<td></td>
<td>Persons with Disability Act</td>
</tr>
<tr>
<td>5. DMHP/HUMAN RIGHTS</td>
<td>1996</td>
<td></td>
<td>DMHP implemented. Budget: 270 million rupees;</td>
</tr>
<tr>
<td></td>
<td>1997</td>
<td>9th FYP</td>
<td>The National Human Rights Commission Report</td>
</tr>
<tr>
<td></td>
<td>1998</td>
<td></td>
<td>Envadi disaster (Tamil Nadu)</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. RESTRATEGISED NMHP</td>
<td>2002</td>
<td>10th FYP, National Health Policy</td>
<td>Re-strategised NMHP. Budget: 1.9 billion rupees</td>
</tr>
<tr>
<td></td>
<td>2004</td>
<td>National Rural Health Mission, ASHA worker created.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2005</td>
<td></td>
<td>UN Convention on the Rights of People with Disabilities</td>
</tr>
</tbody>
</table>

*Based on findings of interviews and references: [16-20].
Human rights violations in psychiatric and religious institutions were exposed through the media (27 chained mentally ill burned to death in an accidental fire in the Erwadi Dargah in 2001), by the Supreme Court (an evaluation of mental hospitals’ poor standards [30], and by human rights lawyers and activists. The human rights movement vilified institutional care. This helped the District Mental Health Programme (DMHP), launched in 1996, to gain support. The DMHP strongly advocated community care as part of the comprehensive integration of tertiary, secondary and primary care.

6. 2002 to 2007: The 10th Five Year Plan

The NMHP in the 9th Five Year Plan had only focussed on the DMHP, so the 10th plan ‘restrategised’ the NMHP to strengthen and modernise state-level administration, mental institutions and medical colleges [31]. Few changes were made to the DMHP. New government officials were however favourable to the NMHP and increased its budget seven-fold, even though these funds were subsequently under-spent. A large private mental health sector flourished because of continuing poor government provision.

7. 2007 to 2011: the 11th Five Year Plan

The NMHP was ‘reinvigorated’, following some adverse evaluations of the NMHP/DMHP [31,32]. With a budget increase to 10 billion rupees (still only 2% of the public health expenditure in 2007), new elements were incorporated into the NMHP such as school and suicide prevention programmes. Training of general medical officers became a priority.

What have been the reasons for the achievements and failures of the DMHP?

The oral history interviews and information from documentary sources highlighted both ongoing and enduring issues which have affected the implementation of primary mental health care. Three key areas were identified: governance, financial and delivery arrangements.

1. Governance arrangements and leadership

Since the start of the NMHP, leadership and government commitment have been poor, and have lacked transparent and accountable systems. The reasons for this are presented below.

Inadequate leadership

Firstly, respondents generally agreed that the government had neglected mental health and failed to adequately integrate it into their agenda.

“It was never regarded as sufficiently important. [...] I don’t believe it was a conscious decision that ‘no, we do not need a mental health policy’ – it is just indifference” (bureaucrat 1).

The apathy of central and state governments meant that the NMHP was dormant, “mainly remaining on paper till the 1990s” (psychiatrist/former leader 2). Governments never saw mental health as a public health problem. They were not proactive in mental health planning, certainly not when compared to other health sector planning, such as the family planning programme which started with strong leadership and had a policy in place by 1976 [33]. Despite several meetings with the Committee of the Ministry of Health and Family Welfare particularly throughout the 10th and 11th Five Year Plans, there was little progress in achieving their recommendations. For example from 2000 through to 2010 grant reports mention the problem of getting State level cooperation, but no action was ever taken. Only in 2010 did the report mention that “the Department needs to take a proactive approach to bringing States onboard” [34]. Even this remained a very vague statement rather than a solution.

The interviews concluded that that national leadership of the NMHP had been absent since the start of the programme. Establishing a central leadership was never a government priority because of the federal system – health is run as a central programme, but implemented by the states. This system of devolution derived from the colonial system of “not interfering with local initiative” was often seen as a subterfuge resulting in poor national and state level coordination and integration [35]. The NMHP initiators modelled the programme on the Bhore report and WHO technical recommendations but largely ignored the recommendations to create stronger central leadership as they focussed on local implementation.

Central leadership had been most obvious in the early years of the NMHP. The early community project leaders (1975–82), and the next generation at district level (1982–90) by default also constituted the national leadership. These leaders recognised that they were overburdened by their multiple responsibilities and were therefore unable to commit the time to strengthening the NMHP.

“So, I could not spend so much time. But since I had interest in [community mental health], I spend extra time, travel, then we developed a district program, and so on. That was all in addition to whatever we were expected to do as faculty, which is being an examiner, take lectures, and grand rounds and teach students.” (psychiatrist/former leader 1)

In the 1990s, these NMHP leaders withdrew from the programme to pursue jobs abroad which they explained was not because they lacked commitment.
“Some of us who felt passionately about this were marginalised for various reasons. This happens in India very often that if you are not in the favour of the authorities, your technical capacity does not have any meaning; it is only if you are occupying a particular position” (psychiatrist/former leader 2).

The Indian hierarchical political environment which included more clinically and biomedically-oriented leaders at NIMHANS and within government, wore down the “perseverance and political persuasion” (psychiatrist/international leader 5) of community psychiatric leaders. Published papers and NGO reports confirm that the petty politicking and patronage amongst public health leaders has been a widespread feature in India, with very few examples of Basaglia, Beveridge or Freire social or inclusive pro-poor ideology [36]. Those who did practice pro-poor ideologies also felt that their “unwanted human rights voices were silenced” [37].

A government advisor from the 1990s also recognised that leadership lacked continuity and was perhaps misguided. He felt they were “on the wrong track” (psychiatrist 7) and repeated mistakes from the 1980s. He “re-learned” that the DMHP model’s top-down approach inadequately addressed the ground realities of attrition, poor supervision and utilisation of PHC services [8].

Previous leaders expressed the view that in the last 10 years central leadership had declined because of a lack of sufficiently motivated psychiatrists, and because others had been attracted to the private sector. Government reports also stated that the “dismal performance” of the programme was for these reasons [34].

State-level and local leadership had always been poor. In the 1980s various psychiatrists ran workshops to try to encourage state and district administrators and finance officers to implement the NMHP [38]. These efforts failed to kick-start local leadership and were discontinued in the 1990s. Most respondents suggested that training alone was insufficient.

“So, it is not a lack of technology or know-how of reducing or preventing the illness – it is the delivery. Everything depends on the leader; there is a lack of leadership in many places – the District Health Officers are not convinced that this is one of the priority programmes. [...] At the State Annual Review, there has to be a review of Mental Health; it has to percolate down. If you just train somebody and leave it at that, it is not going to help. That has not occurred.” (psychiatrist/former leader 1)

The NMHP model was not adapted by states’ departments of health because they were expected to adapt and initiate the programme without receiving adequate incentives or technical support.

Furthermore, a prior national bureaucrat/psychiatrist felt that because earlier NMHP projects’ leaders (from Raipur Rani and Bellary) used top-down and oligarchic leadership methods, this led to these projects’ demise.

“These were not dynamic people, they did not have energy [...] they did not involve people [...] When it is an individual centre, it does not survive - when it is a community centre, it survives [...]. Many people would like to be too egoistic to develop that model [...] We must learn how to change their models to suit the needs of the community.” (psychiatrist 4)

One respondent suggested that these projects were unsustainable because the authoritarian approach of local programme leaders harmed the reputation of the community programmes.

“Influential people in rural communities were given better care at home and in hospital by senior leaders, while the poorer were seen by juniors.” (psychiatrist 14)

These personality-driven approaches and these examples of favouritism within the community were antithetical to the values of community care, where one may expect an egalitarian service to reduce rather than reinforce inequalities in provision. This non-democratic process caused much cynicism amongst psychiatric and medical professionals.

**Accountability and transparency**

Certain system weaknesses were identified through internal evaluations [39,40] but were largely ignored. Respondents acknowledged that no mechanisms existed to make authorities accountable for addressing identified weaknesses.

“The biggest problem was that we did not develop indicators. That is the limitation of all health programmes in India except TB [...] they look at it and see [...] if corrective action is possible. In the District Mental Health Programme, no corrective action has been taken” (psychiatrist/former leader 1)

For example, as mentioned in interviews and in the literature, no evaluations assessed patient recovery indicators (psychiatrist 13) [41]. A former government adviser explained the lack of central government ability to intervene:

“Because, health is a state subject we can’t interfere with the health aspect of any State [...] We can provide the money, we can provide the guidelines but, we can’t call them to task, we can’t hold them accountable.” (psychiatrist/former bureaucrat 7)
Government reports also highlighted the system lacked mechanisms to penalise health workers’ non-performance (in any area of healthcare), or to make them legally accountable [10]. This contributed to poor service provision.

**WHO’s influence in setting up the NMHP**

In the early years the most important influence was the WHO’s mental health department.

"Health is the weakest element of the Government of India. [...] [The WHO] was trying to make [the various ministers] do things, use the authority of WHO to promote the programmes that have been composed and that have been accepted by the Government" (psychiatrist/international leader 6).

Indeed, India as well as many countries, were influenced by the WHO. Though some critiques have suggested WHO’s hegemony is a form of neo-colonisation, circumstances here were different. Since the 1960s, Indian psychiatrists worked within the WHO mental health department and influenced their strategies. Indian leaders at the time thought WHO’s input was essential.

"But for WHO support, local ministry of health would have never made the National Programme of Mental Health. This was because WHO has supported it, they were willing to look at it." (psychiatrist/former leader 3)

**Participatory and inclusive decision making**

The stagnation of the NMHP in the 1990s was associated with a dearth of external lobbying groups. However in the late 1990s and early 2000s several human rights outcries pushed the government into a judicial intervention [42], The most influential outcries were created following the release of the 1999 National Human Rights Commission which addressed poor standards of care in mental hospitals, and much more importantly following the media outcry over the Erwadi tragedy.

Grassroot leaders such as established NGO leaders, tried to partake in government-level decision making. They felt their efforts were unsuccessful.

"[Our NGO] is not working with the DMHP […]. We are trying to link up with them, but that’s entirely different thing." (psychiatrist/former NGO leader 11)

In return, bureaucrats were met with often radical and conflicting suggestions, which ignored contemporaneous government priorities, from fragmented mental care stakeholders.

"Policy planners sense dissonance in the group and this gives them a reason not to take action“ (psychiatrist/NGO leader 12)

A current government official recognised the government’s inaction to date, but also recognised NGOs’ untapped potential.

"Government has not yet got around to recognising [NGOs] as training centres. I believe [...] that we have to recognise that these are institutions that have been able to establish a model of community-level care“. (bureaucrat 1)

Recently, more effort to involve different lobbies, such as in the recent revision of the Mental Health Care Act, has occurred. The challenges highlighted in the 10th plan mentioned for the first time the need to “harness NGOs’ help in community based care of mentally ill” [43]. Engagement of consumers within the public sector however is still non-existent.

**2. Financial arrangements**

**Funding in the NMHP's early years**

The 1970s pilot projects were well funded (10 million rupees) by NIMHANS and the WHO, as were the early years of the NMHP.

"NIMHANS was totally committed in the ’70s and ’80s [so] the programme went so quickly. When there was no money- the District Mental Health Programme came up without the NMHP money – it came up with the local money like the Government of Karnataka, [and] the NIMHANS local funds." (psychiatrist 2)

With an increasing unfavourable international financial climate in the late 1980s, the WHO withdrew their support for their pilot project. Changing priorities within NIMHANS meant their pilot programme funding also dwindled. However central government budgets increased:

"Now, people were beginning to realise that unless you invest in basic health care in rural areas, things are not going to change. [...] So, for the first time in 1996, the Government of India health budget, community mental health figured. They accepted it for the district mental health programme delivery. And subsequently, money has never been a problem." (psychiatrist 1)

**Financing hurdles in the last decade**

Since the 10th Five Year Plan (2002) the budget has been more realistic (1.9 billion rupees in the 10th plan, and 10 billion rupees in the 11th). These amounts unfortunately have been under-spent because of "jurassic financial procedures" (psychiatrist 7), a common occurrence in the health sector.

"Money is there but it cannot be used, as the person who has to sanction it sits in Delhi." (psychiatrist 1)
Committee reports throughout the 9th, 10th and 11th plans have mentioned that central fund allocation was often consistently reduced by at least half of the estimated amount because of under-spending, and actual expenditure was often even less. For example in 2002–2003, the first year of the 10th plan, the initial plan was to spend 300 million rupees. Due to previous under-spending only 35 million (one tenth of planned spending) was finally allocated. Of this only 90000 rupees (2.5% of allocated spending) was spent [44,45]. The early reports tended to blame State governments for under-spending because they “failed to forward their proposals without delays”[45], and “the Department [was] in non-receipt of complete proposals from State governments and institutions” [43]. However the Committee reports also recognised and confirmed what policy makers stated, that administrative bottlenecks occurred at central government level which also contributed to inability to access funds. Expenditure on new DMHP plans (such as extending the plan to new districts) was frozen for the first two years of the 10th and 11th plans as the central government had not approved these proposed changes [45,46]. Also decisions on yearly spending were often delayed by holding funding meetings shortly before the end of the financial year [34,44]. These barriers have never been overcome, and continue to appear in more recent reports on the NMHP [10,34]. No solutions have been suggested apart from one vague statement that the “department needs to take proactive approach to bring States on board” [34]. These financing issues are to be found across the health sector, not just in mental health [34].

Fund allocation within States has also been poor. Less than 1% of the total health budget was allocated to the NMHP in the North-Eastern States of India [44]. Across all States, DMHP staff’s low and often delayed remuneration has compounded the problem of attracting and retaining specialists.

Financing has also been subject to petty politics. A former bureaucrat mentioned how power games blocked certain applicants:

“Here were unexpected hurdles[…] we had excellent research proposals, but again, due to obstructionist tactics[…] most of the research proposals […] were blocked” (psychiatrist 7).

Because of the consequent under-spending of the budget, the NMHP lost credibility with the Planning Commission. Funds were disbursed to other programmes like the National Rural Health Mission (NRHM) in 2005. The 11th plan’s funding was submitted to increased bureaucratic hurdles to regularly review performance and spending.

3. Delivery arrangements
Interviewees debated whether the DMHP model was appropriate in terms of its organisation of services and human resources.

Organisation of services at PHC level
Certainly in the early years, the NMHP was described by participants and the literature as advanced in its thinking because it was one of the first LMIC mental health programmes. NIMHANS was responsive and proactive when scaling up from primary care to district level was required. It also had positive outcomes for patient detection and symptom reduction [26].

Criticsms of the Bellary (DMHP) model
The Bellary model was intended to extend coverage in the northern part of Karnataka State, and had heavy psychiatric input (psychiatric outreach camps) from NIMHANS. As a Bellary programme founder explained, this model was utilised after its initial evaluation for a different aim, as a DMHP pilot for national coverage:

“It was very important to recognise that the goal was not that we would be able to reach everyone - universalised coverage; it was increasing coverage – say from 5-10% or nil, to as much as possible. This is a very important thing that needs to be recognised because if we are thinking of universal coverage, then what we were achieving was totally inappropriate.” (psychiatrist/ former leader 2)

Because the motivated new NMHP taskforce were keen to start a model, they pushed forward one of the few models in existence in India.

A Bellary programme founder questioned however why, if the model was not designed with national coverage in mind, the NMHP had continued “picking up the skeleton” of the same model (psychiatrist 2). The only adaptation was to reduce psychiatric support and PHC doctors’ length of training which proved to be detrimental. There was very little questioning of whether overburdened, poorly utilised PHCs within weak health systems [47] should continue to be the DMHP’s main delivery mechanism.

This model was further criticised for its sole focus on medication. Jain and Jadhav [48] argued that the pill provided a ‘technical fix’ that policy makers required to fund and popularise the programme, whilst psychosocial interventions were ignored. A human rights lawyer felt the overmedicalised model was harmful.

“The National Mental Health Programme has very limited imagination. It did not escape the medical paradigm. Whereas mental health needs […] has a
much larger range: [...] social injustice, [...] torturous conditions at work, less than minimum wages, [...] precipitators of poor mental health. Instead of addressing those structural questions we believe that we’re going to give people psychotropic medication and going to set things right. It’s hugely dangerous in a poor country.” (lawyer 1)

A senior advisor of the 10th plan defended these decisions as successful cost reduction of psychotropic drugs had made these affordable and cost effective solutions for the government:

“If I had got involved in the other thing [psychosocial interventions], we could not have got involved anywhere; because the bureaucrats want cut and dried, black and white things, you see. They can’t appreciate shades of grey.” (psychiatrist/former bureaucrat 7)

Though the overmedicalisation critique is valid in essence, there were reasons for the ‘technical fix’. Policy makers were not ready to accept wider changes and innovations. In addition, funds were limited and thus minimising costs was important. Furthermore there was a growing international evidence base for antidepressants and antipsychotics (randomised controlled trials, systematic reviews) and treatment algorithms, and very limited evidence for non-pharmacological interventions [49].

Hardly any cultural or religious paradigms filtered down to community mental health care [41] and some respondents felt that, hospital and community psychiatric care had remained insufficiently ‘Indianised’. The creation of the NMHP was preceded by several decades of controversy over the western versus indigenous medicine debate. At the time the Bellary model was created, few allopathic doctors’ supported integrated approaches with other medical traditions, as a recent attempt to train ‘integrated doctors’ in both medical paradigms had failed [50].

**Poorly motivated and trained health workforce**

Throughout the NMHP’s three decades, building a rural mental health workforce only involved PHC doctors training. Very little was initiated to help psychiatrists adapt to their new supervisory roles.

a. Primary care doctors

Early pilot project leaders explained the initial challenge in the 1980s was to train a new human resource, the PHC doctors.

“This was a great challenge, [...] so, how to train the health worker, what are his responsibilities, can we do it, how to monitor them, what kind of supervision do they require, [...] . Whether it succeeded or not is a different story, and that is the next 20 years’ story.” (psychiatrist 1)

As suggested by this psychiatrist, their initial package was comprehensive but as the model was scaled up in subsequent years, the reality of health workers’ context and qualities soon disrupted this plan. One contributing factor was PHC doctors’ large workload.

“I met primary health care doctors and universally they said, that in the existing state, it was an additional burden – it was not doable, although they were trying their best to do it. So, I could make out that the original concept of Bellary was no longer suited.” (psychiatrist/former bureaucrat 7)

Retaining doctors in rural areas and their frequent transfers was also a problem [51]. Furthermore, a bureaucrat explained that PHC doctors’ competency reduced since independence, making them more difficult to train, motivate and retain.

“The increase in the number of medical colleges and private medical colleges has meant that the quality of teaching has suffered. [...] The result of this is that a very indifferent quality of doctor is coming out of the medical education system. The best amongst these are probably staying in the cities. [...] The GP [family physician] in India pre-independence, [...] came through a much better education system.” (bureaucrat 1)

Despite some international evidence that primary health workers could effectively diagnose and treat mental illnesses [1], in India and elsewhere, PHC doctors only recognised between 20 and 40% of all mental illnesses [40,52]. The DMHP- and other health sector-planners ignored recommendations to evaluate primary health workers’ impact on patient outcomes [49].

Respondents suggested PHC doctors were never properly trained.

“Training has been a token gesture for the departments of health to be ‘seen to be doing’ something.” (psychiatrist 14)

The training manuals produced in Bangalore and Delhi were too complex and not properly adapted. The NIMHANS PHC doctors manual, rather than being clearly focussed on the main issues in primary care, synthesised psychiatric and psychology textbooks. They became more complex throughout the editions from 1985 to 2009 [53-55]. For primary care officers with no or little previous exposure to psychiatry, these increasing
details were overwhelming and could not be integrated into their current practice. The same was true of the Delhi manuals [56]. Furthermore the manuals produced for community health care workers focussed on diagnoses and health worker behaviour, but had no useful information on how to support the family or patient, or the process of referral [57,58]. These manuals were written by specialists at NIMHANS, who did so without evaluation of previous training or consultation with the primary-level health workers.

In addition, the delivery of training was never adequate, and ongoing training reduced over time. In the early years, though initial training was short, there was informal and organised follow-up of PHC doctors by psychiatrists during their outreach activities. In the last decade, only the training component remained, and this continued to be short and didactic (only 15 days in Karnataka for example) or non-existent (in the northern States).

More important than the content of training was the lack of ongoing support to PHC doctors – again a chronically neglected problem.

“As long as continuous support and supervision is not there, they will not perform, or you will not get the outcome.” (psychiatrist 1)

A prior leader suggested this support was absent because of supervisors’ indifference to mental health which lead to demotivated primary care staff.

“If the health authorities higher up [...] do not take [mental health] seriously, they consider it’s useless and all that, then the lower staff also loses interest. [...] Most of them have been untrained and they consider it just a fashion.” (psychiatrist/prior leader 3)

b. Specialists

Since the NMHP’s beginning, there were too few specialists interested in supervisory work. This problem remained unchanged. From 1981, NIMHANS ran several ‘Training for Trainers’ workshops to train specialists in their new supervisory roles but by 1986 only 63 Indian psychiatrists were trained. By the 1990s this training programme had stopped [38]. Motivating psychiatrists to remain in community programmes was also a challenge. For example, those involved in the NIMHANS primary care pilot project requested to return to NIMHANS jobs after two years’ work in the programme (psychiatrist 14).

Specialists’ lack of involvement could have been due to their poor remuneration. Many psychiatrists also lost faith in this model because they felt PHC doctors’ limited training would be insufficient to provide adequate care. Psychiatrists have been reluctant to associate with other mental health professionals under the same umbrella term of ‘specialists’ probably because of a strong hierarchical structure within hospital care. A psychiatrist involved in the Mental Health Care Act revision observed:

“We have created a category called mental health professional [which] includes a psychiatrist, a psychologist, a psychiatric nurse and a psychiatric social worker. [...] Now the psychiatrists are extremely angry about it because they see themselves now being equated with the other professionals.” (psychiatrist 10)

For example psychiatrists quashed recent attempts by psychologists to lobby for greater prescribing powers and representation in decision-making. Such current tensions between mental health professional groups suggest more groundwork and involving them in decisions may be required before they accept shared responsibilities, for example in supervising primary care workers.

Discussion

These oral histories and documentary sources have given insight into the achievements, limitations and personal struggles involved since the 1980s in trying to increase mental health coverage in India. The national programme’s basic model of delivering community mental health care through district hospitals and PHCs, a model commonly seen in high- and low-income countries, certainly followed the WHO 1975 recommendations of extending mental health services. It also has had similar aims to the currently favoured universal health coverage approach: to improve the quality, funding and equity of care [6]. In an attempt to answer our main question of why the DMHP has not succeeded in achieving its aims, several reasons have emerged. The NMHP was very ambitious in its aims and developed a model, perhaps too fast and too dominated by one major institution, NIMHANS. Ownership of the programme at central, state and district levels suffered as a consequence. In the early years (late 1970s-early 1980s) very few mental health initiatives existed - the Bellary model was the best available at the time. However, several generations of psychiatrists since then have retained the same vision of the DMHP, and have romanticised the initial model and insufficiently questioned it. This possibly led to less creativity or inspiration from other models (such as NGO models) to adopt the DMHP programme. WHO have summarised the evidence to suggest using a collaborative and integrated model of delivering mental health care through primary care, but the degree to which the DMHP followed this has been doubtful. All the elements the WHO recommended to ensure successful integration have not occurred (adequate specialist and primary care staff, regular supplies of essential psychotropic
drugs, linkages with specialist care services, referral criteria) or even been considered (developing information and communications systems, appropriate links with other community and social services) – these are also common failings in many LMICs [59,60].

In addition, integration requires more than education of providers or the addition of services. It demands a "new perspective which engages an orientation towards the unique mental, physical, social and cultural needs of the individual", and involves family and community support [61]. India’s NMHP has prioritised mental health literacy of the general population through campaigns but has not re-orientated the primary care provider, either the doctor or the lay health worker, away from a biomedical model to a process of thinking necessary for comprehensive mental and physical care. India may consider remedying this, as have some of its low- and middle-income counterparts, where this re-orientation of health workers is being attempted for example in South Africa (with primary care nurses and health district management) and in Mozambique (with traditional healers) [61–63].

This study highlighted that the implementation of the model has been poor at several levels, particularly at the human resource level. As a middle-income country, and being the 5th largest economy in the World, India should have sufficient resources to provide sufficient mental health specialists and primary health specialists for at least the basic provision of consultation liaison with primary care [64]. However, not only are too few specialist and non-specialist workforce trained, but they are poorly distributed and favour working in the private sector or moving abroad.

One glaring omission in the discussion about increasing human resources within the DMHP - both in the literature and amongst participants interviewed - is the lack of thought and initiative as to how to incorporate the large private mental health sector in India to overcome the lack of specialists, particularly as public health services in India only cover 20-30% of the population [23]. There is growing concern in both high-income countries (like the USA model) and LMICs (such as the Chilean mental health reforms) whether partnering with the private sector contributes to inequity of care [64]. However given the dearth of manpower in India, the option should be considered. Within the health sector, the National Rural Health Mission and other sectors (TB control programmes, surgical procedures, hospital ventures) have encouraged public private partnership development with successful examples mainly with the not-for-profit private sector (e.g. NGOs). Psychiatry being relatively less technology-intensive has had less private involvement as the business models are less robust, are too regulated or are stigmatised. Several caveats also exist to incorporating the for-profit or not-for-profit private sectors. Due to the federal system in India, the decision to accept or promote such partnerships is devolved to each individual State. Other caveats include the private sector's motives, incentivisation, and ensuring adequate governance and monitoring arrangements [66].

In addition, primary care workers have received overall ineffective training and insufficient supervision, and no solution has been implemented to get specialists on-board or to ensure a sturdy state- and national-leadership. These weaknesses have been reinforced by poor mechanisms to evaluate the programme and to ensure accountability, which have meant there is no certainty of the quality of care provided or of patient outcomes. These problems are common to many LMICs [67]. For example in South Africa, despite a decentralisation model which promotes integration of mental health into primary health care, there is a paucity of community-based mental health resources and the same problems of poor identification and treatment of mental disorders by primary care physicians. It also has problems of support, supervision and of providing more than just an emergency reactive service [68].

However, the above criticism of the NMHP/DMHP’s implementation was the result of contextual barriers. The main problem over the years has been to convince policy makers about the public health importance of mental health. Despite the success of some early leaders in lobbying for increased funding for mental health care, the second main hurdle has been the system-wide barriers, the bureaucratic and political hurdles, drug supply issues and the need to strengthen health systems. These required interventions outside the NMHP and were difficult to address by the small group of specialists spearheading the programme. These drawbacks are the case for the whole health sector in India but, programmes which have been successful in overcoming such barriers are those which have had more political and financial support and more structured leadership (such as HIV care and maternal and child health care). Integration of programmes is feasible, and therefore should be achievable for mental health care if the appropriate financing and implementation ingredients are present. For example given the rising burden of non-communicable diseases, more resources could be leveraged for integrated mental health care from the chronic care service delivery platform which is growing in India as it is elsewhere.

How does this history shed light on current policy recommendations?

In the last three years, a group of experts has been commissioned to advise the government on priorities for the next funding cycle, the 12th Five Year Plan. This reflects a growing political commitment to mental health.
The experts conducted intensive investigations into NMHP implementation across India [69]. Their main recommendations feature in Table 3. Two authors of this paper (VP and SJ) were part of this policy group, but we discuss here to what extent the views of our interviewees correlated with these recommendations. Participants broadly agreed with the recommendations but their experiences over the last 30 years put a different emphasis on priority areas. They highlighted the nature of leadership. The lack of continuity in government officials, not just their lack of technical and managerial skills, meant the same lessons were constantly relearned. We suggest here that the challenge to improving continuity would need to start with sensitising, attracting and retaining specialists to be leaders, managers and supervisors. Our analysis also highlighted the common barriers of political and bureaucratic hurdles. Politics and hierarchical power structures could be minimised with safeguards at policy level but also at a more democratic and locally accountable system (such as through the Panchayati Raj as is done in the Southern and North-Eastern States).

PHC doctors are currently overburdened (as are many other government primary care employees). Interviewees did not agree whether a new cadre of community worker might be required to deliver mental health care. The nature of this new cadre is also debatable. The mental health policy group's suggestion to add two community mental health workers to each existing PHC team seems to be potentially unrealistic given human resource shortages. The post of chronic disease worker (a social worker or a lay health worker) who coordinated, counselled and provided psychosocial support for all chronic diseases, might be more sustainable in light of the growing non-communicable disease burden and would be better integrated in primary care, rather than setting up an exceptional service for mental health care [70].

Interviewees identified the importance of the quality of health providers (PHC workers and specialists), their motivation and competence. Suggestions for improving PHC workers' competence included changing training to being skills- and problem-based and having more supervision, ongoing training and monitoring. This would be subject to sufficient mental health professionals joining the DMHP. This major specialist manpower caveat may be resolved by better incentives increasing their confidence in the programme and belief in integrated care, and improvements in supervision. These ideas have also been voiced by government reports [34] but they are still to be implemented and will require strong leadership to make them happen.

**Conclusion**

At this important juncture in time, as the 12th Five Year Plan is in preparation, the history of the last 30 years cautions policymakers about the visible poor investment in programme implementation and innovation, which has led to stagnation and reinventing the wheel. The reasons for not achieving adequate implementation are not necessarily failures that could have been entirely avoided. The mindset at the time (such as professional conflicts), and external hurdles influencing the NMHP (such as political neglect, funding problems, patronage) were important barriers which could not be controlled by NMHP advocates or leaders. These factors cannot be changed by adjusting the model as much as by encouraging important stakeholders (central and state governments) for acceptance, financing and technical support for the elements that would make the integration of the DMHP into primary care successful. Amongst the most important elements, programme leadership needs rethinking to have better continuity and to ensure better management at district, state and national levels. This would necessitate more commitment and collaboration.

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### Table 3 Mental Health Policy Group key recommendations

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<tr>
<th>Area of recommendation</th>
<th>Summary of recommendations</th>
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<tr>
<td>Programme management</td>
<td>Ensure a clear structure for funding, management and coordination of teams at central, state and district levels. Promote intra- and inter-sectoral collaborations.</td>
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<td>Community involvement</td>
<td>Improve accountability and local ownership of the DMHP. Promote more participation of NGO/private sector.</td>
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<td>Technical support</td>
<td>Provide an overarching technical support and advisory group (TSAG) for all the States which will provide mentoring to districts to help with implementation difficulties.</td>
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<td>Revitalising human resources:</td>
<td>Provide technical and quality inputs to increase the number of specialist resources (through relaxing educational requirements). Introduce a new cadre, a community mental health worker to identify, treat, provide basic counselling, and help access social benefits. Improve training.</td>
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<tr>
<td>Ensure quality of care is provided</td>
<td>Improve systems for monitoring, evaluation, operational research, a mental health information system, adequate supply of medicines, continuity of care in the community, user/carer involvement in decision making.</td>
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<tr>
<td>Incorporate life skills education and improve current preventative and promotive services</td>
<td>Create collaborations with other concerned departments (such as education).</td>
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<tr>
<td>Extend services to urban areas</td>
<td>Include the provision of a community mental health worker.</td>
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*Based on recommendations provided in reference [69].
between the ministry of health, primary health pro-
grammes and mental health professionals.

Given the growing interest in primary mental health care within India and globally, lessons learned from prior policy and programme challenges, which are often similar to those in other LMICs, should play a stronger role in informing current policy.

**Abbreviations**

DMHP: District Mental Health Programme; GP: General practitioner; HIV: Human immunodeficiency virus; LMICs: Low- and middle-income countries; NGO: Non-governmental organisation; NMHANS: National Institute for mental health and neurosciences; NMHP: National Mental Health Programme; NHMRC: National Rural Health Mission; PHC: Primary health centre; PHWs: Primary health workers; WHO: World Health Organisation.

**Competing interests**

VP and SJ are members of the Mental Health Policy Group which has provided recommendations to the Central Government of India recommendations on restructuring the DMHP for the 12th Five Year Plan.

**Authors’ contributions**

NvG conceived of the study, participated in its design and coordination, carried out the interviews and drafted the manuscript. VB guided NvG in the conception and design of the study, and supervised her work. VP also helped with conception of the study and helped choose relevant participants for the study. VB, SJ and VP provided guidance on analysis and interpretation of the material. All authors read and approved the final manuscript.

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Chapter 6

Human resources and models of mental healthcare integration into primary and community care in India: an exploration of 72 programmes

(research paper 4)
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<td>Vikram Patel</td>
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<tr>
<td>Thesis Title</td>
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If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

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SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

I conceived the design of the study and case-study tools. I shared data collection and analysis with my co-researchers (Meera S.M. and Sarah Ghani). I conducted 30% of interviews/visits, and performed 30% of primary coding. I checked co-researchers’ coding in its entirety though only selectively blindly recoded 20% of their interviews. I did...
all subsequent analysis and wrote the article which has received comments from all co-authors.

Student Signature: 

Date: 3/1/15

Supervisor Signature: 

Date: 

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Human resources and models of mental healthcare integration into primary and community care in India: an exploration of 72 programmes

Authors: Nadja van Ginneken\textsuperscript{1,2}, Meera S.M.\textsuperscript{2}, Sarah Ghani\textsuperscript{2}, Jayashree Ramakrishna\textsuperscript{3}, Anusha Raja\textsuperscript{4} and Vikram Patel\textsuperscript{1,2}

6.1. Abstract

Background: In India, as in many low- and middle-income countries (LMICs), diverse models of primary and community mental healthcare have evolved to respond to the scarcity of specialist mental healthcare. To better understand current service delivery and with the view to improving government provision, this study explores and compares current Indian models of mental healthcare delivered by primary level workers (PHW), and the roles PHWs and specialists have within these.

Methods: Seventy two programmes within 34 organisations (governmental and non-governmental) across 12 states were visited. 204 PHWs, coordinators, leaders, specialists and other staff were interviewed or participated in focus-group discussions to understand the programme structure, the model of mental health delivery and health workers’ roles. Data were analysed using framework analysis.

Results: Programmes in India provide an array of different primary mental healthcare services involving PHWs. Many provide one-off training to PHWs. The collaborative care models are very heterogeneous: many do not collaborate with government primary care settings and some also have weak systems of collecting and analysing routine data. In addition several programmes use a unique community outreach model that is not described in high income countries (HICs) but is common in LMICs whereby PHWs are trained within specialist programmes. These programmes mostly target severe mental and substance use disorders. A majority of programmes use lay health workers (LHWs) with significant complementary and substitution roles. Primary healthcare (PHC)
doctors are less used and often minimally for clinical mental health roles. Other types of widely used resources include numerous care managers and care coordinators.

Discussion and conclusion: In spite of collaborative care having most evidence for improved patient or service delivery outcomes, few programmes implement this model. However there were numerous training, referral and community outreach models, for which there is less evidence. Indian models differ significantly to those in HICs: they work on broader community sector platforms, use LHWs in preference to PHC doctors, use heterogeneous forms of care coordination, specialists provide more outreach clinics and are also poorly incentivised. The priority now is to evaluate the effectiveness and cost-effectiveness of these innovative approaches to collaborative care and within community outreach models as these may have profound implications if scaled up to improve the current government programme.
6.2. Introduction

In low- and middle-income countries (LMICs) very few mentally ill people receive mental healthcare. The scarcity of specialist human resources, as well as large inequities and inefficiencies in resource allocation are significant reasons for this treatment gap (Saxena et al., 2007; Kakuma et al., 2011). Given the renewed interest in achieving universal health coverage, efforts at a global level and within India have advocated task-sharing and better leadership in scaling-up health services (Sengupta, 2013). With regards to mental healthcare, the World Health Organisation’s (WHO) Mental Health Gap Action Programme published guidelines for mental health interventions delivered by primary care doctors and nurses (WHO, 2008b). There is now growing evidence for cost-effective and feasible packages of care (Patel and Thornicroft, 2009) and for the effectiveness of primary-level health workers (PHWs) in providing a range of interventions for mental, neurological and substance abuse disorders (van Ginneken et al., 2013). PHWs include professionals such as primary-level doctors, non-physician clinicians and social workers, as well as non-professionals or lay health workers (LHWs), who are not mental health specialists but have received minimal training in mental healthcare.

India’s ambitions to develop a comprehensive mental health specialist and non-specialist workforce has not yet been achieved, as there is currently still a 40 to 60 fold deficit in psychiatrists (4000), and even fewer psychologists, psychiatric social workers and psychiatric nurses (WHO, 2011). In addition, only one sixth of districts across the country have implemented the District Mental Health Programme which operationalises mental healthcare integration into primary care at the level of a district. Even within these districts not all primary care doctors are trained (GOI, 2011). Since the early 1990s, non-governmental organisations (NGOs) have emerged (where government mental healthcare provision has floundered) with innovative models of PHW-delivered mental healthcare (Patel and Thara, 2003; van Ginneken et al., 2014).

In light of a mixed private and government healthcare system in India, this exploratory study adopted the Alma Ata definition of primary healthcare which “is the first level of contact of individuals, the family and community with the national health system [...].
It involves, in addition to the health sector, all related sectors and aspects of national and community development, and demands the coordinated efforts of all those sectors” (WHO/UNICEF, 1978). First level care therefore incorporated the bottom two tiers of the WHO pyramid: the formal primary health sector and community care (such as schools, development projects or community outreach settings) as well as PHWs within specialist programmes (see figure 1.2 in chapter 1) (WHO-WONCA, 2008). We excluded private-for-profit organisations as the profit-making business model aims to maximise profits which may become more important than healthcare provision itself. The not-for-profit NGO sector on the other hand may also sell goods and services but its purpose is to provide income to cover their activities’ costs (Green and Matthias, 1996). As with the government sector, the NGO sector retains its main focus on healthcare provision.

Exploring the available models of PHW-delivered mental healthcare and their use of human resources is important to identify innovations which potentially could have a profound impact on the current mental health system if implemented on a large scale. This is relevant for future mental health policy and in particular for the community mental health component of the next five year strategy. The objective of this study is to describe and compare current Indian models of PHW-delivered primary and community mental healthcare in India. The analysis focuses on roles and levels of engagement PHWs within service delivery and on their relationship with specialists and other supervisors. This will help to understand how models of mental health integration into primary and community care function.

6.3. Methods

This article is the first of three papers which will emerge from the dataset of 72 case studies of PHW-delivered mental health programmes in India. This paper focuses on describing the programmes’ models and their workforce. The two further studies will cover: 1) qualitative information on perceptions of health workers, their supervisory staff, specialists and organisation founders and 2) the training and supervision characteristics of these programmes and their challenges. Case study methodology has
value when making sense of a messy real world setting as they are important to understand what factors in existence currently seem to fail or succeed (Keen, 2006).

6.3.1. Study setting

Thirty five governmental and non-governmental-led organisations with rural mental health programmes (including those with urban components), were selected purposively from an initial 122 potential organisations identified through snowballing and web searches. Phone meetings with programme leaders informed our decision on programme selection to represent a range of (i) population characteristics, (ii) types of PHWs used and methods of delivering care, (iii) PHWs roles, (iv) the intensity of supervision and training for PHWs and (v) service delivery models. Two eligible organisations refused to participate and were replaced with similar organisations. Thirteen organisations were excluded after unsuccessful contact attempts during the screening process. One organisation was excluded after interviews as it transpired they did not use PHWs. Finally 34 organisations were included in our analysis. Organisations had between 1 and 6 types of PHW-delivered mental health programmes; the total number of programmes analysed was 72.

6.3.2. Sampling

Across the 72 programmes, 104 PHWs, 29 coordinators (people who manage the mental health component of the programme and/or coordinate or supervise PHW activities), 31 leaders (heads and/or founders of the organisations), 36 mental health specialists (such as psychiatrists, psychologists, psychiatric social workers) and four other clinic support staff (such as pharmacists and general clinic managers) were interviewed. Within each programme a leader or coordinator chose the staff for interviews, based on our request for representative and varied staff cadres. In all programmes we interviewed at least two PHWs, one coordinator, specialist or other supervisor for PHWs and one leader or founder of the programme (some interviewees worked in and, therefore represented several programmes).
6.3.3. Data collection

A case study approach was adopted for our fieldwork. Data was collected between 2010 and 2011. Two programmes were selected for in-depth case studies using participant observation, semi-structured interviews and documentary analysis to gain a depth of understanding of these programmes. The other 70 programmes were shorter case studies involving semi-structured interviews, site visits and documentary analysis to explore the breadth of different types of models. Seventy-four semi-structured interviews (with coordinators, managers and specialists), 26 focus groups (mainly with PHWs with or without their supervisors) and visits to all programmes were conducted by NvG, MSM or SG. Two researchers interviewed together in areas prone to unrest (such as in Jharkhand), as advised by the hosting organisations. Interviews were conducted in seven languages. Our team covered English, Kannada and Hindi. For other languages (Tamil, Malayalam, Oriya, Telugu, Mizo), interpreters (researchers or allied project staff) were sourced locally. Interviews and focus groups were conducted in the interviewees’ workplace. Most were recorded (26 interviews were not, due to high background sound levels or participant refusal), transcribed and translated. Workers involved in care (PHWs, care coordinators/ supervisors and specialists) were asked to describe their activities, roles and identified barriers/solutions. Programmatic staff (founders or programme managers) were asked about programme characteristics, funding, management or leadership, plans for expansion and views on PHWs. All were asked about their views on the feasibility, scalability of their own model and for recommendations to improve the government model. Questions were adapted from a case-study methodology that was being developed at the time to monitor and evaluate community mental health programmes in low-income countries (Cohen et al., 2012) (see appendix 4 for consent forms, information sheets and questionnaires used).

Site visits were organised to observe the infrastructure, location and facilities and, where possible, researchers sat in clinics or shadowed rural outreach visits. These observations were recorded in summary sheets completed after each visit.
Documentary sources (annual reports, minutes of meetings, evaluations or other documents) were sought from participants to complement and corroborate interview data. Published project data were gathered from relevant databases (PsycINFO, Web of Science, Medline, Embase, CINAHL) and from participants, for further data triangulation. Little quantitative data existed or was made available apart from annual reports and some leaflets, therefore most information was drawn from qualitative data.

6.3.4. Data analysis

Framework analysis was carried out with the goal of ensuring our findings were relevant to policy-makers. After data familiarisation, a coding framework was created to structure and standardise multiple-researcher coding (NvG, MSM, SG, AR) (Manderson et al., 2001). This facilitated coding numerous transcripts, helped identify new unanticipated themes, and allowed for analyst triangulation: data collected by one person is analysed by others to reduce the risk of selective interpretation and blind interpretive bias (Patton, 1999).

To create the framework, six interviews (chosen to represent different interviewees and topics) were inductively coded in NVIVO by at least two researchers per interview. At a meeting the researchers devised an initial framework based on the inductively-reached themes, and those from the interview guides and the literature. A qualitative expert from a separate institution (JR) read and coded some transcripts at selected points during framework development. The finalised framework was used to code all data. Ongoing dialogue between researchers contributed to the framework’s interpretation. The lead researcher (NvG) cross-checked 15 interviews to ensure that the coding framework was applied consistently and reliably across researchers (Manderson et al., 2001). Good correlation was achieved.

The factual data gathered was taken at face value to represent the ‘truth’, though we incorporated mechanisms to ensure maximal factual accuracy. Thus, we gained perspectives from different workforce members and compared and cross-checked
their reports for inconsistencies and completeness. Reports of factual findings were submitted to organisations to check their accuracy. This respondent validation as well as the process of data triangulation further improved reliability of data interpretation (Patton, 1999; Green and Thorogood, 2004).

Statements to disprove emerging hypotheses were sought (deviant case analysis). These processes increased the internal validity of the data and credibility of the conclusions (Patton, 1999). The coding framework was indexed and charted into tables to compare different features (such as health workers, and programme component characteristics) across interviews and programmes. We then mapped patterns or associations between different human resources and programme features and concepts (Green and Thorogood, 2004).

We attempted to use several established frameworks for analysing and categorising the level of engagement, collaboration and integration between mental health specialists and primary care workers (Bower, 2011; Bower and Gilbody, 2005; Balabanova et al., 2011; Collins et al., 2010; WHO-WONCA, 2008). None fitted our data adequately, therefore we inductively adapted the framework which best fitted our data: the Bower framework (see figure 1.3 in chapter 1). This framework describes four levels of integration of care for depression within primary care in HICs, ranging from relatively more PHW responsibility to relatively more specialist responsibility for mental healthcare.

1. **Training and education**: Aims to make primary care practitioners independent in managing basic mental health conditions through training provision only.

2. **Consultation liaison**: As above but also involves an ongoing educational relationship with a specialist (for example through joint case discussions) to make the primary practitioner more independent and confident in providing mental healthcare and reduce the frequency of referrals to specialist care.

3. **Collaborative care**: Also known as the chronic care model, this has an additional workforce member (a “care manager”) with mental healthcare
responsibilities and who acts as a ‘link’ between the patient, the primary care practitioner and the specialist. This model usually involves some system redesigning including sharing clinical information between specialists and non-specialists (ICIC, 2014).

4. Replacement and referral: Health workers are trained to identify and refer suspected cases to the mental health professional, who retains the main responsibility of care.

As over half our programmes did not fit into the Bower framework with the above definitions, we broadened primary care to include not just government primary care but also NGO-delivered primary care/community care. We also included programmes which did not have a separate or new ‘link worker’ (i.e. the care manager) but some other form of care coordination, as care coordination rather than the care manager is a feature of the collaborative care definition within the chronic care model (ICIC, 2014; Woltmann et al., 2012).

We categorised programmes according to whether or not they were collaborative care models. Collaborative care was chosen as it is the model with the soundest evidence-base (multiple systematic reviews) for effectiveness in many chronic disorders. Within mental healthcare it is an effective intervention for improving outcomes for patients with depression (Archer et al., 2012; Bower et al., 2006; Gilbody et al., 2006; Thota et al., 2012), anxiety (Archer et al., 2012) and combined diabetes and depression (Atlantis et al., 2014). However there is still insufficient evidence (as little research) for its role in other MNS disorders (substance abuse, child and adolescent problems, dementia or epilepsy) (Callahan et al., 2006; Hilt et al., 2013; Sarvet et al., 2010). Most of this evidence comes from HICs and there is still a dearth of evidence from LMICs, though some trials suggest minimal improvement (van Ginneken et al., 2013).

6.4. Results

6.4.1. Overview of programmes and their human resources

6.4.1.1. Types of programmes
The 72 selected PHW programmes were from 34 organisations in 12 states (figure 6.1). Only 15/72 programmes were collaborative care models (table 6.1; supplementary table 1 in appendix 7). The remaining were non-collaborative models (supplementary tables 2, 3 and 4 in appendix 7). The organisations were mainly non-governmental voluntary organisations. Other NGOs included two not-for-profit hospitals, two academic institutions and one religious institution. The remaining five programmes were government district mental health programmes. Most programmes covered all mental disorders (Table 6.1). Only 22/72 programmes had incorporated mental healthcare within a general healthcare setting. The others had either incorporated mental healthcare into HIV or disability care, or were vertical programmes (i.e. which solely provided mental healthcare).

6.4.1.2. **Types of human resources**

Below we describe the types and spread of human resources across all 72 programmes. The most commonly used PHWs were LHWs (45 programmes) (table 6.2). They were mainly utilised by NGOs, but four government programmes also provided minimal mental health training to PHC-based LHWs who have general healthcare and health promotion roles (auxiliary nurse midwives (ANMs) and accredited social health activists (ASHAs)). Other PHWs used included doctors (30 programmes) and community members (20 programmes) (table 6.2). In addition 38 programmes trained PHWs from other outside programmes (supplementary table 2). There was no difference between the use of PHWs (in terms of diversity or type of PHW) in urban and rural areas.

A large array of care coordination occurred: care managers and coordinators were from a specialist or non-specialist background. They supervised and/or trained PHWs, and oversaw the programme. Specialist resources included mainly psychiatrists (49 programmes), psychologists (28 programmes), and psychiatric social workers (PSWs) (23 programmes). However the seven most remote programmes had limited

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1 Some organisations also provided purely specialist services (such as rehabilitation homes and acute psychiatric care), which are not covered in this paper.
specialists’ involvement compared with the majority of other programmes (which provided urban and rural care), where at least one specialist was involved regularly.

Figure 6.1: Location of the 72 programmes

As the complexity of the programme grew, particularly those in the collaborative care and specialist integrated models, so did the number or tiers of PHWs and coordinators within these programmes. Twelve programmes had between two and four types of PHWs (such as a doctor, a social worker and/or a LHW), and 26 programmes also had two to four coordinators (such as administrative coordinators and a hierarchy of clinical coordinators between different levels of PHWs).
Table 6.1 Summary of programme characteristics by model

<table>
<thead>
<tr>
<th>Model</th>
<th>Types of organisation s</th>
<th>Types of programmes§</th>
<th>State</th>
<th>Urban/ral</th>
<th>Mental disorders addressed§</th>
<th>Specialist/ support platform§</th>
<th>PHW platform§</th>
<th>Programme characteristics</th>
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<tbody>
<tr>
<td>COLLABORATIVE CARE (n=15)</td>
<td>NGOs (15)</td>
<td>Non-specialist and specialist care provided</td>
<td>Karnataka (2); Tamil Nadu (7); Kerala (1); Andhra Pradesh (1); Madhya Pradesh (1); Assam (2); Jharkhand (1)</td>
<td>Rural (14); urban (1)*</td>
<td>All mental disorders (MDs) (14) (1 focused on women; 1 on homeless); 1 depression; 1 alcohol abuse.</td>
<td>Specialist hospital (6); general hospital (2); community mental health services (CMHS) (8).</td>
<td>Community NGOs (including disability sector NGOs) (16), PHC (6); self-care (5).</td>
<td>Drug supply: good within NGOs (donor funding); Clinical information system (CIS) (Ashwini, early Karuna Trust, SACRED, NBJK); System redesign: all programmes (addition of new LHWs / care managers, shared care and multi-disciplinary teams (MDTs). Matched care: by psychiatrists (except by SW (TTK) and gynaecologist (Ashwini)). Stepped care (Ashadeep, Banyan FPA)</td>
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<tr>
<td>Model</td>
<td>Types of organisation</td>
<td>Types of programmes</td>
<td>State</td>
<td>Urban/ rural</td>
<td>Mental disorders addressed</td>
<td>Specialist/ support platform</td>
<td>PHW platform</td>
<td>Programme characteristics</td>
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<td><strong>Non-collaborative care models</strong></td>
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<tr>
<td>EDUCATION AND TRAINING (n=16)</td>
<td>NGOs (9); government programmes (7); government-NGO partnership (1).</td>
<td>PHC doctor training by government (5), NGOs (4) and government-NGO partnership (1); certificated courses (3); caregiver/support groups training (3).</td>
<td>Karnataka (7); Tamil Nadu (3); West Bengal (1); Delhi (2); Jharkhand (1); Mizoram (1); Assam (1).</td>
<td>Rural (12); urban (2)*; urban and rural (2).</td>
<td>All MDs (16); homeless (1); substance abuse and HIV (1).</td>
<td>Specialist hospitals (7); general hospitals (8); CMHS (6); community organisations (4).</td>
<td>Government primary healthcare (10); other community care (6); self care (3).</td>
<td>Drug supply: government provision poor; CIS: in government system and one NGOs (Karuna Trust); System redesign: none.</td>
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<tr>
<td>REPLACEMENT, REFERRAL AND AWARENESS-RAISING (n=24)</td>
<td>NGOs (20); academic institution (1); government-religious institution partnership (1); private (2).</td>
<td>PHC doctor (7) /LHW training (3); training external HWs to refer only (4); training non-health workers (eg police) (5); awareness raising through campaigns (6).</td>
<td>Karnataka (6); Tamil Nadu (8); Andhra Pradesh (1); Maharashtra (3); Delhi/Kashmir (2); Jharkhand (1); Assam (2); Mizoram (1).</td>
<td>Rural (14); urban and rural (3); urban (7).*</td>
<td>All MDs (17); severe mental disorders (2); suicide prevention (1); substance abuse (4); homeless (1).</td>
<td>Specialist hospital (4); general hospital (2); CMHS (14); community disability or general health services (4).</td>
<td>Community outreach (18); primary health centre-based (9).</td>
<td>Drug supply: N/A; CIS: none; System redesign: none.</td>
</tr>
<tr>
<td>Model</td>
<td>Types of organisation s</td>
<td>Types of programmes§</td>
<td>State</td>
<td>Urban/ ral</td>
<td>Mental disorders addressed§</td>
<td>Specialist/ support platform§</td>
<td>PHW platform§</td>
<td>Programme characteristics</td>
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<td>COMMUNITY OUTREACH (n=17)</td>
<td>NGOs (17)</td>
<td>Outreach clinics with PHW support (2); PHWs as lay counsellors (5); help-lines with PHWs (3); rescue operations with PHWs (2); community rehabilitation by PHWs (5).</td>
<td>Karnataka (1); Tamil Nadu (7); Kerala (1); Maharashtra (4); Delhi (2); Orissa (1); Mizoram (1).</td>
<td>Rural (8); rural and urban (4); urban (5).*</td>
<td>SMDs (8); all MDs (7); substance abuse (3); homeless (1).</td>
<td>Specialist hospital (3); general hospital (1); CMHS (13); community disability or general health services (1.).</td>
<td>Specialist hospital (1); community-based care (9); self care (5 - all the vocational training programmes).</td>
<td>Drug supply: good within NGOs (donor funding); CIS: 4 programmes (SCARF, Sneha, MHAT, Antara); System redesign: in all programmes (new LHWs, shared care and MDTs); Matched care: by psychiatrist (MHAT, Bapu Trust, Mukhtangan Mitra) or PHW (Banyan UMHP). Stepped care: Saarthak, VOLCOM; One intervention: SCARF, Sneha, 3 help-lines, and 5 vocational training/rehabilitation programmes</td>
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</table>
Table 6.2: Roles of PHWs, coordinators and specialists by model

<table>
<thead>
<tr>
<th>Health worker (number of programmes)</th>
<th>Collaborative care model (n=15)</th>
<th>Non-collaborative models</th>
<th>Replacement, referral and awareness-raising (n=24)</th>
<th>Community outreach (n=17)</th>
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<tr>
<td>PHWs</td>
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<tr>
<td><strong>Doctors (n=30)</strong></td>
<td>11 programmes:</td>
<td>11 programmes:</td>
<td>6 programmes:</td>
<td>2 programmes:</td>
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<td></td>
<td>Background: most PHC doctors, 2 gynaecologist (Ashwini, Banyan FPA), 1 BAMS (combined ayurvedic medicine) doctor (Ashagram)</td>
<td>Background: PHC doctors</td>
<td>Background: PHC doctors</td>
<td>Background: generalist doctors</td>
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<td>Roles: exclude organic disease and general healthcare (MICP, Ashagram, Ashadeep, Banyan CMHP, TTK rural camps, Chellamuthu Trust treatment camps); identification referral and follow-up (CHAD, early Karuna Trust programme, MICP, Ashagram); diagnosis and treatment (Banyan-FPA, Ashwini, Ant); counselling(Ant).</td>
<td>Roles: all expected to diagnose, treat, refer, and educate patients.</td>
<td>Roles: identification, referral and follow-up (Current PHC doctor training: Chellamuthu Trust, Banyan; Closed: AIIMS, RFS Siddlaghatta, SCARF telemedicine, AIIMS Kashmir).</td>
<td>Roles: exclude organic disorders (Bapu Trust and TTK)</td>
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<td>Training: lengths variable; 4 Karnataka DMHP sites meant to be 30 days but actually 9; other DMHP (RINPAS Jharkhand, Karuna Trust): 15 days; NGOs (GASS, SCARF, CHAD, IIAMS – all now closed): 3 days.</td>
<td>Training and supervision: All training 1-3 days except AIIMS Kashmir relief intervention (7 days) and Chellamuthu Trust (15 days). No ongoing support.</td>
<td>Training and supervision:</td>
<td>Training and supervision: none</td>
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<td>Supervision: One NGO (Karuna Trust) monitors and supports PHC doctors on programme implementation</td>
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<td></td>
<td>Training/supervision: Ad hoc/ weekly supervision for docs with MH roles.</td>
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<td>Health worker (number of programmes)</td>
<td>Collaborative care model (n=15)</td>
<td>Non-collaborative models</td>
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| **Non-physician professionals (n=11)** | 4 programmes' Background and roles: social workers (Banyan CMHP, Chellamuthu Trust CMHP, CHAD, Ashadeep): outreach work (identify, refer, follow-up, facilitate rehab activities), supervise LHWs/ care managers; counselling (Banyan CMHP). 1 nurse (MICP); similar outreach work to SWs above. Training and supervision: regular. Delivered by a psychiatrist (all 4 programmes), psychologist (Ashadeep) (all 4 programmes) or PHW coordinator (Banyan CMHP). | **Education and training (n=16)**
- 3 programmes: Background and roles: 2 pharmacists in DMHP: dispense drugs, awareness-raising (Gulbarga, Karwar); 1 CBR worker (Samuha): social worker roles and non-specific counselling. Training and supervision: by specialists: ad hoc (DMHP), regular (Samuha). **Replacement, referral and awareness-raising (n=24)**
- 1 programme: Background and roles: social work and nursing students (TTK) trained to identify and refer people with alcohol problems. Training: On-off training. No supervision. **Community outreach (n=17)**
- 3 programmes: Background and roles: social workers (Mission Ashra, Banyan UMHP, VOLCOM); nurses and pharmacist (Mission Ashra); part of outreach teams. Training and supervision: by specialists. Regular supervision. |
<p>| LHWs (n=45) | 14 programmes: Background: basic primary or secondary school education for most. 1 programme: graduate CBR | 7 programmes: Background: government LHWs (ANMs, ASHAs in Karnataka DMHP | 9 programmes: Background: external government LHWs (ANMs, ASHAs) (RFS Siddlaghatta, GASS, Chellamuthu | 15 programmes: Background: primary or secondary school education (Banyan UMHP, MHAT, SCARF COPSI, Bapu Trust, |</p>
<table>
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<tr>
<th>Health worker (number of programmes)</th>
<th>Collaborative care model (n=15)</th>
<th>Non-collaborative models</th>
<th>Replacement, referral and awareness-raising (n=24)</th>
<th>Community outreach (n=17)</th>
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<tr>
<td><strong>LHWs (continued)</strong></td>
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<td>worker (GASS)</td>
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<td>Trust, NBJK); external NGO LHWs (Banyan BALM, Bapu Trust, Maitra, Ant, Ashadeep)</td>
<td>Mukhtangan Mitra, Saarthak PACT, VOLCOM, Sneha, Maitra, Uduvam Ulangal; recovered users (VOLCOM, Samuha, Banyan day centre, Chellamuthu Trust vocational rehab, Saarthak vocational rehab); graduates (MHAT, Mukhtangan Mitra, Saarthak PACT)</td>
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<td>Roles: all programmes except</td>
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<td>Roles: identification/referral, follow up (all); awareness raising (NBJK, Ashadeep, SACRED) and psychosocial support (SACRED). Training and supervision: 1 day training for all, except GASS (5 days) and RFS (2-3 days). No ongoing supervision, except NBJK (ad hoc supervision).</td>
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<tr>
<td>Banyan FPA use LHWs. Most have</td>
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<td>complementary roles (psychosocial</td>
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<td>support, identification, referral,</td>
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<td>awareness, medication adherence).</td>
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<td>Other specific roles: counselling</td>
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<td>(Banyan CMHP, GASS, Ashwini,</td>
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<td>Ashadeep, CHAD, NBJK); income</td>
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<td>generating activities/self-help</td>
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<td>groups/lobby government (Chellamuthu Trust, SACRED); conducting surveys (Ashagram); only identification and referral (Karuna Trust); bring patients to camps (GASS, TTK, NBJK, Chellamuthu Trust volunteers)</td>
<td>Training and supervision: training by specialists, supervision by care managers.</td>
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<tr>
<td><strong>Roles:</strong> counselling (Bapu Trust, SCARF COPSI, Saarthak, VOLCOM), emotional first aid (helplines: Sneha, Mukhtangan Mitra and Maitra), and vocational training (recovered patients or CBR workers in Samuha, Banyan day care and Adaikalam, Chellamuthu Trust and Saarthak); minor administrative or supportive roles (MHAT, NBJK) Training and supervision: well</td>
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<tr>
<td>Health worker (number of programmes)</td>
<td>Collaborative care model (n=15)</td>
<td>Non-collaborative models</td>
<td>Community outreach (n=17)</td>
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<td>Community members (n=20)</td>
<td>3 programmes:</td>
<td>5 programmes:</td>
<td>supported by coordinators, care managers and specialists.</td>
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<td></td>
<td>Background: community leaders</td>
<td>Background: community</td>
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<td></td>
<td>(MICP), self-help groups</td>
<td>leaders (Chellamuthu Trust);</td>
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<td></td>
<td>(Ashagram), caregiver forum</td>
<td>anganwadis and self-help</td>
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<td></td>
<td>(SACRED)</td>
<td>groups (RFS Siddlaghatta);</td>
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<tr>
<td>Roles: identification/referral (CHAD,</td>
<td>caregivers (Ashadeep, Antara</td>
<td>caregivers (Chellamuthu Trust).</td>
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<td>MICP, Ashagram), general support</td>
<td>and Chellamuthu Trust).</td>
<td>Roles: training on coping</td>
<td></td>
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<tr>
<td>and patient advocacy (Ashagram,</td>
<td></td>
<td>strategies, self care, and</td>
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<td>SACRED)</td>
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<td>referral indications;</td>
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<td>Training and supervision: ad hoc by</td>
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<td>networking/advocacy</td>
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<td>coordinators.</td>
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<td>(community leaders in</td>
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<td>Chellamuthu Trust); and</td>
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<td>medical adherence (Antara,</td>
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<td>Ashadeep)</td>
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<td>Training: by specialists; no</td>
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<td>supervision.</td>
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<td>11 programmes:</td>
<td>Background: community leaders</td>
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<td></td>
<td>(Banyan Panchayat academy);</td>
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<td>religious leaders (Murgamalla);</td>
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<td>police/other community workers</td>
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<td>(TTK, Sneha, Mukhtangan Mitra,</td>
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<td>Saarthak, Ashok Pai, RFS,</td>
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<td>VOLCOM); anganwadis/ self-help</td>
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<td></td>
<td>groups (GASS, SACRED).</td>
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<td>Roles: identification/referral by</td>
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<td>anganwadis/self-help groups or</td>
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<td>police/community leaders;</td>
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<td>psychosocial support (Maitra,</td>
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<td>Mukthangan Mitra); campaigns/</td>
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<td>awareness raising (GASS volunteers,</td>
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<td>Banyan panchayat academy, Bapu Trust,</td>
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<td>RFS, Ashok Pai, TTK, Ashadeep,</td>
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<td>VOLCOM, Saarthak volunteer campaigns)</td>
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<td>1 programme:</td>
<td>Background: any educational</td>
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<td>Roles: reintegation of patients into</td>
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<td>their families/community (Banyan</td>
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<td>reintegration)</td>
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<td>Training and supervision: by</td>
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<td>specialists.</td>
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<td>Health worker (number of programmes)</td>
<td>Collaborative care model (n=15)</td>
<td>Non-collaborative models</td>
<td>Community outreach (n=17)</td>
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<tr>
<td>Community members (continued)</td>
<td></td>
<td>Education and training (n=16)</td>
<td>Replacement, referral and awareness-raising (n=24)</td>
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<td></td>
<td></td>
<td>Training and supervision: trained by specialists; no ongoing supervision, except for ad hoc supervision (Murgamalla and Banyan Panchayat academy).</td>
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<td>Coordinators</td>
<td>9 programmes:</td>
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<td>Care managers (n=20)</td>
<td>Background: mainly experienced LHWs (Chellamuthu Trust CMHP and Sathya Sai camps, CHAD, Ashadeep, Ant, Ashagram, GASS, TTK rural camps) or graduates/SW (Banyan CMHP)</td>
<td>Roles: clinical roles (as above); liaise between patients, LHWs, specialists; supervise LHWs</td>
<td>11 programmes: Background: experienced LHWs/lay counsellors (Bapu Trust, Sneha, VOLCOM, MHAT); social workers or graduates (Banyan, Mukhtangan Mitra (helpline and outreach), Maitra, VOLCOM, Saarthak, Uduvam Ulangal),or psychologists/PSWs(Muktangan Mitra, Maitra)</td>
<td>Roles: clinical roles as above; liaise between patients, LHWs and specialists; supervise LHWs; train LHWs (the three helplines), reintegration activities (Uduvam Ulangal)</td>
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<td></td>
<td>Training and supervision: supervised by SW, PSW or graduate coordinator (for LHW care managers), by psychiatrist or organisation head (for professional</td>
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<tr>
<td>Health worker (number of programmes)</td>
<td>Collaborative care model (n=15)</td>
<td>Non-collaborative models</td>
<td>Community outreach (n=17)</td>
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<tr>
<td><strong>Care managers</strong></td>
<td>Care managers. Trained by specialists.</td>
<td>All programmes (16): <strong>Background</strong>: specialist background in all programmes except for 4 programme: social workers or (post)graduate (BNI/Samuha, GASS and Karuna Trust, Antara). Only 3 programmes have a dedicated training coordinator (BNI/Samuha, GASS and Karuna Trust) <strong>Roles</strong>: Training coordination administration by PHWs. <strong>Training</strong> and supervision: by specialists. <strong>No ongoing supervision.</strong></td>
<td>All programmes (24): <strong>Background</strong>: Most coordinators are non-health graduates: general coordinators who also coordinate training (GASS, Murgamalla, Sneha) and specific training coordinators (Banyan Panchayat academy, Banyan BALM, SACRED, Ashadeep, NBJK, Ant). Some programmes have coordinator hierarchy. <strong>Roles</strong>: provide training coordination. <strong>Training and supervision</strong>: Training delivery by specialists; 3 programmes include ongoing support (see above) through</td>
<td>Training and supervision: regular by specialists.</td>
</tr>
<tr>
<td><strong>Other coordinators (n=64)</strong></td>
<td>6 programmes: <strong>Background</strong>: Graduates (Karuna Trust early programme, SACRED, NBJK); gynaecologist (Banyan FPA, Ashwini); psychiatrist (MICP); <strong>Roles</strong>: Many levels of administrative and programme coordinators. Coordinate activities, train and supervise LHWs. <strong>Training and supervision</strong>: by specialists.</td>
<td>All programmes (24): <strong>Background</strong>: graduate (Banyan day care); social worker/CBR worker (Samuha), PSW (SCARF); psychologist (SCARF, Saarthak); psychiatrist (Mission Ashra, Chellamuthu Trust vocational rehab, Banyan Adaikalam, Saarthak vocational rehab) <strong>Roles</strong>: Several coordinators with only administrative roles (no clinical roles) (MHAT, SCARF), or existing clinical or psychosocial support roles with added coordinator roles (Saarthak PACT, Mission Ashra, Samuha, Chellamuthu Trust vocational rehab, Saarthak vocational rehab, Banyan Nadja van Ginneken Thesis Page 189</td>
<td>8 programmes:</td>
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<tr>
<td>Health worker (number of programmes)</td>
<td>Collaborative care model (n=15)</td>
<td>Non-collaborative models</td>
<td>Replacement, referral and awareness-raising (n=24)</td>
<td>Community outreach (n=17)</td>
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<td>Education and training</td>
<td>coordinators.</td>
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<td>(n=16)</td>
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<tr>
<td>Specialists</td>
<td>Psychiatrists: outreach clinics (most), training of most PHWs. Supervision of professional PHWs (Banyan CMHP, early Karuna Trust programme, MICP, TTK, Banyan FPA) and of care managers/coordinators (Banyan CMHP, Chellamuthu Trust CMHP, early Karuna Trust programme, Ashadeep, GASS, TTK, Banyan FPA, Sacred, Ashwini, NBJK). Hierarchical supervision structure: Psychiatrists: PHC doctor training (DMHP in Karnataka and Jharkhand, Karuna Trust, GASS, SCARF, CHAD, IIAHS); CBR worker training together with PSW (Samuha); LHW training (Karuna Trust, Saarthak), caregiver training (Chellamuthu Trust). Multidisciplinary team (psychologist, psychiatric nurse, PSW) train LHWs</td>
<td>Psychiatrists: train PHC doctors, LHWs or community members (RFS, Ashok Pai, SCARF, Banyan, AIIMS Kashmir, Sneha, SACRED) or as part of a multidisciplinary team (including psychologist/PSW (Chellamuthu Trust, Banyan BALM, Muktangan Mitra, TTK, Saarthak). Outreach camps (Murgamalla, Chellamuthu Trust, SCARF, Banyan, RFS). Psychiatrists train LHWs (Bapu</td>
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<tr>
<td>Specialists (n=72)</td>
<td>Psychiatrists, psychologists: clinical roles mainly within outreach teams, training, support coordinators and in some instances PHWs directly (less support in rescue operation and rehabilitation models); some provide care coordination (see above).</td>
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Nadja van Ginneken Thesis Page 190
<table>
<thead>
<tr>
<th>Health worker (number of programmes)</th>
<th>Collaborative care model (n=15)</th>
<th>Non-collaborative models</th>
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<tbody>
<tr>
<td></td>
<td>specialist to professional coordinator/care manager to lay PHWs.</td>
<td><strong>Education and training (n=16)</strong></td>
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<td></td>
<td>(VOLCOM) PSW trains caregivers (Chellamuthu Trust).</td>
<td>Trust, Maitra), campaign leaders (VOLCOM) or as part of team with PSW (LHWs: NBJK; community members: TTK). PSWs: train community members (Banyan Panchayat academy).</td>
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</tbody>
</table>

**Abbreviations:** *The Ant*: partner organisation of Ashadeep; **AIIMS**: All India Institute of Medical Sciences; **ANM**: Auxiliary nurse midwife; **ASHA**: Accredited social health activist; **BALM**: The Banyan Academy in Leadership in Mental Health; **BAMS**: Bachelor of Ayurveda, Medicine and Surgery; **CBR**: Community-based rehabilitation; **CHAD**: Department of Community Health, Christian Medical College Vellore; **CMHP**: Community mental health programme; **CMHS**: Community mental health services; **COPSI**: Care for people with Schizophrenia in India; **DMHP**: District Mental Health Programme; **FPA**: Family Planning Association; **GASS**: Grameena Abhyudaya Seva Samasthe; **IIAHS**: Indian Institute of Allied Health Sciences; **MHAT**: Mental Health Action Trust; **MICP**: Malappuram Initiative in Community Psychiatry; **NBJK**: Nav Bharat Jagrath Kendra; **PACT**: Saarthak reintegration project for people recovering from severe mental illness; **PSW**: Psychiatric social worker; **RFS**: Richmond Fellowship Society; **SCARF**: Schizophrenia Research Foundation; **SW**: Social worker; **TTK**: TTK Ranganathan Clinical Research Foundation; **UMHP**: Urban mental health program; **VOLCOM**: Volunteers for Community Mental Health
6.4.2. Models of mental healthcare delivery and their human resources

The 72 programmes were categorised into collaborative and non-collaborative care.

6.4.2.1. Collaborative care

Details of models

Fifteen of the 72 programmes were categorised as collaborative care models (table 6.1; supplementary table 1 in appendix 7). They addressed all mental disorders though three programmes focused on women, homelessness or alcohol abuse. All programmes were rural and run by NGOs. They were generally longstanding programmes (in existence since the mid 1990s for most).

Only five of the 15 collaborative care programmes involved government primary healthcare (PHC). All had regular or close collaboration (defined as organised regular contact and visiting specialist with clinical involvement) between specialists and PHC-linked or NGO-trained LHWs – but not with PHC doctors. They tended to use the primary care infrastructure as a platform for delivery rather than utilising their human resources (except for a public private partnership). All five programmes involving government primary care utilised psychiatrists to match the appropriate care to the patient rather than a stepped care approach (where patients enter the care pathway at a basic level of care and get stepwise increasing different care if they fail to respond to the first level of care) (Gask and Khanna, 2011).

The other 10 collaborative care programmes occurred in community settings. They had similarities with PHC-based collaborative care. Collaboration still happened across three sectors: the patients, a non-specialised sector (in this case non-specialised NGOs, i.e. disability- or development-focused NGOs) and a specialised sector (government or NGO-based). These collaborations were complex as there could be collaboration with several organisations within the same sector level. For example, three programmes had two specialist organisations supporting the non-specialist sector: 1) a mental health NGO provided ongoing technical support and monitoring but had no mental health specialists to deliver care and 2) specialists were only contracted in for some
training, or to be referred to. Most of them provided matched care too, though two programmes provided stepped care. Two programmes were in theory collaborative though they were in the process of changing to having little psychiatric support and possibly becoming consultation-liaison-type models.

These models of collaborative care included system redesigning (introduce a new health worker and/or care manager, shared care and multidisciplinary team support system). However only four incorporated data sharing where records were created for mentally ill patients in primary care (see table 6.1). None of these programmes regularly audited or monitored their routinely collected data.

Human resources

Care coordination is the lynchpin to the collaborative care model. Traditionally care managers (a new ‘linking’ cadre between primary care provider, specialist and patient, with clinical responsibilities) are the care coordinators. In these case studies we identified other care coordinators (coordinators without clinical responsibilities or existing PHWs with care coordination roles) too. Care managers were either experienced LHWs (6 – of whom 3 were unpaid) or graduates/ social workers (3) who had been put in place by an NGO, even within the primary care models. They liaised between patients, PHC or NGO staff and specialist professionals, had several clinical responsibilities for psychosocial support and often training and supervision duties for less experienced LHWs. Other types of care coordinators were present in six programmes and were all highly trained. Both in government primary care and community initiatives, three coordinators had strictly coordinator roles but no clinical duties, and three programmes had clinicians (a PHC doctor, two gynaecologists and one psychiatrist) who coordinated care in addition to their usual clinical duties (Table 6.2; supplementary table 1). Care managers and care coordinators were supervised, apart from three programmes (where a gynaecologist, a LHW and a psychiatrist were the care coordinators). Most had regular supervision (such as during outreach clinics) from professional PHW coordinators (for experienced LHW care managers), or by psychiatrists (for professional care coordinators/managers) (table 6.2).
Programmes had several layers of PHWs, whether in primary care or community care. All programmes had LHWs (NGO-paid LHWs and/or government LHWs), except for one partnership where there was only one gynaecologist as a non-specialist. In addition to LHWs, there could be a generalist doctor and/or social worker/graduate. In only three of the 11 programmes which had generalist doctors were they expected to diagnose and treat mental illness. The others identified, referred and followed up after psychiatric assessment (4 programmes) and/or excluded organic disorders (6 programmes).

LHWs’ roles varied from identification and referral to conducting significant amounts of psychosocial support (counselling, lobbying, income generation, benefits etc) through home visits. When there were several types of LHWs within a programme, their roles were divided. Six programmes had adapted counselling for delivery by LHWs (4), (though one programme also used a doctor, and 2 programmes, a social worker). They were supervised by non-specialist care managers or care coordinators and were provided with more intensive training than government LHWs: an initial 3-12 days training with subsequent ongoing refresher and on-the-job training (compared to one or two days for government LHWs). LHWs were not always remunerated. Three programmes did not pay their volunteers even though they had similar roles to other LHWs. Also the three programmes which utilised government LHWs did not remunerate or incentivise them for their mental health roles.

Specialists involved were either employed by the organisation or were external. Specialists conducted outreach clinics to diagnose, treat and review PHW-referred patients. They also provided initial training to most PHWs. Psychiatrists supervised professional PHWs or care managers/coordinators, but were not involved in supervising LHWs (who were supervised by coordinators). External psychiatrists were commissioned by six programmes to perform outreach clinics and had no roles in training or supervision of PHWs, though some supervised care managers (supplementary table 1 in appendix 7). They were more likely to disappear from the programme within two or three years of its initiation. Three collaborations between specialist programmes however had planned to phase out support once identification,
referral and follow-up mechanisms were established within their partner community based organisation.

6.4.2.2. **Non-collaborative care models**

The non-collaborative programmes fitted into three categories. Two of them reflect Bower’s categories at the extremes of spectrum of specialist versus primary care collaborations: 1) the education and training model which gives PHWs initial care responsibility (i.e. in diagnosis and treatment) with possibility of referral to specialist care for more complex care or when patients have failed to respond to primary mental healthcare; and 2) the replacement and referral model, where specialists retain the full responsibility of care. No programmes were found that fitted into the consultation-liaison model. The third category is a new category which has not been described in current frameworks: the community outreach model. This model is organised by specialist services but delivers a primary-level based service delivery of identification and basic interventions through recruited and trained PHWs.

6.4.2.2.1. **Education and training**

**Details of the model**

Sixteen programmes used this model. These programmes usually provided one-off training of varying lengths, with no further supervision or involvement. Most (10) organisations involved in delivering training were NGOs (table 6.1). These training sessions usually occurred reactively to a request, rather than being a continuous commitment by organisations. Most programmes trained PHWs on all mental disorders, although only three organisations provided accredited certificated courses for paraprofessionals. Only two NGOs had monitored training processes but none had evaluated health workers’ competency or clinical impact as they retained no contact with PHWs after training.

In addition, the government programmes had many problems with the reliability of their drug supply. This model did not redesign its system, though the government

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2 Some of these organisations also provided degree courses for specialists
programme in Karnataka did have mental disorder case record cards to document and report presenting symptoms and care. However, no system was in place for this clinical information system to result in monitoring management decisions.

**Human resources**

Within government PHC settings (in Karnataka and Delhi), PHC doctors were trained to diagnose and treat all mental disorders (11 programmes). PHC staff were trained by government DMHP- and by NGO- psychiatrists (two NGOs had been commissioned by DMHP, the others just trained PHC doctors in their locality) (table 6.2; supplementary table 2: appendix 7). They had no engagement in programme decision-making. Their contact with specialists was restricted to receiving training and referring, and no formal patient information sharing existed. Few other professional PHC staff were trained – for example no nurses or social workers were trained. However three government programmes trained ANMs and ASHAs. This was only a one-day training in identification and referral with no provision for ongoing support. Government PHC doctor training was much longer than that provided by most NGOs. They received between 15 and 30 days training over 3 to 5 years though in reality most PHC doctors had only received 3 to 9 days. Four of the five NGOs on the other hand, had trained PHC doctors for shorter lengths (3 days). These four programmes had since abandoned PHC doctor training as they found it poorly utilised their time and resources due to frequent transfers of doctors to other posts, which meant they had to repeatedly retrain new doctors. They had redirected their resources towards their own PHWs and other organisational priorities. One NGO however was in a public private partnership with the government DMHP programme so followed the government stipulations (Table 6.2).

From our observation, there was no organised supervision for PHC staff, partly because DMHP teams were short-staffed. The only exception was the NGO-government partnership programme which had a mental health coordinator (a non-specialist). This coordinator provided ongoing monitoring but no technical support to PHC doctors. PHC doctors thus took all mental clinical decisions independently, though
the paucity of diagnosed mental patients suggested this was inadequate, and most did not supervise their community staff (ANMs, ASHAs) out of lack of confidence and time.

Three NGOs (CMHS and general NGOs) also trained external LHWs from other programmes to identify mental disorders, follow-up and perform psychosocial interventions including non-specific counselling. In addition three programmes trained caregivers to identify and cope with their affected family member at home and encouraged them to form support groups. Other community members were also involved in community support and advocacy (table 6.2; supplementary table 2). Despite several training coordinators who organised training sessions, neither external LHWs nor caregivers received ongoing support following their training.

6.4.2.2.2. Replacement, referral and raising awareness

Details of model

Twenty-four rural and urban programme components fitted this model where PHWs were mostly trained to identify potential mental illnesses and refer these patients to specialist care. Some PHWs also raised mental health awareness. Most programmes were run by NGOs which specialised in specific mental disorders, physical disabilities or reproductive health. They provided outreach camps, telemedicine or just trained PHWs (table 6.1; supplementary table 3 in appendix 7). Many organisations which provided this model also provided programmes under the ‘education and training’ model and implemented these programmes in a similar way in that none provided ongoing supervision (except for two programmes). Also none of these programmes included a clinical information system, or system redesign.

Human resources

The main resources trained to identify and refer (with the responsibility for care remaining with specialists) were community members (11), LHWs (9) and doctors (6). Ten NGO- or academic- programmes trained government PHC staff (PHC doctors (6) and LHWs (4)) to identify and refer patients to psychiatric outreach camps. Training was coordinated by a separate coordinator but delivered by a specialist. Specialists
were remunerated in NGOs but not in government settings. Training length was one to five days usually, although two programmes provided 7-15 days (including a humanitarian relief programme). Two programmes trained PHC doctors within Tamil Nadu DMHP districts. DMHP in this state functioned differently to that in Karnataka and Northern states, where PHC staff were expected to diagnose and also treat (see above under training and education). However similarly to other DMHP districts, there was also no ongoing supervision (table 6.2; supplementary table 3). As per education and training models, four NGOs had ceased training government PHC doctors because either they were no longer contracted to or because of perceived ineffectiveness. In fact across both these models, 8/17 or 47% of programmes that had trained PHC doctors and allied health workers had closed due to funding shortages and discontinuation due to perceived ineffectiveness.

Eleven programmes trained community members (such as police officers, development workers, self-help group members and leaders) and LHWs in other NGOs (5 programmes). Their roles were to identify and refer. Some provided psychosocial support (3) (supplementary table 3). Training of police officers occurred within organisations that focused on substance abuse, homelessness and suicide prevention. These programmes had coordinators to organise outreach clinics, and monitoring referrals. Supervision was minimal: only three programmes provided minimal support to community members (2) and LHWs (1) such as ad hoc communication, expecting them to bring patients to camps (Table 6.2; supplementary table 3).

Six programmes provided mental health awareness to the general population or to at-risk populations (college students or people with disability). Within these, PHWs (LHWs and social workers) were involved in local dissemination of knowledge (e.g. pamphlet distribution). They also provided extra support within awareness campaigns delivered by specialists (films, mental health awareness days etc).

6.4.2.2.3. Community outreach models in specialist programmes

This model has not been described in any frameworks before. They are different from fully integrated models which assume involvement of primary care, shared care and decision making, and co-location of specialist and primary care services (Collins et al.,
Instead, specialist programmes or organisations recruit and train their own PHWs to deliver primary mental healthcare at community level or within clinics. The decision-making and programme structure remains specialist-centric rather than sharing power with non-specialists. These programmes used care managers and coordinators. So rather than collaborating with a separate primary or community care institution, these PHWs act as a referral mechanism to psychiatric care if needed. Psychiatric input may not be needed beyond diagnosing and forming a management plan.

Details of model

A total of 17 programmes fitted this model. Close to two thirds (11/17) of programmes targeted specific severe mental disorders (schizophrenia) and substance abuse. Twelve specialist programmes provided ambulatory care (outreach clinics) in which PHWs had a significant role. These programmes were part of NGOs that also provided other services such as collaborative care, training or specialist care (such as acute mental healthcare, rehabilitation homes, palliative care and disability). Only six programmes provided a system of matched or stepped care. The other programmes only offered single interventions (such as a stigma intervention, rescue missions for the homeless or help-lines).

These outreach programmes had two types of focus. Firstly, primary outreach services (first level care) included outreach programmes to rescue homeless people (2 organisations), outreach clinics within which PHWs provided psychosocial support (2 organisations), PHW-led lay counselling (5 programmes), and urban-based phone help-lines for general crises and for substance abuse (3 programmes) (though accessible to both urban and rural populations) (table 6.1; supplementary table 4 in appendix 7). The second set of PHW-interventions was the reintegration/rehabilitation of patients following long-stay psychiatric care (5 programmes). Four programmes provided vocational employment rehabilitation, which differed from other specialist vocational units as care was provided by non-specialists at community-level. These rehabilitation programmes were founded 5 to 10 years after other mental health programmes within NGOs, suggesting they were added on after establishing essential treatment services.
These programmes offered vocational training (skills training), though only two offered supportive employment (whereby the employer helps achieve an adapted return to work) (supplementary table 4 for details). A further programme trained community volunteers (business men, rickshaw drivers etc) to help facilitate reintegration of patients after a period in residential care.

Similar to collaborative care programmes, these outreach programmes were well funded, as they were all within NGOs who rely on donors and wealthier patients paying for their care. This meant their drug supply was adequate, and some had also built clinical information systems (table 6.1). They had also redesigned their system (through the addition of new health workers, shared care and multidisciplinary teams) though their system relied more heavily on specialists than collaborative care models.

**Human resources**

These programmes all included elements of care coordination. They employed care managers (11), care coordinators (8) or both (2 programmes). Their backgrounds varied across programmes. The majority of care managers were experienced PHWs, whereas care coordinators were predominantly specialists (table 6.2; supplementary table 4). Although we distinguished care managers from other care coordinators, they had similar coordination roles of liaising with, supervising and sometimes training PHWs. In programmes where other coordinators did not have clinical or care roles (which would have been performed by care managers in other programmes), these roles tended to be redistributed amongst one or several PHWs. All care coordinators and managers were supervised except those who were psychiatrists.

Professional PHWs (doctors, social workers, nurses and pharmacists) only provided care during the outreach teams’ clinics rather than in the community. PHC doctors (2 programmes) had no mental health roles; they excluded organic causes. Most programmes (15) used LHWs, though three also used graduates or social workers, and one used community members. LHWs were assigned interventional roles: psychosocial support, supportive roles at clinics (triage, taking a history/screening) and post-specialist follow-up (including adherence monitoring) (2 programmes). Within a further eight programmes LHWs, (but not professionals) had counselling roles for all
Types of counselling included non-specific counselling (4), emotional first aid (2) and specific behavioural psychotherapy techniques (2), though four programmes focused on substance abuse or schizophrenia. In rehabilitation programmes, health workers and non-health workers (such as recovered users, carers, community members) were trained as vocational skills trainers, a task usually assigned to more skilled cadres within specialist rehabilitation units.

Unlike collaborative care programmes, PHWs received intensive (usually weekly or monthly) support by one or several specialists (psychiatrists, psychologists and psychiatric social workers) as well as from non-specialist care managers (for the case of LHWs) (see supplementary table 4). Their specialist-delivered training was also longer and ongoing training more frequent than in collaborative care models.

6.5. Discussion

The results show that there is a rich array of models of mental healthcare delivery that are not possible to fit into the currently available frameworks for analysis which have been devised based on studies in HICs. The Bower framework remained the most suited framework for most models, allbeit, by broadening the definitions of 1) care managers to include other care coordinators and 2) primary care to include NGO-delivery in primary or community care. However this study adds a unique model of community outreach services to this framework (where PHWs were employed within specialist organisations to deliver a form of primary-level community care). This excluded primary care all together. Below we discuss whether the models and human resources used were appropriate and what further research is needed.

6.5.1. Are the models used appropriate?

Several models of primary mental healthcare delivery in India covered the same spectrum of collaboration models as in HICs. However, important variations exist. Numerous NGOs bypassed primary care and worked instead with other community based platforms. In India this is in response to a large unmet need for treatment and support for the mentally ill and their carers (van Ginneken et al., 2014). This pattern is
not common in HICs, but is in other LMICs (Petersen et al., 2011; van Ginneken et al., 2013).

Below we discuss the findings in light of current evidence. Given that the collaborative care model has most evidence for effectiveness in HICs (Coleman et al., 2009), still less than a quarter of programmes implemented this model (15/72 programmes). Although these figures are not representative of available programmes across India (as the case study sampling strategy was purposive), they give an idea of which programmes may be most available (Keen, 2006). These collaborative care models showed interesting innovative variations, such as using sectors other than primary care, matched care rather than stepped care even in government primary care settings, and a variety of care managers and coordinators. Care managers are known to be a factor for mental health collaborations working better (Gilbody et al., 2006), but other forms of care coordination are less evaluated. Few programmes had shared systems of care, clinical information systems or healthcare organisation support (ICIC, 2014; Woltmann et al., 2012), despite these programme elements improving the success of programmes. Also few collaborative care models focused on severe mental disorders and substance abuse. Collaborative care may be particularly important to ensure that the physical as well as mental needs of these patients are adequately met (Druss and von Esenwein, 2006). More research is needed to know whether collaborative care is effective given the above variations and if implemented at scale.

Unfortunately we found that the education and training model, for which there is little evidence of effectiveness on its own (Gilbody et al., 2003), was utilised by 22% (16/72) of all programmes, particularly for training external organisations’ PHWs. Disturbingly, it has remained the main stay of the Indian government’s DMHP model (and those in public private partnership). The DMHP trains PHC staff (doctors in diagnosis and treatment and government LHWs in identification and referral), but barriers to its effective implementation include a weak primary care system and shortages of drug supply. Furthermore, the lack of this model’s sustainability was exemplified by the fact that more than half the programmes training PHC doctors (all of these provided by NGOs) had shut down. Reasons given by NGOs for closure of their PHC-based programmes included withdrawal of funding, usually due to a change in the
organisation’s or funder’s priorities, but also due to perceived ineffectiveness of this programme. Ineffectiveness was attributed to the PHC doctor being frequently transferred, making it labour and cost-intensive to retrain their successors. Also this model lacked system redesign to bring out any collaborative aspect between specialists and PHWs. This training model remains attractive to policy makers because it is cheap (short training duration), and has little requirement of a heavily-burdened specialist workforce (Gilbody et al., 2003). However, training is only effective when combined with other models such as with collaborative care. For example in the UK, trained physicians then liaise closely with community mental health teams, specialist crisis intervention services, and with specialists in early psychosis identification (Goldberg and Gournay, 1998; Walters and Tylee, 2003).

Thirty three percent of programmes (24/72) trained PHWs to identify and refer, where specialists retained responsibility for care. This model has some evidence for improving patient and service outcomes in HICs (Richards, 2010; Clark et al., 2009; Bortolotti et al., 2008). However its sustainability on a larger scale in India and other LMICs is still doubtful given the current sparse specialist resources. In addition, in the models described, the majority of these provided training to PHWs but no ongoing support. These programmes may, therefore, be as ineffective as the education and training models.

Several specialist organisations had set up primary community extension or outreach services through PHWs (24% of programmes (17/72), half of whom targeted specific conditions which generally require greater specialist input (substance abuse and severe mental disorders). This model was adopted by many NGOs, partly as a reaction to failed attempts at establishing government partnerships or training their workforce, and due to government inefficiencies and unwillingness. This model is common in many LMICs where primary healthcare systems are weak. These models have the advantage of providing specialist and community-based care from within the same organisation (Dudley and Garner, 2011; WHO, 2008a; Frenk, 2009), thus minimising the difficulties of information sharing and care coordination which occur in collaborative models. Their downside is they rely heavily on specialists, which was possible within NGOs because of their access to donor funding, but may not be
feasible at scale (Patel and Varghese, 2005). In addition, they fail to incorporate any clinical primary (non-mental health) care, which fully integrated programmes would have.

These community outreach models remain poorly described and unevaluated in India and elsewhere, though a recent trial suggests a modest effect of such a programme in reducing symptoms and disability from schizophrenia (Chatterjee et al., 2014). In addition, the practices of some of these programmes were not evidence-based. Few vocational rehabilitation programmes used the evidence-based intervention of supportive employment (Kinoshita et al., 2013). Providing technical skills training is less effective at getting patients back into work (Crowther et al., 2001). There is little evidence for cost-effectiveness of specialist models in HICs (Bower, 2011) and no cost-effectiveness has been conducted in LMICs, even when applied to targeted populations. The widespread use of these integrated models is therefore concerning. It would be inappropriate to currently recommend the government to implement such services, where financial and human resources are more limited.

Several weaknesses remain within all programmes. For example, collaborative care models and community outreach models had redesigned their systems to integrate new PHWs, multidisciplinary teams and had some shared care. However, most of them were still weak on having clinical information systems. Those that did, did not systematically audit or monitor the routine data they collected. In addition the push for cheaper care also needs to be balanced with adequate staff incentives: several programmes relied heavily on the spirit of volunteerism for their LHWs and also for specialist involvement. Some programmes suffered from PHW attrition. In addition, it is known that the DMHP and other LMIC mental health programmes currently have difficulties attracting and retaining specialists due to lack of incentives, mentorship, career opportunities and workplace conditions (chapters 2 and 5). Scaling up these models is therefore unfeasible unless specialists are better incentivised and PHWs better retained (see implications for practice below for details).

In addition, despite widespread alcohol problem-drinking and abuse in India and elsewhere, and substantial evidence for feasibility of delivery of screening and
providing brief interventions in primary or community care (Kaner et al., 2007) this study only identified one Indian programme which trained their PHWs to do so. While many case study programmes provided interventions for all mental disorders, impact evaluations on which the evidence of effectiveness of PHWs is based provide psychological interventions for specific disorders (depression, post-traumatic stress disorder in adults and children, dementia and alcohol abuse) (van Ginneken et al., 2013; Kakuma et al., 2011). It is therefore not possible currently to draw conclusions whether or which types of programmes are adequate for providing care for all mental disorders.

6.5.2. Are the human resources used appropriate?

6.5.2.1. PHWs

This section compares the types of PHWs and their roles within these Indian models to the current available evidence. The current evidence for collaborative care is for using professional primary care staff (doctors, nurses) and graduate care managers (Plummer and Haddad, 2009; Bower, 2011; Bower and Gilbody, 2005). Only 19/72 (26%) programmes utilised PHC doctors and of these a quarter had closed. Many Indian programmes substituted a professional for a lay PHW workforce. Most collaborative and community outreach models used LHWs or general social workers rather than generalist doctors or nurses as their main PHW resource. Also NGOs - but not government programmes - utilised community members (teachers, police, village leaders etc) in similar roles to LHWs. These models were similar to those in a recent systematic review on the effectiveness of LHWs in that many used lay counsellors (LHWs) (A few also used social workers/ graduates, and 1 doctor) (van Ginneken et al., 2013). However they differed in having non-specialised and often non-professional care managers (experienced LHWs), whereas studies included in the Cochrane review had professional (social workers, midwives) or specialist care managers (psychiatric social workers).

Several reasons for using LHWs instead of non-specialist clinical professionals are postulated. India has a dearth of human resources in mental healthcare and of
professionals in general healthcare, as do many LMICs (Kakuma et al., 2011) (chapters 1 and 2), and these resources are usually not permanent within communities. On the other hand, LHWs are usually stable residents. LHWs tended to have similar roles to social workers (such as psychosocial support). Government institutions solely focused on identification and pharmacological interventions and used LHWs at most (if at all) for identification and referral. Only NGO programmes had trained PHWs to do psychosocial interventions. Predominantly LHWs (and rarely doctors and social workers in two collaborative care models) provided counselling. Using lay counsellors was not as widespread in these India case studies (about 40% of collaborative care and community outreach models, and 16% of education and training models) compared to those in study settings identified in the recent systematic review on effectiveness of PHWs (90%) (van Ginneken et al., 2013). Collaborative care models only provided non-specific counselling, whereas, the community outreach models, similarly to those in the Cochrane review, had trained several PHWs (professional and non-professional PHWs) to deliver specific psychological techniques such as cognitive behaviour therapy or interpersonal therapy. These important variations of intensity of specific therapies within study settings may be difficult to scale up to more generalist interventions and PHWs on the ground in India or other LMICs.

Nurses were under-utilised in these programmes as they are relatively scarce in India, unlike in African countries and many other LMICs where they are widely utilised (Kakuma et al., 2011). Also Indian nurses have maintained traditional roles of providing first aid and injections (Johnson et al., 2014) so insufficient consideration of their potential use has occurred within efforts to broaden access to mental healthcare.

PHWs’ training was also often inconsistent or inadequate. More intensively trained LHWs tended to have more significant interventional roles (such as brief interventions, counselling, psychosocial support) than those with less training. However, this was not the case for PHC doctors. PHC doctors had variable lengths of training (1 to 15 days) regardless of their expected roles (diagnosis and treatment versus identification and referral). This is contrary to case in LMICs generally where roles generally do depend on PHWs’ level of training (Kakuma et al., 2011). These results also highlighted that these programmes provided short and therefore probably ineffective or insufficient
training. Furthermore, Indian PHC doctors’ may be poorly equipped to diagnose and treat mental disorders, not only because of poor training, but also because of inherent primary health system weaknesses that have led to poor staff motivation and attrition (van Ginneken et al., 2014) (further discussed in chapter 7). However even within HICs where health systems are stronger, PHC doctors are also poor at screening and diagnosing common mental disorders (Mitchell et al., 2011). Interestingly, two factors may improve detection accuracy: poor access to specialist care and working in small practices. These may force practitioners to be more self-reliant (Mitchell et al., 2011). This was reflected in this study as programmes with greater specialist involvement relegated their PHC doctors to excluding organic disorders (community outreach programmes), or to identification and referral roles in the wealthier states of Kerala and Tamil Nadu which had PHC-based psychiatric outreach clinics (replacement and referral programmes).

6.5.2.2. Care coordination

Although care coordination has been described within collaborative care as a feasible way within primary care to improve detection and treatment of patients with mental or other chronic disorders (ICIC, 2014), these cadres were also used within community outreach models. Three types of care coordinator were identified in this study: 1) the care manager, an additional ‘linking’ health worker between specialists, PHWs and patients, who also had clinical responsibilities; 2) existing PHW or specialist clinical cadres and assigning them additional care coordination roles, and 3) coordinators with similar linking, coordination and supervisory activities (they had no clinical responsibilities, and were sometimes from a non-clinical background). The first two categories have so far only been described in the literature as relating to collaborative care models (Bower and Gilbody, 2005; ICIC, 2014). However in this study, the non-clinical coordinator (the third type) has not properly been described in the literature. Moreover, in spite of care coordinators’ obvious differences in background (ranging from non-health workers, to PHWs, to specialists), which represent greater variations that those in HICs (where care coordination is usually performed by professional cadres), the care coordination remit of these cadres were similar: they all acted as links between specialists and PHWs (and patients for those with clinical roles), and provided
PHW supervision and programme coordination. Compared with care coordinators described in the HIC literature, they also had broader remits than care coordination, such as being involved in patient advocacy. Their supervisory roles were more complex in India than in HICs: many collaborative care and community outreach models had two levels of coordinators who may be involved in training staff/management of the programme and those with more clinical on-the-ground duties linked to LHWs or as LHWs themselves. These variations are likely to be related to trying to overcome not just shortages of specialist human resources but also to minimise the pitfalls of task-sharing. Merely shifting tasks from a specialist to a non-specialist cadre may not be a feasible burden to impose on one cadre. NGOs (though not government programmes) have been creative in using multiple PHWs and coordinators to split and share these tasks.

6.5.2.3. Specialist support

Specialists were used differently in India compared with HICs. Whereas in HICs, their roles are more supportive and supervisory (Bower and Gilbody, 2005), in Indian NGOs and across all models, specialists were more intensively used as clinicians in outreach clinics and for training PHWs. Some specialists also had additional leadership and management responsibilities as directors or founders of NGOs. Psychologists also had broader roles beyond psychotherapeutic and psychological assessment roles, as supervisors or trainers. Psychiatric social workers were used in better resourced settings (Southern and Western states), whereas general social workers adopted PSW roles in areas with scarce mental human resources (North-Eastern states).

Specialist input tended to decrease throughout the lifecycle of the project, particularly within collaborative care and community outreach models. This gradual withdrawal of intensive specialist support was justified by organisations once the PHW workforce and coordinators were more independent. However, no organisations had a system to assess when the PHWs’ and coordinators’ competency was sufficient to be independent. Also, greater use and retention of specialist human resources (both for clinical input and as skilled care managers) occurred in better resourced areas, such as within urban or peri-urban areas, or in better resourced states (Delhi and Tamil Nadu).
Withdrawal of specialist intensive involvement from some programmes may therefore be motivated by resource shortages rather than being clinically warranted.

6.5.3. Study Limitations

This study was subject to limitations of scope, sampling, data collection and analysis.

6.5.3.1. Limitations of scope

This thesis’s methods did not allow for proper impact and process evaluation of all the variations in models, human resources and their roles (further discussed in chapter 7). Further programme evaluations also need to include assessing the feasibility of volunteerism in this context.

6.5.3.2. Sampling limitations

Programmes were selected purposively and also subjected to convenience sampling so the figures presented above are not representative of all programmes in India but of the programmes willing to take part in our study. As only two programmes refused to participate, this was unlikely to be a major barrier. Sampling of participants within programmes was also subjected to convenience sampling as they were chosen by organisations based on our stipulations to meet a variety of cadres (health workers, managers/supervisors and specialists). Therefore participants interviewed may not have fully represented views for their cadre. For example we may have been presented to only the best staff or those who would portray the organisation or their work positively.

6.5.3.3. Data collection limitations

Several interviews and focus groups were conducted in languages the main researcher was not familiar with. Despite the anthropological and qualitative traditions having generally rejected using interpreters, some have used them successfully (Borchgrevink, 2003; Pool, 1994). Understanding language subtleties would not have been achievable by the researcher merely learning the languages (Borchgrevink, 2003; Temple, 2002;
Davidson et al., 2004; Pool, 1994). The co-researchers (SG and MSM) were not just bi- or tri-lingual (English/Kannada/Hindi) but also bi- or tri-cultural.³ For the shorter case-studies conducted in other languages (Mizo, Oriya, Tamil, Malayalam, Telugu), the researchers relied on local programme staff to provide bilingual interpreters. Co-researchers and other interpreters perceived linguistic and cultural nuances and ambiguities and were able to explain respondents’ answers in light of the cultural context. They also were helpful in establishing rapport with the informants. For example in the first stages of the in-depth case studies, co-researchers indicated and taught the main researcher proper ways of behaving and the proper phrases to greet people (Buechler, 1969; Ellen, 1984). Furthermore the main researcher had learned some Kannada to help with communication and understanding the gist of conversations (Ellen, 1984). This allowed the researcher to partially check the interpreter’s face-to-face interpretations. The co-researchers’ ability to bridge the gap between the researcher’s and the informants’ cultures was felt to be crucial in the field of mental health where explanatory models of illness can differ significantly (Shklarov, 2007).

Interviews and observations were located in health workers’ work settings, which was convenient for the researcher and for the staff. However the naturalist setting may have affected PHWs’ answers: they may have felt rushed or disrupted as they had work commitments either side of the interview, they may also have felt inhibited to be open about specific issues as they were often within earshot of their supervisors or other colleagues.

The results should further be interpreted with caution as information gathered was reliant on staff recall and subject to reporting bias, where participants may intentionally or unintentionally omit information - inconsistencies and contradictions are common (Bloor, 1977). This respondent bias may have limited the completeness of information. In the in-depth case studies, we noted for example that in interviews, two health workers described their roles to be much more comprehensive compared with what we observed their roles to be in practice. To minimise respondent bias and

³ Though both researchers spoke all three languages, SG was more bilingual/bicultural in Hindi and MSM in Kannada.
improve completeness of facts, we interviewed staff at different levels thus getting a multi-source account (triangulation of programme staff) and included focus group discussions (for correcting inaccurate or incomplete reporting) (Patton, 2002). Multiple sources of data allowed us to unpack contents of the cases individually, as well as view them as a whole (Patton, 2002).

Group discussions could have also hindered completeness of accounts as they may not allow for socially deviant or marginal opinions (Krueger, 1994). In interviews because of convenience sampling, some group interviews combined for example PHWs with their supervisor (this was the case for only two of the 26 focus groups). The presence of supervisors may have ‘silenced’ or distorted PHWs’ views, to reflect what was ‘meant to be done’ as opposed to what was ‘actually done’.

The findings of health workers’ beliefs and behaviours may also have been distorted by the effects of the researchers’ presence. There was some evidence of this Hawthorne effect (Green and Thorogood, 2004). Within shorter case studies, some PHW had voiced concerns about being judged and that this would lead to job insecurity, despite our reassurance that collected information was confidential. Furthermore, in one in-depth case study a PHC doctor’s behaviour markedly changed because of the first author (NvG)’s presence. During the first phase of research (5 weeks), NvG and her interpreter/research assistant (SG) stayed in the PHC for data gathering. However during the second phase (10 days) NvG was substituted with her research coordinator, an experienced Indian anthropologist (MSM), as she had health problems. The PHC doctor was markedly more relaxed and more open with the Indian co-researchers.

To minimise this perceived threat, NvG employed her extensive experience in both clinical and research interview and communication skills to strive to make people feel at ease, and respected whilst still being critical and inquisitive (Bochner, 2000). She also instilled this into her co-researchers and monitored their demeanour in interviews by listening to their interview audio-recordings and providing them with feedback. Personal reflection as well as debriefing meetings with her co-researchers and supervisor did not highlight specific threatening elements to her manner. However the
PHC doctor may have felt threatened by NvG’s professional background: although she was also a generalist doctor, she was from a HIC and was an academic. In his words NvG would have classed as a ‘big person’ (a person of importance) as opposed to himself whom he described as a ‘little person’. He would have felt more judged or evaluated by the main researcher as she was the only one who was able to cast judgement on his clinical accuracy and quality. Although he communicated adequately in English, he revealed to the co-researchers on the second visit that he felt more comfortable in Kannada, the local language in Karnataka. The first author and her co-researchers were technically ‘outsiders’ to this rural setting, but the co-researchers benefited from an ‘in between insider and outsider’ status which has been described in other ethnographic literature (Kerstetter, 2012): they were culturally more linked to him and shared his language (both co-researchers were also from Karnataka). They were also perceived as non-threatening as they did not have clinical backgrounds. Further discussion of limitations of co-researchers is detailed in chapter 7 under observer bias.

6.5.3.4. Data analysis limitations

We acknowledge that factual data retrieval is not the usual way of utilising qualitative data, but is a known process of content analysis (Bernard, 2006). Qualitative factual data was compared to written sources (such as website information, annual reports) but as detailed documentation and evaluation was sparse, the analysis had to rely on a more detailed understanding from participants. To maximise completeness of the data retrieval, coding was performed by several coders (NvG, MSM, SG and AG), working from the same worksheet, which was constantly compared and updated.

There are however limitations of using quantitative/factual analysis of qualitative data. The main limitation was the need to take participants’ word at face value rather than seeing their account as their interpretation of events/facts (their perspectives and views of events and of their work are going to be presented in a subsequent paper). Most qualitative research uses an interpretivist or constructionist approach, and does not take participants account as ‘truth’, but treats their views as valid accounts that need interpreting within a theoretical understanding of healthcare organisations, of
professional values and of professional-client encounters (Green and Thorogood, 2004). However using this post-positivist approach was justified for two reasons: 1) as little is known about these cases, the purpose of the analysis was intentionally focused more on description than interpretation (Padgett, 2012); and 2) hearing participants’ roles and structures from their perspective is as valid an account as a list of theoretical organisational structure and roles, were these to have been available.

Certain limitations also pertain to the use of case-study analysis. One issue was that the choice of a case shifted during sampling, from the organisation itself to programmes within them. It was soon apparent organisations often had several different models within them. Changing the case definition has been recognised in the wider literature on case studies and seems not to have an impact on the quality of the analysis, as long as this shift is acknowledged (Patton, 2002). Also difficulties of multiple case study analyses were faced. The authors attempted to maintain the integrity of all 72 programmes during aggregation through the use of thematic analysis and pattern recognition (Padgett, 2012).

6.5.4. Future research priorities

Many of these models remain unevaluated. Quantitative impact evaluations of current programmes in India and other LMICs are necessary, to confirm whether their current mix of human resources, and their delivery in community settings (rather than government primary care) achieve similar outcomes to collaborative care in HICs. In addition, the study identified a unique model of community outreach services which does not feature in the currently established classifications. Given their intensive use of specialists, they are more likely to have a place in targeted interventions for people with severe mental disorders or substance abuse. Authors acknowledge the difficulties NGOs face in implementing such evaluations due to limited time, prioritisation, and funding opportunities. Researchers should therefore be encouraged to conduct randomised controlled trials as new interventions or in conjunction with NGOs.
NGOs and government programmes need encouragement to perform evaluations, and funders encouraged to pay for these to assess how the human resource substitutions and differences in PHW-support affect effectiveness and impact of collaborative care programmes. In particular the impact of having tiers of managers needs to be assessed as this may reduce the need for specialist input but may also add layers of complexity to an already bureaucratic set-up.

Furthermore, the mental health literature (Kakuma et al., 2011) as well as wider health literature (Bosch-Capblanch and Garner, 2008) suggest supervision and regular follow-up are more important. Indeed, models with evidence of effectiveness (collaborative care, and identification and refer) incorporate supervision in addition to training. Our study corroborates with these findings, as programmes that had closed or seemed to be struggling (the DMHP) did not supervise PHWs. This study was not able to ascertain (as the methods use were not appropriate) the quality of the training and supervision. This would require formal evaluation to explore feasible and effective ways to improve the supervision of PHWs.

Beyond the evidence, is the question of their feasibility and sustainability if implemented at scale. Currently nationwide there are insufficient specialist resources to support the most effective programme (collaborative care) or others with heavy specialist involvement (community outreach models), and these models have to contend with a weak primary healthcare system, an issue most LMICs and some HICs also face (Mangham and Hanson, 2010). Further evaluations of models and cost-effectiveness research, focusing therefore not solely on mental healthcare through formal primary care but also through other community sectors is needed for collaborative and community outreach models, before being able to advise which models the DMHP may consider scaling up.

6.5.5. Implications for practice

This study is the first exploratory study of its kind in India. Therefore it cannot provide firm recommendations regarding models and human resources mix. It
also cannot generalise these findings for scaling up to improve the current DMHP, or for application to mental health programmes in other LMICs. This study however has identified important innovative elements of NGO-led community programmes’ models and human resources that differ from HICs, notably the heterogeneous collaborative care models and the community outreach models, which may have potential for profound change if implemented on a large scale.

Organisations need to become aware that some of their programmes (such as PHW one-off training) have no evidence of effectiveness, and they may need to be encouraged and supported to re-orient efforts towards more effective endeavours. This re-orientation will also need to target funders as they currently promote funding programmes which are time-bound and cheap.

Though this study is not able to provide actual recommendations on one specific model, it can provide conceptual generalisability. These findings, as well as those from our policy paper (van Ginneken et al., 2014) (chapter 5) suggest that due to a weak primary care system, the government and DMHP may consider having a more feasible expectation of doctors to identify and refer, but not to diagnose and treat. An extra link worker, the care manager seems essential to take over the role of care coordination from the PHC doctors, a role the latter are currently unable to fulfil. The widespread use and sustainability of LHWs by NGOs for various forms of psychosocial interventions and follow-up/medical adherence suggests the government DMHP should also consider training their LHWs in psychosocial roles as complementary to current solely pharmacological interventions. This expansion of roles and of PHW workforce correlates with recent policy recommendations (Mental-Health-Policy-Group, 2012) and also seems acceptable to health workers (Mendenhall et al., 2014). However this study highlights that ongoing supervision or support of PHWs is a key feature of programmes which are deemed more effective, but this necessitates significant specialist involvement. While the Indian policy environment is currently favourable, as exemplified by the national mental healthcare bill and policy currently under consideration within parliament (Shidhaye and Patel, 2014), the success of these recommendations relies on their implementation within the health system and on the buy-in and redistribution of specialists. This would imply redistributing available
specialist care to provide more outreach services and support to care managers and/or PHWs. Particular conditions would have to be met to attract specialists to this new way of working which have been identified in parallel studies. These include adequate remuneration, providing them with career opportunities and better workplace conditions (chapters 2 and 5)(Kakuma et al., 2011; van Ginneken et al., 2014).

Given that there are large geographical variations in availability of specialist resources within India, the above recommendations may be difficult to implement and variations of the collaborative care model may be needed. However the add-on of a care manager suggests that specialist support could be provided largely by remote communications, with the use of technology such as mobile phones for supervision (which many NGO programmes have explored), and potentially with the use of telemedicine for diagnosis, an option currently poorly explored by programmes. Though there are several barriers to mobile technology, the current literature suggests mobile technology can be effective in certain areas of health such as anti-retroviral treatment adherence and smoking cessation, but need further exploration within the mental health field (Aggarwal, 2012; Free et al., 2013). How far this is contextually generalisable needs to be determined on a case-by-case basis for different states depending on their levels of resources and heterogeneity of settings.

This study also highlighted that most collaborative models functioned outside formal government primary care (such as within the NGO sectors of disability care, HIV care, gynaecology clinics etc). The DMHP programme has so far solely focused on working through government primary care and it is known that this programme has not adequately met its targets partly due to political, but also due to health system weaknesses (van Ginneken et al., 2014). Health system strengthening through the National Rural Health Mission (NRHM) and the broader vision of universal health coverage (Sengupta, 2013) will be necessary to improve the likelihood of mental healthcare delivery being effective through India’s primary care system. Opportunities to incorporate or collaborate with the community sector (NGO initiatives for example) should be explored to overcome the governmental primary mental system weaknesses (see chapter 7 for more detailed discussion on health system strengthening).
6.6. Conclusion

Many programmes in India provided an array of different primary mental healthcare services involving PHWs, but several of these, particularly one-off training, have no evidence for improved patient or service delivery outcomes. The collaborative care models are very heterogeneous and differ significantly to those in HICs. Many do not collaborate with formal government primary care settings, and some also have weak systems of collecting and analysing routine data. In addition, several programmes use a unique community outreach model that is not described in HICs but is common in LMICs. Types of resources are also different: care managers and care coordinators are more numerous and their roles are more complex than in HICs. A large majority of programmes use LHWs with significant complementary and substitution roles. Further research is needed to assess the clinical and cost-effectiveness of these variations of collaborative care and of community outreach models. The main stakeholders within government and NGOs may be encouraged to evaluate their innovative models of PHW-delivered mental healthcare, and to consider reducing cheap but ineffective one-off training sessions. Researchers should also consider repeating this study and undertaking larger comparative studies and trials in other LMICs to see if the findings and implications of this study are relevant in other settings.
6.7. References


Chapter 7

Discussion and conclusions
7.1. Summary and triangulation of findings

The findings within each method of this thesis have already been contextualised with the wider literature in the discussion sections relevant to each paper. Below is a synthesis of the thesis findings (3 papers and 1 draft publication – chapter 2, 4, 5 and 6), and what each method or paper has contributed to answer the primary research questions.

7.1.1. Effectiveness and cost-effectiveness of PHWs in LMICs and India

The effectiveness of primary-level health workers (PHWs) in low- and middle-income countries (LMICs) was assessed through the Cochrane review (Chapter 4) through meta-analyses of 38 randomised controlled trials and some non-randomised controlled trials. Within LMICs, PHWs were modestly to moderately effective in delivering care for MNS disorders. More specifically they may be effective in improving symptoms of people with common mental disorders (CMDs), perinatal depression, post traumatic stress disorder (PTSD) in adults and dementia. They may also improve wellbeing of carers of people with dementia, and reduce the amount of alcohol consumed by people with alcohol-use disorders. There may be some evidence that psychological interventions delivered particularly by lay health workers (LHWs) for CMDs and PTSD are an effective strategy. There was inconclusive evidence whether LHWs or teachers reduce PTSD symptoms among children or impact on people with other mental neurological and substance use (MNS) disorders.

The paper on human resources for mental health worldwide (chapter 2) also identified an additional 15 quasi-experimental studies of PHW interventions in primary or community adult care in LMICs (appendix 1: table 1) which did not fit the inclusion criteria in the Cochrane review but which agreed with the Cochrane findings, that PHWs were effective in improving symptoms of CMDs (2 studies) and post-traumatic mental illness (2 studies). PHW interventions for maternal depression not only improved symptoms of maternal depression and mother child engagement but also neonatal mortality (3 studies). There were in addition more studies that suggested symptoms of epilepsy (4 studies) and psychosis (4 studies) were improved.
The evidence from India is growing but still limited. Only two studies in the systematic review were from India, both from Goa, and both were collaborative care models. One showed that a collaborative care model for CMDs versus usual care was effective in improving the prevalence and symptoms of CMDs in public facilities, and reducing the number of disability days (number of days of no or reduced work) (Patel et al., 2010). The second study showed a home intervention with home care advisors and lay counsellors improved behaviour, quality of life and functional impairment in patients with dementia and improved the well-being, burden and distress in their carers (Dias et al., 2008). In the wider literature, as covered by the paper in chapter 2 (appendix 1: table 1), eight of the 15 studies of quasi-experimental design were from India. These showed CBR workers, LHWs and in one study a primary healthcare (PHC) doctor improved psychotic symptoms and disability, mental distress post-tsunami, CMD symptoms and infant outcomes in interventions for maternal depression. Four of these were collaborative care-type models and the other two specialist outreach models.

Since these two papers (chapters 2 and 4) were published, a further randomised controlled trial has been published of patients living with schizophrenia receiving a community outreach programme (LHWs supervised by specialists) plus facility-based care for versus those only receiving facility-based care. Schizophrenic symptoms and disability reduced in one of the three sites (Tamil Nadu) where patients had had no or little previous psychiatric input but not the other two sites (Maharashtra and Goa) where patients were recruited from pre-existing clinics and were therefore were receiving prior psychiatric care. Across sites there was also improved medical adherence and a reduction in reported experienced stigma and discrimination but no improvement in knowledge, burden and willingness to disclose to others or in perceived stigma (Chatterjee et al., 2014). Furthermore there are several ongoing qualitative and quantitative evaluations to measure the impact of PHW-delivered psychological interventions for depression and alcohol use disorders in India (Patel et al., 2014), and to assess the feasibility, impact and scalability of a primary care-based mental care package in India and four other LMICs (Lund et al., 2012).

There are insufficient data to draw global conclusions on costs or cost-effectiveness of PHW-delivered interventions in LMICs from the Lancet or Cochrane reviews (chapters
2 and 4), as the studies were sparse and heterogeneous. In chapter 4 three cost analyses identified suggested direct or indirect costs were reduced with certain PHWs interventions compared to specialist care (table 14 in chapter 4). PHW interventions may also be cost effective. Only two cost-effectiveness analyses were linked to included studies in the Cochrane review, both of which were collaborative care models for depression. One trial in Chile, suggested collaborative care was cost-effective (table 14 in chapter 4). Since this review was published, the Indian collaborative care trial (Patel et al., 2010) published that this intervention is not only cost-effective but cost-saving (Buttorff et al., 2012). A review of the wider economic literature revealed a further two LMIC studies that showed collaborative care was cost-effective within formal primary care settings for depression (Chile) and all MNS disorders (Nigeria) (appendix 3 of Cochrane review, in appendix 5 of thesis).

7.1.2. Models of PHW-delivered mental healthcare in primary care in India

Chapter 6 aimed to identify and describe current PHW-delivered models of mental healthcare delivery across India, including the government district mental health programme (DMHP) and non-government organisation (NGO)-led models. The purpose was to describe how these models functioned and structured their PHW and specialist workforce. Chapter 5 contextualised these current programmes’ progress within the past and current policy attempts to integrate mental healthcare into primary care. A detailed discussion of the evidence base, challenges and opportunities of these models can be found in chapter 6 (discussion). Below we summarise available models in India and draw together findings from the mixed methods of this thesis.

Collaborative care involving government primary care has most evidence in high income countries (HICs) whereas there is minimal available evidence in LMICs. The Cochrane review only found five studies of collaborative care models for CMDs and one for dementia (chapter 4). This model showed moderate clinical benefit in the meta-analyses but the evidence was of low or very low quality making the results inconclusive for CMDs. Of the Indian case studies (chapter 6), only 22% of programmes used this model. Of these only 15% were delivered through formal government (or
private) primary care. The remaining programmes used collaborative care in other settings where NGOs trained their own community-based health workers rather than formal primary care workers. The effectiveness of the collaborative care model in community settings remains unevaluated as there have been no randomised trials outside government primary care.

Chapter 6 identified that the government DMHP used an education and training model for which there is evidence of ineffectiveness (the references for this are provided in chapter 6 discussion and methods). The historical and current data gathered seem to reflect this evidence. Historically, policy makers and programme implementers identified that the DMHP had ‘failed’ to reach universal coverage across India (as it still only implemented in one in six districts) (chapter 5). Both chapters suggest the DMHP training strategy may be unsustainable. DMHP programmes had a de-motivated and incomplete primary care workforce and specialist support system (chapter 5). Also training was unreliable particularly when commissioned by NGOs. Most NGOs had stopped providing DMHP training partly because they felt it was ineffective, but also because they were subject to their own, or their funders’ changing priorities.

While many NGOs had stopped helping with DMHP training, they continued to provide LHW training-only programmes to other NGOs. Chapter 2 also identified several evaluated one-off training programmes across LMICs which showed predominantly post-test improvement in knowledge and skills (e.g. in microcounselling, patient management, diagnostic accuracy, or no improvement (1 study)), for professional and lay health workers in primary care settings (chapter 2, see appendix 1 table 2). However none of these studies had performed evaluations in practice, nor assessed patient outcomes. A third of case studies also used the replacement and referral models within DMHP settings or NGO/community settings, but these too have limited evidence of effectiveness and place responsibility of care on specialists (see chapter 6 discussion for the evidence).

In addition the case studies revealed a unique model of community outreach services delivered by specialist organisations (53%) which bypassed the primary healthcare system. This model is unique in that it has not previously been described in
frameworks for primary mental healthcare models (chapter 6). They trained their own
community-based PHW workforce (including care managers or coordinators) to
identify, but also to provide psychosocial interventions and ongoing support to
patients and their carers. The PHWs and care coordinators were closely supervised by
specialists or tiers of specialists and non-specialists. This model was also frequently
used by research teams as seen in the Cochrane review (see chapter 2 results,
comparison 1: PHW single psychological interventions), as well as in the recent study
by Chatterjee et al. (2014). These models focused more on severe mental disorders
(such as schizophrenia) and substance abuse than did collaborative care models, but
not exclusively.

7.1.3. The roles of human resources within these models

Chapter 6 discusses and compares roles of different PHWs, care managers and
specialists. Below these findings are summarised and compared to the current
evidence (chapters 2 and 4), and contextualised with oral history findings in chapter 5.

In the government DMHP programme, PHC doctors were expected to identify,
diagnose and treat all mental disorders except in the states of Tamil Nadu and Kerala
where they were expected only to identify and refer to specialists and follow-up the
ensuing management plan. They were also expected to train and supervise
community-level workers to identify and refer to them in most of India, though this did
not occur much in practice (chapter 6). Chapter 5 however highlighted PHC doctors’
ineffectiveness in the DMHP. Where NGOs did utilise PHC doctors, this tended to be
for excluding organic disorders and had limited roles in clinical care (if so in
identification and referral mainly) or supervisory roles of LHWs. The only exception
was in one case study where the head but also founder of the NGO’s mental health
programme was a generalist. Though the DMHP since the 1980s has kept the same
PHC doctor-centred model as many HICs, in India the PHC doctor may not be the most
appropriate main care provider or care coordinator of mental health services in
primary care (chapter 5).
This study identified an array of other PHWs, mainly LHWs, who provided a comprehensive package of care with psychosocial interventions, some degree of counselling, social support and follow-up of medication to check understanding and adherence (chapters 5 and 6). The advantages of LHWs were that they were settled working close to communities which meant they were better placed to identify and refer mental illnesses.

Collaborative care models in HICs often rely on PHC doctors as care coordinators. However the case-studies in India (chapter 6) agreed with the findings from other LMICs (chapter 2) that the most feasible and appropriate human resource as a care manager were other PHWs, particularly experienced LHWs (of minimal education or graduates) or social workers as they were closer to the community and could also provide psychosocial support. Care managers were also a feature of community outreach models in which specialist resources were used more intensively. Care managers had similar roles in both collaborative care and community outreach models. Care managers were not just a link between specialists, other PHWs, and the community but also minimised the need for specialists’ involvement at community level by providing preliminary support to PHWs and acting as a triage system for specialist support. They also received significant support themselves from specialists. This is significant because PHWs’ increased ongoing monitoring and supervision has been shown in the literature in LMICs to improve confidence, detection, treatment and treatment adherence (chapter 2).

With regards to specialists, quantitative, historical and case-study data (chapters 2, 4, 5 and 6) all suggest they are best utilised at community level for training and ongoing monitoring of PHWs or care managers, and may also be needed for initial diagnosis and initiating a management plan (chapter 6). However the oral history paper (chapter 5) warns us that few specialists are willing to take on more managerial or supervisory roles for community care. They lack faith in task-sharing because they believe PHWs’ limited training would be insufficient to provide adequate care. Furthermore task-sharing is not instilled in their work ethos and they are not trained or incentivised to provide PHW supervision.
7.1.4. Barriers to integrating mental healthcare into primary care

7.1.4.1. Paucity of specialist and primary care human resources

Specialist human resources in India and in LMICs are scarce (chapter 1). The Lancet human resources for mental healthcare article (chapter 2) found this current discrepancy is endemic across all LMICs. There are 200 fold fewer psychiatrists (similarly for psychologists, nurses, social workers and occupational therapists) in LMICs compared to HICs. Also the numbers of psychiatrists between 2005 and 2011 have fallen in low income countries, and in 2011 there was a shortage of 1.18 million mental health workers in LMICs to deliver a core set of mental health interventions. One reason for this of particular relevance to India, is that many specialists, particularly psychiatrists, have emigrated to HICs. If this didn’t occur, many countries would have more than double (sometimes up to 8 times) the number of mental health specialists. The lack of specialists has been a rationale for shifting tasks to non-specialist human resources. However, this paucity is still an issue even when integrated primary mental healthcare systems exist, because sufficient specialists are needed to train, supervise and support PHWs.

7.1.4.2. A weak primary healthcare system

A weak primary healthcare system has provided a fragile base on which to then integrate disease-specific programmes such as the DMHP. There is an overall shortage of the primary care workforce in India (chapter 1). In addition, the available workforce is not used to its full potential. For example, very few programmes in India explored options of how to utilise nurses in mental healthcare, in contrast to other LMICs, particularly in Africa (chapter 6 discussion). Further manpower issues include high attrition rates of PHC doctors and new cadres of government LHWs every 10 years because of failure to retain these at community level (chapter 5).

Compounding the issues above, the provision of primary mental healthcare in India is currently divided between the primary care sector, the NGO (or voluntary) sector and the for-profit private sector. These different sectors are usually poor at collaborating or coordinating in most health fields despite plans in the late 1990s to increase
partnerships with the voluntary and private sector (though some vertical control programmes in India such as AIDS, tuberculosis and blindness have embraced and encouraged these partnerships) (WHO, 2004). This work described in this thesis found weak public-private partnerships for mental healthcare in LMICs and in India (chapters 3 and 5). Though involving the private sector would make sense given it provides 70-80% of healthcare in India, many in India and other LMICs resist partnering with the private sector (for profit and not-for-profit) as this sector is unregulated, to some extend unaccountable and may provide inequitable as well as poor standards of care (chapter 5) (Sengupta and Prasad, 2011).

7.1.4.3. PHWs’ lack of motivation and skills in the government sector

From exploring government PHC doctors’ roles within Indian case studies (chapter 6), within the literature in LMICs (chapter 3), and from the interviews with policy makers in India (chapter 5), it is clear that there have been longstanding barriers to PHC doctors being effective in NGO and government settings, not just for mental healthcare but for healthcare in general. The greatest barriers to decent quality of care are their work burden, poor motivation and high attrition rates (chapters 5 and 6). For example, PHC doctors are often ineffective at recognising, diagnosing and treating mental illnesses (chapter 5). Some policy makers expressed the view that the limited quality and competencies of PHC doctors may be a reflection of the lack of value the government assigned to these doctors, and the insufficient training and incentives to attract and retain a good calibre of doctor to these posts (chapter 5). PHC doctors are also difficult to train because they are often transferred to other posts (chapter 6). The above factors make PHC doctors poor care coordinators of primary mental healthcare delivery compared with care managers. Both the historical and descriptive chapter on Indian case studies (chapters 5 and 6) suggest that non-existent follow-up or supervision of PHC doctors is compounding their pre-existing weaknesses.

Government LHWSs are also underutilised because of the poor implementation of service delivery. They receive poor training in mental health and little or no supervision from PHC doctors which resulted in them having no motivation or incentive to identify, refer or follow up people with mental healthcare needs.

Nadja van Ginneken Thesis Page 231
7.1.4.4. **Poor accessibility to government DMHP care provision**

A specific criticism of the DMHP is that it is overly medicalised and poorly adapted across different states and resource settings (chapter 5). Government programmes were also mainly facility-based, such as in primary care and outreach clinics. While the government system has started to train their LHWs, they remain largely unused and ineffective. Research trial settings (chapter 4) and NGOs (chapter 6) conversely, often had a mechanism to train and support PHW interventions delivered at home or in the community, which allowed for greater accessibility to simple interventions, and identification and referral of mental disorders.

7.1.4.5. **Political and governance barriers**

Oral history participants attributed the lack of the DMHP’s progress to political neglect, inadequate leadership at central, state and district levels and inaccessible funding (chapter 5). Similar barriers affect other LMIC mental health programmes (chapter 2). These barriers are summarised here but are discussed in detail in the oral history paper (chapter 5, results and discussion). Mental healthcare has been relatively neglected by policymakers compared with other health issues because of their poor knowledge but also poor technical support in decision making. For example decision makers’ lack of understanding of mental healthcare needs may explain why the DMHP model has been based on pharmacological interventions. Progress in mental healthcare policy and accessibility to funding has been further hindered by political and bureaucratic hurdles and issues of accountability. Moreover the DMHP is poorly appropriated by state governments partly as they are not consulted or influential in central government guidance, but also because they lack technical support to adapt the model to their settings.

7.1.4.6. **Inadequate integration with health system strengthening**

The integration of mental healthcare into primary care in India has been affected by a weak primary health system. Better integration cannot be achieved without concurrent efforts at health system strengthening, which requires better strategies, financing, evaluation and inter-sectoral collaboration (Mangham and Hanson, 2010;
India has been attempting to strengthen its government health system through various reforms, such as creating a decentralised system of care and allowing in private and voluntary players into the health market since the 1990s (WHO, 2004). It has also subscribed to universal health coverage more recently, where health system strengthening is one of the key priorities (Reddy et al., 2011). Unfortunately, in practice progress in strengthening the Indian health system has been limited. There is still poor inter-sectoral collaboration, such as partnering between the DMHP and the National Rural Health Mission (NRHM), which is a programme attempting to strengthen the health system. While India says it is committed to universal health coverage, India is currently showing least improvement in public health funding out of the BRICS countries (Brazil, Russia, India, China, South Africa) despite coming second for economic growth. Like its counterparts, it is also having difficulties addressing further targets to reach universal health coverage: stewarding mixed private and public health systems, ensuring equity, meeting the demands for more human resources, managing changing demographics and disease burdens, and addressing the social determinants of health (Marten et al., 2014). A recent analysis of National Sample Survey Organisation data revealed that despite a slight increase in usage of public sector facilities, the financial inequities of care are more prominent as there is a lack of access to ‘free’ healthcare with the need of the poorest to consult private practitioners (Ghosh, 2014). These health system failures and weak implementation of universal health coverage further compound the difficulty in adequately integrating more vertical initiatives such as the DMHP.

7.2. Limitations and reflection of the study’s contribution

The limitations of the individual methods used in the different papers have been covered in each relevant paper (chapters 2, 4, 5 and 6). Below the cross cutting limitations of the study are discussed in more detail.

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1 I use the first person in this section as several points made relate to personal reflections on the conduct of the study
7.2.1. Selection bias

It is inevitable that the researcher has some subjectivity and points of view that influence the topic they study and the methods they use to explore it (Padgett, 2012). My theoretical starting points and assumptions may have shaped the study. There may have been selection bias (or decisions made and alternatives not pursued) in both the overall research question and within individual methods. Given my background as a general practitioner and public health researcher, I have both clinical and research experience of working within health organisations. My skills-base likely influenced my choice of a health system perspective to explore PHWs roles. This health system perspective also meant that I did not explore patients’ perspectives as this excessively broadened the scope of the thesis. Answering the question of acceptability of these interventions is therefore incomplete.

I had prior interest and enthusiasm in working on task-sharing approaches, in particular looking at the history and use of LHWs in LMICs (Senegal and South Africa). While I could justify this as a natural progression and that I was building on prior strengths in human resources research, it could also be argued that I chose an area of study that I am keen to show is successful. My biased approach to task-sharing was hopefully minimised through my applying scientific analytical rigour to identify cases and theories to disprove the usefulness of task-sharing approaches. This for example is evidenced by my reporting and discussion about failed or closed programmes in chapter 6, and the inadequacies of the current task-sharing approach in the oral history (chapter 5).

I could have also been biased in how I selected programmes as case studies, or participants for oral history interviews. For example I could have selected those with similar world views to my own. The snowballing sampling strategy I used in both these studies may have this inherent weakness as relying on a networking of organisations may only highlight those that are similar to each other. However, firstly I was not the only person involved in sampling case studies: there was a research team of two co-researchers which maximised the chances of identifying a wider range of programmes.
Secondly, we attempted to also identify programmes through other methods, notably websearches.

In addition, the selection of programmes and participants may have been influenced by their enthusiasm, as it was subjected to convenience sampling (in that it relied on people accepting to take part). This research was timely in India as it came at a time of greater political will than ever before, and when the twelfth Five-Year Plan (the government’s five-year strategic plan) was being discussed. Hence this research may have been viewed by organisations as an opportunity to better inform the next five-year mental health strategy. This perhaps increased their willingness to partake in the study. The selection of participants and case studies was however also limited in its scope by bureaucracy and unavailability or non-response of government DMHP staff which may have limited the completeness of data on the DMHP implementation throughout the country.

7.2.2. Responder bias

Responder bias could have occurred both in the oral history interviews and in the case studies as informants’ accounts can never be completely objective. Subjectivity is a limitation of all narrative accounts (Perks, 1992). Participants may have been selective in their answers according to what they believe the researcher wants to be told (Portelli, 2006). They could have also withheld important information, which was a feature I was aware of when discussing political issues (reporting bias). Furthermore, oral history interviews are particularly prone to recall bias, as the interviewee is recounting events that usually occurred more than 10 years back. Their memories may be oversimplified, their or their organisations’ roles and importance exaggerated, be influenced by hindsight, and may lead to a partisan perspective (Perks, 1992; Seldon, 1996). I attempted to minimise these limitations in the data collection and analysis. To minimise recall bias, I prompted questions, and requested clarification during the interview if interviewees provided information that was inconsistent with historical timelines for example. To minimise reporting bias, I attempted to create the most conducive and open environment within the interview to encourage participants to be truthful and not withhold important facts. I also tried to identify in the analysis of
transcripts what was not being said (identifying areas where participants avoided the question for example). The discussion in chapter 6 (data collection limitations) gives a more detailed account of the impact and methods used to minimise respondent bias within the case studies.

7.2.3. Observer bias

Within all research, but especially within research using observational methods, the researcher is part of the process of producing data and their meanings. Qualitative researchers’ and historians’ preconceptions and assumptions may compromise what data they decide to collect (as seen above) and their analysis. They may then create the narrative rather than discovering it, by ‘ventriloquising’ their discourse through a narrator’s testimony (Portelli, 2006). This was minimised through critical reflection during analysis and multi-coder analysis.

My presence as an ‘outsider’ research (as I was a foreigner and removed from their work or political circles) may have been an asset for the oral history interviews as it may have allowed participants to give sincere answers. This distance also allowed me to challenge some of the importance some people attributed to their achievements. My Indian ethnic heritage and academic background also gave me common ground with interviewees. Though I don’t think this would have given me an ‘insider’ status, this common ground may have allowed participants to identify with me and be more relaxed. Furthermore as these were elite interviews (Seldon, 1996) these were highly positioned people who hierarchically likely felt superior to me, and therefore did not view me as threatening. Conversely, being an outsider could have also made them feel I was intruding and they may have withheld information because of this. This same ‘outsider’ position however was shown to have impacted on the PHC doctor’s behaviour in one case study (see chapter 6 discussion ‘limitations’). My status (as well as that of my co-researchers) was elevated compared to the PHWs we were interviewing and we were sometimes perceived as threatening (at least by this PHC doctor). Though attempts were made to minimise our perceived threat throughout the

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2 This concept of insider and outsider is discussed in chapter 6.
study (see chapter 6 discussion), this barrier may have been beyond our control as the health worker’s interpretation of our role and presence may be a reflection of their work conditions and insecurities. Had I adopted a different focus, perhaps a sociological focus on workforce issues and had I not been identified with PHWs’ bosses, I may have been perceived as less threatening. Alternatively employing local co-researchers or people of similar standing, or even health workers themselves with participant action research methods may have greater minimised this threat (Patton, 2002). However this would then have removed me completely from the reality and insights of data collection.

The research findings were also not just affected by me, but may have also been subjected to strengths and weaknesses from having two co-researchers who collected about 70% of the case studies data (though I collected all the history interview data). This introduced an element of lack of control over the quality of the data collected for the case studies. However I made sure I chose suitable candidates who had to demonstrate in their recruitment interviews their motivation and skills (bicultural, bilingual, affinity to be sensitive when interviewing, and capacity for independent thinking) for this area of research. As my co-researchers and I had divided up the programmes and organisations amongst ourselves, I felt perhaps more detached from the case studies I had not been involved in compared to those I had. To maintain the integrity and quality of the collected data I introduced several mechanisms: in-depth training of co-researchers; close supervision (regular phone contact during their visits/stays in the community, debriefing meetings following observation of their interviewing techniques during case-studies or joint interviews, discussions); reading transcripts and having debriefing and feedback sessions with co-researchers. I was also able to check my understanding and queries of these programmes with my co-researchers at various stages of coding, analysis and writing programme feedback reports and articles. The co-researchers’ motivation was further enhanced by encouraging them to partake in inductive thinking about how to steer available research findings towards future data collection and partook in data coding and analysis (Platt, 1976). This process of the co-researcher’s active
participation in data gathering and multiple-coder analysis, called researcher
triangulation, has been shown to provide rich and reliable data (Borchgrevink,
2003). This is because it improves the completeness of extracted data, and
provides added perspectives and angles to the interpretation of the data (Denzin,
1989).

7.2.4. The limitations and opportunities of a mixed methods design

This study was a predominantly qualitative design (which itself had mixed methods:
historical interviews and case-studies), but concurrently had a quantitative
component, the Cochrane systematic review and meta-analyses. The epistemological
approaches (the idea of how we come to know the world) were mixed because of this
mixed methods approach. I felt able to switch between different standpoints, as I have
dual training in qualitative and quantitative methods. Juxtaposing qualitative and
quantitative data has sometimes been deemed inappropriate by methodologists who
feel that mixing paradigms (positivist and interpretivist or social constructionist
approaches) cannot be done in a meaningful way (Padgett, 2012). These forms of
triangulation were justified however as the purpose was not to expect that a point of
convergence was reached. The purpose was rather to juxtapose these data as a point
of comparison (Caracelli and Greene, 1997). This identified the convergences and
divergences between the established objective, post-positivist evidence (chapters 2
and 4) and qualitative experiences on the ground in India (chapter 5 and 6).

Furthermore, the qualitative methods in the case-studies and oral histories had
different epistemological approaches to gain information on two elements: 1) people’s
interpretation of service delivery and policy, as well as their opportunities, challenges
and solutions (interpretivist approach) and 2) factual data on programmes (post-
positivist approach in case studies only). This post-positivist paradigm (taking the facts
at face-value for the purpose of describing programmes and roles), which is usually
associated with quantitative data, was applied to the qualitative descriptive data set.
This has been done in other studies too (Patton, 2002) and can be valid for entirely
descriptive data as long as the methods for doing so were rigorous. This decision to
approach the data with a post-positivist paradigm was determined by the fact there was little factual or quantitative information otherwise available.

The completeness of data and analysis were limited by two issues. Firstly, we did not do any quantitative evaluations of case-study programmes in India which would have been interesting to compare to the quantitative LMIC data (chapters 2 and 4). This was because the purpose of the thesis was a mapping exercise of different models and roles, and the historical and policy context that has allowed these models to develop, rather than quantifying the impact of these programmes. Also outlined above, little quantitative information was available, particularly baseline data at the outset of these programmes. Secondly this study was unable to use the same data set and interpret this with different theories or epistemological paradigms. Completeness of triangulation is gained by triangulation of theories of the same data set, which would provide greater reliability of the findings and help to uncover more facets of the data (Flick, 2004; Padgett, 2012; Denzin, 1989). This study was only able to corroborate the findings between different sets of data that had different epistemological approaches and methods. Theory triangulation would be possible within the case studies once the qualitative data on PHWs’ and their supervisors’ perspectives and experiences is analysed using an interpretivist approach and comparing it to the factual data presented in chapter 6. As analysing this further data was not within the remit of this thesis (there were too many data to analyse within the thesis’ scope and timeframe), the current corroboration is less certain than it could be regarding the reliability of the findings. However the fact our conclusions regarding the use of PHWs in certain models corroborates with the current available evidence at least suggest that these are plausible findings (Green and Thorogood, 2004).

7.2.5. Limitations of the generalisability and the scope of these findings

Several factors may limit the scope and generalisability of these findings. Firstly findings from different countries were compared, or at least juxtaposed. The systematic review covered all LMICs, and the qualitative data just Indian settings. The reasons for not limiting the systematic review to India were because there were not enough data just within India to make the review worthwhile. It was also beneficial to
know what the effectiveness of PHWs was for all LMICs, as many of these countries have similar barriers to care and policy as India (see Chapter 4: introduction for justification of including LMICs in the review). However the comparison between LMIC studies and Indian data needs to be interpreted with caution as when results from different contexts and sources concur, one could conclude perhaps prematurely that our findings are confirmed (Padgett, 2012).

Secondly, children and adolescent mental disorders were not explored thoroughly. The Cochrane review focused on adult and children mental disorders whereas the Indian case-study data focused on adult mental disorders only. Though the aim of the thesis was to maintain the focus on adult mental disorders, peer reviewers of my Cochrane review protocol suggested that present adult and child mental disorder data would be more useful. Within the Indian case-studies, we decided that because of the breadth of models available for adult mental healthcare and the likelihood of very different models for child mental healthcare (including the need to look beyond the healthcare sector such as the use of non-health workers like teachers and non-health settings like schools), their inclusion would be too wide for the scope of this thesis. Child and adolescent mental healthcare data from the Cochrane review were therefore not triangulated with other findings from the thesis.

Furthermore the limited number of papers identified in the Cochrane review (38) and the types of models we explored (72) did not allow us to do meaningful sub-group analyses to identify a link between types of mental disorders and types of models for example, though there was some suggestion that disorders that necessitated more specialist care (SMDs and substance abuse), tended to have more specialist involvement, and more targeted PHW interventions.

Certain PHWs may have also been overlooked. For example, we did not identify models which used private general practitioners in the case-study paper (chapter 6). As is suggested in the oral history paper (chapter 5), this cadre may be more motivated and more effective than government PHC doctors at diagnosing and managing people with mental disorders.
7.3. Implications for future research

This study, which was mainly exploratory in nature, was principally useful in guiding future directions for research and elements of programmes that need to be evaluated. It also provided broader thinking about practical issues necessary to improve the integration mental healthcare within primary care. The implications for future research on models of mental healthcare are stated in the discussion sections of the systematic review (Chapter 4), the oral history paper (chapter 5) and the case-study analysis (chapter 6). However this section presents the overall research recommendations which have emerged from the triangulation of findings and identification of barriers and limitations of scope of this study as stated above.

7.3.1. Research on the feasibility and impact of scaling up collaborative care

This thesis has shown agreement between different methods about the appropriate model of mental healthcare delivery involving some form of care collaboration and coordination. However this evidence comes from the perspective within the mental health field of how to improve their health system. Further research is needed to gain the perspectives of people from outside the mental health sector (such as those in the ministry of health) on how to integrate mental health better and more feasibly in the general health system. Health sector-wide research will be needed to also assess and evaluate whether DMHP changes, as are likely in the current 12th Five Year Plan, are effective. This will need to include not just quantitative evaluation of PHWs’ impact within mental healthcare, but also the impact on general healthcare delivery, and on health system strengthening. This would mean broadening the evaluation beyond the clinical setting to assess the breadth of, for example, inter-sectoral collaboration (such as with the voluntary and private sectors, non-health sectors). In addition, to explore factors affecting the sustainability of PHWs and models, a qualitative exploration of various current stakeholders’ views and perspectives on the successes and challenges of collaborating with the government will provide structured targets for governments to improve. Further research into the mechanisms for integrating LHW programmes
into the formal health system, and the equity impacts of these programmes, will be necessary.

All the above would hopefully better inform development of policy in mental health, and would encourage decision-makers to use such evidence in policy implementation rather than relying, as India currently does within the maternal and child health sector, on informal evidence and hearsay (Mirzoev et al., 2013).

7.3.2. Comparative effectiveness of different PHW-delivered models of mental healthcare

More quantitative/impact evaluations of current programmes and of new interventions (including randomised controlled trials) are necessary to evaluate which models work best in which context, as the transferability of these exploratory findings to specific contexts is currently limited (Padgett, 2012). In particular, within these collaborative care and community outreach models the focus should be on evaluating and comparing impacts, costs and cost-effectiveness of different variations. This should include 1) different types of human resources and how they are combined (PHWs, care coordinator/manager, specialist); 2) different roles of PHWs (clinical and management/linkage roles); 3) which models may be appropriate for different mental disorders and 4) settings (primary care versus community care). Research is also needed to identify how these models can be adapted to different states and human and financial resources settings. From the above discussion it would also be important for new trials to create models that are as realistic as possible, using a feasible human resource mix, thereby not using too much specialist input, particularly for care coordination. Within India, and four other LMICs, this process is already underway with a large Programme for Improving Mental Health Care (PRIME) which is seeking to generate evidence on the implementation and scaling up of integrated packages of care for priority mental disorders in primary and maternal healthcare settings (Lund et al., 2012).

Issues that were not covered in this thesis but are related and relevant are the need to explore the acceptability of these models for PHWs, their supervisory workforce and for patients. Furthermore models for child and adolescent mental health delivered by
PHWs or teachers in India need to be further described and evaluated. The above research recommendations may benefit researchers in other LMICs in prioritising research needs for the integration of mental healthcare in their respective countries.

7.3.3. Evaluation of methods for training and supervision of PHWs

One significant barrier identified was the lack of motivation and skills of PHWs. An evaluation of how to better supervise, train and retain PHWs, care managers and specialists. This will necessitate comparing types of supervision (such as remotely or face-to-face: see chapter 6 for more detailed discussion on remote supervision), the intensity of supervision and whether supervisors are specialists or non-specialists. The findings from these assessments would have significant resource implications, for example if experienced non-specialists were as effective supervisors as specialists, without affecting the quality of care provided. Indeed a recent publication from Goa, India has indicated that peer-led supervision may be as effective as specialist supervision within psychological interventions delivered by LHWs for the care of depression and alcohol use disorders (Singla et al., 2014).

7.4. Implications for policy and practice

What the findings are not aimed at doing, nor can do at this stage without further research, is recommend a specific model to roll out across India. Indeed, within a country as diverse as India, it is unlikely one model would suit the whole country. Recommendations of concepts to scale up, rather than suggesting a rigid model with a rigid set of health workers, are more appropriate and would allow the model to be adapted to local needs and resources. This has also been the conclusion drawn by a systematic review of the right skill mix in the healthcare workforce worldwide (Buchan and Dal Poz, 2002).

7.4.1. Deployment of care managers and LHWs

The triangulation of findings from the systematic review with those of the oral histories and case-studies of current programmes suggests several concepts may be generalisable and transferrable to other contexts within India. Chapters 4 and 6 suggest the add-on of a care manager and use of LHWs to provide psychosocial
support are crucial to effective and accessible primary mental healthcare. They seem more acceptable and feasible than PHC doctors who are poor at identifying and treating cases and at care coordination (chapters 5 and 6). This would mean the health system, in its strengthening process, needs to create a new cadre of care manager at primary care/community care level and better utilise LHWs. We saw however in section 7.1.4.1 and in the oral history paper (chapter 5) that specialists were sparse and often not motivated to join the government DMHP. As the use of care managers and LHWs necessitates the involvement of specialists, PHWs would only be feasible with better buy-in and redistribution of specialist roles to provide ongoing supervision to care managers, which could potentially be done remotely, and possibly more outreach work for diagnosis and establishing management plans. These implications of health worker roles, and aspects that may be conceptually or contextually generalisable, are further discussed in chapter 6 (implications for practice).

7.4.2. Integrating mental health with established health system strengthening programmes

The inadequate collaboration between health system strengthening and implementing the DMHP was identified as a barrier. Efforts are therefore required for the DMHP and NRHM to collaborate on adapting the DMHP model in parallel to health system strengthening efforts. Although the collaboration between these two initiatives is often discussed in DMHP’s reports, no strategic plan has been devised to address this (GOI, 2011). Nor has the NRHM yet accepted mental health or chronic diseases within their strategic plan (GOI, 2009). To bridge the traditional divide between the horizontal (general health system strengthening) and vertical approaches (introducing disease-specific programmes), a ‘diagonal’ approach whereby explicit intervention priorities are used to drive improvements of the health system (Frenk, 2010), may well be relevant in India. The strengthening of the primary healthcare system’s workforce could for example partly be driven through specific strengthening of the workforce which would be implemented through the DMHP. Strategies could include a multistage process to finally achieve a greater use of primary care, as health system strengthening is a slow process. For example, there is currently a mismatch of the expectations of PHC doctors’ roles with the practical aspects of them implementing coordinated care
for mental health as well as another 12 national programmes (such as TB, Mother and Child health etc). In India, this may mean initially withdrawing diagnosis and treatment of mental disorders from PHC doctors and utilising specialists instead, whilst efforts are made to retain PHC doctors, improve this workforce’s competence, expand the community LHW workforce and introduce care managers.

The addition of an extra health worker, a care manager in every primary care centre is an enormous objective in a country the size of India. All care managers identified in the case studies solely focused on mental healthcare (chapter 6). Given the limited resources, and a growing burden of many chronic diseases which also feature in the universal health coverage agenda (Patel et al., 2011), the question posed by other researchers in HICs and LMICs (and which is also discussed in the chapter 5), is whether one or several care managers and the creation of multi-disciplinary teams for all chronic disorders may be more feasible (Beaglehole et al., 2008). Most models however currently focus on providing care for individual diseases such as diabetes, hypertension, chronic respiratory diseases, epilepsy or depression. Very few studies looked at combining roles for PHWs. A few from HICs have shown the effectiveness of combining diabetes and hypertension (Joshi et al., 2014), and one study also included asthma and epilepsy (Coleman et al., 1998). Roles included identifying, referring, and following up for medical adherence. Some non-physician health workers (such as clinical officers and nurses) also prescribed and provided supportive management for conditions (Joshi et al., 2014). One randomised controlled trial in the UK trained all primary care staff (rather than having a care manager) to attempt to improve self management of three chronic disorders (irritable bowel syndrome, chronic obstructive pulmonary disease and diabetes) but this showed no improvement in patient outcomes (Bower et al., 2012; Kennedy et al., 2013). No examples have yet been identified with this combined chronic disease manager in practice (i.e. outside a research setting), neither in India, nor elsewhere, as most health systems expect their current primary care workforce to manage these (Ngo et al., 2013).
7.4.3. Engagement of civil society

The qualitative study suggests collaboration with NGOs would be beneficial due to several innovative practices and complementary nature to government provision. For example it may be effective to partner with other providers, such as the specialist community outreach models for targeted high risk groups or those with severe mental disorders or substance use disorders (WHO, 2005). This may partly improve the dearth of specialists by involving private specialists who are already active in this field, even though they are outside the government sector. NGOs also help locally adapt programmes at a district level as they work close to the community. This makes them aware of and thus in good position to advise on community needs. NGOs however are keen not to be considered merely as commissioned service providers and frequently try to establish partnerships with local and state-level government to influence the delivery of mental healthcare (chapter 5) (Patel and Varghese, 2005; Patel and Thara, 2003), having done so for many years in all health sectors (Antia and Bhatia, 1993). However, partnerships require a built-in government mechanism to minimise the challenges of involving the NGO/ private sector. The concerns are how sustainable these organisations are (due to their fragile resource base), how they can be adequately regulated to maintain standards of service delivery, and how accountable they are (Green and Matthias, 1996).

The systematic review (chapter 4) also showed the importance of involving non-health workers (e.g. teachers) for children. Though our study in India focused on adult mental healthcare, this is an area that is important and needs further attention and integration into primary care. Finally, collaboration with community members, patients and carer groups would be important. These collaborations have been established by some NGOs. Patient and community participation in most government programmes in India is remarkably absent, despite this too being a goal of universal health coverage (Reddy et al., 2011). Positive steps towards better community participation and accountability are being taken by NRHM which has initiated a community monitoring committee system (NRHM, 2007).
7.4.4. Providing technical support for better leadership, implementation and evaluation

Several political barriers mentioned above such as poor governance, the federalised system of care and poor understanding of mental healthcare amongst decision makers are caveats to establishing these collaborations and to effectively improving the DMHP. However, if the leadership system were enhanced with better more persuasive central leadership, state-level decision makers could be aided technically and decisions across states harmonised. This central- and state-level technical support would contribute to educating policy makers at district and state levels about public health importance of mental health. For example constructive technical support to help central and state leadership could help better adapt and implement the DMHP model to their needs and resources. It would also help funding become less bureaucratic and more accessible. Continuity is important for a strong and effective leadership; this would be helped by attracting and retaining specialists as leaders (chapter 5).

Although a national mental health policy is close to being established in India, it has taken since 1982 to actually devise a policy due to the lack of political will, a common scenario in many other LMICs too (Omar et al., 2010). Chapter 5 provides more discussion on the political hurdles which need to be overcome as well as what efforts are needed to create safeguards to have a more democratic and locally accountable system.

7.5. Conclusions

This study has shown that PHWs can be effective in delivering care for MNS disorders through a quantitative and qualitative review of the existing literature in LMICs, including India. There is however insufficient information to determine whether PHWs are cost effective. The historical policy analysis identified that the government DMHP was perceived to have failed and reasons for this included poor leadership and inadequate political commitment. Poor government primary mental healthcare provision has resulted in a disparate medley of NGO-run community-based programmes.
Despite the evidence for the effectiveness of collaborative care models in HICs, in India few models implemented collaborative care and those that did had significant variations compared with their counterparts in HICs. In particular most collaborations did not include government primary healthcare workers but included other PHWs within community-based organisations’ (such as disability sector NGOs). Many programmes, including the government DMHP, used the training and education model which has no evidence of effectiveness. A third of programmes also trained PHWs only to identify and refer. This may be effective but is unlikely to be cost-effective as this model intensively uses specialists who retain responsibility for care. A unique model, the community outreach model was identified; this has not been previously described in model frameworks. Many of these services focused on severe mental disorders or substance abuse and used specialist resources more intensively than collaborative care. They also trained their own PHWs and care coordinators to provide significant first-level community-based care and psychosocial support.

PHC doctors were often ineffective in government settings, and had very limited use in NGO settings due to factors such as attrition, lack of motivation, poor calibre, and insufficient training and supervision. LHWs and care managers were more feasible and appropriate across different models and provided broader psychosocial interventions. Specialists were used in these community settings for PHWs’ and care managers’ training and ongoing support. Specialists were often also used for initial diagnosis and initiating a management plan.

Several barriers were identified to the adequate implementation of these models. These include the paucity of specialist and primary care human resources and poor willingness of specialists to incorporate PHW support into their roles. This is compounded by a weak primary care system, PHWs’ lack of motivation and skills in the government sector and a ‘failed’ DMHP model. Further system-wide and political barriers include the lack of accountability, inadequate leadership, funding issues, and inadequate implementation of health system strengthening and of inter-sectoral collaboration.
The next research priorities are to evaluate specific models identified in India to confirm whether variations of collaborative models are similarly effective to those described in HICs and are feasible and effective if implemented at scale. Furthermore, methods for training and supervising LHWs and care managers need to be evaluated. Similar studies should be encouraged in other LMICs.

These findings have policy implications for India. The government needs to consider deploying care managers and LHWs and reorient as well as incentivise specialists to support them. Better inter-sectoral collaborations with health strengthening initiatives (such as the NRHM) and with civil society (NGOs, non health sectors and the community) are needed. Given the growing chronic disease burden and human resource limitations within India, exploring how care managers may be merged for several chronic diseases, not just mental health, may be more appropriate. Better technical support at central and state government levels may help improve leadership, implementation and evaluation of mental healthcare integration into primary care across India.
7.6. References


Appendices
Supplementary webappendix

This webappendix formed part of the original submission and has been peer reviewed. We post it as supplied by the authors.


*Studies on PHWs in primary/community adult mental healthcare not included in the Cochrane review*
<table>
<thead>
<tr>
<th>Setting</th>
<th>Study design (model or intervention)</th>
<th>Mental disorder</th>
<th>Workforce (intended roles)</th>
<th>Training received</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina (Lyketsos, 1999)</td>
<td>Intervention study (primary care doctor vs psychiatrist)</td>
<td>Depression</td>
<td>Primary-care doctors (diagnosis and treatment)</td>
<td>0.5-day training by a psychiatrist</td>
<td>Reductions in symptoms of depression were noted in both settings; no significant difference between primary care and psychiatric office settings</td>
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<tr>
<td>Brazil (Heldt, 2003)</td>
<td>Controlled trial (group cognitive behaviour therapy)</td>
<td>Panic disorder</td>
<td>Psychiatrist and psychiatric nurse (group cognitive behaviour therapy)</td>
<td>Not reported</td>
<td>Group cognitive behaviour therapy significantly reduced symptom severity (frequency, phobic avoidance, anticipatory anxiety, and intensity of panic attacks) after the 12-week programme</td>
</tr>
<tr>
<td>Cameroon (Kenge, 2008)</td>
<td>Pre/post-evaluation of nurse-led programme for epilepsy care</td>
<td>Epilepsy</td>
<td>Nurses (prescribing of drug treatment)</td>
<td>Not reported</td>
<td>Reduction in number of days per month with seizures</td>
</tr>
<tr>
<td>Chile (Araya, 2003)</td>
<td>Randomised controlled trial (stepped care [psychoeducation, follow-up, drug therapy] vs usual care [antidepressants given by primary-care doctor])</td>
<td>Depression</td>
<td>Psychiatrist (training and supervision); primary care doctor (structured pharmacotherapy); nurses and social workers (psychoeducation and monitoring)</td>
<td>Nurses and social workers underwent 12 h of training and 8 h of supervision by a psychiatrist; primary-care doctors received 4 h of training by a psychiatrist</td>
<td>Greater improvements in depression at 6 months</td>
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<tr>
<td>Chile (Gutierrez-Maldonado, 2007, 2009)</td>
<td>Randomised controlled trial (psychoeducation and conventional services vs conventional services only)</td>
<td>Schizophrenia</td>
<td>Psychologists (psychoeducation intervention for caregivers); parent-caregivers (management of attention-deficit hyperactivity disorder)</td>
<td>Not reported</td>
<td>Reduction in caregiver burden in all three areas (burden, rejection; and incompetence); improvements in attitudes of relatives toward schizophrenia in behaviour (cognitive and affective) components; carers have learnt how to act, feel, and think in a more positive and flexible way with respect to the disorder</td>
</tr>
<tr>
<td>Chile (Rojas, 2007)</td>
<td>Randomised controlled trial (multicomponent intervention [group psychoeducation, treatment adherence support and pharmacotherapy if needed] vs usual care)</td>
<td>Maternal depression</td>
<td>Primary care doctors (structured pharmacotherapy protocol); midwives and nurses (psychoeducation); lay worker (monitoring of consultations and group sessions, support and advice about antidepressant use)</td>
<td>Midwives and nurses received 8 h of training and supervision once a week by a psychiatrist; primary-care doctors underwent 5 h of training to deliver a structured pharmacotherapy protocol by a psychiatrist</td>
<td>Better depression outcomes at 3 and 6-months follow-up; greater reduction in use of antidepressant drugs</td>
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<tr>
<td>China (Xiang, 1994)</td>
<td>Randomised controlled trial (psychosocial and cultural family intervention and drugs vs drugs alone)</td>
<td>Schizophrenia and affective psychoses</td>
<td>Family caregivers (monitoring, patient management)</td>
<td>Psychoeducational family intervention with monthly supervision</td>
<td>Reduction in provision of insufficient care or inappropriate treatment at follow-up; compared with control, higher total rate of improvement, higher proportion of people who could do full-time or part-time farm work or housework, and greater reduction in the proportion of people who showed poor social functioning</td>
</tr>
<tr>
<td>China (Zhang, 1998)</td>
<td>Experimental (psychoeducation and conventional services vs conventional services only)</td>
<td>Schizophrenia</td>
<td>Unlclear</td>
<td>Psychoeducation included 14 lectures and five group discussions with conventional services</td>
<td>At 2-year follow-up, lower relapse rates, higher rate of regular work, less caregiver burden, better caregiver physical and mental health status, greater knowledge of caring for their relative with schizophrenia</td>
</tr>
<tr>
<td>China (Li, 2005)</td>
<td>Cluster-randomised controlled trial with pre/post-test experimental design (education programme for patients and families)</td>
<td>Schizophrenia</td>
<td>Nurses (education programme for patients and families, treatment)</td>
<td>Not reported</td>
<td>Symptoms improved at 9 months after discharge</td>
</tr>
<tr>
<td>Setting</td>
<td>Study design (model or intervention)</td>
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<td>Main findings</td>
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<td>China (Ran, 2003)</td>
<td>Community Cluster-randomised controlled trial (psychoeducational family intervention and drugs vs drugs alone vs control)</td>
<td>Schizophrenia</td>
<td>Psychiatrists and village doctors (family psychoeducational interventions for 9 months)</td>
<td>Not reported</td>
<td>At 9-month follow-up, intervention group had greater knowledge gain, change in relatives’ attitudes towards the patient, and increase in treatment adherence; relapse rate was significantly higher in psychoeducation group than in drug-only and control groups</td>
</tr>
<tr>
<td>Ecuador (Placencia, 1993)</td>
<td>Primary health care Cohort study (community-based epilepsy care vs external data of hospital-based care)</td>
<td>Epilepsy</td>
<td>Neurologists (diagnosis and treatment monitoring), rural primary care doctor (monthly follow-up at clinic [monitor occurrence of seizures, side-effects, and change dose if necessary] and referral if needed), health visitors (home visits for monitoring adherence and adverse experiences)</td>
<td>Not reported</td>
<td>Treatments were effective for control of seizures (53% seizure-free and 14% had &gt;50% reduction in seizures in the 6-12 month follow-up period); results were similar to hospital-based studies in developed countries, high adherence rate</td>
</tr>
<tr>
<td>India (Becker, 2009)</td>
<td>Community Psychosocial care for 3 months vs no psychosocial care</td>
<td>Post tsunami mental disability</td>
<td>Community health workers (psychosocial care to women survivors of 2004 tsunami)</td>
<td>3-day experiential train-the-trainer programme (&quot;essentials of psychosocial care&quot;) provided by a psychiatrist and social workers (ventilation of emotions, empathy, active listening, problem-solving, and facilitation of group support)</td>
<td>Women receiving psychosocial care had significant reduction in emotional distress at the end of the 3-month intervention; emotional distress was significantly lower in psychosocial-care group than in controls</td>
</tr>
<tr>
<td>India (Chatterjee, 2003)</td>
<td>Outpatient care Experimental design (community-based rehabilitation vs outpatient care)</td>
<td>Schizophrenia</td>
<td>Mental health workers (community-based rehabilitation), family members and key community people [&quot;samitis&quot;] (forum for planning relevant rehabilitation measure and reduce social exclusion)</td>
<td>60-day training</td>
<td>Better clinical and disability outcomes, adherence, and drug retention in the rehabilitation group than with outpatient care</td>
</tr>
<tr>
<td>India (Chatterjee, 2009)</td>
<td>Outpatient care Pre/post-evaluation of community-based rehabilitation intervention</td>
<td>Psychotic disorders (schizophrenia, bipolar disorder, and other psychotic conditions)</td>
<td>Psychiatrist (monthly outreach services, undertaking new and follow-up assessments, prescribing drug treatments, and ongoing training and supervision); community-based rehabilitation workers (case management, detection and management, supporting and training of self-help groups and local community networks); affected individuals (self-help groups for adherence support, rehabilitation, education support for families and affected individual with psychosis, and livelihood support through microcredit facilities and social reintegration); skilled community-based rehabilitation practitioner (cluster coordinator, clinical and administrative responsibility for cluster 20-30 villages, quality assurance, stakeholder linkages, training and management for self-help groups)</td>
<td>Not reported</td>
<td>Reductions in disability</td>
</tr>
<tr>
<td>India (Dias, 2008)</td>
<td>Community Randomised controlled trial (stepped-care home-care programme vs no home-care programme [on waiting list for home-care programme])</td>
<td>Dementia (mild to moderate)</td>
<td>Home-care adviser (supervision, education, caregiver support, referral, maximisation of caregiving resources, and improvement of caregiving skills)</td>
<td>Home-care advisers received 1 week’s training by a psychiatrist and had subsequent bi-weekly meetings with a counsellor to share experiences, provide mutual support to one another, and problem-solve difficult situations</td>
<td>Home-care programme was effective at reduction of caregiver burden (mental health status and distress)</td>
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</tr>
</thead>
<tbody>
<tr>
<td>India (Kulhara, 2009)</td>
<td>Randomised controlled trial (structured psychoeducational intervention vs routine outpatient care)</td>
<td>Schizophrenia</td>
<td>Mental health professionals (psychoeducational intervention)</td>
<td>Mental health professionals had 2 months’ training by consultant psychiatrists with didactic lectures and hands-on experience with patients and their families</td>
<td>Better outpatient care on psychopathology, disability, caregiver support, and caregiver satisfaction</td>
</tr>
<tr>
<td>India (Mani, 1998, 2001, 2003)</td>
<td>Non-randomised trial (adherent to treatment vs non-adherent)</td>
<td>Epilepsy</td>
<td>Neurologist, primary care doctors, and paediatrician (diagnosis and treatment); paramedic workers (detection, referral, and follow-up care in the community)</td>
<td>Paramedic workers (mainly local graduates) were trained by researchers in epidemiological methods, case ascertainment, practical management of epilepsy, and health education</td>
<td>Greater terminal remission rates in the group adherent to treatment (58–60%) than in the non-adherent group (6–16%) at each of the 4 successive years of follow-up</td>
</tr>
<tr>
<td>India (Patei, 2003)</td>
<td>Randomised controlled trial (antidepressant vs placebo vs psychological treatment)</td>
<td>Common mental health disorders</td>
<td>Therapist (psychological treatment, including psychoeducation, relaxation, symptom-targeted activities, and problem-solving)</td>
<td>Not reported</td>
<td>Antidepressants led to significantly better psychiatric outcomes than placebo; no significant differences in outcomes between psychological treatment and placebo groups</td>
</tr>
<tr>
<td>India (Patei, 2008, 2010; Chatterjee, 2008)</td>
<td>Cluster-randomised controlled trial (collaborative stepped care [detection, drug or interpersonal treatment, adherence, referral] vs enhanced usual care [doctors receive screening care]; results)</td>
<td>Psychiatric (management of treatment-resistant or suicidal patients); primary-care doctor (consultation and drug treatment); health assistant (screening); health counsellor (screening, psychoeducation, interpersonal treatment)</td>
<td>Training and supervision by psychiatrist</td>
<td>In public primary health setting, individuals receiving stepped care had 55% greater likelihood of recovery compared with enhanced usual care (66% vs 43%) and had lower prevalence of common mental health disorders (28% vs 53%) at 6 months; no difference was seen in the private family doctor setting</td>
<td></td>
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<tr>
<td>India (Srinivasa Murthy, 2005)</td>
<td>Intervention study (pre/post-community outreach programme)</td>
<td>Schizophrenia</td>
<td>Social worker (coordinated group discussions); multidisciplinary community mental health team (psychotropic drug and psychosocial support [psychoeducation])</td>
<td>Not reported</td>
<td>Reduction in psychotic symptoms, disability, and family burden during 18-month follow-up; reductions in costs of informal care sector visits and family caregiver time</td>
</tr>
<tr>
<td>India (Tripathy, 2010)</td>
<td>Cluster-randomised controlled trial (group discussion [13 per month with 13 groups] vs usual care [existing women’s groups])</td>
<td>Maternal depression</td>
<td>Lay workers (facilitation of group discussion meetings)</td>
<td>7-day residential training course and support through fortnightly meetings with district coordinators</td>
<td>Lower neonatal mortality during the 3 years of the study; no significant effect on maternal depression overall, but a 57% reduction in moderate depression in 3rd year</td>
</tr>
<tr>
<td>India (Vijayakumar, 2008)</td>
<td>Controlled trial (trained volunteer mental health support vs no mental health support)</td>
<td>Post-tsunami bereavement</td>
<td>Trained volunteers (mental health support for bereaved members of post-tsunami community)</td>
<td>Not reported</td>
<td>Less depressive symptoms and general psychological distress at 12-month follow-up</td>
</tr>
<tr>
<td>India and Pakistan (Chisholm, 2000; James, 2002)</td>
<td>Cost-outcome study (mental health integrated primary health care vs standard primary health care)</td>
<td>Common mental health disorders</td>
<td>Psychiatrists (diagnostic assessment, provision of information about treatment options, how and where to seek local treatment and advice about psychological problems); field workers (screening)</td>
<td>Not reported</td>
<td>Improvements in symptoms in three of four districts; use of services was low among patients diagnosed with a mental disorder, particularly in the public sector; cost of care, distance from treatment centre, perception that treatment will be ineffective, and stigma were barriers to treatment seeking</td>
</tr>
<tr>
<td>Iran (Ghanizadeh, 2005)</td>
<td>Referred from private practitioners, paediatricians, psychiatrists, and tertiary care</td>
<td>Attention-deficit hyperactivity disorder</td>
<td>Parents (attention-deficit hyperactivity disorder management)</td>
<td>Improvement in conduct difficulties, learning problems, and hyperactivity in children and in parental mental health; no effect on teacher-rated measures</td>
<td>5 h in sessions every week for 8 weeks</td>
</tr>
<tr>
<td>Setting</td>
<td>Study design (model or intervention)</td>
<td>Mental disorder</td>
<td>Workforce (intended roles)</td>
<td>Training received</td>
<td>Main findings</td>
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<tr>
<td>Iran (Javadpour, 2009)</td>
<td>Primary health care</td>
<td>Randomised controlled trial (education support group vs non-education group)</td>
<td>Dementia</td>
<td>Senior psychiatry resident (facilitation of caregiver support group)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Iran (Malakouti, 2009)</td>
<td>Primary health care</td>
<td>Quasi-experimental design (mental health workers vs consumers’ family members as case managers)</td>
<td>Schizophrenia</td>
<td>Consumers’ family members (case management); mental health workers with a bachelor’s degree in psychology (case management, education)</td>
<td>Mental-health workers received 32 h of theoretical training; consumers’ family members had 66 h of theoretical training and ten practical sessions</td>
</tr>
<tr>
<td>Jamaica (Baker-Henningham, 2005)</td>
<td>Community (12 nutrition clinics)</td>
<td>Controlled trial (home visits every week for 1 year by community-health aides for improving child health and parenting skills plus standard health and nutrition care vs standard health and nutrition clinics only)</td>
<td>Maternal depression</td>
<td>Community health aides (weekly home visits to improve child development by improving mothers’ knowledge, child rearing practices and parenting self-esteem)</td>
<td>Community health aides received 4-week pre-service training on health and nutrition and further 2-week training covering child development, parenting issues, and how to do the intervention with regular supervision</td>
</tr>
<tr>
<td>Kenya (Feksi, 1991)</td>
<td>Primary health care</td>
<td>Cohort study (12-month follow up)</td>
<td>Epilepsy</td>
<td>Psychiatrist (diagnosis and treatment); key informants (case identification); health visitors (community management programme [screening, referral, and follow-up, educational counselling, and ensuring adherence to treatment])</td>
<td>Training and supervision by psychiatrist</td>
</tr>
<tr>
<td>Nigeria (Agara, 2007)</td>
<td>Tertiary hospital</td>
<td>Randomised controlled trial (group psychoeducation vs none [usual care])</td>
<td>Psychosis and depression</td>
<td>Senior nurses and graduate assistant psychologists (group psychoeducation)</td>
<td>2-week training on how to use the group psychoeducational schedules</td>
</tr>
<tr>
<td>Nigeria (Olley, 2001)</td>
<td>Tertiary hospital</td>
<td>Pre/post-evaluation of training programme</td>
<td>Epilepsy</td>
<td>Psychologist (psychoeducational programme to patients)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Pakistan (Ali, 2010)</td>
<td>Two underprivileged communities in Karachi</td>
<td>Pre/post-evaluation (counselling by community women counsellors vs no counselling)</td>
<td>Depression, anxiety</td>
<td>Community women counsellors (cognitive behavioural treatment and supportive and problem-solving counselling)</td>
<td>Five 3-h sessions per week for 4 weeks by family practitioners, psychiatrist, and a clinical psychologist</td>
</tr>
<tr>
<td>Pakistan (Rahman, 1998)</td>
<td>School</td>
<td>Randomised controlled trial (school mental health programme vs no school mental health programme)</td>
<td>Mental illnesses</td>
<td>Trained teachers (awareness raising)</td>
<td>Training and supervision by doctor, psychologist, and social worker</td>
</tr>
<tr>
<td>Pakistan (Rahman, 2008)</td>
<td>Community-based primary health care</td>
<td>Cluster-randomised controlled trial (training health programme by lay health worker vs enhanced routine care by lay health worker)</td>
<td>Maternal depression</td>
<td>Lay health workers (thinking healthy programme vs enhanced routine care)</td>
<td>Supervision and monitoring by psychiatrist</td>
</tr>
<tr>
<td>Russia (Gavrilova, 2009)</td>
<td>Primary health care</td>
<td>Randomised controlled trial (caregiver education and training plus medical care as usual vs medical care as usual)</td>
<td>Dementia</td>
<td>Newly qualified doctors (education for caregivers); caregivers (monitoring and management)</td>
<td>Structured, manual-based, 2-day training programme comprising vignettes, role play, and live interviews</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Setting</th>
<th>Study design (model or intervention)</th>
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<th>Workforce (intended roles)</th>
<th>Training received</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa (Cooper, 2002) Primary health care</td>
<td>Controlled trial (mother-infant intervention vs no mother-infant intervention)</td>
<td>Maternal depression</td>
<td>Lay community workers (mother-infant intervention emotional support and encourage new mothers on sensitive responsive interactions with their infants)</td>
<td>Training in basic counselling skills and specific mother-infant intervention</td>
<td>No effect on maternal depression, positive effect on mother-infant engagement</td>
</tr>
<tr>
<td>South Africa (Cooper, 2009) Primary health care</td>
<td>Randomised controlled trial (mother-infant intervention vs no mother-infant intervention)</td>
<td>Maternal depression</td>
<td>Lay community workers (mother-infant intervention emotional support and encourage new mothers on sensitive responsive interactions with their infants)</td>
<td>Training in basic counselling skills and specific mother-infant intervention</td>
<td>Improved maternal-infant relationship at 6 and 12 months postpartum (eg, more sensitive and less intrusive in their interaction with their infants) and higher rate of secure infant attachments at 18 months; improved symptoms of maternal depression at 12 months</td>
</tr>
<tr>
<td>Taiwan (Chou, 2002) Hospital</td>
<td>Time series non-equivalent control-group design (professionally led support group vs control group)</td>
<td>Schizophrenia</td>
<td>Mental health nurse (facilitation of caregiver-support groups)</td>
<td>Not reported</td>
<td>No effect on patients’ outcomes; positive effect on caregiver burden and caregiver depression status</td>
</tr>
<tr>
<td>Thailand (Maneesakorn, 2007) Hospital inpatient and outpatient (outpatient for follow-up)</td>
<td>Randomised controlled trial (adherence treatment vs no adherence treatment)</td>
<td>Schizophrenia</td>
<td>Nursing therapist (adherence treatment)</td>
<td>Not reported</td>
<td>Greater improvements in overall psychotic symptoms, attitudes towards drugs, and satisfaction with drugs; no differences in general functioning and drug side-effects</td>
</tr>
<tr>
<td>Thailand (Worakul, 2007) Hospital psychiatric department</td>
<td>Pre/post-evaluation (psychoeducational programme for caregivers or family members of schizophrenic patients)</td>
<td>Schizophrenia</td>
<td>Psychiatrists (psychoeducational programme to caregivers); caregivers (peer support group)</td>
<td>Not reported</td>
<td>Improvements in knowledge and attitude of caregivers</td>
</tr>
<tr>
<td>Turkey (Dogan, 2003) Hospital psychiatric department</td>
<td>Controlled trial (education vs no education)</td>
<td>Bipolar disorder</td>
<td>Mental health nurses (education for patients)</td>
<td>Not reported</td>
<td>Increase in medical knowledge, decrease in symptom level, increase in quality of life and improved adherence at the end of the 3-month education programme</td>
</tr>
<tr>
<td>Uganda (Bolton, 2003; Bass, 2006) Community</td>
<td>Cluster-randomised controlled trial (group interpersonal treatment vs no group interpersonal treatment)</td>
<td>Depression</td>
<td>Community member (facilitation of group interpersonal treatment)</td>
<td>2-week training session of intensive instruction by psychiatrist</td>
<td>Reduced depression and dysfunction severity at 2-week and 6-month follow-up</td>
</tr>
<tr>
<td>Zimbabwe (Adamolekun, 1999) Hospital</td>
<td>Pre/post-training evaluation</td>
<td>Epilepsy</td>
<td>Neurologists, a pharmacist, clinical pharmacologist, a social worker, and the district nursing officer (resource people), primary care nurses (diagnosis and initiation of treatment); environmental-health technicians (community health education and disease prevention)</td>
<td>1-day workshop on the management of epilepsy; supervision by neurologists, a pharmacist, clinical pharmacologist, a social worker, and the district nursing officer</td>
<td>Improved overall knowledge of epilepsy, increase in patients’ recruitment, and striking improvement in patients’ drug adherence over the 6-month study period</td>
</tr>
</tbody>
</table>

Maternal depression includes both antenatal and postnatal depression.

**Table 1: Summary of evidence on the effect of task shifting on patients’ and caregivers’ outcomes.**
<table>
<thead>
<tr>
<th>Author &amp; Year</th>
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<tbody>
<tr>
<td>Setting</td>
<td>Study design</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>Mental health specialists</strong></td>
<td></td>
</tr>
<tr>
<td>Turkey (Engin, 2009)</td>
<td>Hospital Pre/post-evaluation of self-awareness education programme</td>
</tr>
<tr>
<td><strong>Non-specialist health professionals</strong></td>
<td></td>
</tr>
<tr>
<td>Afghanistan (Mohit, 1999)</td>
<td>Primary health care Pre/post-evaluation of training programme</td>
</tr>
<tr>
<td>India (Siram, 1990)</td>
<td>Primary health care Pre/post-evaluation of training programme</td>
</tr>
<tr>
<td>Nigeria (Abiodun, 1991)</td>
<td>Primary health care Retrospective cohort (mental health training vs no mental health training)</td>
</tr>
<tr>
<td>Saudi Arabia (Al-Faris, 1997)</td>
<td>Primary health care Randomised controlled trial (trained primary-care doctors vs untrained primary-care doctors from the same clinic vs untrained primary-care doctors from a different clinic)</td>
</tr>
<tr>
<td>South Africa (Petersen, 1999)</td>
<td>Primary health care Pre/post-evaluation of reorientation programme</td>
</tr>
<tr>
<td>Sri Lanka (Budosan, 2009)</td>
<td>Primary health care Pre/post-evaluation of training programme</td>
</tr>
<tr>
<td>Turkey (Akar, 1997)</td>
<td>Academic institution Non-randomised controlled trial (psychiatric training vs no psychiatric training [ophthalmology])</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Setting</th>
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<th>Workforce (role)</th>
<th>Training</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Turkey (Ucok, 2005)</strong></td>
<td>Pre/post-evaluation of anti-stigma education</td>
<td>Schizophrenia</td>
<td>Family doctors</td>
<td>Anti stigma education for family doctors by psychiatrists</td>
<td>3 months after the education session, fewer family doctors believed that schizophrenia could be recognised by appearances, that affected individuals are untrustworthy, and that they could harm children; more family doctors believed that patients with schizophrenia can be treated and that they can comprehend and apply suggested treatment</td>
</tr>
<tr>
<td><strong>Chile (substudy) [Lewis, 1992]</strong></td>
<td>Non-randomised controlled trial (lay health workers vs psychiatrist)</td>
<td>Minor psychiatric disorder</td>
<td>Lay health workers (detection)</td>
<td>2-h theoretical teaching, observation, and discussion by psychiatrists</td>
<td>Lay interviewers were as reliable as the psychiatrists in undertaking of assessments for minor psychiatric disorders</td>
</tr>
<tr>
<td><strong>India (Chinnayya, 1990)</strong></td>
<td>Pre/post-evaluation of a 1-week mental health training programme for multipurpose workers</td>
<td>Psychosis, mental retardation, epilepsy</td>
<td>Multipurpose workers (home visits, monitor various health and take appropriate action [emergency management, health education, referral to primary care and follow-up as necessary])</td>
<td>1 week of training at the National Institute of Mental Health and Neuro Sciences in Bangalore, India, including lectures, case demonstrations, and role play</td>
<td>Trainees showed significant positive changes in attitudes about causation and management for psychosis, mental retardation, and epilepsy, immediately after the training course (last day of course)</td>
</tr>
<tr>
<td><strong>India (Jacob, 2007)</strong></td>
<td>Quasi-experimental (screening [no comparison group])</td>
<td>Dementia</td>
<td>Community health workers (detection and referral)</td>
<td>2-h interactive training session (10/66 dementia research group training module) to identify people in their community with dementia</td>
<td>Informal screening by community-health-workers had low sensitivity and positive predictive values; community health workers were not effective in detecting people with dementia in the community (low prevalence rates)</td>
</tr>
<tr>
<td><strong>India (Joel, 2003, 2006)</strong></td>
<td>Non-randomised controlled trial (biomedical education vs no education for community health workers)</td>
<td>Psychosis (schizophrenia)</td>
<td>Community health workers (detection)</td>
<td>2-h teaching programme on biomedical aspects of schizophrenia and local beliefs about mental illness, symptoms, causes, treatment, and referral</td>
<td>Treatment-seeking was significantly associated with receiving biomedical education at follow-up; education as effective in changing explanatory models of psychosis</td>
</tr>
<tr>
<td><strong>India (Shaji, 2002)</strong></td>
<td>Quasi-experimental (Anganwadi [community worker vs psychiatrist])</td>
<td>Dementia</td>
<td>Anganwadi workers (screening)</td>
<td>Introductory 90-min training session, practical application, and subsequent 1-h advanced training</td>
<td>Positive predictive value 65%; Anganwadi workers can have a role in identification of cases of dementia in the general population</td>
</tr>
<tr>
<td><strong>Nigeria (Eaton, 2008)</strong></td>
<td>Pre/post-evaluation of community-based awareness programme</td>
<td>Mental illnesses</td>
<td>Village health workers (detection, referral, and work with the nurse to maintain contact and provide follow-up monitoring)</td>
<td>Mental-health awareness programme by clinic psychiatric nurses and local primary-health-care coordinator</td>
<td>The awareness programme led by community psychiatric nurses and primary-health-care coordinators delivered to village health workers significantly increased use of community-based mental health services</td>
</tr>
<tr>
<td><strong>Uganda (Kabura, 2005)</strong></td>
<td>Pre/post-assessment microcounselling skills training</td>
<td>Mental illnesses</td>
<td>Informal health workers</td>
<td>5-day intensive microcounselling-skills training programme (total 40 h)</td>
<td>Helpers who underwent microcounselling-skills training showed improved basic microcounselling skills and knowledge</td>
</tr>
<tr>
<td><strong>Zimbabwe (Ball, 2000)</strong></td>
<td>Cohort study (single arm)</td>
<td>Epilepsy</td>
<td>Community leaders—ie, local board members, teachers, nurses, police officers, traditional healers, prophets (detection and referral)</td>
<td>Education about epilepsy, its causes, and how it can be managed by orthodox medicine by members of the epilepsy support foundation (a Zimbabwean non-profit organisation to support people with epilepsy), and a doctor or pharmacist</td>
<td>At 6-month follow-up, no newly diagnosed patients were detected; training did not seem to be effective in increasing detection or treatment-seeking but without a comparison group the results are inconclusive</td>
</tr>
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</table>

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Caregivers</td>
<td></td>
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<tr>
<td>Brazil (Roque, 2009)</td>
<td>Community Quasi-experimental (pre/post-evaluation of communication strategies training programme for caregivers)</td>
<td>Dementia</td>
<td>Caregivers (patients’ management)</td>
<td>Four 1·5-hour sessions on communication strategies for caregivers by a speech-language pathologist</td>
<td>Increased use of the proposed strategies but no change with respect to effectiveness of these strategies</td>
</tr>
<tr>
<td>China (Xiang, 1994)</td>
<td>Community Randomised controlled trial (psychoeducational family intervention and drugs vs drugs alone)</td>
<td>Schizophrenia and affective psychoses</td>
<td>Caregivers (management at home, monitoring, detection, problem-solving)</td>
<td>Psychoeducational family intervention aimed to teach family members basic knowledge of mental diseases and their treatment</td>
<td>Reduction in provision of insufficient or inappropriate actual maltreatment; higher total rate of improvement, higher proportion of people who could do full-time or part-time farm work or housework; greater reduction in the proportion of people who showed poor social functioning</td>
</tr>
<tr>
<td>China (Zhang, 1998)</td>
<td>Primary health care Non-randomised controlled trial (psychoeducation and conventional services vs conventional services only)</td>
<td>Schizophrenia</td>
<td>Caregivers (management at home, monitoring, detection, problem-solving)</td>
<td>Psychoeducation included 14 lectures and five group discussions with conventional services</td>
<td>Greater improvements than control group at 2-year follow up (lower relapse rates, higher rate of regular work, less caregiver burden, better caregiver physical and mental health status, greater knowledge of caring for their relative with schizophrenia)</td>
</tr>
<tr>
<td>India (Das, 2006)</td>
<td>Hospital outpatient Randomised controlled trial (educational programme on explanatory and treatment models vs no educational programme for caregivers)</td>
<td>Schizophrenia</td>
<td>Caregivers (patients’ management)</td>
<td>Structured educational programme on explanatory and treatment models (two sessions)</td>
<td>Caregivers in the education group had significant reduction in non-biomedical explanatory beliefs of psychosis compared with control groups but no differences were found in treatment models</td>
</tr>
<tr>
<td>Iran (Asadollahi, 2000)</td>
<td>Hospital psychiatric department Quasi-experimental (pre/post-assessment of training programme)</td>
<td>Schizophrenia</td>
<td>Caregivers (patients’ management)</td>
<td>Curriculum-based training course (one month after training)</td>
<td>1 month after training, more parents had the necessary skills to manage the verbal and non-verbal behaviours of their children (parents’ reaction to verbal and non-verbal behaviours and use of appropriate skills in dealing with both types of behaviours)</td>
</tr>
<tr>
<td>Russia (Gavrilova, 2009)</td>
<td>Primary health care Randomised controlled trial (caregiver education and training plus medical care as usual vs medical care as usual)</td>
<td>Dementia</td>
<td>Caregivers (counselling, assessment, monitoring)</td>
<td>Caregiver received five weekly 0·5-h sessions at home by newly qualified doctors, newly qualified doctors with no previous experience working with patients with dementia and their families (eg, health worker) attended a structured, manual-based 2-day training programme comprising vignettes, role play, and live interviews</td>
<td>Caregivers in the education group had significantly greater improvements compared with controls at 6-month follow-up in caregiver burden; no significant differences were noted in caregivers’ and patients’ quality of life or caregivers’ psychological distress</td>
</tr>
</tbody>
</table>

Table 2: Summary of evidence on evaluation of training programmes for workforce capacity
<table>
<thead>
<tr>
<th>Author &amp; Year</th>
<th>Reference</th>
</tr>
</thead>
</table>
Title: The roles of non specialist health workers in mental health care provision in low-and-middle-income countries

This application is approved by the Committee.

Chair of the Ethics Committee

Date 26 March 2010

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form.
2b. **SANGATH INSTITUTIONAL REVIEW BOARD**

**Title:** The roles of non specialist health workers in mental health care provision in low-and-middle-income countries.

<table>
<thead>
<tr>
<th>MEMBERS:</th>
<th>DECISION:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dr. Amit Dias:</strong> Chairperson</td>
<td>Opinion of the Sangath Institutional review board:</td>
</tr>
<tr>
<td><strong>Anita Haladi</strong> Professor in Economics</td>
<td>1. Approved ☑️</td>
</tr>
<tr>
<td><strong>Gracy Andrew:</strong> Clinical Psychologist</td>
<td>2. Approved subject to suggested modifications</td>
</tr>
<tr>
<td><strong>Dr. Mirja Koschorke:</strong> Psychiatrist</td>
<td>(does not need further committee review)</td>
</tr>
<tr>
<td><strong>Mudhumitta Balaji:</strong> Clinical Psychologist</td>
<td></td>
</tr>
<tr>
<td><strong>Dr. Maryam Shahmanesh:</strong> Medical Epidemiologist</td>
<td>3. Not approved (can be resubmitted but will need second review)</td>
</tr>
<tr>
<td><strong>Dr. Neerja Chowdhary:</strong> Psychiatrist</td>
<td></td>
</tr>
<tr>
<td><strong>Raj Vaidya:</strong> Pharmacist</td>
<td></td>
</tr>
<tr>
<td><strong>Rajal Shinkre</strong> Principal, Goa Home Science College</td>
<td>4. Not approved</td>
</tr>
<tr>
<td><strong>Dr. Sheela Gupte</strong> Medical Practitioner</td>
<td></td>
</tr>
<tr>
<td><strong>Mr. Vishram Gupte</strong> Lawyer</td>
<td></td>
</tr>
<tr>
<td><strong>Prof. Vikram Patel</strong> Psychiatrist</td>
<td></td>
</tr>
</tbody>
</table>

The researcher is hereby informed that the Sangath Institutional review board will require the following:

1. A progress report to be submitted to the board annually
2. Upon completion of the study a final study report to be submitted
3. Any adverse event that is serious and unexpected it is to be reported promptly to the board
4. One board member would be conducting a site visit and any adverse conditions reported by the member regarding the ethical considerations of the project would subject to a fresh review of the project.

**Date:** 19\textsuperscript{th} May 2010

**SANGATH**

A SOCIETY FOR CHILD DEVELOPMENT AND FAMILY GUIDANCE
Reg. No. 138/GOA/886
841/1, Behind Electricity Dept., Alt Porvorim, 2414916

Dr. Amit Dias
Chairperson
Appendix 3 - Oral history (chapter 5) consent process and data collection tool

3a. Information sheet for informed consent – oral histories

The roles of non-specialist health workers in mental health care in low- and-middle income countries

Principal investigator
Dr Nadja van Ginneken, Nutrition and Public Health Intervention Research Unit, London School of Hygiene and Tropical Medicine, Keppel Street, WC1R 7HT.
Phone: +44 (0)7986107976, or +91 9902119005 or +91 (0)8041472653; Email: nadja.vanginneken@lshtm.ac.uk

Co-investigators
Professor Vikram Patel, Professor of International Mental Health, School of Hygiene and Tropical Medicine, Keppel Street, WC1R 7HT.
Email: vikram.patel@lshtm.ac.uk

Professor Virginia Berridge, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, Keppel St, London, WC1E 7HT, UK.
Email: Virginia.berridge@lshtm.ac.uk

Why is the study being done?
I, Nadja van Ginneken, am a PhD student from the London School of Hygiene and Tropical Medicine in the UK and would like to interview you with regards to community and primary health care provision of mental health in India.

Mental illness is a significant burden in developing countries. The scarcity of skilled mental health staff (psychiatrists, psychiatric nurses/social workers) and inequities in their distribution has led to many people not receiving the treatment they need. Shifting tasks to non-specialist health workers (NSHWs) (professionals - primary care doctors/nurses - and non-professionals - community health workers) can improve coverage of mental health care, as evidenced by some preliminary research.

India has pioneered community mental health services since the 1970s but so far has had limited success. The past is essential to informing the present. Understanding previous and current achievements, failures and roles of NSHWs within mental health care will inform policy makers on how to effectively implement and expand community mental health services in India and other low-and-middle income countries (LMICs). The aim of this project is to explore the history of NSHWs’ roles in mental health care in India. Historical analysis of this period will help to gain insight into the reasons and challenges for current day mental health programmes. It also aims to describe NSHWs current roles. The final workshop with key international and Indian stakeholders will examine the acceptability and feasibility of non-specialists’ roles to inform the development of policies in LMICs.

What will the interview involve?
We would like to ask your permission to be interviewed, however you are under no obligation to participate. An outline of the types of questions you’ll be asked is outlined below:

1/ what position you held and what your roles were;
2/ what your views are on the development of mental health services in India,
3/ how you got involved, what your motivations were,
4/ how you feel your efforts fitted in with the prevailing national mental health and community health plans and socio-political context,
5/ what are the opportunities and challenges you saw within your field of work,
6/ what opportunity and challenges you see for the future.

These interviews will be tape recorded for the purpose of analysis, and will feed into my doctoral thesis for the London School of Hygiene and Tropical Medicine (LSHTM), and into potential publications and wider dissemination. My final thesis will be made available to all participants.

**Your involvement.**
I hope that you will agree to be one of the ‘key informants’ for the research. The interview can be as long or as short as you like and you are free to say as little or as much as you like within what you feel comfortable saying. It will be conducted by Nadja van Ginneken, a PhD student at the LSHTM with a background as a general practitioner, and/or by an Indian co-researcher/interpreter if you would like to conduct the interview in Kannada (or other local language).

No quotes or other results resulting from your participation in this study will be included in any reports, even anonymously without your agreement. Please indicate on the consent form your wishes.

If you agree to take part in a the witness seminar (focus group interview), the researcher will request that focus group members respect each others’ confidentiality by not speaking to others about matters raised in the group.

**Storage of data**
The interview data would be kept in a locked filing cabinet and, material held on a computer would be password protected, stored in our office at the London School of Hygiene and Tropical Medicine.

We would like to ask your permission to archive the oral history interview transcripts and/or audio-recordings at a later date after our study. The reason for archiving material is for that data to be available in future to other researchers or members of the public that wish to explore similar issues, and in which the data would be valuable. Interview data will not be archived without your agreement.

**Ethical approval.**
This study has been approved by the London School of Hygiene and Tropical Medicine, and by the IRB of Sangath, Goa, India.
3b. Consent form – oral histories

The roles of non-specialist health workers in mental health care in low- and-middle income countries

Principal investigator
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Email: Virginia.berridge@lshtm.ac.uk

The purpose of this form is to allow the use of your interview for research purposes. Please fill in the form according to your wishes.

I have been invited to take part in a study on the roles of non-specialist health workers in mental health care in low-and-middle income countries. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without consequence.

I agree that the researcher is allowed to tape the interview. [ ]
I agree to my name being used with quotes from the interview, in reports about it [ ]
I wish to be consulted before publication of named quotes. [ ]
I wish quotes to be used anonymously in reports about it [ ]
I do not agree to quotes or other results arising from my participation in the study being included even anonymously in any reports about the study [ ]

Archiving:
I agree to a transcript of my interview being archived at a future date [ ]
I agree to an audio-recording of my interview being archived at a future date [ ]
I do not wish the archived transcript to be labelled with my name [ ]

Name of participant: ____________________________________________
Signed: ________________________________ Date: __________________
____________________________________________________________________________

I, THE UNDERSIGNED, HAVE DEFINED AND EXPLAINED TO THE VOLUNTEER IN A LANGUAGE THAT SHE/HE UNDERSTANDS THE PROCEDURES TO BE FOLLOWED AND THE OBLIGATIONS OF THE INTERVIEWER.

Name of interviewer(s): (1)_________________  (2)___________________________
Signed: ________________________________  _____________________________
Date: __________________    ______________
3c. In depth interview guide – oral histories

1. what position they held and what their roles were
2. how they got involved, what their motivations were
3. how did they feel their efforts fitted in with the prevailing national mental health and community health plans and socio-political context
4. what are the opportunities and challenges they saw (or see) within their own projects
5. what their views are on the development of mental health services in India
6. what opportunity and challenges do they see for the future
Appendix 4 - Case studies’ (chapter 6) consent process and data collection tools

4a. Information sheet for informed consent (in-depth case studies)

The roles of non-specialist health workers in mental health care in low-and-middle income countries

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Email: vikram.patel@lshtm.ac.uk

Professor Virginia Berridge, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, Keppel St, London, WC1E 7HT, UK.
Email: Virginia.berridge@lshtm.ac.uk

Why is the study being done?
I, Nadja van Ginneken, am a PhD student from the London School of Hygiene and Tropical Medicine in the UK and would like to interview you with regards to community and primary health care provision of mental health in India.

Mental illness is a significant burden in developing countries. The scarcity of skilled mental health staff (psychiatrists, psychiatric nurses/social workers) and inequities in their distribution has led to many people not receiving the treatment they need. Shifting tasks to non-specialist health workers (NSHWs) (professionals - primary care doctors/nurses - and non-professionals - community health workers) can improve coverage of mental health care, as evidenced by some preliminary research.

India has pioneered community mental health services since the 1970s but so far has had limited success. The past is essential to informing the present. Understanding previous and current achievements, failures and roles of NSHWs within mental health care will inform policy makers on how to effectively implement and expand community mental health services in India and other low-and-middle income countries (LMICs). The aim of this project is to explore the history of NSHWs’ roles in mental health care in India. It also aims to describe NSHWs current roles. The final workshop with key international and Indian stakeholders will examine the acceptability and feasibility of non-specialists’ roles to inform the development of policies in LMICs.

What will the case study involve?
We would like to ask your permission to be interviewed and/or observed, however you are under no obligation to participate. An outline of the types of questions you’ll be asked, as well as an idea of what the observations entail are outlined below:

a. observations will look at:
1/ present status (who are the stakeholders, organisational structure, population served);
2/ what is the nature of current mental health services (including quality of service provided);
3/ how this relates to existing goals, protocols and guidelines;
4/ how mental health and other tasks are managed in your setting;
5/ How wide the remit of your work and your organisation’s is within health care delivery (such as advocacy, political involvement, involvement in livelihood programs or social benefits);
6/ medication supply and usage;
7/ characteristics of human resources and what they do;
8/ adequacy of physical infrastructure and transportation;

b. The issues to be explored within the interviews of health workers:
1/ how was the programme founded? (including major achievements and milestones since its founding; what the current roles of NSHWs and specialists within mental health are;)
2/ how your roles fit into other roles/expectations of you within the health system;
3/ what is your support like (supervision, ongoing training, incentivisation);
4/ what vision do you see for future mental health care delivery in their programme and outside;

These interviews will be tape recorded for the purpose of analysis, and will feed into my doctoral thesis for the London School of Hygiene and Tropical Medicine (LSHTM), and into potential publications and wider dissemination. My final thesis will be made available to all participants.

Your involvement.
I hope that you will agree to be one of the ‘key informants’ for the research. The observations will take place over a month, with repeated visits and will be as unobtrusive as possible. Interviews can be as long or as short as you like and you are free to say as little or as much as you feel comfortable saying. It will be conducted by Nadja van Ginneken, a PhD student at the LSHTM with a background as a general practitioner, and/or by an Indian co-researcher/interpreter if you would like to conduct the interview in Kannada (or other local language).

No quotes or other results resulting from your participation in this study will be included in any reports, even anonymously without your agreement. Please indicate on the consent form your wishes.

If you require anonymity, this means we will not quote your name. However we will need to identify you by your professional status (e.g. nurse, volunteer, doctor etc) when writing up about the project, but not by any other characteristics.

Storage of data
The interview data would be kept in a locked filing cabinet and, material held on a computer would be password protected, stored in our office at the London School of Hygiene and Tropical Medicine.

Ethical approval
This study has been approved by the Ethical Boards of the London School of Hygiene and Tropical Medicine and by Sangath, Goa, India. It also has approval from the Health Secretary and the Director of Family and Child Welfare Services for Karnataka in Bangalore.

Nadja van Ginneken Thesis Page 274
4b. Information sheet for informed consent (semi-structured interviews shorter case studies)

The roles of non-specialist health workers in mental health care in low-and-middle income countries

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Professor Virginia Berridge, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, Keppel St, London, WC1E 7HT, UK.
Email: Virginia.berridge@lshtm.ac.uk

Why is the study being done?
I, Nadja van Ginneken, am a PhD student from the London School of Hygiene and Tropical Medicine in the UK and would like to interview you with regards to community and primary health care provision of mental health in India.

Mental illness is a significant burden in developing countries. The scarcity of skilled mental health staff (psychiatrists, psychiatric nurses/social workers) and inequities in their distribution has led to many people not receiving the treatment they need. Shifting tasks to non-specialist health workers (NSHWs) (professionals - primary care doctors/nurses - and non-professionals - community health workers) can improve coverage of mental health care, as evidenced by some preliminary research.

India has pioneered community mental health services since the 1970s but so far has had limited success. The past is essential to informing the present. Understanding previous and current achievements, failures and roles of NSHWs within mental health care will inform policy makers on how to effectively implement and expand community mental health services in India and other low-and-middle income countries (LMICs). The aim of this project is to explore the history of NSHWs’ roles in mental health care in India. It also aims to describe NSHWs current roles. The final workshop with key international and Indian stakeholders will examine the acceptability and feasibility of non-specialists’ roles to inform the development of policies in LMICs.

What will the interview involve?
We would like to ask your permission to be interviewed, however you are under no obligation to participate. An outline of the types of questions you’ll be asked is outlined below:

- How you came to work in this field of mental health
- how was/were the programme(s) you worked for founded?; major achievements and milestones since its founding;
- Questions about your views on the use of non-specialist health workers within the setting you have worked in.(their roles, their support)
- what vision do you see for future mental health care delivery in their programme and outside;
These interviews will be audio recorded for the purpose of analysis, and will feed into my doctoral thesis for the London School of Hygiene and Tropical Medicine (LSHTM), and into potential publications and wider dissemination. My final thesis will be made available to all participants.

**Your involvement.**
I hope that you will agree to be one of the ‘key informants’ for the research. The interview can be as long or as short as you like and you are free to say as little or as much as you like within what you feel comfortable saying. It will be conducted by Nadja van Ginneken, a PhD student at the LSHTM with a background as a general practitioner, and/or by an Indian co-researcher/interpreter if you would like to conduct the interview in Kannada (or other local language).

No quotes or other results resulting from your participation in this study will be included in any reports, even anonymously without your agreement. Please indicate on the consent form your wishes.

**Storage of data**
The interview data would be kept in a locked filing cabinet and, material held on a computer would be password protected, stored in our office at the London School of Hygiene and Tropical Medicine.

**Ethical approval.**
This study has been approved by the London School of Hygiene and Tropical Medicine, by Sangath, Goa, India, and has state approval from the director of Family and Child Welfare Services for Karnataka in Bangalore.
4c. Consent form (in-depth case studies)

The roles of non-specialist health workers in mental health care in low-and-middle income countries

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Co-investigators
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Email: vikram.patel@lshtm.ac.uk

Professor Virginia Berridge, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, Keppel St, London, WC1E 7HT, UK.
Email: Virginia.berridge@lshtm.ac.uk

The purpose of this form is to allow the use of your interview for research purposes. Please fill in the form according to your wishes.

I have been invited to take part in a study on the roles of non-specialist health workers in mental health care in low-and-middle income countries. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without consequence.

I agree that the researcher is allowed to tape the interview. [ ]
I agree to my name being used with quotes from the interview, in reports about it [ ]
I wish to be consulted before publication of named quotes. [ ]
I wish quotes to be used anonymously in reports about it [ ]
I do not agree to quotes or other results arising from my participation in the study being included even anonymously in any reports about the study [ ]

Name of participant: __________________________________________
Signed: ________________________________ Date: ________________

I, THE UNDERSIGNED, HAVE DEFINED AND EXPLAINED TO THE VOLUNTEER IN A LANGUAGE THAT SHE/HE UNDERSTANDS THE PROCEDURES TO BE FOLLOWED AND THE OBLIGATIONS OF THE INTERVIEWER.

Name of interviewer(s): (1)___________________  (2)_____________________
Signed:   _________________________________  _______________________
Date: __________________     ______________
4d. Consent form (semi-structured interviews shorter case studies)

The roles of non-specialist health workers in mental health care in low- and-middle income countries

Principal investigator
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Co-investigators
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Professor Virginia Berridge, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, Keppel St, London, WC1E 7HT, UK.
Email: Virginia.berridge@lshtm.ac.uk

The purpose of this form is to allow the use of your interview for research purposes. Please fill in the form according to your wishes.

I have been invited to take part in a study on the roles of non-specialist health workers in mental health care in low-and-middle income countries. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without consequence.

I agree that the researcher is allowed to tape the interview. [ ]
I agree to my name being used with quotes from the interview, in reports about it [ ]
I wish to be consulted before publication of named quotes. [ ]
I wish quotes to be used anonymously in reports about it [ ]
I do not agree to quotes or other results arising from my participation in the study being included even anonymously in any reports about the study [ ]

Archiving:
I agree to a transcript of my interview being archived at a future date [ ]
I agree to an audio-recording of my interview being archived at a future date [ ]
I do not wish the archived transcript to be labelled with my name [ ]

Name of participant: ____________________________________
Signed: ________________________________ Date: __________________

Interviewer’s statement
I, THE UNDERSIGNED, HAVE DEFINED AND EXPLAINED TO THE VOLUNTEER IN A LANGUAGE THAT SHE/HE UNDERSTANDS THE PROCEDURES TO BE FOLLOWED AND THE OBLIGATIONS OF THE INTERVIEWER.

Name of interviewer(s): (1)____________________  (2)____________________
Signed: ___________________________________  ______________________
Date: __________________     ______________
4e. Hindi information sheet and consent form (semi-structured interviews, shorter case studies)

सूचित सहमति (इन्फोर्मेंड कंसेंट- Informed consent) के लिए जानकारी पत्र (इन्फोर्मेशन शीट- information sheet) - इन-डेथ इंटरव्यू (Indepth- interview)

कम और मध्यम इंडिया में मेनेटल हेल्ट केर में प्राथमिक स्वास्थ्य कार्यक्तियों [नॉन स्पेस्टिलस्ट कार्यक्तियों(NSHW)] की भूमिका

नादिया वैन गिन्नेक, मिदिशान एवं पत्रिका हेल्थ इंटरव्यूशन रिसर्च यूनिट, लंदन स्कूल ऑफ हेल्थिज अंड ट्रीफिकल मेडिसिन, केपेल स्ट्रीट, WC1R 7HT. फोन: 44 (0) 7986107976, या +91 9663534685 5, फैक्स: 44 (0)207 958 8111.ईमेल: nadja.vanginmekke@lshtm.ac.uk

को-इंटरव्यूरेटर

विवाद पत्तल, इंटरव्यूशन जोड़ तथा, लंदन स्कूल ऑफ हेल्थिज अंड ट्रीफिकल मेडिसिन, केपेल स्ट्रीट, WC1R 7HT.

ईमेल: vlakrapatel@lshtm.ac.uk

दिव्याधिकरण स्टीफ्ल, फोर इंटरव्यू इंटरव्यू तथा, पत्रिका हेल्थल, लंदन स्कूल ऑफ हेल्थिज अंड ट्रीफिकल मेडिसिन, केपेल स्ट्रीट, WC1R 7HT, ब्रिटेन.

ईमेल: virginia.berridge@lshtm.ac.uk

क्यों अथायत किया जा रहा है

में नादिया वैन गिन्नेक, ब्रिटेन में लंदन स्कूल ऑफ हेल्थिज अंड ट्रीफिकल मेडिसिन से एक पीएच.डी के छात्र हूँ और समुदाय (कम्यूनिटी) और भारत में प्राथमिक स्वास्थ्य मानसिक स्वास्थ्य (मेनेटल हेल्त) की देखभाल के प्रावधान (प्रॉटोकॉल) के सार्वजनिक के साथ इंटरव्यू करना चाहती हूँ।

मानसिक बीमारी देवलपिंग क्षेत्र में एक महत्वपूर्ण बोझ है: स्किलल्ड मानसिक स्वास्थ्य खात [मनोविकारों, मनोरोगी नर्सी / सामाजिक कार्यकर्ता (सेक्सियारिस्ट, सेक्सियारिक नर्सी / साइंस्ट सर्कस) और उनके विरोध में कमी के कारण कई लोगों को जो ट्रीफिकल की भूमिका है वह प्राप्त नहीं हो रहा है। यह कार्य करने के लिए में प्राथमिक स्वास्थ्य कार्यकर्ता / सामाजिक कार्यकर्ता को साँप गाया है | जिसे प्रिलिमिनरी इंटरव्यू के साथ के दौरा देखा गया है कि मानसिक स्वास्थ्य की देखभाल के कार्य के में सँगत हो स्वाता है।

भारत से 1970 के दशक के बाद से कम्यूनिटी मेनेटल हेल्त सर्विस ले जाया है लेकिन अभी तक सीमित सफलता मिली है। अतिरिक्त विस्मय सृजित करने के लिए आवश्यक है। निर्देश और अन्य कार्यकारिणी ले जाने वाले वांछित (LMICs) में कम्यूनिटी मेनेटल हेल्त सर्विस के द्वारा कर सकते हैं।

इस परियोजना का उद्देश्य बिहार में मेनेटल हेल्त केर के भीतर NSHWs की भूमिका कि इतिहास को पता करने, यह भी उद्देश्य है कि प्राथमिक स्वास्थ्य कार्यकर्ता कार्यकर्ताओं / सामाजिक कार्यकर्ता हाजी की भूमिका को प्रणय करना है।

अंतिम कार्यालय (workshop) के साथ प्रमुख अंतरराष्ट्रीय और भारतीय टेक्नोलॉजी के साथ की भूमिका के स्वीकारक और संभावना के जानकारी ले लाये LMICs में मायिया के विकास को सृजित करने।

इंटरव्यू में व्यक्तित्व होगा

हम आपकी इंटरव्यू करने के लिए अनुमश्न पूर्व आते हैं, लेकिन आप भाग लेने के दावत के अधीन नहीं हैं। आप से जो सवाल पूछ जाएगा उसी प्रकार की एक स्पष्ट नीचे उल्लिखित (outlined) है

- आप कैसे मेनेटल हेल्त के इस क्षेत्र में काम पे आए?
- कैसे आप काम किया गया कार्यक्रम का स्वाप्न भिदा? ; प्रमुख अचीवमेंट्स साथ नयी स्वाप्न के बाद से मेनेटल्सन।
- आप काम किया गया सेटिंग के ऑफर लॉन्स्टिल्स कार्यकर्ताओं (NSHW) पर अपने दिखाई के बाद में मृत (उनकी भूमिकाओं, उनके सपोटें)
- क्या इंटरव्यू आप भविष्य के अनुमान कार्य कार्यक्रम और वाहर में मेनेटल हेल्त केर देलिवरी के लिए देखते हैं?
- इंटरव्यू को ओप्टिशन विवेकने से प्रोत्साहन के लिए दर्ज हो सकता है, और लंदन स्कूल ऑफ हेल्थिज अंड ट्रीफिकल मेडिसिन, के लिए मेरे डिलीवरी शीमिस सीड होगे और समानित पूलिकेस्ट और व्यापक प्रसार में होगे। मेरा अंतिम शीमिस सब पूलिकेम्स्ट्स के लिए उल्लघ कराया जाएगा।

आपकी इंटरव्यूमैंट
रिसर्च के लिये की इंफोर्मेंट बने के लिए मुझे आशा है कि आप राजी होंगे. इंटरनेट अप जैसे चाहिये वैसे लंबे या कम बी हो सकता है और आप स्वतंत्र हैं कम या अप जैसे चाहिये वैसे बोल सकते हैं. नादिया वैन गीनेकेन, एक सामाजिक चिकित्सक, LSHTM में एक पीएचूडी के छात्र है, और / या भारतीय co-researcher/interpreter द्वारा आयोजित किया जाएगा अगर आप कन्नड में स... इंटरनेट (या अन्य स्थानीय भाषा) आचरण करते हैं.

आपकी सहमति के बिना, इस अध्ययन में आपकी पाठिसपेशन से उत्पन्न कोई उद्धरण या अन्य परिणाम किसी भी रिपोर्ट में शामिल नहीं किया जाएगा. आपकी सहमति के बिना गुमनाम भी नहीं. क्योंकि अपनी इच्छाओं को केंद्रित फार्म पर बतलाना.

हेटा स्टोरेज

इंटरनेट हेटा एक बंद फाइलिंग कैबिनेट में रखा जाएगा और, एक कंप्यूटर पर आयोजित सामग्री पासवर्ड से सुरक्षित होगा. लंदन स्कूल ऑफ इंजिनियरिंग ट्रांसामिक मेडिसिन में हमारे कार्यालय में संगीत करा होगा.

नैतिक अनुमोदन (एथिकल अप्प्रॉवल)

इस अध्ययन को लंदन स्कूल ऑफ हेडिजन एंड ट्रांसामिक मेडिसिन के द्वारा अप्प्रॉवल किया गया है, Sangath, गोवा, भारत, और बंगाल और डिरेक्टर ऑफ हेमिली एंड चाउड़ेल वेल्फेयर सेव्स के मालिक हैं.
CONSENT FORM

sarafiket af konsent - In-depth interview (Indepth- interview)

Kam o megym ipek dey in manem helg kaur i em praphik swastik karyakrti / samajik karyakrti kee bhoomika

Nadiya van Ginniken, Muhitshon Ang Pablik Helthy Indraveshan Risarh Yuniet, Lunden Skool Aaf Hairejion Ang Tropikal Medisik, Kapel Stript, WC1R 7HT. Fon: 44 (0) 7986107976, Ya +91 9663534685, Faks: 44 (0)207 958 8111, Emil: Nadja. vanginneken @ lshtm. ac.uk

Ko-ukranyesthe

Vikram Patel, Indraveshon Maitd Helthy kee Prifesar, Lunden Skool Aaf Hairejion Ang Tropikal Medisik, Kapel Stript, WC1R 7HT.

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Vjaleuyi Berridge, Sone For Hirseri In Pablik Helthy, Lunden Skool Aaf Hairejion Ang Tropikal Medisik, Kapel Stript, WC1R 7HT, Wibetin.

Emil: virginia. berridge @ lshtm. ac.uk

his form kee udheshy risarh pape kee lihe aapek indravhyo uapoyon karen kee lihe anumatt kare kee lihe.

Kupya auprne iiccha kee anuwar has form ko bharyay.

Mekam o megym Amit aare deey jee manmahik swastik deykhbal kee krestee m eee vishesh swastik karyakarti kee bhoomika pe aadhyey m bhang karen kee lihe anamrit kiyi gaya hay. Mee purvaabhi jankari pahaay, Hay yah mere lihe padhaya hay. Mee eykay bari me swaal o mere aupni santushh kee lihe uttar deya gaya hay kahaya hay kooy prshn pune bhe kee avsar pahaay. Mee svetchay se ees aadhyay m ek bhoogidray bhannya kee lihe sahmatt o sahmayaay hay ki mee parinam kee bhina kisi bhi samay swashakar se vapora lene kee adhikar hay.

Mee manat/a manati hoon ki rispher ko indravhyo tep karen kee anumatt dehay.

Mee manat/a manati hoon ki eyskay bari me rispher me indravhyo se upvan huaa udparan (quotes) kee saath name istelemal karen kee lihe sahmatt hay.

Mee name udparan (named quotes) kee puchlekehon se phale konsalt kiyaa jana chaata hoon.

Mee eykay bari me rispher me udparan (quotes) kee lihe istelemal kiyaa gumanay(anonymously) chaata hay.

Mee udparan ya aapn aadhyey kee bari me kooy rispher me bhi gumanay shamil aadhyey m mee bhoogidray(participation) se upvan hanea bhe pareenam kee lihe sahmatt nahii.

Sahay karen:

Mee ek bhavyay kee taarih mee sahbhiit kiyaa ja rahee mere indravhyo ke ek pratilhik(archived) kee lihe sahmatt hay.

Mee mere indravhyo kee module y riskarding(advisors rekiarding) ek bhavyay kee taarih mee sahbhiit karen kee lihe sahmatt hay.

Mee sahbhiit pratilhik(archived) mere name kee saath leban kee iiccha nahii hay.

Patrisipet kee name: ________________ Sahi: ________________ Dinak: ________________

Indraveshana strepmet

Mee, Aapnostaaarhi, Parihahit o ek aatho me swaryavek samagna hay ki yaha / yeha ka palan kiyaa jaana prakriyaaay o swashakarkartas o dathiyas ko sahmayaay hay.

Indraveshana(swastakar) kee name: 1)__________________ 2)__________________

Sahay: ________________ Dinak: ________________

Nadja van Ginneken Thesis Page 281
4f. Kannada information sheets and consent forms  
(in-depth and shorter case studies)

Nadja van Ginneken Thesis Page 282
A. What are the implications of various events on the local community and society?

1. During the event (e.g., a natural disaster, economic crisis, political upheaval, etc.), the community experienced significant changes, impacting their daily lives and social structures.

2. The government's response to the event was crucial, as it affected the community's resilience and recovery process.

3. The local government and community leaders worked together to mitigate the event's impact, utilizing various resources and strategies.

4. The challenges and opportunities presented by the event led to shifts in community values and behaviors.

5. The event's aftermath required long-term planning and support to ensure sustainable recovery.

B. How does the event affect the local economy?

1. The economic impact of the event was severe, affecting various sectors, including agriculture, tourism, and manufacturing.

2. Small and medium-sized businesses were particularly vulnerable, facing closure or reduced operations.

3. The government implemented economic policies to support affected businesses and households, including financial aid and job creation programs.

4. The event's impact on the local economy required a coordinated effort across different levels of government and the private sector.
ಶ್ರೇಮ್ಧಿಗಳಂತೆ, ಸಾಮಾನ್ಯವಾಗಿ ವರ್ಗೆಯದೊಡನ್ನು ಕನ್ನಡದಲ್ಲಿ ಸಂಪೂರ್ಣವಾಗಿ ದೊರೆದುಕೊಂಡಿರುತ್ತದೆ.

ಇದು ಶ್ರೇಮ್ಧಿಗಳಾದ ಸಂಸ್ಥಾಪನೆಗಳಿಗೆ ದೊರೆದುಕೊಂಡಿರುತ್ತದೆ. ಪ್ರತಿಯೊಂದು ಸಂಸ್ಥಾಪನೆಯಲ್ಲಿಯರು ಸಂಸ್ಥಾಪಕರು ವಾಸಿಯಾಗಿ ಇದು ಸಂಪೂರ್ಣವಾಗಿ ದೊರೆಗುತ್ತದೆ. ಸಂಸ್ಥಾಪಕರು ಸಾಮಾನ್ಯವಾಗಿ ಶ್ರೇಮ್ಧಿಗಳಾದ ಸಂಸ್ಥಾಪನೆಗಳ ಎಲ್ಲಾ ಕ್ರಮದಲ್ಲಿ ಸಂಪೂರ್ಣವಾಗಿ ದೊರೆದುಕೊಂಡಿರುತ್ತವೆ.

ಬಿದ್ದ ಶಿಕ್ಷಣ

ಶ್ರೇಮ್ಧಿಗಳಂತೆ, ಸಾಮಾನ್ಯವಾಗಿ ವರ್ಗೆಯದೊಡನ್ನು ಕನ್ನಡದಲ್ಲಿ ಸಂಪೂರ್ಣವಾಗಿ ದೊರೆದುಕೊಂಡಿರುತ್ತದೆ. ಪ್ರತಿಯೊಂದು ಸಂಸ್ಥಾಪನೆಯಲ್ಲಿಯರು ಸಂಸ್ಥಾಪಕರು ವಾಸಿಯಾಗಿ ಇದು ಸಂಪೂರ್ಣವಾಗಿ ದೊರೆಗುತ್ತದೆ. ಸಂಸ್ಥಾಪಕರು ಸಾಮಾನ್ಯವಾಗಿ ಶ್ರೇಮ್ಧಿಗಳಾದ ಸಂಸ್ಥಾಪನೆಗಳಿಗೆ ದೊರೆದುಕೊಂಡಿರುತ್ತವೆ.
Nadja van Ginneken Thesis Page 285
ನಾದಿಯ ಗೀತಿಯ ಅನುಲಿಪ್ಪಾಣ:

ನೆಂದರೆ: ..........................................................................................................................

ನಿಧಾನ

ನಾದಿಯ ಗೀತಿ

ಶಾಶ್ವತ ಮನೋರಂಭದಲ್ಲಿ, ನಾದಿಯ ಗೀತಿಯ ಕ್ರಮಾನುವರ್ಧನ ಮಹತ್ವದಲ್ಲಿ ನೀರು ದೇಗುಲ ರೂಪ/ಸ್ವಾತಂತ್ರ್ಯ ಮಹತ್ವದಲ್ಲಿ ನಾದಿಯ ಗೀತಿಯ ಮುಂದೆ ಸಾಧನಾತ್ಮಕವಾಗಿ ಸೂಚಿಸುತ್ತದೆ. ನಾದಿಯ ಗೀತಿ, ಮಹತ್ವದಲ್ಲಿ

ನಾದಿಯ ಗೀತಿ(೧)ದ ಅಂಶ: (೧)..................................................................

ನೆಂದರೆ: ..........................................................................................................................

ನಿಧಾನ:

ನಾದಿಯ ಗೀತಿ(೨)ದ ಅಂಶ: (೨)..................................................................

ನೆಂದರೆ: ..........................................................................................................................

ನಿಧಾನ:

Nadja van Ginneken Thesis Page 286
ನ್ಯಾಜಾ ವಾನ್ ಗಿನ್ನೆಕನ್ ಹಿಳಾಡೆ:..........................................................................................................................  

ನ್ಯಾಜಾ ವಾನ್ ಗಿನ್ನೆಕನ್ ಹಿಳಾಡೆ: ...........................................................................................................

ಎನ್ವಿಡ್ಯಾಯಿಕ್ಸ್  

ಕೇವಲ ಮಹಾವಿದ್ಯಾಲಯ ರಾಜ್ಯ, ಎಂಬ್ರೂಸ್ ಕೆಮ್ಬ್ರಿಯಾ ರಾಜ್ಯ/ಸ್ಟೇಟ್ ವಿದ್ಯಾರ್ಥಿಗಳು ಪ್ರತಿ ಸಾಲು ಸರೀಸೃಪವಾಗಿ ಮುಂದುವರಿಯುವುದಾಗಿದ್ದು ಲೆಸ್ಸರ್ ಕೆಮ್ರಿಯಾ ಮುಂದುವರಿಯುವ ಪ್ರತಿ ಸಾಲು ಸರೀಸೃಪವಾಗಿ ಎಂಬ್ರೂಸ್ ಕೆಮ್ರಿಯಾ ಮುಂದುವರಿಯುವುದಾಗಿದ್ದು ಎಂಬ್ರೂಸ್ ಕೆಮ್ರಿಯಾ ಮುಂದುವರಿಯುವುದಾಗಿದ್ದು, ಎಂಬ್ರೂಸ್ ಕೆಮ್ರಿಯಾ  

ಎಂಬ್ರೂಸ್ ಕೆಮ್ರಿಯಾ(೧) ಎಂಬ್ರೂಸ್ ಕೆಮ್ರಿಯಾ: (೧)..........................................................................................  

ನ್ಯಾಜಾ ವಾನ್ ಗಿನ್ನೆಕನ್ ಹಿಳಾಡೆ: ...........................................................................................................

ಎಂಬ್ರೂಸ್ ಕೆಮ್ರಿಯಾ(೨) ಎಂಬ್ರೂಸ್ ಕೆಮ್ರಿಯಾ: (೨)..........................................................................................  

ನ್ಯಾಜಾ ವಾನ್ ಗಿನ್ನೆಕನ್ ಹಿಳಾಡೆ: ...........................................................................................................
Nadja van Ginneken Thesis Page 289
L stated, it is clear that although it is not possible to quantify the
impact of these factors, they do contribute to the overall mental
health of individuals living in these areas. For example, the lack of
opportunities for social interaction and the lack of access to
educational resources can lead to feelings of isolation and
depression. Additionally, the high levels of poverty and
unemployment in these areas can contribute to a sense of
powerlessness and hopelessness, which can further exacerbate
mental health issues.

The implications of these findings are significant and
highlight the need for targeted interventions to address the
specific needs of these populations. It is clear that addressing the
environmental factors that contribute to mental health issues is
vital, and interventions should focus on creating opportunities
for social interaction and access to educational resources. It is
also important to consider the broader systemic issues that
contribute to these problems, such as poverty and
unemployment, and to address these root causes in order to
improve mental health outcomes.
Appendix 4g. Data collection tools (in-depth case studies)

1. Questions for interviews/ in conversations

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Founders, managers, NGO headquarters, long term staff</td>
<td>A) Domain 1 HISTORY OF THE PROGRAM</td>
</tr>
<tr>
<td></td>
<td>1) The program is very interesting and unique so can you present the flashback of this program like when, was the program initiated, why was it developed, for whom and how the program evolved over the period of time. By whom the program was developed?</td>
</tr>
<tr>
<td></td>
<td>2) Your understandings of the mental health care program since you are in this program and working for a cause.</td>
</tr>
<tr>
<td>Founders managers, all staff</td>
<td>B) Domain 2: KEY EVENTS</td>
</tr>
<tr>
<td></td>
<td>3) What have been the key milestones in your programme?</td>
</tr>
<tr>
<td></td>
<td>4) The problems, the success you have encountered in this situation in delivering mental health. If problems arose what you think could be done to solve these problems. It might be the patients’ myth towards mental health or fear, concerns and expectation.</td>
</tr>
<tr>
<td></td>
<td>5) Your experiences within this program (obstacles/ difficulties/ sociocultural/ language)</td>
</tr>
<tr>
<td></td>
<td>6) What are the major achievements of the program since it began?</td>
</tr>
<tr>
<td>NSHWs, NCS, specialists</td>
<td>C) Domain 3: ENVIRONMENT IN WHICH THE PROGRAM FUNCTIONS</td>
</tr>
<tr>
<td></td>
<td>7) What categories of people come to you? Do wealthy people come to you or do they prefer going to the city?</td>
</tr>
<tr>
<td></td>
<td>8) Do people get differential treatment depending on their socioeconomic background?</td>
</tr>
<tr>
<td></td>
<td>9) Which community is the majority here? What is their attitude towards the minorities?</td>
</tr>
<tr>
<td></td>
<td>10) What are the people’s outlooks of coming to you as you belong to a different caste/ religion? Any examples where the patients had an issue because of that reason?</td>
</tr>
<tr>
<td></td>
<td>11) What is the major occupation of the people here?</td>
</tr>
<tr>
<td>NSHWs Specialists Managers PO (progr.off) Other health providers in locality</td>
<td>D) Domain 4: HEALTH SYSTEM IN WHICH THE PROGRAM FUNCTIONS</td>
</tr>
<tr>
<td></td>
<td>12) What other health providers including MH service providers are there in the area/ at proximity?</td>
</tr>
<tr>
<td></td>
<td>13) If people don’t come to you for service then whom do they go to? Do you recommend the patients to go to them?</td>
</tr>
<tr>
<td></td>
<td>14) How does the NSHW program differ from other mental health provision in the area?</td>
</tr>
<tr>
<td></td>
<td>15) How does the mental health service function within the PHC system?</td>
</tr>
<tr>
<td></td>
<td>16) What links does it have to regional/national or international health systems?</td>
</tr>
</tbody>
</table>
specialists

| 17) | What links to the spiritual/religious/traditional sector? |
| 18) | Is it in competition with any other services (any of the above or other allopaths – private sector, independent pharmacies etc) |
| 19) | What kind of other health service is available in the area? How many centres are there? Does it have facilities for major operations? |

Founders/ coordinators/ NSHWs

| E) | Domain 5: PROGRAM CONCEPTUAL FRAMEWORK |
| 20) | What do feel is the main vision/ focus of this programme? |
| 21) | What is your evaluation procedure? Do the government or anyone in charge come to evaluate? How do they evaluate? What are the criteria for evaluating? |
| 22) | What indicators do you use for evaluation? (activity monitoring or also quality indicators?) |

Founders/ coordinators/ doctors

| F) | Domain 6: ENGAGEMENT WITH BROADER SYSTEMS |
| 23) | Has the programme been accepted or had any difficulties at political level? |
| 24) | Apart from with the health system, does the programme engage with any other systems (social justice, economics, welfare, education, transport etc) |
| 25) | Does the programme do any advocacy work at local, national and international levels? Does it have any direct contact with policy makers? |

Non-clinical staff (NCS) NSHW Specialists Coordinators

| G) | Domain 7: PROGRAM RESOURCES |
| Human |
| 26) | How many NSHWs (doctors / nurses/psychologist/social workers/ volunteers) and how many people supporting them (programme officer, psychiatric specialist)? |
| a) | In the clinic programme |
| b) | Other organisation in the area and proximity |
| 27) | How many and which non-clinical staff are included? (managerial, supporting staff) |
| 28) | Are there enough clinical staff to take care of the number of patients in that locality? Have you had any situation when there were too many patients and you felt the need of having more people in the team? When was that? |
| 29) | In which activities other than delivering mental health does the NSHW involve and eg- in community participation? |

Transportation

| 30) | Is the centre located in the center for all the people coming from nearby villages to visit? |
| 31) | What are the means of transportation? |
| 32) | Is there any bus/van facilities provided by the programme for the other villagers to come here? |

Funding

| 33) | What is the NSHW salary? Any other incentives? |
| 34) | What funding do you get for your programme? From whom? (diversity of funding) |
| 35) | Do you believe your support system and financial resources are |

Nadja van Ginneken Thesis Page 293
doctors
ALL and PO adequate?

H) Domain 8: PROGRAM MANAGEMENT

Organisational structure
36) Give the program organogram and who among them are in touch with the mental health patients or family and the major activities/roles. Specify who works at community level and who works in the clinic.

Delivery/ implementation of the program
37) How have the staff been selected? (transferred there, community selection, their own personal selection to work here)
38) What training have you had? Have you been on job training? How does this compare to other standard training methods.
39) Are you in your position able to utilise the knowledge and skills acquired during your training?
40) What is your view on your current mental health roles (is it easy or difficult, what is their workload like)
41) Are they able to combine/integrate their mental health roles satisfactorily into their other health roles? How is the ‘combination of having to do everything’. Do they use any shortcuts?
42) What do NSHWs perceive as being patients’ fears, concerns and expectations, and how do they address these?
43) What specialist, technical and managerial support is provided to NSHWs? What support for other cadres?
44) Your expectation from the team supervising you and the team below you.
45) How do managers/coordinators view that mental health and other tasks are managed (the distribution of tasks and the balance between administrative task and clinical care delivery)
46) Is there support from the broader system (government, district, national, international)
47) What is the relation between the staff/different cadres? Any tension between them?
48) Who is in charge here? What is the chain of command like? Who takes care of what?
49) What kinds of facilities are available if the people are from very low socio-economic background, or for equity of service provision (gender, cast, other vulnerable groups)

Finances
50) Who takes care of the finances? Have you ever had a situation where you have trouble with your programme finances? Eg. Stocking medicines
51) Who takes care of the centre? Who makes sure that all the resources, medicines are in stock? Who provides money for that?

Safety
52) What kind of security does the staff when they have community visits? Have the family members or any patient behaved violent? What were the measures taken?
53) What kind of mechanism for keeping the patient or carers safe? (e.g. keeping a carer safe from a violent patient, or keeping a stigmatised patient safe from their oppressive family)

Plans for improvement and/or scaling up?
| Coordinates | 54) Do you have any plans for the improvement of the system in the future?  
If yes, then what are they? How will they implement it?  
55) Who makes decisions about the programming priorities in the health facility  
56) Do you plan or have you tried to scale-up the programme? If so how?  
What were the facilitating and/or inhibiting factors?  
57) Do you think your programme is sustainable? Or could be reproduced in other areas? What factors are important for this to happen? |
| NSHW / Specialists (opinions) |
| NSHWs Specialists |
| I) Domain 9: PATHWAYS TO CARE & REFERRAL NETWORKS  
Patterns of help seeking /pathways to care/case finding  
58) How do the patients find you? Do they come on their own?  
59) What background of people comes to you for treatment/ consultation?  
What is their main occupation?  
60) Do you get referrals from anywhere(other PHC’s, other healers)?  
Community level Case finding and detection  
61) Do you go door to door and find people with problems/case finding?  
62) What kinds of facilities are available if the people are from very low socio-economic background?  
Referral networks  
63) Who do you refer the patients to if the problem is serious? When do you refer?  
64) What is the protocol for referring a patient? |
| NSHWs Specialists |
| J) Domain 10: CLIENT POPULATIONS  
65) What background of people comes to you for treatment/ consultation?  
What is their main occupation?  
66) To what extent the people utilise this program  
67) What are the main conditions you treat here? (SMD, CMD, epilepsy, MR, Substance abuse etc)  
68) Are any of the conditions more or less difficult to treat in your setting with your resources? |
| NSHWs Specialists (all questions) |
| K) Domain 11: CLINICAL INTERVENTIONS  
69) What form of case finding do you do in the clinic? Do you opportunistically ask people at high risk of mental disorders any screening questions? Do you follow up the children of whose parents have mental disorders  
What kind of interventions do you do? For eg- A patient with OCD, depression, anxiety, Panic attacks, phobia, psychosis  
70) What kind of mental health treatments are available in the clinic/ programme?  
71) Do they provide outreach services? (for eg treated at door to door)  
72) How and who provides it? Is it free or paying? When are these treatments available?  
73) Do you have any protocols or guidelines?  
74) What are your methods of evaluating the impact of your interventions?  
75) What are the outcomes of these interventions?  
76) Comparison of handling mental health cases before and after non |
77) Are you satisfied with the services rendered by the non specialist team? (question for specialist)
78) Are the types of interventions provided related to other health activities NSHWs are doing? (ie are NSHWs doing opportunistic interventions, are the fact they have ‘physical health’ problems affect how well/thoroughly they deal with mental health issues?)
79) Do NSHWs only deal with mental health issues during their ‘mental health clinics’ or also in normal clinics? To what extent?
80) DO you follow up patients with disorders so that they don’t relapse? What is the mechanism for follow-up?

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<tr>
<th>L) Domain 12: MEDICATIONS</th>
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<tbody>
<tr>
<td>81) What kind of medications are prescribed?</td>
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<tr>
<td>82) Who’s in charge of the medicines (stocking, checking)? Where are they stocked, and who provides the money for them?</td>
</tr>
<tr>
<td>83) Has there been any situation when you run out of stock of medicines? If so where did you source? Which are the reliable drug companies?</td>
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<td>84) Is there any pharmacist closeby.</td>
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<tr>
<th>M) Domain 13: PSYCHOSOCIAL INTERVENTIONS</th>
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</thead>
<tbody>
<tr>
<td>85) Which psycho- social interventions (if any) are used and for which patients/ dx categories (non-pharmacological therapies, but also empowerment, re-training for employment, reintegration into community etc)?</td>
</tr>
<tr>
<td>For eg- A patient with OCD, depression, anxiety, Panic attacks, phobia, psychosis</td>
</tr>
<tr>
<td>86) What prevention or promotion interventions do you do? When?</td>
</tr>
<tr>
<td>87) Any support with benefit systems? Which NSHWs are responsible for this (if any?)</td>
</tr>
<tr>
<td>88) Do you have any protocols or guidelines for these?</td>
</tr>
<tr>
<td>89) How do you evaluate their impact?</td>
</tr>
<tr>
<td>90) What outcomes to you measure? And what are the outcomes of these programmes?</td>
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<tr>
<th>N) Domain 13 a: SHGs and LIVELIHOOD PROGRAMS</th>
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<tbody>
<tr>
<td>91) Are they running any self help groups or livelihood programmes? How, when for who, by who, etc</td>
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<tr>
<th>O) Domain 14: ACCESSIBILITY OF SERVICES</th>
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<tbody>
<tr>
<td>92) Is the location central, is the provision of transportation accessible for patients? Is there any pharmacy close by?</td>
</tr>
<tr>
<td>93) Are there affordable fees?</td>
</tr>
<tr>
<td>94) What are your opening and closing hours? How much time do you give each client</td>
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<tr>
<td>95) What in-home/outreach services are provided?</td>
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<th>P) Domain 15: INFORMATION SYSTEM</th>
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<tr>
<td>96) Do you maintain records of the patients? Their follow ups? Who maintains? What are the rules /guidelines for keeping records? How long does it take to maintain records</td>
</tr>
<tr>
<td>97) Do you keep administrative records</td>
</tr>
<tr>
<td>98) Who is the information for? Is it analysed to improve practice and care.</td>
</tr>
<tr>
<td>99) How was the information system created? Is it standardised with other PHCs or does it vary?</td>
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**SWOT ANALYSIS+LESSONS & NEEDS FOR FURTHER RESEARCH**

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**Strengths/Weaknesses:**

100) Do you think your programme is sustainable? Or could be reproduced in other areas? What factors are important for this to happen?

**Opportunities:**

101) Suggestions for improving the NSHW way of delivering mental health
102) Do you wish you could implement NSHW concepts and practices on a great scale

**Threats:**

103) What are the factors (including resources) which inhibit you from implementing NSHW care concepts?

104) **Lessons learned**
105) **Research currently undertaken or research needs identified**
2. Observation tool/guide

GENERAL OBSERVATIONS IN AND AROUND THE CLINIC AND OF NON-CLINICAL STAFF

Domain 3: environment

1) What is the physical setting like? Is it adequate for what it is trying to do? Are things functional?
2) What are the socio-cultural attitudes
3) What socioeconomic measures does the clinic seem to take for patients of different SE backgrounds?
4) Outside and inside the clinic what is the political environment?

Domain 4: Health system in which the programme functions (ie try to go an meet some of the other health systems in that area eg private providers, healers, pharmacists, other PHCs)

5) What MH and general health services and alternative services are close by?
6) How does the mental health service function within the PHC system?
7) What links does it have to regional/national or international health systems?
8) What links to the spiritual/religious/traditional sector?
9) Is it in competition with any other services (any of the above or other allopaths – private sector, independent pharmacies etc)

Domain 6: engagement with broader systems

10) What is the visible advocacy work or work with broader systems? Any meetings that took place around this? Any discussions?

Domain 7: program resources

11) Are there any visible discrepancy of resources around the clinic? (human, financial, transportation, other)

Domain 8: project management

12) Who are the stakeholders? Do these seem to fit with the organogram (official one or that gained from interviews)
13) How mental health and other tasks are managed by the NCS (including which providers are doing what, when, etc). What is the balance between administrative tasks and clinical care delivery overall in the program?

Domain 12: Medications

1) What is the medication supply like? Look at coldchain, stocks, expiry dates, completeness of stock
2) What is the medication usage like?

Domain 14: accessibility of services

3) Is the location central, is the provision of transportation accessible for patients? Is there any pharmacy close by?
4) Are there affordable fees?
5) What are your opening and closing hours? How much time do you give each client
6) What in-home/outreach services are provided?
OBSERVATIONS of PHWS AND SPECIALISTS DURING CONSULTATIONS AND OTHER DAILY WORK WITH PATIENTS

Domain 7: Program resources

7) How many doctors / nurses/psychologist/social workers/ volunteers?
8) How many and which other staff are included
9) What volume of patients are coming to clinic? Does it seem representative compared to the expected volume? Is there a feeling of whether there is the adequate number of staff for the current patient population?
10) Are the patients coming from as wide a range of locations as is claimed? Are there any transport facilities?
11) As a marker of adequate funding of the programme, are the things people have said have been funded actually functioning or in existence.

Domain 8: Project Management (delivery and implementation and safety)

12) What is the NSHW workload like? (and specialist and NCS’s workload). What general health roles to do they have?
13) The way the mental health knowledge and skills is adopted in their every day practice(clinical consultations, quality of their diagnostic skills and treatment regimens? le how do the MH roles fit into their general roles, are they detecting mental health problems opportunistically? Do they seem overburdened, taking shortcuts, etc
14) What activities are they doing (re safety, according to their job profile?)
15) Quality of consultations with patients with mental disorders: What are their attitudes in consultation? Any discrepancies according to certain groups? Cultural appropriateness of any interaction with patient consultation? Are the patient’s fears, concerns and expectations addressed?
16) Are the lay health workers (LHW) able to build a reliable and secure relationships with the community( beneficiary).
17) Are the LHWs/ other NSHWs able to respond to psychosocial as well as medical needs? E.g.- a client of one volunteer was dropping out of the program because of the constrains of money, so the volunteer is worried and tries to do something about it.
18) What support do they get during or after consultations from specialists? (face to face, by phone/ any other way)?
19) Is there any on the job training? Receiving any incentives (financial or other reward)
20) What are the relationships between different cadres, who’s in charge, what is the chain of command etc?
21) What seem to be their visible opportunities and challenges?
22) What contextual factors are influencing the running of the program

Domain 10: Client populations

23) Look in consultations what types of diagnoses people have who come in.
24) Who are the type of people coming in (age, sex, socio economic status, minority or vulnerable groups). Are there carers as well?

Domain 11: Clinical interventions
25) What treatments (pharmacological and non-pharmacological) treatments are they providing?
26) Where are they providing these (in clinic or outreach)
27) Are these delivered the way they are meant to be (according to pay structure and guidelines)
28) Do NSHWs only deal with mental health issues during their ‘mental health clinics’ or also in normal clinics? To what extent?

Domain 12: Medications

29) What kind of medications are prescribed? Adequate doses and quality?

Domain 13: psychosocial interventions AND 13a: SHGs and livelihood programmes

30) Any psychosocial interventions/preventions/promotion activities occurring or support with benefits?
31) Are they running any self help groups or livelihood programmes?

3. Documentary analysis (if available)

RECORDS ANALYSIS

Administrative records and other literature on the clinic (meeting notes, reports, evaluations etc):

14) Local language and terminology to describe phenomena
15) Domains 1 and 2: History of the program and key events: when the program was established, where, why, what, who and how. Timeline and major achievements
16) Domains 3 and 14: environment in which the program functions and accessibility of services
   a. figures of the locality (population covered socio-economic groups, patient characteristics, number of people from different backgrounds, ages, sex).
   b. Details of the locality of Gumballi
   c. Details of the infrastructure of the building and programme
   d. Affordable fees, service hours, in home/outreach services? Do the plans (in written proposals and recommendations) match the current status of the clinic?
17) Domains 4 and 6: health system and broader systems: What information can we find from reports or internal documents and wider reading (perhaps ask at district level) about the existing health system and the programme’s engagement with broader systems (political, social systems, advocacy etc)
18) Domain 5: programme conceptual framework
   a. What is documented as the programme’s conceptual framework and orientation of services.
   b. For evaluation: what are their indicators? Just service indicators/monitoring of activities or also quality indicators (how is this changing patient outcomes, improvement in patient care, improvement in accessing the right populations etc)? Have there been any previous evaluations?
19) Domain 7: Program resources:
   a. facts and figures on types/quantity/quality of resources (human, financial, transportation, other) and change over time (increase, decrease, changes of resources etc)
20) Domain 8: project management
a. Look to collect and photocopy all staff job profiles and training manuals or courses to compare to their actual work.
b. See if we can have access to the budget or financial statements in reports to look at financial stability of the project

21) Domains 9 and 10: pathways to care, referrals and client populations
   a. Any reports, publications from that project on pathways to care, help-seeking, referral networks etc.
   b. Administrative records for sociodemographic characteristics,

22) Domains 11, 12, 13 and 13b: interventions and medicines
   a. Any reports/evaluations with outcomes analysis of interventions from records or studies.
   b. Any records about medication supply and usage

23) Domains 14: Accessibility of services
   a. Any reports or feasibility studies or evaluations that look at distance and cost (geographical accessibility and affordability)

MEDICAL RECORDS

24) Domain 10: Client populations
   a. What background of people whose records are kept? Sociodemographic characteristics
   b. What are the main conditions treated?
   c. Nadja to evaluate how adequate the diagnostic categories are
   d. What is the treatment coverage by diagnostic category

25) Domain 11: clinical interventions
   a. Adequacy of diagnosis
   b. What treatment offered, adequacy (how often, effective doses, correct treatment, changes in types or quantities of specific interventions).
   c. Are guidelines followed/protocols?
   d. What are the outcomes? How are they followed-up?

26) Domain 12: medications: adequacy of meds prescribed. Any documentation of their being gaps in meds and why?

27) Domain 13: psychosocial interventions: are any psychosoc interventions documented? Which and for what? How are they monitored and followed-up? Any support with benefits
Appendix 4h. Data collection tools (shorter case studies)

1. Interview guide for semi-structured interviews

<table>
<thead>
<tr>
<th>Category</th>
<th>Content</th>
<th>Interview Guide</th>
<th>Prompts</th>
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<tbody>
<tr>
<td><strong>Questions to all staff (founders/managers/coordinators/NSHWs) about the programme and various roles</strong></td>
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<tr>
<td>1) Program description</td>
<td>1a). Why and what the programme is for?</td>
<td>• Why the program started/was founded? Philosophy of the program? What personal reason for setting up a program?</td>
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<td></td>
<td>1b). Major achievements and milestones since the program began</td>
<td>• Can you share examples of what issues have come up over time that may have changed the direction of your programme or refined your current work?</td>
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<tr>
<td>2) Role description of non specialised workers</td>
<td>2a) The role of NSHWs within the mental health program?</td>
<td>• have you helped designing practices which respond to mental health concerns? Examples to illustrate.</td>
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<td></td>
<td>2b) Other NSHW roles</td>
<td>• And also review available documents</td>
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<td></td>
<td>2c) Who are the NSHWs? • Titles • Their roles • How MH roles fit in non-MH roles? Challenges to this. • Their workload</td>
<td>• Prompts: NSHW roles in detecting, treating mental disorders, follow up, training of other NSHWs</td>
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<td></td>
<td>2d) Do you have any role as supervisor/coordinator toward NSHWs?</td>
<td>• Prompts: roles in advocacy, livelihood programmes</td>
<td></td>
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<tr>
<td>3) Specialist/ supervisory staff Qualifications, expertise and roles</td>
<td>3a) Founder/manager/coordinator’s expertise/background in delivering mental health</td>
<td>• Who supports NSHWs in their MH work?</td>
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<td></td>
<td>3b) NSHW expertise in delivering mental health (Ongoing expertise and oversight in the area of mental health services)</td>
<td>• what is your background/training?</td>
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<td></td>
<td></td>
<td>• What training do the NSHW’s/specialists get? (the Length of training and if it’s repeated)</td>
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<td></td>
<td></td>
<td>• experience of the person who provides this</td>
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<tr>
<td>Category</td>
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<td>Interview Guide</td>
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<td>3c). What supervisory roles to the coordinator / roles of specialists(MH specialists) ?</td>
<td>expertise for the program&lt;br&gt;• What roles: support, supervision, training, overseeing</td>
</tr>
<tr>
<td>**Specific questions if the staff are recovered patients /users)</td>
<td>1)**Staff (who are recovered patients) views&lt;br&gt;2) their contributio to the program me</td>
<td>1) clients view about their work and mental health which relates to their status as recovered users&lt;br&gt;2) any specific roles they can have related to them being a recovered user</td>
<td>• 1a. Do their patients accept them as recovered patients and also as staff?&lt;br&gt;• 1b. Give examples of some of your strengths and weaknesses as a recovered user in your work.</td>
</tr>
<tr>
<td>**Specific questions for religious leaders</td>
<td>Specific questions relating to the religious element</td>
<td>• 1) Did any client oppose you saying that you are not specialised.&lt;br&gt;• Any circumstance where the client s were unhappy about the service&lt;br&gt;• What are their linkages to the allopathic system?</td>
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<td></td>
<td>1) Is the service affordable and is it accessible to patients?</td>
<td>1a.) How much does it cost to get from door to door&lt;br&gt;1b) How often do they need to come to clinic&lt;br&gt;1c) How far is the clinic&lt;br&gt;1d) Other indirect costs to the patients</td>
<td>• Are they (clients) able to reach the service place&lt;br&gt;• Are there situations where the programme is running in one place and the service is accessed dominantly in number by other village people&lt;br&gt;• Are they (clients) able to afford to come and take the mental health care service</td>
</tr>
<tr>
<td></td>
<td>2) Socio-Demograph ic details</td>
<td>2a) What category of people come to them and their income level&lt;br&gt;2b) What are their reasons for attending</td>
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<td>3) Service characteris tics</td>
<td>3a) What are the most prevalent disorders they see (&amp; presentations&lt;br&gt;3b) Infrastructure of the MH service&lt;br&gt;• Capacity of the clinic&lt;br&gt;• Drug supply (from where, cost, reliability/stock)&lt;br&gt;3c. Linkages to&lt;br&gt;• DMHP/NRHM&lt;br&gt;• Other MH services/</td>
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<tr>
<td>Category</td>
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| Interventions by NSHWs and by others | 1) Addressing mental health concerns                                   | 1a) Identifying the mental health concerns/screening  
1b) Awareness raising and Screening  
1c) Treatment- Which by national (NSHWs)  
1d) Follow up And supervision                                  | • What role do you play in the program’s efforts to conduct screening to identify mental sickness  
• What treatments do NSHWs perform? (prompts: prescribing, counselling, motivational interviewing etc)  
• How do you coordinate services to ensure that mental health needs are communicated, and that follow-up occurs?  
• Can you share an example of a referral made this year and its resolution?  
• What follow-up is done by NSHWs? By which NSHWs? |
|                               | 2) What are the other livelihood program for the community (patients family) with the mental health programme | 2a) SHG self help groups  
2b) Income generating activities  
2c) Any other groups/interventions                                                                                                                                                                                                                           |                                                                                                                                                                                                      |
| Monitoring                    | Monitoring                                                              | 1) Ongoing monitoring and overview of the programme                                                                                                                                                                                                            | • What do you do if you detect problems or weaknesses with the programme’s mental health services?  
• How do you monitor delivery of the programme’s mental health services and the programme’s compliance with regulations?  
• Have you requested formally patient feedback |
| Success or limitations of implement | Implementing Mental Health Services/im | 1) Success and limitations in regard to NSHWs  
• Recruiting NSHWs  
• Training/Ongoing                                                                                                                             | • What challenges of using NSHWs = examples of |
## 2. General observations during site visits

### Domain 3: environment

1) What is the physical setting like? Is it adequate for what it is trying to do? Are things functional?

### Domain 4: Health system in which the programme functions (ie try to go an meet some of the other health systems in that area eg private providers, healers, pharmacists, other PHCs)

2) What MH and general health services and alternative services are close by?
3) How does the mental health service function within the PHC system?

### Domain 7: program resources

4) Are there any visible discrepancy of resources around the clinic? (human, financial, transportation, other)
Domain 14: accessibility of services

5) Is the location central, is the provision of transportation accessible for patients? Is there any pharmacy close by?
6) What are your opening and closing hours?
7) What in-home/outreach services are provided?
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Table 15. Agreements and disagreements with related reviews

This review went further and found a statistically significant benefit for improving internalising symptoms (SMD -0.34, 95% CI -0.40 to -0.09). For adults, a potential benefit of interventions was also seen

APPENDICES

Appendix 1. Search strategies

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<td>(intellectually adj (disabled or handicapped or retarded or deficient)).ti,ab</td>
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<td>(mental health service? or mental health care or mental health-care or mental care).ti,ab</td>
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<td>Developing Countries.sh,kf.</td>
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<td>(Africa or Asia or Caribbean or West Indies or South America or Latin America or Central America).hw,kf,ti,ab,cp</td>
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<td>(Afghanistan or Albania or Algeria or Angola or Antigua or Barbuda or Argentina or Armenia or Armenian or Aruba or Azerbaijan or Bahrain or Bangladesh or Barbados or Benin or Byelarus or Byelorussian or Belarus or Belorussian or Belorussia or Belize or Bhutan or Bolivia or Bosnia or Herzegovina or hercegovina or Botswana or Brazil or Brasil or Bulgaria or Burkina Faso or Burkina Fasso or Upper Volta or Burundi or Urundi or Cambodia or Khmer Republic or Kampuchea or Camero or Cameroons or Cameroon or Camerons or Cape Verde or Central African Republic or Chad or Chile or China or Colombia or Comoros or Comoro Islands or Comores or Mayotte or Congo or Zaïre or Costa Rica or Cote d’Ivoire or Ivory Coast or Croatia or Cuba or Cyprus or Czechoslovakia or Czech Republic or Slovakia or Slovak Republic or Djibouti or French Somaliland or Domínica or Dominican Republic or East Timor or East Timur or Timor Leste or Ecuador or Egypt or United Arab Republic or El Salvador or Eritrea or Estonia or Ethiopia or Fiji or Gabon or Gabonese Republic or Gambia or Gaza or Georgia Republic or Georgian Republic or Ghana or Gold Coast or Greece or Grenada or Guatemala or Guinea or Guam or Guiana or Guyana or Haiti or Honduras or Hungary or India or Maldives or Indonesia or Iran or Iraq or Isle of Man or Jamaica or Jordan or Kazakhstan or Kazakh or Kenya or Kiribati or Korea or Kosovo or Kyrgyzstan or Kirghizia or Kyrgyz Republic or Kirghiz or Kirgisistan or Lao PDR or Laos or Latvia or Lebanon or Lesotho or Basutoland or Lesotha or Libya or Lithuania or Macedonia or Madagascar or Malagasy Republic or Malaysia or Malaya or Malay or Sabah or Sarawak or Malawi or Nyasaland or Mal or Malta or Marshall Islands or Mauritania or Mauritius or Agalega Islands or Mexico or Micronesia or Middle East or Moldova or Moldova or Moldovian or Mongolia or Montenegro or Morocco or Ifni or Mozambique or Myanmar or Myanma or Burma or Namibia or Nepal or Netherlands Antilles or New Caledonia or Nicaragua or Niger or Nigeria or Northern Mariana Islands or Oman or Muscat or</td>
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<td>((developing or less* developed or under developed or under-developed or middle income or low* income or underserved or under served or deprived or poor*) adj (countr* or nation? or population? or world)).ti,ab</td>
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<td>(low* adj (gdp or gnp or gross domestic or gross national)).ti,ab</td>
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<td>(low adj3 middle adj3 countr*).ti,ab.</td>
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<td>((pretest or pre test) and (posttest or post test)).ti,ab.</td>
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Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)

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Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)

Copyright © 2013 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
<p>| S55 | TI (psychiatric or psychosocial) W0 (service* or care or assistance or help or work) ) OR AB (psychiatric or psychosocial) W0 (service* or care or assistance or help or work) | 2777 |
| S54 | TI (mental W0 health W0 service* or &quot;mental health care&quot; or &quot;mental healthcare&quot; or &quot;mental care&quot;) OR AB (mental W0 service* or &quot;mental health care&quot; or &quot;mental healthcare&quot;) | 7729 |
| S53 | TI (psychiatric W0 (patient* or service* or care or assistance or help or work) ) OR AB (psychiatric W0 (patient* or service* or care or assistance or help or work) ) | 3312 |
| S52 | TI (depression or anxiety or schizophrenia or psychoses or stress W0 syndrome* or distress W0 syndrome* or combat W0 disorder* or war W0 disorder* or pain W0 disorder* or dementia or alzheimer or epilepsy or down* W0 syndrome or alcoholism or substance W0 abus* or drug W0 addict* or drug W0 abus* or drug W0 misuse or drug W0 user*) ) OR AB (depression or anxiety or schizophrenia or psychoses or stress W0 syndrome* or distress W0 syndrome* or combat W0 disorder* or war W0 disorder* or pain W0 disorder* or dementia or alzheimer or epilepsy or down* W0 syndrome or alcoholism or substance W0 abus* or drug W0 addict* or drug W0 abus* or drug W0 misuse or drug W0 user*) ) | 88,617 |
| S51 | TI (&quot;substance related&quot; or alcohol or opioid or morphine or marijuana or heroin or cocaine) W0 (disorder* or illness* or dependence or abuse or misuse) ) OR AB (&quot;substance related&quot; or alcohol or opioid or morphine or marijuana or heroin or cocaine) W0 (disorder* or illness* or dependence or abuse or misuse) ) | 4339 |
| S50 | TI (mental or behavioural or behavioral or anxiety or obsessive or compulsive or panic or phobic or schizotypal or delusional or stress or cognitive or cognition or dissociative or personality or “impulse control” or mood or affective or bipolar or depressive or neurotic or paranoid or psychotic or somatoform or neurologic* or nervous or eating) W0 (disorder* or illness* or disease* ) ) OR AB (mental or behavioural or behavioral or anxiety or obsessive or compulsive or panic or phobic or schizotypal or delusional or stress or cognitive or cognition or dissociative or personality or “impulse control” or mood or affective or bipolar or depressive or neurotic or paranoid or psychotic or somatoform or neurologic* or nervous or eating) W0 (disorder* or illness* or disease* ) ) | 29,445 |
| S49 | TI ( mental W0 (retardation or deficiency*) ) OR AB ( mental W0 (retardation or deficiency*) ) | 1450 |
| S48 | TI ( intellectually W0 (disabled or handicapped or retarded or deficient) ) OR AB ( intellectually W0 (disabled or handicapped or retarded or deficient) ) | 121 |
| S47 | TI ( (mentally or psychologists) W0 (ill or disabled or handicapped or retarded or disturb* or traumat* or deficient) ) OR AB ( (mentally or psychologists) W0 (ill or disabled or handicapped or retarded or disturb* or traumat* or deficient) ) | 2829 |
| S46 | (MH “Social Work, Psychiatric”) | 519 |
| S45 | (MH “Psychiatric Emergencies”) | 595 |
| S44 | (MH “Emergency Services, Psychiatric”) | 77 |
| S43 | (MH “Community Mental Health Nursing”) | 1628 |
| S42 | (MH “Community Mental Health Services”) | 5226 |
| S41 | (MH “Mental Health Services”) | 14,691 |
| S40 | (MH “Epilepsy”) | 4719 |
| S39 | (MH “Nervous System Diseases”) | 2663 |
| S38 | (MH “Substance Abusers+”) | 3348 |
| S37 | (MH “Mentally Disabled Persons”) | 1275 |
| S36 | (MH “Psychiatric Patients+”) | 7664 |
| S35 | (MH “Mental Disorders+”) | 208,797 |
| S34 | S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 | 103,048 |
| S33 | TI staff* N3 chang* OR AB staff* N3 chang* | 886 |
| S32 | TI ( (task or tasks) N3 shift* ) OR AB ( (task or tasks) N3 shift* ) | 135 |
| S31 | TI “human resources” OR AB “human resources” | 1490 |</p>
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**PsycINFO (OvidSP)**

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(mental* or psych* or psiq*) AND (nurse or nurses or midwife or midwives or physician or physicians or clinician or clinicians or doctor or doctors or practitioner or practitioners or dentist or dentists or pharmacist or pharmacists or “health care staff” or “healthcare staff” or “medical staff” or “health personnel” or “health care personnel” or “healthcare personnel” or “medical personnel” or “health worker” or “health workers” or “health care worker” or “healthcare worker” or “healthcare workers” or “medical worker” or “medical workers” or “health professional” or “health professionals” or “health care professional” or “health care professionals” or “healthcare professional” or “healthcare professionals” or “medical professional” or “medical professionals” or “health provider” or “health care provider” or “health care providers” or “healthcare provider” or “healthcare providers” or “medical provider” or “medical providers” or “health workforce” or “health care workforce” or “healthcare workforce” or “medical workforce” or “health manpower” or “human resources” or enfermer* or enfermeir* or medico* or odontologo* or farmaceutico* or partera* or parteira* or “equipo sanitario” or “trabajadores de salud” or “trabajadores de la salud” or “profissionais de saude” or “recursos humanos”) **AND**

(recruit* or retain* or retention or distribut* or “scale up” or “scaling up” or turnover or “turn over” or “brain drain” or maldistribut* or distribucion or retencion or distribuicao or fixacao or retencao) **AND**

(randomised or randomized or “random allocation” or “randomly allocated” or “controlled trial” or “control group” or “control groups” or effect or evaluat* or intervention* or impact or “multicenter study” or “multi center study” or “multicentre study” or “multi centre study” or “pretest and posttest” or quasieperiment* or “quasi experiment*” or “time series” or “time point” or “time points” or “repeated measure” or “repeated measures” or “repeated measurement” or “repeated measurements” or “ensayo clinico controlado aleatorio” or “ensayo clinico controlado” or “ensayo clinico controlado aleatorio”) **AND**

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)

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Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)
before and after) or pretest or (pre and test) or posttest or (post and test) or intervention* or evaluat* or effect or impact or (time and series) or (time and points) or (repeated and measure*)

OpenGrey

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<tr>
<td>6</td>
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<tr>
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13  “mental” and “school”  
Latvian: 2; Czech: 2  41

14  “mental” and “teacher”  
Latvian: 1; Czech: 1  2

Total screened from MIC (Middle Income Countries): 259

Meta Register of Controlled Trials (mRCT)
Search 1: mental and health worker - 12 records
Search 2: psychiatrist* and health worker - 6 records
Search 3: paramedic and mental - 1 record
Search 4: paramedic and psychiatrist* - 1 record
Search 5: paraprofessional and mental - 13 records
Search 6: paraprofessional and psychiatrist* - 8 records
Search 7: non-specialist and mental - 2 records
Search 8: non-specialist and psychiatrist* - 0 records
Search 9: lay and worker and mental - 1 record
Search 10: lay and worker and psychiatrist* - 0 records
Search 11: community and worker and mental - 25 records
Search 12: community and worker and psychiatrist* - 13 records
Search 13: carer and mental - 27 records
Search 14: carer and psychiatrist* - 26 records
Search 15: caregiver and mental - 0 records
Search 16: caregiver and psychiatrist* - 0 records
Search 17: teacher and mental - 78 records
Search 18: teacher and psychiatrist* - 61 records

International Clinical Trials Registry Platform, (ICTRP)
Search 1: 119 records
mental or psych (in condition field) AND non-specialist or nonspecialist or paramedic or paraprofessional or communit or non-professional or nonprofessional or carer or caregiver or teacher or school or task-shift or taskshift (in intervention field)
Search 2: 10 records
mental or psych (in condition field) AND lay and worker (in intervention field)
Search 3: 0 records
mental or psych (in condition field) AND human and recourses (in intervention field)
Search 4: 1 record
mental or psych (in condition field) AND task and shift (in intervention field)
Search 5: 0 records
non-specialist and mental (in title field)
Search 6: 0 records
non-specialist and psych (in title field)
Search 7: 0 records
nonspecialist and mental (in title field)
Search 8: 0 records
nonspecialist and psych (in title field)
Search 9: 1 record
paramedic and mental (in title field)
Search 10: 0 records
paramedic and psych (in title field)
Search 11: 0 records
paraprofessional and mental (in title field)
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paraprofessional and psych (in title field)
Search 13: 1 record
community and worker and mental (in title field)
Search 14: 0 records
community and worker and psych (in title field)
Search 15: 1 record
lay and worker and mental (in title field)
Search 16: 1 record
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Search 17: 0 records
non-professional and mental (in title field)
Search 18: 0 records
non-professional and psych (in title field)
Search 19: 0 records
nonprofessional and mental (in title field)
Search 20: 0 records
nonprofessional and psych (in title field)
Search 21: 2 records
carer and mental (in title field)
Search 22: 16 records
carer and psych (in title field)
Search 23: 6 records
caregiver and mental (in title field)
Search 24: 24 records
caregiver and psych (in title field)
Search 25: 3 records
teacher and mental (in title field)
Search 26: 1 record
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Search 27: 18 records
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task-shift and psych (in title field)
Search 31: 0 records	taskshift and mental (in title field)
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task and shift and mental (in title field)
Search 34: 0 records
task and shift and psych (in title field)
Search 35: 0 records
human and resources and mental (in title field)
Search 36: 0 records
human and resources and psych (in title field)

Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries (Review)
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Recruitment status: ALL.

### Appendix 2. Adapted CHEC criteria list

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<th>no</th>
<th>Not applicable</th>
<th>Details</th>
</tr>
</thead>
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<tr>
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<td>Are competing alternatives clearly described?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is a well defined economic question posed in an answerable form?</td>
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<tr>
<td>3</td>
<td>Is the economic study design appropriate to the stated objective?</td>
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<td>4</td>
<td>Was there a comparison between 2 more groups receiving different interventions?</td>
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<tr>
<td>5</td>
<td>Is the chosen time horizon appropriate to include relevant costs and consequences?</td>
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<tr>
<td>6</td>
<td>Is the perspective/viewpoint** of the analysis explicitly stated? If yes, give details</td>
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</tr>
<tr>
<td>7</td>
<td>Is the actual perspective chosen appropriate?</td>
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<tr>
<td>8</td>
<td>Are all important and relevant costs for each alternative identified?</td>
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<tr>
<td>9</td>
<td>Are costs measured? If yes, give details of costs measured.</td>
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<tr>
<td>10</td>
<td>Are all costs measured appropriately in physical units?</td>
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<tr>
<td>11</td>
<td>Are costs valued appropriately?</td>
<td></td>
<td></td>
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</tbody>
</table>
12 Are all important and relevant outcomes for each alternative identified?

13 Were outcomes measured? If yes, give details of outcomes measured

14 Are all outcomes measured appropriately?

15 Are outcomes valued appropriately?

16 Is an incremental analysis of costs and outcomes of alternatives performed?

17 Are all future costs and outcomes discounted appropriately? *(where appropriate)

18 Were sensitivity analyses undertaken? If yes, give details of forms of sensitivity analyses.

19 Are all important variables, whose values are uncertain, appropriately subjected to sensitivity analysis?

20 Do the conclusions follow from the data reported?

21 Does the study discuss the generalizability of the results to other settings and patient/client groups?

22 Does the article indicate that there is no po-
Appendix 3. Other economic studies of relevance but not included

Thirteen economic studies did not meet our inclusion criteria, as they did not relate to one of the included studies. Their findings are presented and compared with those that are included in this review to enhance the usefulness and applicability of the Cochrane review for healthcare decision making. The economic questions addressed in excluded studies mainly fall into three broad categories in terms of cost analysis of specific disease conditions, carer and family burden, and comparison of improved or integrated mental health care with primary care with usual or no care.

The studies that looked at healthcare costs cannot be compared with those of included studies as they were from different settings, conditions and outcomes.

Health services costs: Chisholm 2000 dealt with integration of mental health services into primary health care in India and Pakistan and found that a significant category of healthcare costs were consultitations with GPs. In Luengo-Fernandez 2011, primary care was costed in European middle-income countries as constituting 36% (Portugal) and 9% (Greece) of total healthcare costs. There is no costing specific to NSHWs. One review showed that collaborative care costs are no greater than usual care (Woltmann 2012). A community outreach intervention in rural India for untreated schizophrenia study found that the costs of informal care sector visits and family care giving costs considerably reduced during the follow-up period from USD10 to about USD2 (Murthy 2005). This study gives detailed costs of outreach clinic set up, unit costs per person accessing services and outcome data at intervention baseline and follow-up to 18 months. It shows that costs of services increase over time (the increase in costs is of the specialist outreach services, not of PHC services) and that overall costs remain stable (around USD34). This study also emphasises the need for early diagnosis and availability of services close to the affected populations helps in increased uptake of services and reduces associated costs. The most promising study on service changes and costs is from South Africa, where Petersen 2012 estimated that the costs of a primary healthcare staffing package (one post for a mental health counsellor or equivalent and 7.2 community mental health worker posts) would be offset by a reduction in the number of other specialist and non-specialist health personnel required to close service gaps at primary care level. The cost of these personnel amounts to GBP28,457 per 100,000 population.

Costs of specific interventions: Suh 2006 in their study on economic costs of dementia in Korea found that costs of care for dementia patients needing full-time care in community (USD44,121) were about 10 times higher than those who did not need long-term care (USD3986) and found that costs of informal care were very high, but it is unclear what the costs relating to NSHWs were. Another study dealt with societal costs of dementia (mainly informal costs) in both developed and LMICs, but does not explicitly state the costs of a NSHW-delivered service (Wimo 2007). The costs of providing epilepsy care through primary care in Zambia is estimated at under USD25 a day (Birbeck 2012).

Informal care costs: The high level of burden among family carers was also highlighted in other studies (Chisholm 2000; Murthy 2005; Papastavrou 2010; van Steenbergen-Weijenburg 2010; Woltmann 2012), and that was significantly related to the severity and frequency of the patients symptoms, gender and educational level of the carer.

Resource requirement analysis and resource use: Some studies described the status of resource use; Chisholm 2000 study showed low level of service utilisation in the government centres. Others attempt to calculate resource requirements. Scaling up specific interventions like the child and adolescent mental health services in their country context was done by modelling (Lund 2009), for different levels of coverage in South Africa. The model suggests most costs should be spent at primary care level with a range of NSHWs (occupational therapists, social workers, general nurses) and specialists (psychiatric nurses). However, this forecasted ideal situation is currently unrealistic due to budgetary constraints. Siskind 2010 estimated cost-effectiveness of usual care compared with improved primary care for depression in Chile using computer-based Markov cohort model. They found the incremental cost-effectiveness ratio (ICER) of usual care CLP113 per quality adjusted life year (QALY) gained versus no treatment, whereas stepped care had an ICER of CLP468 per
QALY versus usual care. A sensitivity analysis was also performed and the results were sensitive to assumptions made about recurrent episodes coverage, cost of treatment and insensitive to changes in health state utility of depression and rate of recurrence. We found one cost-effectiveness study on mental health intervention package in Nigeria (Gureje 2007), which estimated cost per DALYs averted for schizophrenia, depression, epilepsy and alcohol use. The most cost effective intervention for schizophrenia was a 70% coverage of antipsychotic drugs with either psychosocial treatment or case management with cost per DALY USD642 and USD680 respectively. Cost per DALY averted for depression was lowest for older antidepressant drug with psychotherapy at USD767. Similarly, for epilepsy older antiepileptic drugs in primary care implemented at 80% coverage offered the best cost per DALY at USD100 per DALY averted. Random road-side breath testing for alcohol had a cost per DALY averted at USD85 (Gureje 2007). A systematic review which included two cost-effectiveness studies in LMIC of costs of collaborative showed these to be cost-effective (van Steenbergen-Weijenburg 2010).

Appendix 4. Description of studies not included in meta-analyses

1. Non-specialist health workers versus usual care (life-skills training) in improving drug abuse outcomes (RCT)
Sutcliffe2009RCT Thailand peer-led education programme versus a best practice intervention (life skills building approach) probably improves index patients’ recovery of depressive symptoms at 12 months (MD -2.20, 95% CI -4.03 to -0.37), though this did not apply to reducing the prevalence of depression. However, this benefit did not filter to their network group (not involved in the intervention) (MD 0.00, 95% CI -1.55 to 1.55). There was no significant effect on methamphetamine use (RR 1.01, 95% 0.91 to 1.13) at six months or at one year post intervention.

2. Non-specialist health workers versus usual care for treating schizophrenia (controlled before-and-after study)
A medical assistant-delivered psychoeducation programme for carers of people with schizophrenia in Malaysia reported slightly fewer cases of readmission rates (3/54 versus 5/55) and a better defaulter rate (6/54 versus 14/65) in the intervention versus the control group (Paranthaman2010CBAMalaysia). It may have little or no impact on carer burden, on activities of daily living, or on other outcomes (such as financial expenditure, reduction in worry, impact on daily routines and supervision).

3. Non-specialist health workers versus specialist care in treating epilepsy (equivalence trial RCT)
In China, Li's study shows that there is equivalence between NSHW (trained village doctors) and specialists (psychiatrists) in reducing how many of their patients had an 80% or more reduction in epileptic seizures after three-month treatment with phenobarbital (60% versus 55%) (Li 1989 RCT China). This also applied to patients with a 20% to 79% seizure rate reduction (30% versus 35%) or below 20% seizure rate reduction (5% versus 15%). However, there seems to be improvements in reported side effects in the NSHW versus specialist group, such as somnolence (2/20 versus 10/20) and drowsiness (6/20 versus 17/20). There was no difference in other reported side effects: dizziness, ataxia, nausea and vomiting, and return visits.

4. Other professionals with health roles versus usual care in delivering a psychosocial/activities intervention for parents of children with intellectual disabilities (RCT)
The Vietnamese RCT introduced a teacher-led Portage curriculum for parents of preschool children with intellectual disabilities versus wait-list control (Shin 2009 RCT Vietnam). The results are difficult to interpret, as often baseline data were different in both groups. This intervention may slightly improve behavioural changes (MD 1.10, 95% CI -7.82 to 10.02), motor skills (MD -1.40, 95% CI -12.93 to 10.13) and social skills (MD 0.80, 95% CI -11.51 to 13.11) at six months (with similar scores at 12 months).

WHAT’S NEW

Last assessed as up-to-date: 2 October 2012.

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## Appendix 7 Supplementary tables for chapter 6

### Supplementary table 1: Characteristics of collaborative care programmes

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<th>Mental Disorders (MD)</th>
<th>Specialist Platform</th>
<th>PHW Platform</th>
<th>Level of PHC/community and specialist collaboration</th>
<th>Stepdown/matched care</th>
<th>PHWs: background and roles</th>
<th>Specialists: background and roles</th>
<th>Care manager: background + roles</th>
<th>Other care coordinator: background + roles</th>
<th>Training + supervision of care manager/coordinator</th>
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<td>Tamil Nadu Rural (R)</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>PHC+ community</td>
<td>Intensive contact for LHWs (weekly or fortnightly contact with specialist and daily contact with coordinator). Minimal collaboration of PHC doctor with specialists (currently trying to improve).</td>
<td>Matched care determined by psychiatrist</td>
<td>CHWs (LHWs): awareness, detection, follow-up, psychosocial support/ coping strategies/ counselling (home). Intensive apprenticeship and periodic training with psychiatrist+ coordinator. Social worker (SW): joint visits with CHW, psychosocial support, community rehabilitation, benefits advice (+ general roles). Generalist doctor: medical role only.</td>
<td>Banyan psychiatrist: diagnosis, treatment. Supervise care manager. Psychologist: therapies. (outreach clinics in PHC).</td>
<td>Coordinator (Postgraduate): joint/separate home visits with CHWs. Liaise between patients, CHWs and specialists (CHWs liaise with patients).</td>
<td>Periodic training and ongoing support supervision by psychiatrist - regular meetings.</td>
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<td>Mental disorders (MD)</td>
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<td>PHW platform</td>
<td>Level of PHC/community and specialist collaboration</td>
<td>Steppe d/matched care</td>
<td>PHWs: background and roles</td>
<td>Specialists: background and roles</td>
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<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>PHC+ communit y+ self-care</td>
<td>Close collaboration between specialists and LHWs (both NGO-linked). Minimal collaboration with PHC (used as a platform for delivery).</td>
<td>Matched care determined by psychiatrist.</td>
<td>LHWs: identification, referral, follow up, home-based care, contribute to income-generating activities, awareness raising, surveys (home visits). Other health workers: screen children for disabilities. PHC staff: identify and refer (also have general roles). Initiation of Self health groups (SHGs).</td>
<td>Specialist team (psychiatrist, psychologist, PSW): diagnosis, treatment, follow up (outreach clinics in PHC, +early identification camps for child disorders). Psychiatrists trained PHWs.</td>
<td>Community care workers (community volunteers) (LHWs): care roles and Liaise between patients, PHC and specialists.</td>
<td>Project coordinator: administration of project and supervises social workers.</td>
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<td>CHAD (department of community health, CMC Vellore)- CMHP</td>
<td>Tamil Nadu</td>
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<td>all- mainl y depr essio n detected</td>
<td>General hospital (NGO)</td>
<td>PHC + communi ty</td>
<td>Close collaboration between specialists and LHWs (NGO-linked, and government ANMs). Minimal collaboration with PHC.</td>
<td>Matched care determined by psychiatrist.</td>
<td>Health aides (LHWs): generalist LHWs (focus ANC/PNC) with mental health roles: identification, referral, some psychosocial support; volunteers (LHWs): follow-up, 2 psychiatrists: diagnosis, treatment, follow-up, rehabilitation (outreach clinics). Used to train LHWs.</td>
<td>Health aides (LHW): identification, referral and psychosocial support. Liaise between PHC,</td>
<td>Project coordinator : administration of project and supervises social workers.</td>
<td>LHW supervision by social worker (most medical social workers with MH roles) -used to be every month, now once a year.</td>
</tr>
<tr>
<td>Programme</td>
<td>State</td>
<td>Location</td>
<td>Mental disorders (MD)</td>
<td>Specialist platform</td>
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<td>Level of PHC/community and specialist collaboration</td>
<td>Steppe d/matc hed care</td>
<td>PHWs: background and roles</td>
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<tr>
<td>Karuna Trust - Gumballi (early programme) (in-depth case study)</td>
<td>Karnataka</td>
<td>R</td>
<td>all</td>
<td>Specialist hospital (government- NIMHA NS) and community (NGO)</td>
<td>PHC+ community</td>
<td>Close collaboration between PHC doctor, NGO and psychiatrists (government hospital). Intensive bedside-training model of consultation-liaison. (the programme has since moved to simply training PHC doctors with minimal ongoing support from specialists).</td>
<td>Matched care determined by psychiatrist (stepked care in later programme - see educated and training ).</td>
<td>PHC doctor: refer patient to camp, sit in with psychiatrist, follow-up after treatment initiation. Community-based LHWs (multipurpose workers): minimal training in mental health to identify and refer.</td>
<td>Psychiatrists: fortnightly clinics in PHC. Supervised PHC doctor. (planned specialist withdrawal)</td>
<td>PHC coordinator (graduate) manages all aspects of PHC. PHC doctor liaises between patients and specialists.</td>
<td>Significant experiential teaching, supervision and support from psychiatrists.</td>
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<tr>
<td>Programme</td>
<td>State</td>
<td>Location</td>
<td>Mental disorders (MD)</td>
<td>Specialist platform</td>
<td>Level of PHC/community and specialist collaboration</td>
<td>Steppegd/matched care</td>
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<td>Care manager: background + roles</td>
<td>Other care coordinator: background + roles</td>
<td>Training + supervision of care manager/ coordinator</td>
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<td>MICP (Malappuram Initiative in Community Psychiatry) - an add-on to the DMHP initiative</td>
<td>Kerala</td>
<td>R</td>
<td>all</td>
<td>Genera l hospital (NGO)</td>
<td>PHC + comm unity</td>
<td>Ad hoc and minimal collaboration between psychiatrist (NGO/hospital) and PHWs (government LHWs).</td>
<td>Matched care determined by psychiatrist.</td>
<td>ANM, ASHA, pariraksha nurses (panchayat-level homecare nurse): identify, refer, follow-up including check medication adherence, facilitate rehabilitation activities, (also general roles). (Home visits). Panchayat volunteers, health inspectors: identify and refer to the pariraksha nurse who then sends them to PHC. PHC doctor: identify, refer and follow up medical dosage changes (PHC-based); mainly exclude organic cause (during camps)</td>
<td>Psychiatrist: diagnosis, treatment, follow-up (outreach camps). Also supervises all community-level staff. Psychologist: available to be referred to (even for children).</td>
<td>None</td>
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<tr>
<td>Ashadeep outreach programme</td>
<td>Assam</td>
<td>R</td>
<td>all (homeless women)</td>
<td>CMHS (NGO)</td>
<td>Community</td>
<td>Moderate collaboration between specialists (in NGO) and LHWs (in CBOs - community based organisations) during outreach clinics.</td>
<td>Steppe d care (usually see LHWs first before having access to psychiatrist).</td>
<td>LHWs from CBOs: awareness, psychosocial support. Some do counselling (home visits). CBO social worker: identify and refer homeless people (outreach work), awareness raising. LHWs/SWs also have general health or development roles. NGO generalist doctor: part of camps: before psychiatrists were employed, they used to diagnose, treat, follow-up at outreach camps. Now just physical treatment+care in halfway home. Training initially by Ashadeep, then taken over by CBO. Psychiatric team employed through NGO (psychiatrist, psychologist): diagnosis, treatment (CBO-based clinics). Psychologist also supervises social worker. Specialists and leaders: clinical and organisation problem solving/consultation clinics for CBOs (monthly Ashadeep-based clinics).</td>
<td>CBO-level manager (experience d LHW) and Ashadeep coordinator (initially only): Liaise between LHWs, patients, specialists and organisation s regarding activities, needs and clinical information. Supervise LHWs.</td>
<td>Supervised by social worker who is supervised by psychologist.</td>
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Collaborative care with community care (not PHC) + care manager
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<tr>
<td>ANT-outreach programme (Ashadeep-linked CBO)</td>
<td>Assam</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO) and general hospital psychiatrist</td>
<td>Commun ity (CBO)</td>
<td>Minimal collaboration of CBO with government specialists (only visit for camps). Greater collaboration and support from MH NGO (Ashadeep)</td>
<td>Matched care by psychiatrist</td>
<td>LHWS: identify, refer, awareness, psychosocial support, some administer medicines (home visits). Trained by care manager and directors. Generalist doctor: organisation leader, provides general medical and some mental health care including counselling (PHC-like clinic)</td>
<td>Visiting external government psychiatrist (monthly camps): diagnosis and treatment. May access consultation clinics at Ashadeep (monthly).</td>
<td>Experienced LHW (senior LHWS): clinical roles as for PHWs. Liaises between patients, LHWS, ANT and Ashadeep directors if necessary. Also trains LHWS, awareness raising.</td>
<td>Supervised by programme director (a general physician).</td>
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<tr>
<td>Ashagram</td>
<td>Madhya Pradesh</td>
<td>R</td>
<td>all</td>
<td>Tertiary - private psychiatrist</td>
<td>Moderate collaboration between private psychiatrists and NGO coordinators/LHWs.</td>
<td>Matched care by psychiatrist</td>
<td>Key worker (LHW): identify, community follow-up, adherence, surveys, awareness raising. Bring patients to clinic to doctor or psychiatrist outreach clinic; community self help groups; general support; BAMS doctor; follows up and monitors patients after psychiatrist management initiation. Relies on key workers to send him patients. Also attends some psychiatrist-led consultations in clinics.</td>
<td>Visiting external private psychiatrist: outreach clinics (used to have a PSW)</td>
<td>Experienced LHW (called ‘mental health key workers’): Liaise between LHWs, BAMS doctor, head of organisation and psychiatrists. Clinical care as under PHW roles. LHW training and supervision (used to be done by psychiatrist and supervision by PSW).</td>
<td>By coordinator - (experienced key worker) - regular support. Coordinate programme.</td>
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<td>GASS_CBR workers</td>
<td>Kanyakumari</td>
<td>R</td>
<td>all</td>
<td>Private specialist hospital psychiatrists and CMHS (NGO - Basic Needs UK)</td>
<td>Community (NGO - GASS) (+ PHC community ANMs)</td>
<td>Minimal collaboration with specialist. Good collaboration between NGOs and PHC staff.</td>
<td>Matched care by psychiatrist</td>
<td>Community-based rehabilitation (CBR) workers: identification, referral, follow-up, some counselling, psychoeducation, awareness, support, bring patients to camp (also disability roles). Government ANMs (LHW): identification, referral. (home visits). ANMs trained by BasicNeeds-UK and GASS, supervised by MH coordinator.</td>
<td>Visiting external private psychiatrist: diagnosis/treatment camps.</td>
<td>Community based rehabilitation (CBR) worker: clinical roles as under ‘PHW’. Liaise between community and GASS team (but no links with specialists).</td>
<td>Community coordinator, mental retardation specialists, physiotherapists. BasicNeeds-UK provide technical support. MH coordinator supervised by GASS head.</td>
<td>CBR workers used to be trained by psychiatrists when they were more involved. Supervised by MH coordinator, mental retardation specialists, physiotherapists. BasicNeeds-UK provide technical support. MH coordinator supervised by GASS head.</td>
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<tr>
<td>TTK (NGO)-rural camps with local</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>Alcohol abuse</td>
<td>Specialist hospital (NGO)</td>
<td>Community (CBO)</td>
<td>Regular collaboration between specialist NGO and CBO with aim to make CBO independent.</td>
<td>Matched care - triage by social worker</td>
<td>CBO animators (LHW): identify, psychosocial support, bring people to camp, follow-up, raising</td>
<td>Specialist team from NGO (psychologist, PSW) outreach</td>
<td>CBO animator (usually a graduate with no health/MH</td>
<td>Trained and supervised by PSW and psychologists (NGO).</td>
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<td>organisation (CBO) partnership (outreach clinic with PHW support)</td>
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<td>awareness. Clinic volunteers (LHW): support to team only (Home/community care). PHC doctor: organic disorder exclusion only during camps.</td>
<td>clinics every 2 months. No psychiatrist: assessment, detoxification and follow-up. Also train and supervise animators. (planned specialist withdrawal)</td>
<td>background) : Roles as under ‘PHW’. Liaise between CBO, PHC doc and TTK.</td>
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<tr>
<td>Chellamuthu Trust - Sathya Sai treatment camps</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Community (religious organisation)</td>
<td>Minimal collaboration: no organised support structure between specialists and LHWs but communication during camps</td>
<td>Matched care (decided by psychiatrist)</td>
<td>Sathya Sai volunteers (LHWs) identify and refer, also follow up including medical adherence and side effects, bring patients to camps; PHC doctors: exclude organic causes, may refer to camp too</td>
<td>psychiatrist, psychologist, social workers: monthly outreach clinics. ad hoc supervision of volunteers.</td>
<td>Sathya Sai volunteers (religious volunteers): liaise between patient, volunteers and specialist. organise camp and mobilise/get patients there. Mobilise/raid</td>
<td>No organised supervision but ad hoc support during outreach clinics. Two days training by specialist team initially.</td>
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<td><strong>Banyan-Family Planning Association partnership</strong></td>
<td>Tamil Nadu</td>
<td>Urban (U)</td>
<td>all (women health)</td>
<td>CMHS (NGO)</td>
<td>Intensive contact and co-consulting between gynaecologist and psychiatrist, with a view to maintaining a consultation-liaison approach</td>
<td>Steppe d care: seen by gynaecologist first, referred to psychiatrist clinic if needed</td>
<td>Gynaecologist: opportunistically diagnoses and treats MDs, and follows up (though still lacks confidence too). Still relies on psychiatrist to confirm diagnoses. Aim to gradually hand over to gynaecologist with referrals when problematic</td>
<td>Psychiatrist: ongoing training of gynaecologist and does weekly outreach clinics. (planned specialist withdrawal)</td>
<td>By gynaecologist. Liaise between patients and psychiatrist.</td>
<td>Intensive ongoing training and weekly support by a Banyan psychiatrist.</td>
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<tr>
<td>Ashwini</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>Before: specialist hospital individual psychiatrist; now: private psychiatrists.</td>
<td>Community (general health hospital NGO)</td>
<td>Moderate collaboration at the beginning with NIMHANS psychiatrist (regular training, clinics, support) with care coordination by gynaecologist. Now no collaboration (no involvement of psychiatrist apart from referring to them)</td>
<td>Matched care by gynaecologist (PHW)</td>
<td>LHWs (volunteers): do identification, awareness, referral, psychoeducation to family and patients; LHWs (health animators): do the same plus informal counselling, follow-up, help set up self-help groups; gynaecologist: gets patients referred to her from other hospital docs. Does all the diagnosis/treatment. Also trained LHWs.</td>
<td>External psychiatrists: very minimal involvement. Gynaecologist contacts psychiatrist friends only by phone if difficulties. (early programme: visiting psychiatrist for training of gynaecologist, doctors and nurses)</td>
<td>Gynaecologist: does all the MH work, referred from health animators, volunteers and hospital doctors</td>
<td>Used to have regular support from NIMHANS psychiatrist. Now only refers when needed or speak to psychiatrist friend.</td>
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<td>SACRED - outreach MH programme</td>
<td>Andhra Pradesh</td>
<td>all</td>
<td>General hospital (government district psychiatrist) + CMHS (Basic Needs India (BNI)-NGO)</td>
<td>Community (disability NGO - SACRED) + self help (several CBOs)</td>
<td>Minimal collaboration with specialists, but moderate collaboration between mental health NGO (who helps monitor programme), disability NGO (runs the programme) and CBOs (implement self-care and identification).</td>
<td>Matched care by psychiatrist</td>
<td>Development workers (SACRED LHWs): identify and refer, they do follow up and medication adherence. Also lobby government and lead self help groups. Trained by BNI and NIMHANS. Caregiver forum at village level (CBOs): self-help support and voice for rights of patients and carers. These are grouped in a larger federation which represents these caregiver groups. Supervised by CBR workers/ coordinators.</td>
<td>External district psychiatrist: available for referrals.</td>
<td>Several coordinators who are not psychiatrically trained and no care role: SACRED CBR coordinators (administrative coordination of LHWs), SACRED training coordinators (monitor+coordinate training to other CBOs+own development workers); BNI mental health coordinators (monitor programme)</td>
<td>Most training by BNI coordinators/ heads. Supervision hierarchy (see under care coordination roles).</td>
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Nadja van Ginneken Thesis Page 368
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<tr>
<td>NBJK/RI NPAS-outreach programme (outreach clinic with PHW support)</td>
<td>Jharkhand</td>
<td>R all</td>
<td>specialist hospital (RINPAS) (government) +CMHS (NGO - Basic Needs)</td>
<td>community (disability NGO - NBJK) +self-care (CBOs)</td>
<td>moderate collaboration between NGOs and CBOs. Minimal collaboration with specialists</td>
<td>matched care by psychiatrist.</td>
<td>NBJK NGO volunteers (LHWs) - (recovered patients or community members). Identification, referral, follow-up, awareness, psychosocial support (Home care). Clinic volunteers: supportive auxiliary role; CBO partnership volunteers: livelihood activities, care + psychoeducation for families and awareness raising</td>
<td>External government psychiatrists (RINPAS): receive referrals, do monthly outreach clinics. No supervision/ongoing support to any LHWs.</td>
<td>NBJK (NGO) Mental health coordinator (non-healthcare graduate): oversees programme, is link between LHWs and specialists. Also trains and supervises LHWs.</td>
<td>Supervised by NGO (NBJK) programme manager, who is in turn supervised by MH NGO (Basic Needs) coordinator</td>
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<td>Level of specialist/non-specialist collaboration</td>
<td>Roles and training of PHWs/community</td>
<td>Roles of specialists</td>
<td>Training coordination and delivery</td>
<td>Training/supervision for coordinator</td>
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<td>Government of India (GOI) DMHP - Chamarajnagar - PHC doctor training</td>
<td>Karnataka</td>
<td>R</td>
<td>all</td>
<td>Specialist + general hospital (government)</td>
<td>PHC</td>
<td>Education and training (E&amp;T) - PHC</td>
<td>One-time training only</td>
<td>PHC doctor: plan for 3 days x2/year for 5 years (total 30 days planned) but most only trained 1 to 3 batches (i.e., 3 to 9 days). Class-based training, with video and some clinical training (patients brought in), content diagnosis, treatment, and educate family.</td>
<td>General+ specialist hospital psychiatrists train PHC doctors and do clinical work. DMHP psychiatrist post vacant so no support.</td>
<td>By department of health and family welfare joint director (MH).</td>
<td>Director of the department of health and family welfare.</td>
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<td>GOI DMHP-Karwar - PHC doctor and ANM (auxiliary nurse midwife) training</td>
<td>Karnataka</td>
<td>R</td>
<td>all</td>
<td>Specialist + general hospital (government)</td>
<td>PHC</td>
<td>E&amp;T - PHC</td>
<td>In practice, only one way training (as vacant post for DMHP psychiatrist)</td>
<td>As above for PHC doctor. ANM training: 1 day to identify, refer, basic support.</td>
<td>As above for PHC doctor. ANM training by DMHP team (psychologist, psychiatric nurse and PSW).</td>
<td>As above for doctors, by district DMHP team for ANMs.</td>
<td>As above for doctors, programme officer supervises DMHP team.</td>
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<td>GOI DMHP-Shimoga - PHC doctor and ANM training</td>
<td>Karnataka</td>
<td>R</td>
<td>all</td>
<td>Specialist + general hospital (government)</td>
<td>PHC</td>
<td>E&amp;T - PHC</td>
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<td>GOI DMHP - Gulbarga - PHC doctor and ANM training (in-depth case study)</td>
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<td>R</td>
<td>all</td>
<td>Specialist + general hospital (government).</td>
<td>PHC</td>
<td>E&amp;T - PHC</td>
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<td>RINPAS - Community mental health programme (CMHP) - PHC doctor training (for DMHP)</td>
<td>Jharkhand</td>
<td>R</td>
<td>all</td>
<td>Specialist hospital (government).</td>
<td>PHC</td>
<td>E&amp;T - PHC</td>
<td>One-time training only</td>
<td>PHC doctor: 15 days training to diagnose, treat +/- refer</td>
<td>Psychiatrists: training, clinical work</td>
<td>Nodal officer (psychiatrist)</td>
<td>Director of the department of health and family welfare</td>
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<td>Karuna Trust - PHC doctor/ ANM training (for DMHP) (in-depth case study)</td>
<td>Karnataka</td>
<td>R</td>
<td>all</td>
<td>Specialist/ general hospitals (government) + community (NGO - Karuna Trust)</td>
<td>PHC</td>
<td>E&amp;T - PHC - Public private partnership</td>
<td>No long term collaboration with specialists but regular contact between doctors and NGO.</td>
<td>PHC doctors: trained 1-5 times 3 days to diagnose, treat +/- refer; ANMs (community nurses): trained 1-2 days to identify, refer to PHC doctor and basic community support.</td>
<td>Visiting NIMHANS and general hospital psychiatrists: train PHC doctors and ANMs + clinical work</td>
<td>NGO mental health coordinator: (usually a general health professional) supervises PHC doctors and coordinates training/monitoring of programme</td>
<td>NGO director</td>
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<td>PHW platform</td>
<td>Form of collaboration</td>
<td>Level of specialist/non-specialist collaboration</td>
<td>Roles and training of PHWs/community</td>
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<tr>
<td>GASS-PHC doctor training (closed)</td>
<td>Karnataka</td>
<td>R</td>
<td>all</td>
<td>Community (disability NGO-GASS); specialist hospital (individual psychiatrist from NIMHANS)</td>
<td>PHC</td>
<td>E&amp;T - PHC</td>
<td>One-time training only</td>
<td>PHC doctor: diagnose, treat +/- refer (1-3 days training)</td>
<td>Visiting NIMHANS psychiatrist: trained local PHC doctors - now stopped</td>
<td>GASS coordinator</td>
<td>Head of GASS</td>
<td></td>
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<tr>
<td>SCARF-PHC doctor external training (closed)</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>PHC</td>
<td>E&amp;T - PHC</td>
<td>One-time training only</td>
<td>PHC doctor: diagnose, some treat, but most follow-up treatment +/- refer (3 days training)</td>
<td>Psychiatrist: training, clinical work</td>
<td>Psychiatrist</td>
<td>None</td>
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<tr>
<td>CHAD-PHC doctor training (closed)</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>General hospital (NGO)</td>
<td>PHC</td>
<td>E&amp;T - PHC</td>
<td>One-time training only</td>
<td>PHC doctor: diagnose, treat +/- refer (3 days training)</td>
<td>Psychiatrist: training, clinical work</td>
<td>Psychiatrist</td>
<td>None</td>
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<tr>
<td>IIAHS-PHC doctor external training (for DMHP)</td>
<td>Delhi</td>
<td>R</td>
<td>all</td>
<td>General hospital (NGO-academic institution)</td>
<td>PHC</td>
<td>E&amp;T - PHC</td>
<td>One-time training only</td>
<td>PHC doctor: diagnose, treat +/- refer (15 days training)</td>
<td>Psychiatrist: training, clinical work</td>
<td>Psychiatrist</td>
<td>None</td>
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<td>Programme</td>
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<tr>
<td>Basic Needs (NGO) /Samarthyana (NGO) /Samuha (CBO)- certificate training for CBR workers</td>
<td>Kurnatak</td>
<td>R</td>
<td>all</td>
<td>CMHS (Basic Needs NGO) + community (Samarthyana - disability NGO)</td>
<td>Community (CBO)</td>
<td>E&amp;T - accredited course</td>
<td>One -time training only</td>
<td>CBR workers: expected to have social worker type responsibilities in the community for disability and mental healthcare</td>
<td>Psychiatrists, PSWs: training, clinical work.</td>
<td>Training coordinator</td>
<td>NGO managers</td>
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<tr>
<td>Saarthak - NGO health worker external training/capacity building</td>
<td>Delhi</td>
<td>U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Community (other CBO/NGOs)</td>
<td>E&amp;T - accredited course</td>
<td>One -time training only</td>
<td>External LHWs in NGOs: trained in identification and psychosocial interventions relating to the Tsunami and anti-trafficking; also sensitization of development sectors to increase focus on mental health.</td>
<td>Psychiatrists and psychologists: training, clinical work.</td>
<td>Psychiatric team</td>
<td>None</td>
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<tr>
<td>VOLCOM-MH programme: own+ other NGO health worker training+ awareness</td>
<td>Mizoram</td>
<td>R/U</td>
<td>all, substance abuse, HIV</td>
<td>Community (NGO)</td>
<td>Community (other CBO/NGOs)</td>
<td>E&amp;T - accredited courses</td>
<td>One -time training only</td>
<td>External LHWs in NGOs (including Saarthak): trained in identification and psychosocial interventions relating to the HIV, MH, drug abuse.</td>
<td>Psychologist: training, clinical work</td>
<td>Psychologist</td>
<td>None</td>
<td></td>
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<tr>
<td>Programme</td>
<td>State</td>
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<tr>
<td>Chellamuthu Trust - caregiver support groups</td>
<td>Tamil Nadu</td>
<td>R/U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Self-care + community (support groups)</td>
<td>E&amp;T - caretaker and awareness raising</td>
<td>One-time training only</td>
<td>Caregivers receive 1-3 days training to identify relapse, raise awareness, home coping strategies, networking and forming support group</td>
<td>Psychiatrist: training, clinical work</td>
<td>Psychiatrist</td>
<td>None</td>
<td></td>
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<tr>
<td>Antara - caregiver training</td>
<td>West Bengal</td>
<td>U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Self-care + community (caregivers)</td>
<td>E&amp;T - caretaker</td>
<td>One-time training only</td>
<td>Caregivers receive 1 day training to identify relapse, medication adherence and coping strategies.</td>
<td>Social workers: training, clinical work</td>
<td>Social workers</td>
<td>Psychiatrists</td>
<td></td>
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<tr>
<td>Ashadeep - caregiver manual</td>
<td>Assam</td>
<td>R</td>
<td>all (homeless)</td>
<td>CMHS (NGO)</td>
<td>Self-care + community (caregivers)</td>
<td>E&amp;T - caretaker</td>
<td>One-time training only</td>
<td>Caregivers given a self-help manual to identify relapse, medication adherence and coping strategies.</td>
<td>n/a</td>
<td>No training</td>
<td>n/a</td>
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### Supplementary table 3: Characteristics of replacement and referral programmes

<table>
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<tr>
<th>Programme</th>
<th>State</th>
<th>Urban/ Rural</th>
<th>MD</th>
<th>Specialist/ support platform</th>
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<tbody>
<tr>
<td>Richmond Fellowship Society/Sidd laghatta - (closed)</td>
<td>Karnatak</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>PHC</td>
<td>Replace ment &amp; Referral (R&amp;R) - PHC training</td>
<td>One -time training only</td>
<td>PHC doctor, ANM, Anganwadi: a few days training to identify and refer cases to RFS outreach clinics</td>
<td>Psychiatrist: training, clinical work</td>
<td>Psychiatrist</td>
<td>None</td>
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<tr>
<td>Ashok Pai Hospital - PHC doctor external training (closed)</td>
<td>Karnatak</td>
<td>U</td>
<td>all</td>
<td>Specialist hospital (private)</td>
<td>PHC</td>
<td>R&amp;R - PHC training</td>
<td>One -time training only</td>
<td>PHC doctor: Identify and refer (1-3 days training)</td>
<td>Psychiatrist: training, clinical work</td>
<td>Psychiatrist</td>
<td>None</td>
</tr>
<tr>
<td>GASS - Health assistants, anganwadi, ANM, self help groups, teacher training</td>
<td>Karnatak</td>
<td>R</td>
<td>all</td>
<td>Communify (GASS-disability NGO) + CMHS (Basic Needs UK - NGO)</td>
<td>PHC + community</td>
<td>R&amp;R - PHC training</td>
<td>One -time training, regular interaction with community staff for MH and disability</td>
<td>ANMs: 5 days training (ANMs) and Anganwadis, SHG members: 2 days training in identification and referral and sensitisation (street plays).</td>
<td>Basic Needs and GASS coordinators/ leaders (PSW/MSW backgrounds respectively) training, management, leadership</td>
<td>Basic Needs and GASS coordinators and leaders</td>
<td>None</td>
</tr>
<tr>
<td>Programme</td>
<td>State</td>
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<tr>
<td>Chellamuthu Trust - DMHP PHC doctor training + VHNs, Anganwadis</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>PHC + community</td>
<td>R&amp;R - PHC training</td>
<td>One-time training only</td>
<td>PHC doctor (15 days training) and other PHC/community staff (3 days training) identify and refer to psychiatrist at outreach camps.</td>
<td>Psychiatric team (psychiatrist, psychologist, PSW) do regular outreach camps. Train PHC doctors and other PHC staff</td>
<td>Psychiatric team</td>
<td>Head of NGO</td>
</tr>
<tr>
<td>TTK Ranganatha n - external training (medical+ nursing students)</td>
<td>Tamil Nadu</td>
<td>U</td>
<td>substance abuse</td>
<td>Specialist hospital (NGO)</td>
<td>PHC/general care</td>
<td>R&amp;R - PHC training</td>
<td>One-time training only</td>
<td>PHC doctor; identify, preliminarily diagnosis and refer cases of substance abuse</td>
<td>Psychiatrist and PSW; training, clinical work</td>
<td>PSW and psychologist</td>
<td>None</td>
</tr>
<tr>
<td>SCARF - telemedicine (closed)</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>SMDs</td>
<td>CMHS (NGO)</td>
<td>PHC</td>
<td>R&amp;R - PHC training</td>
<td>One-time training, with no supervision but contact to organise teleconference sessions</td>
<td>PHC doctor trained 1-2 days to identify and refer to psychiatrist and organise telemedicine sessions.</td>
<td>Psychiatrists: telemedicine consultations. Train PHC doctor.</td>
<td>Psychiatrist</td>
<td>None</td>
</tr>
<tr>
<td>Banyan - PHC doctor external training (for DMHP)</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>PHC</td>
<td>R&amp;R - PHC training</td>
<td>One-time training only</td>
<td>PHC doctors trained to identify and refer (1-3 days training)</td>
<td>Banyan psychiatrist helped train PHC doctors</td>
<td>Banyan-BALM training coordinator</td>
<td>BALM director</td>
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<tr>
<td>Programme</td>
<td>State</td>
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<td>Specialist/ support platform</td>
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<tr>
<td>AIIMS - Kashmir PHC doctor training (closed)</td>
<td>Kashmir/Delhi</td>
<td>R</td>
<td>all</td>
<td>General hospital (academic government)</td>
<td>PHC</td>
<td>R&amp;R - PHC training</td>
<td>One-time training only</td>
<td>PHC doctor: detect, refer and follow-up patients (up to one week training)</td>
<td>Psychiatrist: training, diagnosis and treatment</td>
<td>Experiential learning within psychiatrist-led outreach clinic (humanitarian relief dispatch)</td>
<td>None</td>
</tr>
<tr>
<td>Basic Needs UK/ NBJK- ANM/Asha training</td>
<td>Jharkhand</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>PHC+ community</td>
<td>R&amp;R - PHC training</td>
<td>One-time training but regular contact re disability/ mental health work</td>
<td>ANM/ASHA in programme locality: 1 day training: identify, refer, follow-up, awareness raising</td>
<td>Basic Needs coordinator (psychology/PS W): training, management, leadership</td>
<td>Assistant mental health coordinator organises training; Basic needs coordinator delivers it</td>
<td>NBJK and BN-UK directors</td>
</tr>
<tr>
<td>Banyan BALM - external NGO training/ capacity building</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Community (other CBO/NG Os)</td>
<td>R&amp;R - community training</td>
<td>External organisation one-time training only</td>
<td>HWs from other NGOs: sensitised to MH and to identify and refer (1 day training)</td>
<td>Psychologists, psychiatrists and PSWs: training, clinical work</td>
<td>Training coordinator (BALM) and delivery by specialists</td>
<td>Director of BALM</td>
</tr>
<tr>
<td>Bapu Trust - external NGO training</td>
<td>Mahrashtra</td>
<td>U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Community</td>
<td>R&amp;R - community training</td>
<td>External organisation one-time training only</td>
<td>HWs from other NGOs: 1 day training: identify, refer</td>
<td>Psychologist: training, clinical work</td>
<td>Psychologist: training, clinical work</td>
<td>NGO director</td>
</tr>
<tr>
<td>Programme</td>
<td>State</td>
<td>Urban/ rural</td>
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<td>Specialist/ support platform</td>
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<tr>
<td>Institute of Psychological Health/ Maitra - NGO and corporate external training</td>
<td>Maha rashtra</td>
<td>U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Commun</td>
<td>R&amp;R - communtiy training</td>
<td>External organisation one-time training only</td>
<td>HWs from other NGOs/corporate sector: trained (1 day) to identify, refer and support patients/families</td>
<td>Psychologist: training, clinical work</td>
<td>Psychologist</td>
<td>NGO director</td>
</tr>
<tr>
<td>ANT - external training to NGOs</td>
<td>Assam</td>
<td>R</td>
<td>all</td>
<td>Communit y (NGO)</td>
<td>Commun</td>
<td>R&amp;R - communitiy training</td>
<td>External organisation one-time training only</td>
<td>HWs from other CBOs and NGOs: trained to include mental health into their development or health initiatives</td>
<td>None</td>
<td>Coordinator (MSW)</td>
<td>NGO head (general physician)</td>
</tr>
<tr>
<td>TTK Ranganatha n - external training</td>
<td>Tamil Nadu</td>
<td>R/U</td>
<td>substance abuse</td>
<td>Specialist hospital (NGO)</td>
<td>Commun</td>
<td>R&amp;R - communitiy training</td>
<td>External organisation one-time training only</td>
<td>Police, clergy, community workers: identify and refer (1 day training)</td>
<td>Psychiatrist and PSWs: training, clinical work</td>
<td>Specialists</td>
<td>Head of NGO</td>
</tr>
<tr>
<td>SNEHA - external training</td>
<td>Tamil Nadu</td>
<td>U</td>
<td>all, mainly suicide prevention</td>
<td>CMHS (NGO)</td>
<td>Commun</td>
<td>R&amp;R - communitiy training</td>
<td>External organisation one-time training only</td>
<td>Police, other community workers: sensitise to MH and to identify and refer (1 day training)</td>
<td>Psychiatrist/ SNEHA director: training, clinical work</td>
<td>Psychiatrist/ SNEHA director and experienced volunteers/clinical coordinators</td>
<td>None</td>
</tr>
<tr>
<td>Programme</td>
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<tr>
<td>Mukhtangan Mitra - community external training</td>
<td>Maharashtra</td>
<td>R/U</td>
<td>substance abuse</td>
<td>Specialist hospital (NGO)</td>
<td>Communuity</td>
<td>R&amp;R - community training</td>
<td>External organisation one-time training only</td>
<td>Police, rehab/de-addiction centres, prison officers, traffic officers: 1 day training on identification and referral for HIV, stress management, alcohol/drug abuse</td>
<td>Psychiatrist, psychologist, PSW: training, clinical work</td>
<td>Specialists</td>
<td>NGO director</td>
</tr>
<tr>
<td>Banyan/panchayat academy training</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Communify (CBO)</td>
<td>R&amp;R - community training</td>
<td>Partnership of organisation, shared decision making about programme direction</td>
<td>Panchayat leaders identify and refer to Banyan. Trained by coordinator and Banyan specialists (1 day)</td>
<td>Banyan leader (PSW); receives referrals, trained Panchayat Academy head and panchayat leaders. Maintains contact with coordinator.</td>
<td>Panchayat Academy head (coordinator): coordinates programme and ensures adequate people referred to Banyan. monitors the programme.</td>
<td>Ad-hoc training, established collaborative rapport between Panchayat Academy head and Banyan</td>
</tr>
<tr>
<td>SNR Hospital Kolar/ Murgamalla dargah camps</td>
<td>Karnataka</td>
<td>R</td>
<td>Severe mental disorders (SMDs)</td>
<td>General hospital (government)</td>
<td>Communify (religious institution)</td>
<td>R&amp;R - community training</td>
<td>Minimal collaboration</td>
<td>Assistant and religious leaders: ad hoc training to identify and refer to psychiatrist during camps</td>
<td>Psychiatrist: outreach camps fortnightly. He also surveys the dargah to check on adequate care (no chaining) for mentally ill.</td>
<td>Assistant: organise psychiatric camps and bring patients to them; Supervisor: administrative coordination</td>
<td>Informal training, no supervision.</td>
</tr>
<tr>
<td>Programme</td>
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<td>Urb &amp; Rura</td>
<td>MD</td>
<td>Specialist/support platform</td>
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<tr>
<td>SACRED - advocacy/awareness campaigns</td>
<td>Andhra Pradesh</td>
<td>R</td>
<td>all</td>
<td>Community (SACRED - disability NGO)</td>
<td>Commun Ity</td>
<td>R&amp;R - campsns</td>
<td>Intermittent campaigns</td>
<td>LHWS and local federations and self-help groups (training from BNI and NIMHANS) help deliver campaigns to general population (also do social-worker-like duties).</td>
<td>Psychiatrists</td>
<td>SACRED training coordinator organises these campaigns and delivers them with PHWs.</td>
<td>SACRED managers</td>
</tr>
<tr>
<td>Saarthak - volunteer-led campaigns</td>
<td>Delhi</td>
<td>U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Commun Ity</td>
<td>R&amp;R - campsns</td>
<td>Intermittent campaigns</td>
<td>200 community volunteers (1 day training) support specialist team for information/education campaigns to general population and advocacy (as well as for rehabilitation).</td>
<td>Psychiatrist, psychologists: train and network with volunteers</td>
<td>NGO specialists</td>
<td>Psychiatrists</td>
</tr>
<tr>
<td>Ashadeep - distribution poster/leaflets</td>
<td>Assam</td>
<td>R</td>
<td>all (homeless)</td>
<td>CMHS (NGO)</td>
<td>Commun ity</td>
<td>R&amp;R - campsns</td>
<td>Ongoing campaign</td>
<td>HWs from linked CBOs/NGOs: regularly disseminate pamphlets and posters for general population.</td>
<td>None</td>
<td>Community resource centre coordinator (training centre).</td>
<td>Ashadeep co-director</td>
</tr>
<tr>
<td>Programme</td>
<td>State</td>
<td>Urban/ rural</td>
<td>MD</td>
<td>Specialist/support platform</td>
<td>PHW platform</td>
<td>Form of collaboration</td>
<td>Level of specialist/non-specialist collaboration</td>
<td>Roles and training of PHWs/community</td>
<td>Roles of specialists</td>
<td>Training coordination and delivery</td>
<td>Training/supervision for coordinator</td>
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<tr>
<td>Ashok Pai Hospital - awareness raising+films</td>
<td>Karnataka</td>
<td>U</td>
<td>all</td>
<td>Specialist hospital (private)</td>
<td>Community</td>
<td>R&amp;R campaigns</td>
<td>Intermittent campaigns</td>
<td>General population: exposed to MH awareness.</td>
<td>Psychiatrist: talks, interviews and making films to raise awareness about MH</td>
<td>Specialist-led</td>
<td>None</td>
</tr>
<tr>
<td>Richmond Fellowship Society - campaigns/ NGO training</td>
<td>Karnataka</td>
<td>R</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Community</td>
<td>R&amp;R campaigns</td>
<td>Intermittent campaigns</td>
<td>General population: exposed to MH awareness</td>
<td>Psychiatrist: training, awareness raising events, lead campaigns.</td>
<td>Specialist coordinator: organises and conducts some awareness-raising events</td>
<td>None</td>
</tr>
<tr>
<td>VOLCOM - college campaigns</td>
<td>Mizoram</td>
<td>R/U</td>
<td>all, substance abuse, HIV</td>
<td>Community (NGO)</td>
<td>Community</td>
<td>R&amp;R campaigns</td>
<td>Intermittent campaigns</td>
<td>Colleges students/young professionals; exposed to MH awareness campaign to help with self or other identification and referral.</td>
<td>Clinical psychologist/ leader lead campaigns.</td>
<td>Leader (clinical psychologist)</td>
<td>None</td>
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</table>
**Supplementary table 4: Characteristics of community outreach programmes**

<table>
<thead>
<tr>
<th>Programme</th>
<th>State</th>
<th>Location</th>
<th>MDs</th>
<th>Specialist platform</th>
<th>PHW platform</th>
<th>Level of PHW/community and specialist interaction</th>
<th>Steppe/d/match or single intervention</th>
<th>PHWs: background and roles</th>
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<th>Care manager: background and roles</th>
<th>Care coordination</th>
<th>Training + supervision of care manager/care coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banyan-Urban Mental Health Programme (outreach clinic with PHW support)</td>
<td>Tamil Nadu</td>
<td>U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>CMHS (clinic)</td>
<td>Regular organised supervisory meetings between psychiatrist, social workers and volunteers</td>
<td>Matched care determined by PHW-delivered triage</td>
<td>Volunteers (LHWs) and social workers: Joint outreach clinics with psychiatrist. Support specialist by doing triage, history taking and also providing support/advice. Refer to psychiatrist only if necessary. Patient contact at clinic only (not home-based)</td>
<td>Psychiatrist: diagnosis, treatment, supervise volunteers (Outreach clinics)</td>
<td>Social workers: Coordinate activities (clinical roles under ‘PHW roles’)</td>
<td></td>
<td>Supervised by psychiatrist</td>
</tr>
<tr>
<td>MHAT (outreach clinic with PHW support)</td>
<td>Kerala</td>
<td>R</td>
<td>Chronic mental disorders (schizophrenia)</td>
<td>CMHS (NGO)</td>
<td>community</td>
<td>Regular organised supervisory meetings between psychiatrists, psychologists and</td>
<td>Matched care determined by psychiatrist</td>
<td>Care volunteers (LHW): existing palliative care volunteer with added MH responsibility; weekly home visits; assigned one patient for life,</td>
<td>Specialist team (psychiatrist, psychologist, PSW): diagnosis, treatment, follow-up (outreach)</td>
<td>Care volunteers: (LHW with certificate). Clinical roles as under ‘PHW’. Liaise between community, other LHWs and specialists</td>
<td></td>
<td>6 month mental health training+dipoma. Intensive supervision for psychologists</td>
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<tr>
<td>SCARF-COPSI (PHWs as lay counsellors)</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>Schizophrenia</td>
<td>CMHS (NGO)</td>
<td>Community level workers (LHWs): complementary roles to specialists (Home visits): identification/referral and supporting families. Stigma intervention, general support, raising awareness. Supervised by coordinators (weekly) and by supervisors (3 monthly)</td>
<td>Psychiatric team (PSW, psychiatrist, psychologist): diagnosis, treatment, follow-up, (weekly outreach clinics in different locations). Also trial monitoring, advocacy + networking</td>
<td>Coordinator (PSW+psychologist background) Supervise PHWs, liaise between community, LHWs+specialists. Coordinate programme, network with agencies. No clinical roles.</td>
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Nadja van Ginneken Thesis Page 383
<table>
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<tr>
<th>Program me</th>
<th>State</th>
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<tbody>
<tr>
<td>Bapu Trust-Seher program me (PHWs as lay counsellors)</td>
<td>Maharashtra</td>
<td>U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>Community</td>
<td>Regular contact and meetings for support and exchange of patient information</td>
<td>Matched care by specialist team</td>
<td>LHW counsellors i.e. field workers and peer supporters (subtype of fieldworker who provide intensive 24/7 support for those in need): identification, referral if necessary, psychoeducation, support, bring patients to camp, also counselling, corner meetings. Generalist doctor: employed just for outreach clinics to rule out organic disorders.</td>
<td>Specialist team does outreach clinics including psychotherapies (psychologist, PSW). Psychiatrist does field worker training.</td>
<td>LHW counsellor called 'fieldworker' - recovered patients: Liaise between patients and specialist. Care roles as under 'phw roles'</td>
<td></td>
<td>Supervised by psychologists and leader/coordinator. Also trained by psychiatrist, psychologist PSWs and coordinators</td>
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<tr>
<td>Mukhtan g Mitra- outreach rural (PHWs as lay counsellors)</td>
<td>Maharashtra</td>
<td>R substant abuse</td>
<td>Specialist hospital (NGO)</td>
<td>Community</td>
<td>Regular organised supervisory meetings between specialists, coordinators and volunteers</td>
<td>Matched care determined by psychiatrist</td>
<td>Volunteers (LHWs): (1 month training or more; some have CBT/REBT training) support specialist care by providing counselling, psychosocial support (outreach clinics); also receive calls in call centre (see below); Caregivers: trained by volunteers.</td>
<td>Psychiatrist and psychologist: diagnosis, treatment, supervise volunteers (Outreach clinics).</td>
<td>Coordinator (clinic-based mental health paraprofessiona l). Coordinates and supervises volunteers and counsellors. Also has treatment/care roles within NGO clinical services.</td>
<td></td>
<td>Training and supervisio by specialists (of all PHWs).</td>
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<tr>
<td>Saarthak PACT (PHWs as lay counsellors)</td>
<td>Delhi</td>
<td>R Sever e or endur ing mental disorders</td>
<td>CMHS (NGO)</td>
<td>Community</td>
<td>Regular organised supervisory meetings between psychiatrists, psychologists and facilitators.</td>
<td>Steppe d care - psycho social support (primary facilitator; counselling (secondary facilitator), referral to psychiatrist)</td>
<td>Primary facilitator (graduates or recovered users); psychosocial support, befriending, activities; secondary facilitator (with 1 year Saarthak diploma): group leaders, counselling and supervise/peer support with primary facilitators. (Home visits)</td>
<td>Psychiatric team (PSW, psychiatrist, psychologist): diagnosis, treatment including therapies. (outreach clinics)</td>
<td>Secondary facilitators: (diploma graduates). lead team, liaise between primary facilitators, community and specialists.</td>
<td>Psychologists coordinate the programme</td>
<td>1 year diploma course. Supervision by therapists and psychiatrists.</td>
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<tr>
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<tr>
<td>VOLCOM - outreach program me (PHWs as lay counsellors)</td>
<td>Mizoram</td>
<td>R all, substance abuse, HIV CMHS (NGO)</td>
<td>Community</td>
<td>Regular organised supervisory meetings between psychologists and outreach workers.</td>
<td>Peer educators (PE's)(recovered users: LHWs): identification, referral, follow-up, some counselling, psychosocial support, awareness raising (3 days training in house). Outreach workers (LHWs): supervise PE's and do livelihood/ benefits work with clients. All PHWs involved in HIV and substance use care too. (Home visits).</td>
<td>Clinical psychologists trained by programme coordinator/leader and perform community-based clinics at VOLCOM centre. No psychiatrists (can refer to government psychiatrist).</td>
<td>Outreach workers: (graduates/SWs or experienced users/previous peer educators (PE's). clinical roles as under 'PHWs'. Liaise between PE's and psychologists/ head of VOLCOM. Supervise PE's including joint visits every week (as do psychologists).</td>
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<tr>
<td>SNEHA-helpline</td>
<td>Tamil Nadu</td>
<td>R/U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>CMHS</td>
<td>Regular meetings between psychiatrist and coordinators and coordinators with volunteers.</td>
<td>One intervention only (befriending)</td>
<td>Volunteers (LHWs). 40 days training + ongoing training. Provide emotional first aid, and keep records of discussions. (Call centre) Also do fundraising.</td>
<td>Psychiartist: supervision, training, external training, overall programme coordination.</td>
<td>Experienced volunteers (non-health lay background (LHW)). Train volunteers, Coordinate and supervise volunteer call receivers. Also clinical roles as under PHW roles.</td>
<td>Both by psychiatrist leader.</td>
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<tr>
<td>Maitra-helpline</td>
<td>Maharashtra</td>
<td>R/U</td>
<td>all</td>
<td>CMHS (NGO)</td>
<td>CMHS</td>
<td>Regular meetings between coordinator, care managers and volunteers</td>
<td>One intervention only (befriending)</td>
<td>Volunteers (LHWs). 3-5 days training and ongoing training every 2-3 months. Provide emotional first aid. (Call centre).</td>
<td>Psychologist and PSW: supervise and train volunteers.</td>
<td>Psychologist and PSWs: coordinate, supervise and train volunteers and some also involved in receiving calls. (also have other clinical roles with the NGO (Maitra).</td>
<td>Supervised by programme coordinator/ counsellor (non-health background initially).</td>
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<tr>
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<tr>
<td>Mukthan g Mitra- helpline</td>
<td>Maha rashtra</td>
<td>R/U</td>
<td>substant</td>
<td>Specialist hospital (NGO)</td>
<td>CMHS</td>
<td>Moderate communication between specialists and coordinators, best contact between coordinators and volunteers</td>
<td>One intervention only (support and crisis intervention)</td>
<td>Volunteers (LHWs): 1 month training, some have additional REBT or CBT training, provide support, advice and minimal counselling. (Call centre)</td>
<td>Psychiatrist, psychologist: supervise and train coordinators</td>
<td>Coordinator (mental health paraprofessiona l): supervises/mon itors volunteers calls. Trains volunteers. Also has treatment/care roles within NGO clinical services</td>
<td>Psychiatrist and coordinato r</td>
<td></td>
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<tr>
<td>Uduvam Ulangal- rescue op eratio n (for shelter)</td>
<td>Tamil Nadu</td>
<td>R</td>
<td>all</td>
<td>General hospital (individual psychiatrist)</td>
<td>community</td>
<td>Specialist team communicati on good</td>
<td>one intervention (rescue operation)</td>
<td>LHWs (lay counsellor/social worker): part of outreach team. Supportive role to the specialist for psychosocial support</td>
<td>Psychiatrist: visit hot spots in community with LHWs. Also diagnosis and treatment</td>
<td>Coordinator (graduate/PHW) : main role administrative coordinating CHAD and government hospital activities. Minor roles in PHW support. Also does patient family reintegration</td>
<td>Psychiatris t</td>
<td></td>
</tr>
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<tr>
<td>Mission Ashra-rescue operation (for care unit)</td>
<td>Orissa</td>
<td>all homeless</td>
<td>Specialist hospital (NGO)</td>
<td>PHWs from specialist hospital (nurses and general social workers)</td>
<td>Minimal interaction between psychiatrist and PHWs</td>
<td>One intervention (rescue operation)</td>
<td>Pharmacist, nurse, social worker: part of outreach team. Supportive role but also do counselling and help with children, refer to the care unit/rehab and do resilience training for community/families</td>
<td>Psychiatrist, psychologist: team (+PHW social worker) visit hot spots in community. Psychiatrist: diagnosis and treatment</td>
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<tr>
<td>Vocational rehabilitation (not a first level access but community based service)</td>
<td>Karnataka</td>
<td>R</td>
<td>SMDs</td>
<td>Community (CBO) + self-care</td>
<td>Minimal contact with specialists (only available for referral). Regular organised contact between coordinators and PHWs</td>
<td>Single intervention (horticulture or tailor training)</td>
<td>Recovered patients: horticultural, tailoring trainers (community centre)</td>
<td>No specialists involved in this service apart from referring to local psychiatrists</td>
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<tr>
<td>Samuha (CBO)/Samarthya (NGO)/Basic Needs India (CMHS) - vocational rehabilitation</td>
<td>Karnatak</td>
<td>R</td>
<td>SMDs</td>
<td>CMHS (NGO) + community (disability NGO)</td>
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Nadja van Ginneken Thesis Page 390
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<tbody>
<tr>
<td>Banyan - day care centre (rehabilitation)</td>
<td>Tamil Nadu</td>
<td>U</td>
<td>SMDs</td>
<td>CMHS (NGO)</td>
<td>Self-care</td>
<td>Regular weekly interaction between psychiatrist and coordinator</td>
<td>Single intervention (computer or crafts training)</td>
<td>Recovered patients: IT and arts/crafts trainers. Also follow-up patients with regards to their medication effect (in a centre)</td>
<td>Psychiatrist: weekly outreach clinics.</td>
<td></td>
<td>Coordinator: (non-health graduate background) coordinates activities and supervises vocational trainers</td>
<td>Hierarchy of training and supervision: Psychiatrist, coordinator, vocational trainers</td>
</tr>
<tr>
<td>Chellamu thu Trust - vocational rehabilitation unit</td>
<td>Tamil Nadu</td>
<td>U</td>
<td>SMDs</td>
<td>CMHS (NGO)</td>
<td>Self-care</td>
<td>Contact of psychiatrist with PHWs at outreach clinics</td>
<td>Single intervention (vocational training)</td>
<td>Recovered patients: tailoring and arts/crafts trainers (in a centre)</td>
<td>Psychiatrist: outreach clinics.</td>
<td></td>
<td>Psychiatrist: coordination and supervision.</td>
<td>None</td>
</tr>
<tr>
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<td>Banyan-Adaikalam reintegration programme (rehabilitation)</td>
<td>Tamil Nadu</td>
<td>R/U SMDs</td>
<td>CMHS (NGO specialist unit)</td>
<td>Visiting team have substantial contact and patient information sharing</td>
<td>Single intervention (reintegration into families)</td>
<td>Reintegration volunteers (non-health workers) in community: reintegration of family member. Family support (home visit). Supervised and trained by Adaikalam outreach team</td>
<td>Psychiatrists, clinical psychologists and psychiatric social workers Adaikalam (institution) outreach team: help with the reintegration team activities and support before/after</td>
<td>Psychiatrist: coordination and supervision</td>
<td>None</td>
<td></td>
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