



Indian J Psychiatry. 2022 Jan-Feb; 64(1): 102–105.

PMCID: PMC8992760

Published online 2022 Jan 21. doi: 10.4103/indianjpsychiatry.indianjpsychiatry_702_21:

PMID: [35400750](https://pubmed.ncbi.nlm.nih.gov/35400750/)

10.4103/indianjpsychiatry.indianjpsychiatry_702_21

Role of accredited social health activists in treatment of persons with severe mental illness in the community

[Thanapal Sivakumar](#), [Channaveerachari Naveen Kumar](#), and [Jagadisha Thirthalli](#)

Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India

Address for correspondence: Dr. Thanapal Sivakumar, Psychiatric Rehabilitation Services, Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru - 560 029, Karnataka, India. E-mail:

drt.sivakumar@yahoo.co.in

Received 2021 Aug 23; Revised 2021 Oct 26; Accepted 2021 Dec 1.

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INTRODUCTION

Schizophrenia and bipolar affective disorders (called severe mental illnesses [SMI]) are among the leading causes of years lived with disability in India.[1,2] According to the National Mental Health Survey, 2015–2016 of India, the lifetime and current prevalence of schizophrenia and other psychotic disorders and bipolar affective disorders are 1.9% and 0.8%, respectively.[3] The treatment gap for schizophrenia, other psychotic disorders, and bipolar affective disorders is as high as 75.5% and 70.4%, respectively.[3]

NEED FOR COMMUNITY MENTAL HEALTH SERVICES

Implementing the World Health Organization recommendations is necessary to reduce the treatment gap.[4] Instead of spending on large, expensive centralized institutions that isolate patients from their family and community support systems, mental health resources should be made available and accessible in the community.[5]

The provision of community mental health services leads to a dramatic fall in the out-of-pocket expenditure of families of persons with mental illness (PMI).[6] The effect could be longstanding to prevent families from getting impoverished due to health expenditure and drifting down the social ladder.[6]

INVOLVEMENT OF NONSPECIALIST HEALTH-CARE PROVIDERS

Task shifting (also known as task sharing), defined as “delegating tasks to existing or new cadres with either less training or narrowly tailored training,” has been suggested as a strategy to handle shortages in mental health professionals.[7] Nonspecialist health workers have played a part in detecting, diagnosing, treating, and preventing common and severe mental disorders.[7]

Involving PMI, their family members, and other informal resources in the community like lay health workers as “nonspecialist health providers” ensures a high level of motivation with the most negligible chances of attrition.[5] Besides, people from the same locality can better understand local realities and address rehabilitation needs.[8] The involvement of nonspecialist health-care providers is necessary to facilitate vocational and economic inclusion for PMI.[9]

ACCREDITED SOCIAL HEALTH ACTIVISTS PROGRAM

As a part of the National Rural Health Mission, India launched the Accredited Social Health Activists (ASHAs) program in 2005.[10] Since its launch, the ASHAs program has become among the world’s most extensive community health worker programs.[10] ASHAs are literate female health workers from the local community. As honorary volunteers, they receive financial compensation ranging from Indian Rupee 1–5000 depending on the task.[11] ASHAs act as an interface between the community and the government health-care services.[12] ASHAs play an essential role in maternal and child health.[13]

ACCREDITED SOCIAL HEALTH ACTIVISTS AND MENTAL HEALTH

With their in-depth knowledge of the local community, ASHAs can help them access mental health services and facilitate community participation in mental health programs.[14] To scale-up mental health services in low- and middle-income countries, ASHAs need to be involved.[15]

Previous studies on ASHAs have reported poor knowledge and understanding of mental illness.^[16-19] However, training on mental health aspects increased their ability to recognize mental illness from a case vignette, reduced stigmatizing attitudes, and ASHAs faith in unhelpful and potentially harmful pharmacological interventions.[20] Trained ASHAs have also screened people for common mental illnesses and referred them for treatment.[21] ASHAs have served as liaisons between PMI and primary health center (PHC) staff including home visits and reminding patients about appointments.[22,23]

When ASHAs were involved in case finding and follow-up treatment of persons with SMI, their attitude toward patients changed positively.[24] Persons with SMI and family members were grateful to ASHAs for facilitating treatment for SMI, which led to improvement. The authors stated that this could have possibly motivated ASHAs despite the lack of financial incentives in the study.

At Ramanagara (Karnataka) district mental health program (DMHP), ASHAs proactively delivered medications to PMI at their doorsteps during the COVID-19 lockdown. In addition, they also offered brief counseling focusing on psychoeducation, the importance of treatment adherence, and the common adverse effects of psychotropics.[14]

OBSTACLES IN INVOLVING ACCREDITED SOCIAL HEALTH ACTIVISTS IN MENTAL HEALTH PROGRAMS AND SOLUTION

ASHAs are already involved in multiple national programs. The addition of mental health programs may be perceived as an additional work away from their primary focus on maternal and child health. ASHAs may become overburdened if they are involved in screening and referring all PMI. The prevalence of SMIs is low compared to other mental illnesses.[3] There are likely to be 5–7 persons with SMI in the area covered by each ASHA worker. Hence, their identification and treatment would not burden the ASHA workers who can cover them during routine community visits.

ASHAs currently are not paid an honorarium for working with PMI. Financial compensation of ASHAs for PMI treatment may enhance referral rates and bring untreated PMI under the treatment umbrella in rural communities.[14,24]

WHY INVOLVE ACCREDITED SOCIAL HEALTH ACTIVISTS IN THE TREATMENT OF PERSONS WITH SEVERE MENTAL ILLNESS?

Besides, ASHA workers can be a good resource for facilitating treatment and rehabilitation of persons with SMI due to the following reasons.

- SMIs are easily identifiable by nonspecialist health workers with minimal training.[25,26] This issue makes them well suited for integrating mental health care with the primary health-care system
- Definitive pharmacological treatments are available for SMI.[27,28] A substantial proportion of them shows considerable benefits with pharmacotherapy and low-intensity psychosocial intervention, which ASHAs can deliver during routine home visits without much burden[29,30,31]
- SMIs are among the most severe forms of mental illness that cause disability and burden.[32] They form the “face” of psychiatry in society. Positive symptoms attract attention and are misunderstood as signs of danger or incompetence by others resulting in social distance, discrimination, and self-stigmatizing beliefs.[33] Treatment of SMIs and consequent reduction in disability will reduce the “stigma” associated with mental illness, which can pave the way for their inclusion in mainstream society.

HOW TO INVOLVE ACCREDITED SOCIAL HEALTH ACTIVISTS?

ASHAs visit households under their jurisdiction frequently and are familiar with every member of these households. In this background, mental health professionals need to reach out to ASHAs and train them briefly on the job with simple tools such as “symptoms in others” to identify persons with SMI.[24] Trained ASHAs can screen and refer persons with SMI for treatment to the nearest PHC.[24,34,35,36] Mental health professionals should train PHC medical officers to treat SMI so that persons with SMI can avail treatment close to their doorsteps. Free psychotropic medications should be made available in the PHC.[6] Close liaison with DMHP for difficult to manage patients and hospitalization (where necessary) in district headquarters should be ensured.

ASHAs are already involved in DOTS (directly observed treatment short-course therapy) for tuberculosis. Similarly, they can supervise the treatment of persons with SMI in their area. As ASHA workers live in the same community, they are likely to supervise psychotropic medications effectively, identify early signs of relapse, contact treating psychiatrists, and initiate remedial measures. They would also be better positioned to cater to the health needs of persons with SMI through referrals to the government health system. These interventions will have a cascading effect on the clinical stability of the person with SMI, resulting in better functioning. When ASHA workers see a person with SMI improve, they will be more receptive to mental health issues and be empowered. We can anticipate that the local community, in turn, will be more supportive of persons with SMI helping in community reintegration.

INCENTIVIZATION OF ACCREDITED SOCIAL HEALTH ACTIVISTS FOR TREATMENT OF MENTAL ILLNESS INSTEAD OF COMMUNITY HEALTH WORKER

The 12th 5-year plan of DMHP proposed recruiting two “community mental health workers” per PHC from the local community who will be paid an honorarium for their services.[37] To our knowledge, this cadre has not yet been recruited. ASHA workers are accepted in society due to multiple services, including pregnancy, delivery, immunization, and DOTS. It is unclear if a separate cadre of “community mental health workers” will be accepted. Suppose ASHAs are adequately trained and offered an honorarium; they can serve as community mental health workers for persons with SMI. The number of ASHAs per village can also be increased as per need.

ONGOING STUDIES INVOLVING ACCREDITED SOCIAL HEALTH ACTIVISTS IN THE TREATMENT OF MENTAL ILLNESS

Currently, the authors are involved in an ongoing randomized controlled trial involving ASHAs in community-based rehabilitation of persons with SMI at Jagalur taluk (Davangere district, Karnataka).[38] In the study, ASHAs are paid an honorarium for their involvement. The study results will help us understand if ASHAs can be cost-effectively involved in follow-up treatment and rehabilitation of persons with SMI.

In another randomized controlled trial, NIMHANS-ECHO blended training program for the DMHP workforce at Ramanagara district (Karnataka state) is being evaluated. The hub specialists are DMHP psychiatrists, and the spokes are the auxiliary nurse midwives (ANMs), ASHAs, and PHC medical officers.[39] Within 6 months of implementation of the project, 37 ANMs and ASHAs of the study PHC have identified >220 patients with deemed psychiatric problems from the local community.[40] The telementoring model shows promise for the capacity building of ASHAs.

More implementation research is required to understand the impact of getting ASHAs to work for PMI.

SUMMARY

There is a strong rationale for involving ASHAs in mental health care as described above. A small investment in addition of mental health conditions to the list of health conditions for which they are paid incentives is likely to result in a significant gain for the community’s mental health. Including identification and

follow-up of SMI in the list of incentivized conditions is a reasonable step in this direction.

Financial support and sponsorship

This study was financially supported by Indian Council for Medical Research under Capacity Building Projects for National Mental Health Program, ICMR-NMHP vide file number 5/4-4/151/M/2017/ NCD-1.

Conflicts of interest

There are no conflicts of interest.

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