Day 1, August 26, 2010		
1.	**Background and History**	**Ms. Ruchika Bahl and Mr. Naidu**

The day started off with an introduction into the history of NAAJMI and the Knowledge Capture exercise.

In order to establish a unifying platform where all the social advocates of mental health – i.e. clinical psychologists, psychiatrists as well persons living with mental illness could participate, *Ashoka: Innovators for the Public*[1]'s *Law For All Initiative*[2] brought together three of its Ashoka Fellows - Bhargavi Davar (Pune), Ratnaboli Ray (Kolkata) and Monica Kumar (Delhi) working in the area of mental health. Along with other players in the mental health sector, they established the '*National Alliance on Access to Justice for Persons living with a Mental Illness*', otherwise known as NAAJMI.

NAAJMI's Vision is to assure "A Life of Dignity for Every Person Living with Mental Illness". In order to accomplish its vision, NAAJMI has a four-point Mission:

(i) Influence policy and public opinion
(ii) Capture and apply knowledge
(iii) Provide a platform for dialogue among all stakeholders in the mental health sector – specially for the voices that have not been heard so far
(iv) Learn from other movements and network with them

NAAJMI has now become a strong collective voice around the country demanding justice and access to justice for persons living with mental illness based on the values of dignity, respect and autonomy. It is an alliance of, by and for people living with mental illness, and is inclusive of a diverse community of people with a personal and / or professional engagement with disability and persons living with mental illness.

1.1.	Background on Knowledge Capture Exercise	Ms. Monica Kumar

The Knowledge Capture exercise was formulated as a way of capturing 'good practices' from community mental health models from across India. The aim was also to strengthen the public-private partnership between the government and NGOs, thereby increasing accessibility to and affordability of mental health services in our country.

[1] Ashoka is a global association of the world's leading social entrepreneurs—men and women with system changing solutions for the world's most urgent social problems. Since 1981, we have elected over 2,000 leading social entrepreneurs as Ashoka Fellows, providing them with living stipends, professional support, and access to a global network of peers in more than 60 countries. Please visit www.ashoka.org

[2] Law for All Initiative works across sectors and across countries to strengthen human rights, democratic spaces, and good governance. Please visit http://lawforall.ashoka.org/

Questionnaires were sent to 40 organisations from across India to elicit information on the salient elements of each organisation's model for community mental health. (For further information on the design of the workshop, please see the Concept Note in Annexure A).

In this meeting, a panel of experts from the mental health sector had been brought together in order to evaluate the information gathered from the questionnaires. The Panelists were as follows:

(i) Mr. D.M. Naidu, Basic Needs (Bangalore), Chairperson NAAJMI,
(ii) Dr. Jagdish Kaur, CMO, Ministry of Health and Family Welfare,
(iii) Prof. Kiran Rao, Ex-NIMHANS Faculty and Head of Department of Clinical Psychology,
(iv) Ms. Vandana Bedi, Consultant – Disability and Development (Delhi),
(v) Dr. Rajesh Sagar, Psychiatrist, AIIMS,
(vi) Dr. Sudipto Chatterjee, Psychiatrist, SANGATH Goa (Ex-Director of Mental Health Unit, ASHAGRAM),
(vii) Ms. Deepika Nair, Founder member of SAATHI for Action (Delhi),
(viii) Mr. Naveen Kumar, Psychologist and Trustee-Manas Foundation (Delhi),
(ix) Ms. Ratnaboli Ray, Ashoka Fellow, Member of NAAJMI, Director of Anjali (Kolkata), and
(x) Ms. Monica Kumar, Clinical Psychologist, Ashoka Fellow, Member of NAAJMI, Trustee-Manas Foundation (Delhi).

Ms Monica Kumar introduced the workshop by discussing the need for a mental health continuum (of mental illness at one end and positive mental health on the other). One of the questions raised with respect to this continuum was: *Where is the focus and where should it be?* She also discussed the '*culture of silence*' in India with respect to mental health.

The other issues discussed were - the inability to think beyond institutions in the context of mental health in India, the need to design pathways to care, lack of access to treatment for the common person, gaps in treatment, need of government policy to tap productivity of people who live with one or other form of mental health issue and the rural-urban divide in service conceptualization and provision.

1.2.	**UNCRPD-NRHM-DMHP: Linkages/Convergence and larger implications of the Knowledge Capture exercise**	**Mr. D.M. Naidu and Mr. Sudipto Chatterjee**

The discussion began with Dr. Sudipto Chatterjee pointing out that there is a large 'treatment gap' in India, i.e. there are effective treatments available, but without adequate delivery mechanisms for people to be able to access them. The ray of hope in this regard is the concept of 'task-shifting' - wherein persons with no mental health background are trained to deliver specific tasks, thereby improving delivery services on the ground. Thus, it is not adequate to merely have a comprehensive mental health model. It is important to ensure that the delivery of the services under the model happens in an acceptable and effective format.

The national scenario in the mental health context is also very grave. Despite increased allocations in the 11th Five-Year Plan for the mental health sector (Rs. 1100 crores), the funds have remained largely unutilized. This is mainly due to the inability of the government to effectively rope in community involvement and participation and thus failing in sustaining the programs and resulting in the channelization of the budgeted funds away from mental health. This, amongst other things, points to a *crisis in leadership* in this sector. Adding to the problems of the sector, there is high fragmentation amongst the voices of the sector. The state of amendment of the Mental Health Act bears testimony to the same.

Dr. Chatterjee emphasized that in developing countries, social interventions are necessary along with treatment and hence focus is required on social determinants of mental health.

Also, India has much to learn from other countries where similar challenges have been effectively tackled. In the Indian context, there is a need for consensus on the fact that services need to be based on strong ethical principles, rigour is essential to build up scientific evidence, and scaling up needs to move beyond the financial investment into investment in the methodology by having serious reflections and focusing on barriers to change.

Thus, where the first generation of National Mental Health Programme (NMHP) was not able to deliver, it is paramount to have clarity on the aspirations of the sector. This is where such an exercise such as this truly matters.

Mr. Naidu agreed with Dr. Sudipto's perspective and reiterated that there is no effective convergence within the mental health sector in India. Absence of mental health as an important component of the over-all well being of an individual within the national level health policies like National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) speaks volumes about the lack of will and consensus to take forward this cause.

Rajive Raturi from Human Rights Law Network (a member of NAAJMI) gave his inputs regarding the mental health climate in India, with respect to the amendment processes, which are currently ongoing for both the Mental Health Act, 1987 and the National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999. The mental health sector is presently looking towards getting a comprehensive law enacted, keeping in mind that transplanting the UN Convention of the Rights of the Persons with Disabilities in its entirety would not work in the Indian scenario. He shared that the present Knowledge Capture exercise could feed directly into the aforementioned advocacy initiatives of NAAJMI.

Dr. Chatterjee concluded the discussion on this note by restating the challenge facing the mental health sector in trying to make the following three angles meet:

(i) Clarity on the framework of comprehensive community-based mental health care;

(ii) Ensuring delivery mechanisms which effectively improve access to mental health care within the community;

(iii) Ensuring quality and fidelity of services through continuous support and supervision for the frontline service delivery staff, who are often people without a background in mental health.

1.3.	**Criteria for extracting models from the information collected from the organizations.**	**Ms. Ratnaboli Ray**

Ms. Ratnaboli commenced the next step in the Knowledge Capture by starting the discussion to determine the criteria which would be utilised to carve out the framework within which the good practices from the 25 completed questionnaires would be culled out.

She presented to the Panel the criteria formulated based on the questionnaires by Mr. Naveen Kumar and herself, prior to the Workshop, and opened it for further discussion and feedback.

Dr. Kiran Rao gave her opinion that in a country like India with high diversity of population, multiple community health models were possible. It is however important to keep in mind the user, who is usually a silent voice in the system.

Ms. Deepika Nair mentioned three aspects of the community mental health issue which would be vital to the deliberations:

(i) Approach: The model is less about 'treatment' and more about 'recovery'. This change in mindset is vital;
(ii) Delivery mechanisms/ capacity and support;
(iii) Ethics.

Dr. Chatterjee reiterated that many countries have grappled with problems similar to the ones that India is facing. He gave the example of the Caracas system. It would be wise for the mental health sector in India to take into account such examples and learn from the same.

Upon subsequent deliberation, where the different members voiced their concern about the lack of proper definitions on the words like 'Replicability', and 'Scalability', the need for a common understanding, language and a vision or framework, certain criteria were agreed upon by the Panel. These criteria were to be utilised by the Panel in order to analyse the information contained in the questionnaires.

S. No.	**Criteria**
(i)	Innovation/Newness of Ideas
(ii)	Resource Utilization (Using resources of the community/ leveraging resources for maximum benefit)
(iii)	Reach
(iv)	Ownership
(v)	Methods of care and treatment
(vi)	Impact
(vii)	Sustainability
(viii)	Vision/ Aspiration

1.4.	**Review of the Models**

The Panel was divided into sub-groups randomly. Each sub-group was given five filled questionnaires from the list attached to the Knowledge Capture Agenda (please see Annexure B).

(i) Group-1:

Panelists: Dr. Kiran Rao & Ms. Monica Kumar

Organizations:
Samuha, Koppal; GASS, Bangalore; Janarth, AVS, Maharashtra; ADD-India, Bangalore and RARE, Orissa.

(ii) Group-2:

Panelists: Mr. Naidu & Ms. Ratnaboli Ray

Organizations:
SACRED, Andhra Pradesh; Narendra Foundation; Sangath, Goa; USS, Orissa; Manas-West Bengal

Group-3:

Panelists: Dr. Sudipto Chatterjee, Mr. Naveen Kumar and Ms. Deepika Nair

Organizations:
DAPTA, Orissa; OLS, Orissa; PRASSANA, Bangalore; RFS(India), Bangalore; SAMPARK, Bangalore.

On the basis of the criteria decided by the Panel collectively, the sub-groups evaluated the information questionnaires. The conclusions from these deliberations are attached hereto as Annexure C.

1.5.	**Presentation and Synthesis of the models (I): Sharing highlights of the models**	**Moderator: Prof. Kiran Rao**

	Group-1	**Group-2**	**Group-3**
Key Findings	✓ IRT Models ✓ Rural severe mental illness (SMI) is mostly commonly addressed ✓ NGO-Govt. Partnership	✓ Core values of the commune (Manas) ✓ Linkages between district level federation and govt. departments (Narendra Foundation)	Diversity of approaches ✓ Institutional ✓ Community based ✓ Integrated with development
Strengths	✓ Complements and links with the public health system; ✓ Linkages with variety of grassroots government functionaries (Samuha/ADD) ✓ Reaches underserved community (Janarth) ✓ SHGs of users/carers for livelihood initiatives(GASS) ✓ Awareness and advocacy (Janarth, AVS)	✓ Self-reliance of the commune (Manas-WB) ✓ Community involvement in designing and assessment of community health interventions(NF) ✓ Training & support of PHC staff/barefoot counsellors (Sangath) ✓ Evaluation methods and strategies (Sangath) ✓ Partnership with Govt. from the beginning (Sangath)	✓ 'Sampark' : Well planned/ detailed process/ outcomes flagged
Gaps	✓ Rehab and recovery piece is missing; Capacity constraints to go beyond SMI ✓ Coverage is limited; access and equity are unaddressed ✓ No psycho-social or alternative healing techniques used		✓ Limited coverage ✓ Workforce training and competences-unclear ✓ Sustainability & scaling up unclear ✓ Lack of focus on population health ✓ Unclear contributions to knowledge capture for community mental health. ✓ Equity

Some of the major points highlighted during the group discussion that followed the presentations were as follows:

- The model of 'Manas' from West Bengal garnered much praise from the Panel as it has no ethos of an institution, possesses autonomy and has made the values of a commune central to the way it operates. The question however was whether the said model would work in a non-agrarian set up. Additionally, the replicability of the model is fairly limited.

- 'Sampark' was also lauded as it has an exciting approach and works primarily with women with a focus on micro credit and women's mental health. The model also lays high emphasis on being community run, as after a specified number of sessions, the community takes over the running of the model. The Panel recommended that in order for the organisation to scale up, it could look at women and child as a unit.

- Ms. Ratnaboli Ray raised the point that most of the models discussed are medical in nature. Further, since many of the models have psychiatrists in the centre, would they qualify as community mental health models? This point was however countered by Dr. Rao, who stated that medication is an important method of treating severe mental illness.

- Ethics and standards followed by the organisations have not been articulated in the questionnaires.

- Questionnaires inherently have limitations, so it would be a good idea to short list organizations for a *second round* of in-depth information gathering either through restructuring the questionnaire and re-sending the same and/ or by visiting the organizations and studying their models.

- Mr. Naveen Kumar pointed out that the government model is missing. In his opinion, it would be worthwhile to examine the various components of the model, whether it has worked and if not, then why? He opined that it was important to consider what role one wants the hospitals to play; what services one wants in the District Mental Health Programme? He was of the point of view that it would be essential to document and develop both the role of NGOs as well as that of the Government.

- Ms. Vandana Bedi raised the issue that the objectives of the Knowledge Capture were too ambitious and suggested that rather than recommending models to the Government, it would be better idea to develop concrete guidelines to help the government in its planning and implementation of the DMHP.

  Dr. Sudipto responded to this by clarifying the framework of this exercise, and contextualizing it to the fact that the Government works within an existing framework and is interested in the NGO response as to what kind of models exists and what works at the community level. Thus, through this workshop an attempt is being made to garner knowledge on existing good practices and to analyze what works in the Indian context.

- Dr. Rajesh Sagar pitched in to express a need for more intense discussion on the point of 'Replicability'. According to him the government would be very interested in the reasons as to why certain models were successful and other not, i.e, replicability as well as obstacles and barriers to it.

  It would also be helpful to clarify the role that community involvement, participation and ownership plays in terms of programme sustainability vis-a-vis individual driven programmes, which tend to collapse when the key person moves out of the project.

  Additionally, the questionnaires do not take into account the effectiveness of the models as they do not ask for outcome indicators. He also asked the Panel to keep in mind that the DMHP has a vital NGO component and mentions public-private partnership. Training of persons in this sector is a vital necessity and institution based organisations can be utilised for this purpose.

- Dr. Kiran Rao, the moderator, also shared some of the lessons learned from the mapping exercise which she and Ms. Bhargavi Davar had undertaken in Gujarat. At that time the NGO sector there was unwilling to get into mental health despite availability of funds. Also, the Gujarat government could not be persuaded to develop policies as this was going to be a first of its kind in this field.

  NIMHANS has also pulled out of community mental health subsequent to the failure of the DMHP. Thus, she emphasized, *it has to be a movement*, and *Community Mental Health has to be initiated at the grass root level owned and run by users, carers and the larger community itself, whereby networking of people and good practices becomes essential to garner the diversity of approaches available and emergent and must allow for evolution and dynamics.*

  Since documentation is a difficult and demanding task, in order to succeed in our objectives it would be essential to geographically map certain zones and conduct small team discussions with the organizations in order to get more in-depth information on their models.

Day 2 - August 27, 2010	
2.1.	**Review of the Remaining Questionnaires**

2.1. <u>Review of the Models:</u>

The day began by reviewing the completed questionnaires from the rest of the organizations.

Group-1:

Panelists: Dr. Sudipto, Mr. Naidu, Mr. Naveen Kumar & Ms. Deepika Nair

Organizations:

VIKASH, Orissa; BISWA, Orissa; YCDA, Orissa; Manas Foundation, New Delhi.

Group-2:

Panelists: Ms. Ratnaboli, Dr. Kiran Rao, Ms. Vandana Bedi & Ms. Monica Kumar

Organizations:

Paripurnata, WB (2 Questionnaires on two programmes); Vidya Sagar, Chennai; Ashagram, Madhya Pradesh; APD, Bangalore; Parivartan, Maharashtra.

2.2.	**Presentation and Synthesis of the models (II): Sharing highlights of the models**	**Moderator: Vandana Bedi**

	Group-1	**Group-2**

Key Findings	✓ Have inclusion in government health and social welfare schemes thereby reaching a high number of people (Biswa) ✓ Inclusion of PLMI in micro-finance groups (Biswa) ✓ Targeted advocacy (Biswa) ✓ User participation in services (Biswa) ✓ Active linkages with NRHM + Grameen Kalyan Samiti (GKS) – ensuring sustainability beyond financial sustainability (YCDA) ✓ Structured capacity building (Manas) ✓ Intervention customized/tailored to the needs of the target group – after needs assessment (Manas) ✓ Training manuals, supervision and handholding (Manas) ✓ Proactive networking for raising awareness/ service delivery (Manas) ✓ Sustainability plans (Manas) ✓ Supervision has fidelity and quality assurance (Manas)	✓ Comprehensive model as it covers most elements of the mental health spectrum (Paripurnata) ✓ High community participation (Paripurnata) ✓ Effective usage of government schemes and policies (AG) ✓ Linkages with DMHP(AG) ✓ Well implemented model especially capacity building (APD)

Some of the major points highlighted during the group discussion that followed the presentations are as follows:

- Organisations which have intrinsic strength and have worked in disability prior to undertaking work on mental health seem to be doing very good work in mental health with their target groups. This could be as they already have contact with the vulnerable populations and hence the services become easier to deliver for the organisations and easier for the target populations to access.

- This also raised the issue as to whether delivery of services for mental health should be a plug-in component into organisations whose main focus of work may be not directly linked (microfinance etc.) to this area or whether mental health services needs to be a separate model unto itself.

  The group agreed that it was easier to look at severe mental illness as a component of social development, as it is an important part of issues such as domestic violence, education etc.

- Although initial rehabilitation has been discussed in most of the models, but life needs for persons living with mental illness has not been extensively discussed in most of the models.

- The issue regarding ethics and confidentiality re these models was raised again by the Panel as clients names have been freely provided in the description of the models.

- Questions were raised regarding the need for certification along the lines of IDEA and IQ testing. The group felt that certification is a need but needs to be done with psychological sensitivity.

- Right to treatment also includes the right to refuse treatment. This perspective however is missing from practitioners and teaching institutes today.

- None of the models discussed are seeing mental health issues outside of the silo approach. This is despite the fact that issues like HIV and mental health are established co-modelled issues.

- Some very good learnings can be derived from the APD model. It is amongst the few organisations operating in urban slums. The National Urban Health Mission is due to be rolled out in the 12th Five Year Plan and work in urban slums can be fitted well into this as well. In fact the lack of a mental health component in urban health scenarios provides a huge area for advocacy.

- Proactive thinking is needed to link mental health with other national level health policies. It is required to understand as to how to break the barriers within the Health Ministry, as mental health is invariably being left out as part of health policies and interventions. Advocacy is required in this context.

- Organisations which have visibility in the community either through health or disability programmes are able to (i) mobilize group level networks, and (ii) better deal with severe mental illness issues in the community.

- There is evidence that knowledge transfer has been successfully happening where organizations are approaching it in a structured way (e.g.- Manas Foundation).

- Discussion also revolved around the 'comprehensive' understanding of mental health services. It was agreed upon that it would ideally cover medical intervention along with psychological rehabilitation with a strong emphasis on social determinants.

  Dr. Chatterjee emphasized that according to the models discussed thus far, a comprehensive mental health system has to have a strong base in social determinants and cannot be restricted to the simple understanding of availability of psychiatric medicine in PHCs, for example. Therefore the challenge is to understand how to take this complex set of issues and translate the same into a minimum set of things that needs to be put forward to the government.

- There was discussion around the importance of general mental health concerns and emotional health and its inclusion into the larger framework of policies. However, it was acknowledged that this topic was cutting across different ministries, and was hence beyond the scope of this exercise.

- Dr. Jagdish Kaur mentioned that the Health Ministry was endeavouring to build inter- linkages between mental health and different programs (e.g. – the existing HIV programs). However, there has been severe resistance to this from various quarters. Additionally, since health is a state subject, it is difficult to implement these issues at the central level. In her opinion, strategic convergence is the key to forming these inter-linkages. A strong component on monitoring and evaluation is also required.

  Integration of mental health into the national urban health programme and the national rural health programme is a definite possibility as a way forward.

2.2.	Mosaic Presentation	Ratnaboli Ray and Naveen Kumar

Ruchika Bahl presented the concept of what a 'mosaic' means in the Ashoka context. Ashoka's 'mosaic' process brings out the key elements from the work of various social entrepreneurs and draws out the few universal principles that open major new strategic opportunities for the key decision makers in a field. In effect, these mosaic collaborations promise our community the ability to entrepreneur together - which produces far bigger impact than anything the sum of any solo ventures could achieve.

Ratnaboli Ray and Naveen Kumar presented a set of parameters to the group along which the mosaic for community mental health in India could be plotted along with the respective strengths and gaps. The mosaic that emerged from the group is set out below:

	STRENGTHS **(open for feedback from panelists)**	**GAPS** **(open for feedback from panelists)**
Conceptualization	➢ Service localization: Increased accessibility/services reaching the individuals with organisations working 'close to home'. ➢ Bottom-up approach: Services formulated based on the needs of the communities (Sampark/Manas-ND) ➢ Services conceptualized to be integrated into existing delivery mechanisms (ex. capacity building of PHC staff, community health, rehabilitation workers etc.) ➢ Mental health being utilised as a plug in component into organisations' existing disability and other programmes.	➢ Target audience reach mostly rural
Training/capacity building	➢ Strong emphasis on sensitization/ orientation & training/capacity building of existing staff whether NGO sector (barefoot counsellors) or govt. personnel involved at various levels (Primary health setting and at district level), community leaders, Asha workers etc.	➢ It is unclear as to how some of the organizations are doing this; process details could be probed during the second round of information gathering whether by questionnaire or visit

		➢ Burn out of family members, carers, Asha workers etc. needs to be taken into consideration.
Integration/Linkages	➢ Some organizations have made effective linkages with existing govt. as well as non-govt. policies, schemes, programmes and benefits (e.g.- NRHM/DMHP/NEREGA/RLP/ SHGs) – is a positive step towards building PPP. ➢ Microfinance/SHGs are being effectively utilised by org.s delivering mental health services for the benefit of the target group in various ways.	➢ Mental health as an issue is operating in silos even in organisations which are working on complementary issues.
Sustainability	➢ Financial sustainability: ensured through various ways like internal funding/community ownership and participation ➢ Approach sustainability: achieved mainly through service components being integrated into existing systems/ plug-ins	➢ Donor-driven as well as individual-driven programmes pose a challenge as there is high risk of the programmes collapsing in the absence of individuals/donors support.
Replicability/Scalability		➢ Mostly small scale. Methodology of scaling missing - individual driven approach.
Supervision/Efficacy	➢ Evaluation methods; documentation and information systems	
Ethics and Rights		➢ Lack of any mention/ information on ethics and rights. This shows the lack of interest in this area for the models.
Delivery	➢ Delivery of services through government-NGO partnership and through barefoot workers/professionals - hence the concept of 'task-	

	shifting' being well utilised.	
Care & Treatment	➢ Through drug distribution	➢ No psychosocial component in the programmes ➢ Recovery piece is missing in the programme (keeping in mind the mental health continuum discussed earlier; Relapse care and management is missing.
Policies & Schemes		➢ Huge policy gap; Strategic noise-making to move the govt. ➢ NGO sector must come to consensus with respect to (i) Definition of policy; and (ii) Parameters of policy.

Action Planning – the Way Forward	**Dr. Jagdish Kaur, CMO**

In this last session the Panel deliberated and decided upon how to take the information that has emerged out of this workshop forward in a manner which would bring about positive changes for the mental health scenario in India today.

Dr. Jagdish Kaur (CMO, Ministry of Health) joined in the deliberations and action planning and promised the government's assistance and support to take the work started during the last two days forward.

The Health Ministry is developing a scheme in order to assess NGOs on whether funding should be given to them for partnering purposes. She offered to circulate the Scheme to the Panel for their comments and suggestions. The group was asked to suggest/ define a set of guidelines/models/ outcomes to help the government understand where the government funding could be given. There is a possibility that this kind of partnership could be included in the 12th Five Year Plan. In order to do so, some amount of track record of the NGO-Government partnership needs to be shown. There needs to be work done towards this today.

The finalised action plan has been set out below:

Action	**Description**	**Timeline**
Rough Cut	Comments and suggestions on the Guidelines for funding NGOs being drafted by the Ministry of Health under the 11th Five Year Plan. This will incorporate the learnings from this workshop alongwith other inputs from the Panel.	September 3, 2010
Resource Mapping/ Collecting Information/ Data Interpretation	State chapters of Indian Psychiatric Association and major NGOs in the States can together undertake state – wise mapping of NGOs working in the area of community mental health and gather information on their models. Professional organisations can be utilised for collection of this information. Funding to be provided by the Government for the above.	December 2010
Micro-level Consultation (Zonal/ Regional)	Regional level consultations to have consensus on Vision – Mission strategies for the mental health sector in the 12th Five Year Plan. Funding to be provided by the Government.	September 2010 (Rollout)
National level Consultation	National level consultation for Vision – Mission strategies for incorporation of mental health in the 12th Five Year	March 2011

	Plan. Funding to be provided by the Government for the above.	

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ANNEXURES

Annexure A

GOOD PRACTICES AROUND COMMUNITY BASED MENTAL HEALTH MODELS IN INDIA

CONCEPT NOTE FOR KNOWLEDGE CAPTURE WORKSHOP, AUGUST 2010

1. Background

1.1. The mental health sector in India has developed in the face of many obstacles (social and socio-legal) in the last few decades. However, the actors in the sector have not been able to resonate with one voice due to its fragmented nature.

1.2. In order to establish a unifying platform where all the social advocates of mental health – i.e. clinical psychologists, psychiatrists as well persons living with mental illness (PLMI) could participate, *Ashoka: Innovators for the Public*[3]'s *Law For All Initiative*[4] brought together three of its Ashoka Fellows - Bhargavi Davar (Pune), Ratnaboli Ray (Kolkata) and Monica Kumar (Delhi) working in the area of mental health. Along with other players in the mental health sector, they established the '*National Alliance on Access to Justice for Persons living with a Mental Illness*', otherwise known as NAAJMI.

1.3. NAAJMI's Vision is to assure "A Life of Dignity for Every Person Living with Mental Illness". In order to accomplish its vision, NAAJMI has a four-point Mission:

3. Influence policy and public opinion
4. Capture and apply knowledge
5. Provide a platform for dialogue among all stakeholders in the mental health sector – specially for the voices that have not been heard so far
6. Learn from other movements and network with them

1.4. NAAJMI has now become a strong collective voice around the country demanding justice and access to justice for persons living with mental illness based on the values of dignity, respect and autonomy. It is an alliance of, by and for people living with mental illness, and is inclusive of a diverse community of people with a personal and / or professional engagement with disability and persons living with mental illness.

1.5. Genesis of the idea for the 'Knowledge Capture' exercise:

Mental Health in India is a huge issue - prevalence, stigma, shame, discrimination, human rights violation, lack of qualified and trained human resources, inadequate & irrelevant policies and acts and of course meagre budgetary allocations. Good, bad and

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[4] Law for All Initiative works across sectors and across countries to strengthen human rights, democratic spaces, and good governance. Please visit http://lawforall.ashoka.org/

indifferent implementation of government schemes is yet another issue that comes in the way of de-institutionalisation of existing custodial and inhuman care. It is difficult to capture the knowledge of whole gamut of issues in a huge country like ours with diverse practices to cater to the needs of different sections of people having mental health problems.

We know that many NGOs are dedicated to the mental health field and that all such organizations need to be connected with one another so as to shape a common platform that represents their work and goals. We feel that the Knowledge Capture exercise will open communication channels through which organizations can be informed of each other's work. This could be an effective way of capturing the 'good practice models' in various mental health activities. This would also provide insights to others who may wish to involve themselves in innovations in mental health care in India. This whole process will also strengthen the public-private partnership between the government and the NGOs thereby increasing accessibility and affordability of mental health services in our country.

In the 11th Five Year Plan, in order to increase the outreach of community mental health initiatives under the District Mental Health Programme, the Plan emphasises on NGOs and 'public - private partnership' for implementation of the NMHP[5]. An allocation of Rs. 1000 crore has been made for the NMHP. However, there is lack of clarity on how these funds will be disbursed and how the relevant departments intend to take work in this sector forward.

1.6. Objectives of the 'Knowledge Capture' workshop

The knowledge capture exercise is being undertaken with the following objectives:

(i) Identifying the 'good practices' currently prevailing on the ground for community based mental health models;
(ii) Incorporation of these 'good practices' into a comprehensive model of delivery of Mental Health services which can be used by all stake holders involved in delivery of Mental Health services and also to integrate these practises into the District Mental Health Programme.

1.7. Design of the 'Knowledge Capture'

The knowledge capture exercise has been designed in order to collate information with respect to community mental health models across India. This will be done in partnership with the Government of India. The good practices that emerge can then be incorporated into the District Mental Health Programme across India.

This exercise will bring information relating to the working models of community mental health in India to the forefront. The identification of the 'Good Practices' will avoid

[5] Excerpt from the 11th Five Year Plan, vol. 2:

"3.1.174 The Plan will strengthen District Mental Health Programme (DMHP) and enhance its visibility at grass root level by promoting greater family and community participation and creating para professionals equipped to address the mental health needs of the community from within.

It will also harness NGOs' and CSOs' help in this endeavour, especially family care of persons with mental illness, and focus on preventive and restorative components of Mental Health."

duplication of efforts by other organisations and serve as a yardstick against which other models can be compared.

2. Process of Knowledge Capture

2.1. In order to distil good practices from the community based mental health models in India, NAAJMI is organising a Knowledge Capture Workshop on **26 – 27th August, 2010**.

2.2. The process for collation of information around community mental health models in India is given below:

(i) Nomination:

Members of NAAJMI along with the partner department of the Government will nominate organizations working on community mental health models across India, whether in institutions, through civil society organizations or through Government of India programs. A sample of roughly 20 community mental health models will be taken.

(ii) Administration of the questionnaire

A questionnaire will be sent to these organizations to elicit information regarding the elements and the working of these models. This questionnaire would be administered electronically and telephonically to the heads of the organizations. A draft of the questionnaire is attached herewith as Annexure A.

Once the questionnaire has been filled up, the filled out questionnaire will be sent back to organization for verification of the data collected and for any extra information that the organization chooses to disclose.

All the organizations will also be asked to submit reports of any evaluation that has been undertaken with respect to their models.

(iii) Panelists

In order to assess the data gathered on different community models, a panel comprising Dr. Jagdish Kaur, CMO, Ministry of Health and Family Welfare, Dr. Kiran Rao, Dr. Sudipto Chatterjee, Ms. Ratnaboli Ray, Anjali (Kolkata), Ms.

Monica Kumar, Manas Foundation (Delhi), Mr. Naveen Kumar, Manas Foundation (Delhi) and Mr. Naidu, Basic Needs (Bangalore) is being formed.

(iv) Preliminary Analysis

The data gathered and the models compiled will be sent electronically to the panel latest by August 15th, 2010 for their review.

Additionally, a preliminary analysis of the data collated shall be undertaken by Monica Kumar and her team at Manas Foundation.

(v) Distilling the Good Practices

On 26th – 27th August, 2010 the panel will meet, discuss and analyze the models in the Knowledge Capture Workshop to be held in Delhi. The good practices from these working models will be distilled by the panelists to formulate a single comprehensive Community Based Mental Health Rehabilitation model.

(vi) Incorporation of Good Practices into the District Mental Health Programme:

The recommendations could be shared with the larger mental health communities and make it open for feedback. At a national level meeting, this model/ good practices that have been identified could be proposed to the Government of India for formal adoption at the District Mental Health Programme level, to be steered by the CMO for a pilot project in Delhi.

***3*. Timelines**

S. No.	Activity	Completion Date
(i)	Nomination of community mental health models by partners	July 28, 2010
(ii)	Administration of questionnaire to the organisations by Manas Foundation	August 15, 2010
(iii)	Sending data collected to panel	August 18, 2010
(iv)	Panel discussion in Delhi	August 26 – 27, 2010
(v)	Collation of good practices emerging from panel discussion to be submitted to the GOI	September 15, 2010