QualityRights: Rights-based Peer Support in India (2014-2016)

Project summary

The peer support intervention was part of a broader WHO QualityRights project, a multi-partner effort aimed at reforming the mental health system in Gujarat State, India. The Centre for Mental Health Law and Policy, Indian Law Society, Pune, led the project in collaboration with the Department of Health and Family Welfare, Government of Gujarat, WHO and other national and international players. Its activities were implemented in six public tertiary hospitals spanning mental health areas. The project's peer support component was implemented specifically with people living with severe mental health conditions.

Context

India – like many other countries – faces a significant mental health treatment gap.[1] Without other support systems, public hospitals are often the only source of assistance for many individuals living with mental health conditions. Hospitals are typically seeing more severe and chronic cases due to delayed care-seeking linked to both demand factors (stigma, discrimination) and supply factors (lack of accessible, affordable and high-quality mental health services and professionals). Similarly, due to a lack of resources, providers' opportunities for interactions with service users are limited. The project implemented and evaluated the WHO's QualityRights initiative, a comprehensive programme aimed at advancing human rights in mental health through a holistic and recovery-based approach. Its initiation followed the QualityRights co-design process and included: i) an initial baseline assessment; ii) priority-setting with senior hospital staff and consultations with people with lived experiences; and iii) implementation of a context-adapted version of the QualityRights training for mental health and administrative professionals as well as people with lived experiences. Through the training, it became apparent that hospital staff understood recovery in theory but not in practice. To make the concept more tangible, the project team – in consultation with the hospitals – planned a peer support programme. Its primary appeal was the prospect of 'practising recovery' and adding value to the hospital's existing efforts (e.g., small-scale employment generation, occupational therapy).

Peer support intervention

WHY (objectives)	1. Improve recovery-based support beyond clinical improvement 2. Increase lived experience expertise within the health systems 3. Reduce the gap between clinicians and people with lived experiences
WHO	Peer support volunteers (PSVs)
WHAT	Question-based sessions (individual) and mutual support sessions (group)
HOW	Individual and open groups (around 10 participants)
WHERE	In-person at tertiary hospitals
WHEN	Continuous (individual) and once a month (group) for approximately one year

Intervention description

The project's peer support model evolved more organically compared to the other case studies. It was grounded in a co-design process which generated some variability across its sites. The PSVs were (i) trained on rights and recovery informed care, (ii) trained to form, plan and run open support groups with a pre-determined agenda, and (iii) tasked with providing continuous one-to-one peer support for people further along their recovery journey (e.g., having shown clinical improvement). In the one-on-one support PSVs helped people to think through their personalised recovery plan, which included their (i) plan for pursuing dreams and goals, (ii) a wellness plan, (iii) a plan for managing difficult times, (iv) a plan for responding to a crisis, and (v) a plan for after a crisis. The PSVs received a small reimbursement, a pro-rata of the state's minimum wage. The selection criteria included individuals with first-hand experience of a severe mental health condition who had shown clinical improvement, commitment to the role, and strong communication skills and empathy. Based on staff feedback, people with substance misuse issues were excluded from being PSVs. Volunteers underwent a six-day training course and ongoing refresher sessions. Peers were recruited through posters put up at

hospitals, existing staff networks, and Facebook groups. The PSVs conducted group sessions, which often included sharing personal experience, practical advice and guidance; for instance, availing social entitlements, seeking support in case of domestic abuse, living with illness symptoms and sharing personal coping strategies. In addition, clinical staff were brought in for topical lectures (e.g., use of and need for medication). The implementation across sites varied and included open and closed groups, different frequencies (two-weekly to monthly) and various group sizes (11 participants on average). Food and snacks at sessions were covered by project funds, the meeting space was provided by the hospital. For the first time in India, PSVs are now financially supported by the State Department's budget, with a provision for all public mental health facilities to include persons with lived experience to promote recovery-oriented services.

Selected lessons learned

- **Peer engagement:** The project staff noticed large differences in group and individual engagement across sites. The best attendance was observed for groups with skilled facilitators (e.g., strong and proactive communicators and narrators) and where session topics were perceived as relevant by peers (e.g., practical tools). Lower attendance rates were linked to newer sites, sessions that did not overlap with clinic days and settings with more marginalised communities. As a response, the project arranged disability benefits, reimbursed travel costs and increased the food budget. These proved useful incentives, while the team highlighted the importance of reflecting on the specific target group's motivation.
- **Formalising the role of peer support:** Despite the ownership by senior hospital staff, clinical frontline staff were sometimes sceptical of PSVs. Their worries included being monitored, potential role overlaps and peers' limited training relative to other health professions. To address these concerns, the project team conducted a co-design session with frontline staff and developed clear role descriptions. Specific changes included avoiding the term peer support workers, as it was less acceptable to policymakers due to its implications around employment rights. In addition, the peers' own recovery journey and the fact that they are not clinical staff were emphasised.
- **Need for organisation-level support:** Spanning the lessons learned, this case study provides a strong call for the co-design of peer support intervention, especially with frontline staff and people with lived experiences. Anchoring decisions in people's preferences helps address the uncertainties of how peer support works and ensures that project stakeholders are confident and affirmed in their roles. The need for contextualisation links to another project learning: Peer support should not be a stand-alone intervention. Without an organisational change component, volunteers will easily end up lost or in conflict with the existing system. This friction can bring intense frustration for peer volunteers and will likely interfere with the project's sustainability.

To learn more about the case study, explore the systematic evaluation of the programme.

This case study was informed by internal project documents and developed jointly with Jasmine Kalha (Centre for Mental Health Law & Policy, Indian Law Society)

Sources

1. Gururaj G, Varghese M, Benegal V, Rao G, Pathak K, Singh L, et al. *National Mental Health Survey of India*, 2015-16.; 2016. https://main.mohfw.gov.in/sites/default/files/National%20Mental%20Health%20Survey%2C%202015-16%20-%20Mental%20Health%20Systems_0.pdf. Accessed March 6, 2024