## Executive Summary

***Purpose of the project:*** Poor quality of mental health services and human rights violations in inpatient and outpatient facilities are a feature of mental health services in India. Many persons with mental disorders are exposed to inhuman and degrading treatment, restraint, seclusion and physical, sexual, and emotional abuse and neglect. Promoting quality services and respect for human rights have been identified as priority areas for action in the Comprehensive Mental Health Action Plan 2013-2020 recently adopted by 194 Member States during the World Health Organization (WHO) Assembly held in May 2013.

 Until now, there has been no systematic approach to addressing this issue. Quality improvement, though an important aspect of improving access to mental health services, has received scant attention from mental health professionals and other stake holders. This project addresses the problem of poor quality of services and rights violations in the State of Gujarat, India, by introducing and scaling up an innovative QualityRights intervention in mental health facilities. This innovative intervention has been piloted in many countries in the past 3 years. Based on lessons learned in these small-scale 'proof of concept' studies, the intervention is now ready to be scaled up in mental health services in the state of Gujarat. The policy and service environment in Gujarat, and in India, is conducive to scaling up this intervention.

***Intervention:*** The project will use the World Health Organization’s innovative QualityRights Tool Kit to promote human rights and establish new standards of care across five interrelated areas which will have a positive impact on the quality of services and promote respect for human rights.

 The core elements of the intervention include: (i) improvements in the facility environment using existing available resources from facilities and government; (ii) training for health workers, service users and families on human rights and changes in attitudes and practices required to move towards a recovery approach which will enhance autonomy and engage service users in recovery plans; (iii) building peer and family support programmes delivered by *non-specialists*; and (iv) introducing facility level policy and mechanisms to govern practices to protect against inhuman, degrading treatment, violence and abuse (including the use of restraints).

***Outcomes and potential impact:*** The project will bring about significant improvements in the quality of mental health services including improved skills, attitudes and practices of health staff and lay persons in relation to treatment and recovery, and human rights leading to reduced stigma, improved accessibility and acceptability of care, and ultimately to reduced disability and improve functioning for people with mental disorders.

***Innovation:*** The project uses an integrated innovation approach to deliver service interventions on a number of dimensions which are traditionally ignored by mental health services. This project is scientifically innovative as it will introduce a scientifically validated and quantified method for assessing and improving quality and human rights in mental health services which can be scaled up in low-resource settings. The technological innovation of the project consists of a web-based online platform to deliver the methodology and training to implement QualityRights in mental health facilities and create collaborative practice communities that can share implementation experiences and results. The social innovation of the project is the incorporation of the social dimension in routine care. Interventions are designed to encourage linkages between mental health services and community resources (e.g. housing, education, employment) to support service users in their efforts to integrate and lead meaningful lives in their communities. Another social innovation is the participatory approach which involves health professionals, service users, families and other key stakeholders, in the management and implementation of the intervention. The business innovation of the project is the adoption of methods commonly used by business and industry for quality improvement and efficient delivery system and applying these in a culturally sensitive and context-specific manner to the mental health sector.

***Sustainability and scale:*** The involvement of all key stakeholders in the delivery of the intervention will help improve acceptability, sustainability and scalability. It is low-cost participatory intervention which can be sustained at the project sites and potentially replicated in many low-resource countries around the world.

**Anticipated Results**

***Ultimate Outcome***

|  |  |
| --- | --- |
| **Ultimate Outcome/Impact** | **Description (where applicable to your project)** |
| 49,500 per year : people with mental disorders at the 6 intervention facilities experiencing a 20% reduction in disability and improvement in functioning  | WHO Disability Assessment Schedule (DAS) will be used to measure the level of disability and functioning experienced by people with mental disorders at baseline and for follow-up for control and intervention groups |

***Intermediate Outcome(s)***

|  |  |
| --- | --- |
| **Intermediate Outcome(s)** | **Description (where applicable to your project)** |
| 49,500 per year : people with mental disorders accessing the integrated service  | This outcome will measure the number of people exposed to the innovative service model and will reflect the number of people accessing better mental health services |
| 20% of people with mental disorders accessing innovative peer support programmes  | This outcome will measure the number of people who have access to a functioning peer support programme run by suitably trained peers |
| 50% family members accessing innovative family support programmes  | This outcome will measure the number of people who have access to a functioning family programme run by suitably trained family members |
| 80% of health-care workers with increased training for providing clinical care, recovery and rehabilitation programmes | Measure of health workers participating in all aspects of the training programme |
| 60% per cent improvement of family members` knowledge, attitudes and practices relating to mental disorders, their management and human rights  | This outcome will use questionnaires at baseline and follow-up to assess knowledge, attitudes and practices for control and intervention groups |
| At least one category increase in QualityRights ratings in facilities for: (i) inclusion and independent living in the community;(ii) protecting against inhuman and degrading treatment, violence and abuse;(iii) legal capacity and enhancing autonomy;(iv) attaining the high standard of health; and (v) adequate standard of living. | This outcome will use the scores generated from the QualityRights assessment in 5 domains to assess changes from baseline to follow-up in control and intervention groups. The QualityRights scores are categorical measures and rated on a 5-point scale |
| 20% reduction in the use of restraints in the facilities | This outcome will directly measure the effect of the intervention in reducing the use of restraints |

***Outputs***

|  |  |
| --- | --- |
| **Output(s)** | **Description (where applicable to your project)** |
| * Innovative prototype of a service delivery model developed
 | Overall integrated service delivery model, covering the 5 QualityRights domains  |
| * 5 scientific papers in peer-reviewed open access journals
 | The expected number of publications from this project |
| * Online platform for supporting the implementation and marketing of QualityRights
 | A new online platform will be created to support the use and dissemination of our innovative process methodology with key target groups, including Ministries of Health, facility managers and NGOs. |
| * # of policy recommendations developed
 | The number of facility-based policy recommendations will depend on the results of the facility-based assessment and cannot be determined a priori. |
| * 7 project reports
 | Number of reports issued throughout the project including final project report (2 per year) |
| * 5 training packages developed
 | The number of training packages developed for the training of assessment committees, health workers, service users and families and peer support |
| * 3 Audio visual materials
 | Film, case study series and photo series will be developed to showcase the issue, the project and the results |
| * 6 Policy Briefs
 | policy briefs describing issues, data and findings of the project will be developed for policy makers and the learning community at global level |

## Project Narrative

**Introduction**

Mental health services in India have a long history of abuse, neglect and poor quality care (NHRC, 2008). The Government of India has committed to taking action through the development of a national policy framework, revision of the District Mental Health Programme, and development of new mental health legislation.

This project will apply the methodology and standards in the WHO QualityRights Tool Kit to introduce an innovative intervention to deliver effective high quality and human rights sensitive mental health and rehabilitation services in existing inpatient and outpatient mental health services in Gujarat to improve health, social and development outcomes for service users. An important goal is to bring about a service re-orientation from a purely medical model focused on improving clinical symptoms to a holistic and comprehensive and participatory approach focused on recovery, empowerment and family and community integration. The ultimate outcome is to reduce disability and improve functioning for people with mental disorders.

## Project Purpose and Background

***1. Proposed solution and its potential impact***: Poor quality and human rights violations are a feature of mental health services in facilities across India. Treatments provided are not in line with evidence and best practice and many service users are exposed to inhuman and degrading treatment, restraint, seclusion and physical, sexual, and emotional abuse and neglect (NHRC, 2008). Despite the widespread nature of the problem and concomitant harms, systematic human rights change has not been attempted. Indeed, promoting quality and respect for human rights have been identified as priority areas for action in the Comprehensive Mental Health Action Plan 2013–2020 adopted by 194 member states at WHO in May 2013 (Saxena et al, 2013). The proposed project provides a solution to the problem of poor quality and rights violations in the State of Gujarat, India, by introducing and scaling up an innovative QualityRights intervention in mental health facilities.

 The project will utilize WHO’s QualityRights Tool Kit (WHO, 2012) to first conduct an assessment of quality and human rights in mental health facilities and then to implement an intervention that improves facilities and mental health outcomes. The Tool Kit establishes standards of care which can be applied in a culturally and socially appropriate manner across five interrelated areas; each addressing an important human rights and quality issue (see project narrative section below and Appendix 1).

 The proposal takes a participatory approach to improving the quality of services and respect for human rights through the active engagement of service users, families and health workers in the change process, including the conduct of assessments and the development, implementation and evaluation of the improvement plan. The expected outcome is improved health, social and development outcomes for people with mental disorders including levels of disability and overall functioning.

***2. Describe why the proposed solution is innovative and would be transformational against the challenge(s) outlined in the Global Mental Health Round 2 Request for Proposals:*** The project will address several challenges outlined in the call for proposals: (i) providing effective and affordable community-based care and rehabilitation; (ii) incorporating functional impairment and disability into assessment; and (iii) developing effective treatments for use by non-specialists, including health workers with minimal training.

 The project is innovative in bringing together interventions on several dimensions which are traditionally ignored and which work together to transform the existing service. The social innovation consists of using a participatory approach to bring about a transformation of culture to emphasise human rights, respect and cooperation between service users, families and health workers. The project promotes business innovation by using process improvement methods commonly used by business and industry for quality improvement and applying these in a culturally sensitive and context specific manner to the mental health sector, and technological innovation through the establishment of a global learning and collaborative electronic platform for the implementation of QualityRights.

***3. Provide evidence that the proposed solution has achieved proof of concept and is ready for refinement, testing and implementation toward scale:*** Studies demonstrating proof of concept of QualityRights have been conducted in Spain, Palestine, Greece and Somaliland. In Somaliland, pre-intervention conditions in Hargesia Hospital were extremely poor. Service users were locked into the facility, hygiene standards were extremely poor, and service users were not provided with treatment plans. As a result of the QualityRights intervention, long-term service users were released from the hospital, several found employment, additional health professionals were appointed, hygiene standards improved, and the practice of chaining service users ceased (O’Hara, 2012). In Asturias, Spain, the assessment of 28 facilities highlighted the failure to obtain informed consent for admission and treatment, failure to use treatment protocols and guidelines, lack of psychoeducation for service users and their families, and failure to provide legal advice and information about complaints mechanisms. The QualityRights intervention in Asturias led to a transformation in the service culture, where health workers, people with mental disorders and family groups co-operated in conducting assessments and formulating recommendations for improvements. Service users are now accepted as key players in service reform. At the policy/health system level, the intervention has led to the development of a mental health strategic plan to improve services and the creation of a Bill of Rights for people with mental disorders. A Mental Health Commission with eight representatives (including service users, family members, human rights experts and a psychiatrist) has also been established to advise the Ministry of Health (Gobierno del Principado de Asturias, 2010). Mental health services in Gujarat face many similar problems and barriers to quality care and respect for human rights as Somaliland and Spain, and experiences of NGOs and mental health professionals working in Gujarat suggest that with a sustained QualityRights intervention, outcomes could be substantial.

***4. Specify the nature of the target population and rationale for region(s) selected:*** Gujarat, India is an ideal location for scaling up the project. At national level, there is a strong political commitment and push towards addressing these challenges and reforming the mental health system. A revised district mental health programme has been drafted which emphasizes quality of care and the need for psychosocial rehabilitation programmes. A national mental health policy is being drafted and a new Mental Health Bill aimed at protecting the rights of persons with mental disorders has been cleared by the Government and will be presented to Parliament in the next few months.

 Gujarat is selected as the site for implementing QualityRights for the following reasons: (1) the government has recognized the need to improve quality and human rights and there is preparedness and willingness for mental health reforms; (2) the public health department has announced its readiness to be involved in the project; and (3) pre-existing health systems conditions for scaling up services are present, including a significant budget for mental health (3% of total public health care expenditure), and the presence of a mental health policy and strategic plan promoting access to quality services and respect for human rights of people with mental disorders (Gujarat Mental Health Policy 2005, unpublished). Importantly, the State Nodal Officer for Mental Health for Gujarat is a member of the project team and a collaborator on this grant application.

Gujarat has a population of 60.38 million (2011 census) and a population density of 312 per sq km. There are 4 public mental hospitals and 10 mental health facilities in public general hospitals, serving approximately 100,000 persons with mental disorders every year. The project will be carried out at 9 of these facilities consisting of an intervention group of 6 mental health facilities (3 mental hospitals, 2 psychiatric units in general hospitals attached to medical colleges, and 1 psychiatric unit at a district general hospital), and the control group consisting of 3 mental health facilities (1 mental hospital, 1 psychiatric unit in a general hospital attached to a medical college, and 1 psychiatric unit at a general hospital).

 The 6 intervention facilities deliver inpatient care through 40 wards covering 790 beds with approximately 715 admissions per year, 6 outpatient units with 655 outpatient contacts daily, employ 220 mental health staff and serve approximately 49,500 patients per year. The 3 control facilities deliver inpatient care through 13 wards covering 115 beds with approximately 210 admissions per year, 3 outpatient units with 250 outpatient contacts daily, employ 56 staff and serve approximately 14,000 patients per year.

***5. Outcome, target population, scientific rationale for impact:*** There is a strong relationship between lack of knowledge, negative attitudes, and stigma among health workers and lay people, and discrimination, violations and poor health outcomes (Corrigan et al., 2003; Thornicroft et al., 2009). Services that violate human rights can directly damage mental and physical health. Providing comprehensive and integrated care that respects human rights can lead to better health outcomes, reduced disability, improved functioning, and improved development outcomes for individuals, families, and communities (Funk et al., 2010; Drew et al., 2011). This project will reduce disability and improve functioning for people with mental disorders in India (ultimate outcome/impact), by improving access to high-quality mental health and social care services that respect human rights. This will be achieved through a number of intermediate outcomes, including improved knowledge, attitudes, and practices of health staff, families, and service users, access to family and peer support, and the implementation of new service policy and standards addressing QualityRights’ five domains (*see Appendix 1*). The 220 mental health workers and staff in the intervention group facilities are an important target and intermediate beneficiaries of the intervention. The end beneficiaries are 49,500 persons with mental disorders each year who use the intervention group facilities and their families.

***6. Describe how this solution is appropriate for wider implementation and scaling in low-resource settings:*** The QualityRights intervention can be scaled up in low-resource settings in a sustainable way beyond the project lifespan. Firstly, the project uses and builds upon existing service infrastructure, resources and good practice, but incorporates new components in order to transform, rather than rebuild, what services are delivered and how they are delivered. The intervention is more than a simple ‘add-on’ to the existing mental health services. Rather, it transforms the delivery approach from a curative to a recovery model, based on a new service culture and a paradigm shift in the understanding and practice of the key stakeholders in terms of what it means to respect rights, to engage service users in their treatment and recovery plans, and to promote autonomy and opportunities for independent living in the community. Secondly, the project capitalizes on the wide availability of motivated informal supports to deliver effective peer support and family interventions. Thirdly, the project integrates service standards into policies governing the way facilities function.

 The solution can be scaled up at national level with the transformed services created in Gujarat serving as models for services in other States of India, as well as in other low-income countries. The project can capitalize on the experience and training of key stakeholders engaged throughout the project by using them to act as agents of change and resources for scaling up in other States and countries. The learning platform to be developed as part of this project will be instrumental in scaling up QualityRights in other low-resource settings.

**Research design**

The project will use a parallel group research design in which 6 mental health facilities (a total of 40 inpatient wards covering 790 beds and approximately 715 admissions per month; 6 outpatient units with approximately 655 patient contacts per day) will be assigned to the intervention condition, and 3 mental health facilities (a total 13 inpatient wards covering 115 beds and approximately 210 admissions per month; 3 outpatient units with approximately 250 patient contacts per day) will be assigned to a control condition. The assignment will control for urban/rural location and socio-economic standards. Both the experimental and control conditions will receive the QualityRights assessment, but only the intervention group will receive the integrated intervention to improve quality of care and protect human rights. Both the intervention and the control groups will be matched on as many baseline variables as possible to minimize pre-existing differences between the services.

**Integrated Intervention**

The project will use the WHO’s innovative QualityRights Tool Kit to promote human rights and establish new standards of care across 5 interrelated areas which have a positive impact on the quality of services and promote respect for human rights (*see Appendix 1*).

The core elements of the intervention include: (i) improvements to the facility environment using existing available resources from facilities and government; (ii) training for health workers, service users and families on human rights and changes in attitudes and practice required to move towards a recovery approach which enhances autonomy and engages service users in recovery plans; (iii) building peer and family groups delivered by non-specialists; and (iv) introducing facility-level policy and mechanisms to govern practices to protect against inhuman, degrading treatment, violence and abuse (including the use of restraints).

**QualityRights Tool Kit**

The Tool Kit establishes standards of care which can be applied in a culturally and socially appropriate manner across five interrelated areas; each addressing an important human rights and quality issue:

(i) Promoting inclusion and independent living in the community. This means establishing links to community services and building support networks, for example, family and peer support. This is important to prevent relapse and promote social inclusion, recovery, and integration into community.

(ii) Protecting against inhuman and degrading treatment, violence and abuse. This includes introducing measures, for example, to document, report and prevent violence, abuse, punishment and neglect, finding alternatives to seclusion and restraints and over-medication.

(iii) Promoting legal capacity and enhancing autonomy. This means ensuring that service users remain central to all decisions that affect them, for example, by enabling service users to participate in the development of their treatment plans and to make informed decisions concerning their care.

(iv) Promoting the highest attainable standard of physical and mental health. This means reorienting the practices of health workers towards providing a holistic, recovery model, care and rehabilitation rather than focusing solely on medication to reduce symptoms.

(v) Promoting an adequate standard of living, for example, ensuring that the environment is caring, supportive, comfortable and stimulating.

**Statistical approach**

The project is designed to capture the factors that impact the quality of mental health care at multiple levels of society – incorporating the experiences of health-care providers at the institutional level and family members at the interpersonal level, in addition to the outcomes for individual service users. Furthermore, the longitudinal nature of the project involves assessing core measures at multiple points in time. Together, these features of the proposed design violate assumptions of classical statistical tests, notably that observations must be independent. To properly account for the inherently dependent data that this project will yield, we will conduct all analyses using cross-classified, 3-level general linear mixed models, where the mental health outcomes are considered to be nested within service users, and service users to be nested within both their mental health facilities and their families. The responses of caregivers will be assumed to be nested within mental health institutions and will be treated as institutional-level data. This approach will allow us to fully represent the complexity of the proposed dataset, while using a statistical approach with the greatest degree of sensitivity for assessing the effectiveness of the experimental programme. All data will be analyzed with the open-source statistical package, R 3.0.

In addition to assessing programme effectiveness with existing quantitative measures, we will use interview methodologies to evaluate the impact of the programme and incorporate the perspectives of participants and community stakeholders. This will ensure that the project is able to most closely meet the needs of the diverse set of participants who will be involved in the study. These interviews will be transcribed, and the transcription content will be analyzed for core themes.

**Statistical** p**ower and sample size calculations**

The potential impact of this research on mental health practices and policy in India is significant, so it is important to minimize the likelihood of both Type I errors by using a significant criterion of *α* = 0.01 and Type II errors by estimating the necessary sample size to achieve 90% *a priori* statistical power. The core measure of improvement will be 20% increase observed across the sub-scales of the WHO DAS. According to the norms established by Guilera et al. (2012), this would equate to an average small effect size of Cohen's *d* = 0.23 (*f*2 = 0.033) across the sub-scales. Allowing for potential covariates in a linear model, we used G\*Power 3.1 to estimate that a required sample size of 228 participants are needed in the control group and 455 participants in the experimental treatment group, for a total target sample size of *N* = 683. To account for as much as 12% attrition, we will recruit a sample of 765 participants. Similarly, we estimated sample sizes for the number of caregivers required to detect a change in attitudes equivalent to what is seen with contact-related interventions (*r* = -0.184, *f*2 = 0.072) (Pettigrew and Tropp, 2006). To obtain 90% power with a Type I error rate of *α* = 0.01, we are targeting final sample sizes of 106 health care staff from the control institutions and 211 health care staff from the intervention institutions. Again, assuming a maximum of 12% attrition, we will originally recruit approximately 355 health care staff from the participating institutions.

**Project Implementation plan**

The broad outline of project implementation is as follows:

***(i) Establish Advisory Group and Management Team***

As a first step, an Advisory Group will be set up bringing together representatives from the State Department and Federal Ministry of Health and Family Welfare, human rights advocates and senior mental health professionals. The Advisory Group will help us engage with the policy-makers, facilitate engagement with public health service officials and also overcome implementation difficulties. This group will be instrumental in further scaling up of the QualityRights intervention beyond the life of this project.

A project Management Team including the project team, heads of mental health facilities where this project will be carried out and representatives of service users and family members will be established. The Management Team will be responsible for managing the overall implementation and evaluation of the project, determining the working methods of the committees undertaking service assessments (see below) and on the processes for developing the services after the assessments, and for trouble shooting barriers along the way.

***(ii) Establish implementation plan***

The implementation plan will cover the detailed planning and scheduling required for the development and implementation of the project. Implementation will be conducted in a phased way; with the baseline assessment and subsequent intervention (for intervention facilities) occurring in a small select number of facilities (as determined by the Management Team), before being scaled up in a similar phased manner in remaining facilities. This will provide the opportunity to understand better and improve, on a continual basis, the practical and technical aspects related to implementation and management of the project ranging from the training of ‘assessment’ committees, the logistics of carrying out the baseline assessments of facilities, the setting up of peer support and family interventions, and the development of facility-based strategic plans and their implementation.

***(iii) Undertake baseline assessment***

Baseline assessment for individual outcomes: Service users will be assessed on measures related to disability and functioning, knowledge, attitudes and practices in relation to their condition and human rights, as well as satisfaction with services. Family members and health care workers will also be assessed on all these dimensions except for disability and functioning.

Baseline assessment of mental health facilities: All services in the intervention and control group will undergo assessment using the WHO QualityRights Tool Kit at baseline to measure the degree to which mental health facilities meet a set number of standards and criteria in the 5 domains of the WHO Tool Kit (*see Appendix 1*).

The assessment will be conducted by trained visiting committees. These committees will be made up of health professionals, persons with mental disorders, family and non-family care givers, human rights advocates and representatives of NGOs working in the field of mental health, in order to ensure a broad range of skills and knowledge required for the assessment process. Each committee will receive training on quality care and human rights standards and how to conduct the assessment and report findings using the WHO QualityRights Tool Kit.

In line with the methodology outlined in the Tool Kit, assessments will be based on: interviews with service users, family and staff, direct observation of conditions in mental health facilities, and reviewing relevant documentation (e.g. service policy documents, administrative records, service user files etc.). The data collected will be used to establish the quantitative ratings (supplemented by qualitative information) for the domains and standards of the QualityRights Tool Kit.

***(iv) Implementation of interventions***

The QR Intervention: Immediately following the QualityRights assessment and based on the results of the assessment, workshops will be conducted to feed back and discuss findings with health-care workers of the facility, service users, and families. Facility based strategic plans will then be developed to address gaps in the five interrelated areas of QualityRights for the intervention group facilities, using a participatory approach through discussions and workshops with service users themselves, family members and health-care workers. The specificities of the facility-based intervention will be determined by the results of the assessments and participatory discussions with all the stakeholder groups. However, the core elements will address: (i) improvements to the facility environment, emphasising the social environment and the quality of interactions and using existing available resources from facilities and government; (ii) training of health workers, service users and families on human rights and changes in attitudes and practice required to move towards a recovery approach which enhances autonomy and engages service users in recovery plans. In this respect, core competencies of health workers will be enhanced, including the ability to conduct medical assessments incorporating functional impairment, disability and recovery goals; (iii) introducing facility-level policy and mechanisms to govern practices to protect against inhuman, degrading treatment, violence and abuse (including the use of restraints) and (iv) building peer and family groups delivered by non-specialists. Peer support networks will enable service users to provide mutual support, information on issues related to treatment, assistance for lodging appeals and complaints, and to facilitate access to community resources including housing, employment, legal, educational and other services. Family programmes will provide family members with the skills and knowledge to support their relatives with mental illness to manage their condition, and facilitate independent community living.

The activities described above will be completed in a period of 4-6 months from the baseline assessment of the facilities. In addition, mechanisms will be established in all intervention mental health facilities, to ensure the ongoing implementation and monitoring of these plans. At each intervention site, we will identify two QualityRights Champions (from within the health care staff) who will receive special training at CAMH to observe and learn how quality and rights interventions can be integrated into service delivery and sustained over time. Health workers will serve as change agents and service users and families will help maintain quality control. Furthermore, the project will also lead to the creation of advisory committees to drive the process forward, and the establishment of weekly meetings to monitor progress and identify barriers and solutions to implementation of activities.

***(v) Follow-up assessment***

The follow-up service assessment of the intervention and control facilities using the WHO QualityRights Tool Kit will be done on completion of the intervention. Service users, family members and health workers will undergo a follow-up assessment on the measures of disability, knowledge attitudes and practices, and service satisfaction outlined above, 6 months post intervention (to take into account the lag period between service improvement and changes in disability outcomes).

***(vi) Evaluation***

Quantitative and qualitative data on the major outcomes will be gathered at baseline and at endpoint as described above. The following outcomes will be evaluated:

(a) Disability levels: Disability levels and overall functioning for service users will be assessed using the WHO DAS.

(b) Knowledge, attitudes, practices: Knowledge, attitudes and practices of the key stakeholder groups (people with mental disorders; families and health workers) will be evaluated in relation to mental illness, its management and to human rights.

(c) Levels of service satisfaction: Health workers, people with mental disorders and families will be asked to complete ratings to understand their satisfaction with the service provided.

(d) Quality and human rights conditions: The QualityRights Tool Kit will be used to assess human rights and quality conditions in mental health facilities for each of its domains: (i) promoting inclusion and independent living in the community; (ii) protecting against inhuman and degrading treatment, violence and abuse; (iii) promoting the highest attainable standard of health; (iv) promoting legal capacity and enhancing autonomy; and (v) promoting an adequate standard of living in mental health facilities. The assessment uses information from interviews with service users, families and health care workers as well as facility observation and documentation review to derive scores in each of these domains. These scores are supplemented and substantiated by the qualitative information obtained.

(e) Health systems evaluation: Information derived from the assessment using the QualityRights Tool Kit will feed into the health system evaluation at mental health facility level. This will include data covering the following key health systems domains: leadership and governance (policy, standards); health and social service delivery; health workforce; and access to medicines.

(f) Economic evaluation: The economic evaluation will assess the costs for achieving a reduction in disability and improved functioning using the change in WHO DAS scores from baseline to follow-up as the main outcome measure. Information will be collected on the major costs associated with the implementation of the integrated intervention including: training of assessment teams in QualityRights; conducting QualityRights assessments; workshops to develop mental health facility-based strategic plans; costs associated with training for treatment, recovery and rehabilitation, and human rights; and implementation of family and peer support programmes.

(g) Evaluation of barriers: The project will document barriers to implementation throughout the project, as well as the solutions used to overcome the barriers.

***(vii) Dissemination and further scaling up***

A dissemination and communication plan will be developed with inputs from all partners to the project. The overall communication objective is to highlight the importance and impact of scaling up quality and human rights in mental health services. Indicators of achievement of the dissemination and communications objectives and mechanisms of feedback and evaluation will be included as part of the plan. The plan will be flexible to take advantage of opportunities that arise during the course of the project.

Dissemination of information emanating from the project will be conducted at appropriate stages throughout the duration of the project and beyond. It will be interactive, engaging with the target populations, and involving influential figures, national mental health champions, policy makers, politicians and civil society.

At the start of the project, a national meeting will be organized to officially launch the project. The event will bring together high-level representatives from national and local government along with other project stakeholders, in order to raise awareness on the project and promote national ownership. The stakeholders will also include mental health nodal officers from other States in India to facilitate the eventual uptake of the QualityRights intervention in their States. The media will be invited to attend and a press conference will be held in order to bring visibility to the project.

The following communication materials and resources will be developed and disseminated to promote visibility of the project:

* Press releases and press conferences (to disseminate project information and results at appropriate intervals throughout the project)
* Journal articles (*refer to previous Section C.II. Anticipated Results: Outputs Table*)
* Information flyers, brochures and posters,
* Facility-based field reports (to be developed at regular, appropriate intervals throughout the project, highlighting progress being made within the services)
* Final project report (describing the overall project, including results and achievements)
* Policy briefs that provide succinct and tailored information, based on project data and findings, highlighting the importance of addressing quality and rights in services, the mechanisms and actions for improving quality and rights, and the benefits and outcomes that can be achieved by scaling up actions for the health and development outcomes of service users, families and the community
* Community radio programmes about the project and related issues
* Case studies and photo series to document changes in service standards over time as a result of the project.
* Two high-profile supporters of QualityRights – Mr Gary Foster (Hollywood producer) and Mr Gregory David Roberts (best-selling author of Shantaram, a novel based in India, and renowned internationally and throughout India) – will also help publicize the project and disseminate the results and achievements both nationally and internationally.
* A five-minute film (to be uploaded on Youtube and distributed via other social media) will also be produced to disseminate key messages about the need to address Quality and Rights in mental health services and will document the transformation of services through QualityRights in India. The film, will target policy-makers and other groups, and will be relevant for national and international audiences.
* The project will develop a web-based online platform that delivers the methodology and training required to implement QualityRights in mental health facilities and to create collaborative practice communities that can share implementation experiences and results.

At the end of the project a conference will be organized, bringing together stakeholders involved in the project as well as health workers and managers, service users and families from ‘non-project/intervention’ services in Gujarat and other States in India, with an interest in implementing the integrated service model in their facilities. The forum will be an opportunity to (i) launch the project results, report, policy briefs, case studies, photo series and film; (ii) raise awareness among high level, influential national and state-level figures in India (including politicians, Ministry of Health officials from national and state level) on the urgent need to promote good quality treatment and care that promotes human rights; and (iii) share information and experiences on the process for developing the integrated service model and the outcomes achieved. International mental health advocates, will also be invited to speak at the conference. In addition, representatives from other countries interested in applying this model will be invited to participate in the forum.

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