ATMIYATA

Promoting Wellbeing, Reducing Distress and Improving Access to Mental Care through Self Help Groups and Farmers Clubs in Rural Maharashtra: A Community Based Field Trial

THE BOLD IDEA

We propose to address these challenges by working with community based groups and mobilizers, primarily self-help groups (SHGs) and farmer's clubs (FCs). SHGs consist of a group of 15-20 underprivileged women in rural parts of India who voluntarily come together to collectively gather savings, lend money, and support micro-finance or entrepreneurship activities in areas ranging from sanitation to health to business. There are over 200 000 SHGs in the state of Maharashtra alone, usually with one elected SHG leader who is the community mobilizer and main change agent. SHGs empower rural women to participate in economic activities and utilise peer support, offering a unique opportunity to identify and detect mental illness in the women and their families. Farmer's clubs are grassroots-level forums of male farmers coming together for similar purposes to SHGs, though largely focused on agriculture. Working together with FC's is especially important in helping to address the high rate of farmer suicides in India.

The project aims to utilise existing community resources in a participatory manner to more effectively identify undetected cases of mental illness in an underserved, rural area of India, and facilitate access to both social and mental health care. It will tackle several global mental health challenges: [1] Provide effective and affordable community-based care and rehabilitation; [2] Develop mobile and IT technologies to increase access to evidence-based care and [3] Develop effective treatments for use by non-specialists, including lay health workers with minimal training.

Why India?

3 reasons why this project would be beneficial in India:

- Mental illness poses a substantial public health burden (prevalence rates estimated to be 5-7% of the population; 3% of all reported deaths attributed to suicide.[1-4]
- There is a shortage of mental health professionals, particularly community-based professionals. It therefore becomes crucial to find alternative configurations of care, by harnessing existing community resources to aid in the provision of mental health care?
- Third, case detection rates and help-seeking behaviour are low, especially in rural areas. This is further compounded by high stigma and the lack of easily accessible mental health care, thus many people do not receive the care that they need, resulting in a startling treatment gap of nearly 80-90% for mental illness in India.[4]

Self help groups *Photo: BAIF*

Farmers' clubs *Photo: BAIF*

ATMIYATA Intervention

The intervention will use local resources (SHGs and farmer's clubs) to provide a forum for wellness promotion, detection, referral and follow up of mental illness. The intervention also includes a first referral unit at a base primary level facility and tertiary level care at the district hospital.

The intervention will focus on "wellness" provision of emotional support and problem solving skills to help cope with stress and anxiety. At the same time it includes a defined system where common and severe mental illness are detected, referred and followed up. The AMTIYATA intervention combines a community based preventive approach to mental health with increasing access to treatment of common and severe mental illnesses.

The ATMIYATA intervention targets 3 populations experiencing varying levels of distress. First are people with emotional distress and stress, who will receive support from community groups (SHG, farmers' clubs) so they (and their families) can better cope with stress. This level of intervention is necessary as a prevention measure for the development of CMHD's and SMI. The second intervention level is targeted at people with CMHD's. The leaders of SHG's/FC's in 35 villages will be trained to detect, refer and follow-up CMHDs. The third level targets SMI. The intervention facilitates access to treatment for SMI at both the first referral unit (FRU) and district hospital levels. The second crucial part of the intervention is ensuring access and entitlement to social benefits available to persons with mental illness. Entitlement to other social benefits will also be promoted. Disability certificates can also be obtained from the district hospital (a social care benefit). Facilitators will aid in accessing social care benefits for all people they consult throughout the intervention.

Figure 1 The Pyramid of Mental Distress and Illness

Figure 1. The ATMIYATA intervention addresses the pyramid of mental distress, beginning with a base of people with stress and anxiety, who with adequate support from community groups (self help groups, farmers clubs) and their families can better cope with stress. This is absolutely necessary to prevent the occurrence of common and severe mental illnesses. At the next level are people with common mental illnesses. The intervention will provide training to one key member each of the SHGs and FCs in 31 villages to detect, counsel, refer and follow up common mental illnesses. SMIs lie at the top of the pyramid. People with severe mental illness can access treatment and care at both the FRU and district hospital levels.

Study Methodology

A quasi experimental field trial with a pre and post test is proposed at intervention and control sites. The intervention will be implemented in 35 villages in Peth block of Nashik district in Maharashtra. A matching block with similar characteristics as Peth block will be taken as the control block and the baseline and endline surveys will cover 35 villages in the control block.

Study Population

The study population will include women and men in 31 villages.

Sample size

The sample size will be 1800 with 900 people (450 women and 450 men) in the control group and 900 people in the intervention group.

Data Collection

Data collection will occur twice during the study – at baseline and at endline (one year post-intervention). A research agency will be hired to collect the data. The focus will be on the measurement of social, behavioural and medical determinants of outcome measurements. Data will be collected through a questionnaire administered by trained investigators – background information (socio-demographics), common mental disorders, severe mental disorders, quality of life, emotional well being. self esteem levels, communication patterns, social influence, mobility etc. The Pachod Paisa scale will be used as a response scale to measure measure quality of life, emotional well being etc. The Pachod paisa scale is a culturally appropriate and scientifically validated scale.[14]

Project Outcomes

(1) Increase in detection of persons with CMDs
(2) Increase in treatment of persons with CMDs
(3) Increase in detection of persons with severe MI
(4) Increase in treatment of persons with severe MI
(5) Increase in persons with MI claiming social benefits
(6) Improved quality of life and wellness

Cost evaluation of Atmiyata

The HEE will be conducted as a health-economic modelling study. The computational algorithm of the HEE model has been described elsewhere (e.g., Smit et al., 2011; Lokkerbol et al., in press), but is essentially laid out in Briggs et al (2006). The model's design is closely related to the Assessing Cost Effectiveness (ACE) models in Australia (cf. ACE cancer, ACE heart disease, ACE mental disorders and ACE prevention), and to the CHOICE models from WHO. The model can simulate the cost-effectiveness of a (regional) health care system for multiple target groups and multiple interventions, and conducts extensive multivariate sensitivity analyses to ascertain the robustness of the cost-effectiveness outcomes (uncertainty in outcomes is reported accordingly). Based on input parameters from the Atmiyata intervention (size of target population, coverage rate, adherence rate, effectiveness, and per-patient costs of the intervention in Indian rupees), three types of analyses will be conducted with the HEE model. First, a cost utility analysis to obtain the incremental cost effectiveness ratio (ICER), the number of QALY's gained from the programme and the cumulative costs in the base-case scenario and the alternative (intervention) scenario; a cost-benefit analysis to show the return on investment of every rupee invested in the health care programme, with health-related benefits expressed in monetary units to demonstrate whether the programme offers good value for money; third, a budget impact analysis, conducted at the macro level of a regional health care system (in this case, Maharashtra) by conducting a series of "what if" analyses for different implementation (coverage) levels of the health care programme and how this impacts the health care budget overall. This is important to better understand the new health care programme's economic sustainability.

Atmiyata means empathy or compassion in Marathi. It is the core tenet of the intervention and will apply to self help groups, farmers clubs, families and the community at large. It will enable the creation of a community environment where people will not feel afraid to come forward to seek help. The community will also include "vaidus" or local healers that are often approached in the case of severe mental illness.

Artist: Anu, IHMP

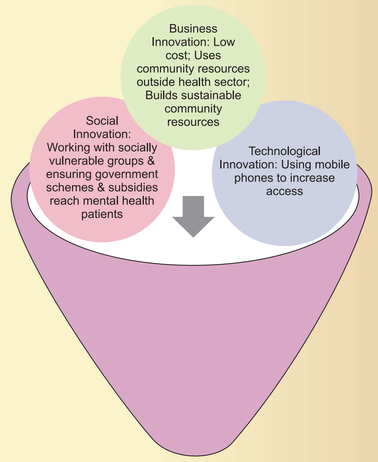
ATMIYATA and mobile phones

A unique innovation about this project from a technological standpoint is that it utilises high-impact emerging technologies (mobile IT) as a training tool for community mobilisers, utilising non-written communication methods via films uploaded on smartphones. This has been done for maternal and child health, which we will draw upon for mental health training for SHGs and FCs. Using innovative training methods is important as many SHG/FC leaders may be illiterate, and a mobile IT solution where training is delivered via non-written communication tackles the issue of illiteracy. Films will be used in lieu of manuals as it was felt that a more interactive, accessible training tool that considers illiteracy would result in a higher usage rate by SHG/FC leaders.

In the ATMIYATA project, the mobile phone will enable the implementation of a "standardized" intervention, providing all the main information that the women's and men's group leaders require on wellbeing, detection, referral and follow up. This information will be loaded on the phone. The mobile phone will have several films, including: a "role" model film showing local community members accessing care and support; a community-oriented film on acceptance and support for people coping with mental distress and illness; detection and referral; myth busting in the form of frequently asked questions (FAQ's) with a psychiatrist in the local language (data collected in the needs assessment); and films on "what can you do?"

Integrated innovation

ATMIYATA is innovative on 3 dimensions. A major technological innovation is the use of multimedia mobile phones to provide basic guidance to the self help group and farmers club leaders on how to promote wellbeing, detect CMHDs and SMI, refer and follow up. Short films will be loaded on the mobile phones that will encourage community members to adopt wellbeing practices, to go for treatment and to seek help at community, FRU and district levels. Developing content for such an intervention will require the judicious use of information, keeping it simple and "actionable" [8, 12-13]. It is socially innovative as the intervention addresses contextual factors that could impact implementation of the project – such as targeting vulnerable groups (women, farmers) often afflicted with poverty and living in under-served rural tribal areas. It also addresses barriers such as illiteracy by using the mobile films as an audio-visual method to deliver important information to community facilitators. It is innovative in a business sense as it is a low-cost intervention utilising existing community resources that are not reliant on the health sector, and engages stakeholders (in the community, and in the private/public sector) to participate. It can therefore be seen as a participatory community-based inexpensive model, which could secure government buy-in.



Integrated innovation

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17. Quality-Adjusted Life Years

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