Tele MANAS
National Tele Mental Health Programme
14416

Ministry of Health & Family Welfare
Government of India
सत्यमेव जयते

World Health Organization
India

RAPID ASSESSMENT REPORT ON

Tele MANAS

Tele Mental Health Assistance and Networking Across States

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Table of contents

Abbreviations

AAM	Ayushman Arogya Mandirs
COVID-19	novel coronavirus
CHC	Community Health Centre
CPHC	Comprehensive primary health care
DMHP	District Mental Health Programme
EQUIP	Ensuring Quality in Psychological Support
GBV	Gender based violence
GOI	Government of India
HR	human resources
IEC	information, education and communication
IIIT-B	International Institute of Information Technology-Bengaluru
INR	Indian rupees
IT	information technology
IVRS	interactive voice response system
LMS	learning management system
MHP	mental health provider
NCD	noncommunicable disease
NGO	non-governmental organization
NHSRC	National Health Systems Resource Centre
NIMHANS	National Institute of Mental Health and Neurosciences
OPD	out patient department
PHC	primary health centre
PTSD	Post Traumatic Stress Disorder
PwMIs	people with mental illnesses
RCC	regional coordinating centres
SOP	standard operating procedures
Tele MANAS	National Tele Mental Health Programme of India, Tele Mental Health Assistance and Networking Across States
TMC	Tele MANAS cell
UT	union territory
YLD	years lived with disability

Executive summary

The National Tele Mental Health Programme of India, Tele Mental Health Assistance and Networking Across States (Tele MANAS) stands as a remarkable and visionary initiative that was unveiled in February 2022. **Tele MANAS reflects the government's commitment to nurture the nation's mental well-being.** This visionary programme seeks to narrow the gap between mental health demand and accessible services and herald a future where digital technology can be leveraged to transform lives and reshape the landscape of mental health support in India.

Launched on the World Mental Health Day, 10 October 2022, Tele MANAS seeks to function as a comprehensive, integrated, and inclusive 24x7 tele-mental health facility in each state and union territory. Serving as a digital component of the National Mental Health Programme, Tele MANAS aims to provide universal access to equitable, accessible, affordable, and quality mental health care through 24x7 tele-mental health counselling services across the country with assured linkages.

Globally, Tele MANAS is one of the largest deployments of a digital, phone-based mental health initiative in a country. The programme is well-resourced, both in terms of technical and financial resources. **The evolving linkages with the larger health system is one of the hallmarks of this initiative, which distinguishes it from other such telephone-based services.**

A rapid assessment[1] of Tele MANAS shows that since its launch in October 2022, the Tele MANAS programme has already grown and scaled across 34 states/UTs. **The scale and complexity of the programme is evident by the fact that 47 out of 51 Tele MANAS cells are functional across 34 states/UTs wherein services are offered in 20 languages[2] by 1900+ trained and paid counsellors and other staff.** Two remaining states/UTs, namely Lakshadweep and Puducherry are due to go live soon. **In a span of one year, there has been significant progress - over 351 454 calls have been received on the Tele MANAS helpline.** And these numbers continue to increase each day, thereby indicating that the programme is meeting otherwise unaddressed need.

Nation-wide analyses of Tele MANAS users shows that majority of the callers on Tele MANAS helpline are male (56.15%) and aged 18–45 years (71.5%). Most callers (70.75%) seek advice regarding their own mental health while 18.4% of callers are caregivers, calling on behalf of someone else. 93% of the calls received on Tele MANAS are classified as routine calls. 3.49% of calls are classified as emergency and escalated to a mental health specialist. 2.2% of calls are prank calls. An overview of the type of complaints shows that the top four complaints relate to sleep disturbances (14%), sadness of mood (14%), stress-related (11%) and anxiety

1. Rapid assessment comprised of a combination of methods to gain insights into the programme's strengths, challenges, and potential areas for enhancement. This included: desk review, analysis of national level data, primary data collection in four states/UTs (Jammu and Kashmir, Karnataka, Madhya Pradesh, and Odisha) and documentation of stories of persons who have benefited from the Tele MANAS programme as shared by the states/UTs. The rapid assessment offered insights into implementation experience, helped identify programme strengths and possible areas for improvements which are summarized in this section.
2. Hindi, English, Kannada, Telugu, Tamil, Malayalam, Konkani, Marathi, Gujarati, Assamese, Bengali, Odia, Punjabi, Kashmiri, Bodo, Dogri, Urdu, Manipuri, Mizo and Rajasthani.

(9%). Overall, less than 3% of total complaints have been identified as suicide-related cases. While it is recognized that an individual may present with more than one complaint, majority of the complaints received on Tele MANAS are for common mental disorders, indicating the appropriateness of the model and its approach.

A unique element of this programme is the tiered organizational and support framework which ensures provision of continued technical and operational support. The programme comprises of a network of 23 tele-mental health centres of excellence, with National Institute of Mental Health and Neurosciences (NIMHANS) at the forefront as the nodal centre and lead on mental health service delivery. The International Institute of Information Technology-Bengaluru (IIITB) works closely with NIMHANS and plays a pivotal role by offering robust technological support and leading on the IT Architecture. And the National Health Systems Resource Centre (NHSRC) provides technical support and leads on the health systems domain.

The two-tiered Tele MANAS structure at state level, comprising of trained counsellors and mental health professionals at Tier 1 and mental health specialists at Tier 2 is uniquely supported with ongoing technical support and handholding by mentoring institutions and regional collaborating centres across the country. These mentoring institutions and regional centres in turn leverage the institutional expertise of apex institutions.

Tele MANAS is underpinned by a meticulously crafted training and capacity building framework. The essence of the training lies in its tailored approach, encompassing diverse counselling strategies fine-tuned for different callers' age groups, gender, and socio-demographic backgrounds. Notably, the entire training is conducted in local languages, enabling counsellors to communicate effectively and empathize with callers. Overall, the counsellors are well-trained through the blended methodology (online and on-site) and supervised. Based on the available data, the stepped care process is being managed without major technical or process difficulties.

The backbone of this programme is the robust and stable technological architecture. Its potential for open access is noteworthy, as the platform could be shared with other users under suitable agreements. Privacy considerations are threaded into the platform's operation, underscored by measures at various levels, including data storage, access controls, and caller-specific protocols. Informed by field-level insights, the platform has undergone three iterative improvements, refining its user-friendliness, intuitiveness, and overall efficacy. In keeping with the overall vision of Tele MANAS, increasingly, these updates focus on linkages with district mental health programme and district hospitals and broader aspects of digital health such as eSanjeevani initiative. The platform offers the possibility of compatibility with the Ayushman Bharat system architecture **and tracking across various verticals. The programme also offers hitherto unexplored potential to create referral pathways and linkages with other non-health sectors**.

Overall, the foundational aspects of the Tele MANAS programme are sound and there is every reason to be optimistic about its progress in the coming years. Given the global importance of Tele MANAS, aspects which could be further strengthened include:

- Augmenting national-level support for promotional efforts to help further raise awareness of the Tele MANAS service and increase uptake.

- Strengthen the training and capacity building model further by including competency-based training and supervision approaches to support ongoing capacity building.
- Introduction of a screening tool as the programme matures, to screen callers and establish a more objective approach to understanding their needs and the circumstances under which they are stepped up from counsellors to MHPs. This would also support the introduction of scalable psychological interventions.
- Addressing the operational challenges such as IT connectivity would further improve the caller experience and increase service uptake.
- Developing a deeper understanding of the end user and programme impact. Data systems could be further developed to provide capability for disaggregated analyses. A robust monitoring and evaluation framework would support detailed understanding of the impact of Tele MANAS ensuring that the service it reaches the broadest possible user base and that decisions are data-driven.

Specific recommendations across key thematic areas include:

- **Support and strengthening of the Tele MANAS workforce** through workplace enhancement for improved service delivery, human resource planning and recruitment and human resource management.
- **Augmenting service delivery** through strengthening triage, implementation of structured interventions and stepped care, strengthening role of mental health professionals.
- **Building on existing capacity development strategies** through introduction of competency-based training and supervision, enhancements in supervision and mentoring structure, task-sharing in training and mentoring.
- **Strengthening data systems and implementation research** and monitoring and evaluation.
- **Strengthening linkages and partnerships** within the community, beyond the health sector as well as linkages and integration within the existing health system and other departments/ministries.
- **Knowledge sharing** through development of national case study on Tele MANAS programme, introduction of exchange programme to facilitate sharing within the country as well as to share learning and innovations globally.

1. Introduction

Background

Today, globally India denotes a significant presence, accounting for around 18% of the world's population. While India's health sector has achieved several milestones, there are high levels of mental health need in the country. One in every seven people in India is believed to be affected by mental disorder of varying severity. In the year 2019, mental disorders were the second leading cause of years lived with disability (YLDs). Simultaneously, self-harm and violence were the tenth leading cause of death[3].

The National Mental Health Survey 2016[4] showed that approximately 10% of India's adult population is experiencing mental health concerns that require intervention. A treatment gap of 70–92% exists between the individuals needing assistance and those receiving it for various mental disorders. While the actual burden of psychological distress remains unclear, indications point to a significant amount.

The public health imperative for bolstering mental health services becomes even more compelling when viewed from the economic lens. Studies highlight that compromised mental health exacts a significant toll on productivity and a country's economic prowess. India stands to lose US$ 4.58 trillion before 2030 due to noncommunicable diseases and mental health conditions. Cardiovascular diseases, accounting for US$ 2.17 trillion, and mental health conditions (US$ 1.03 trillion), are expected to lead the way in economic loss[5].

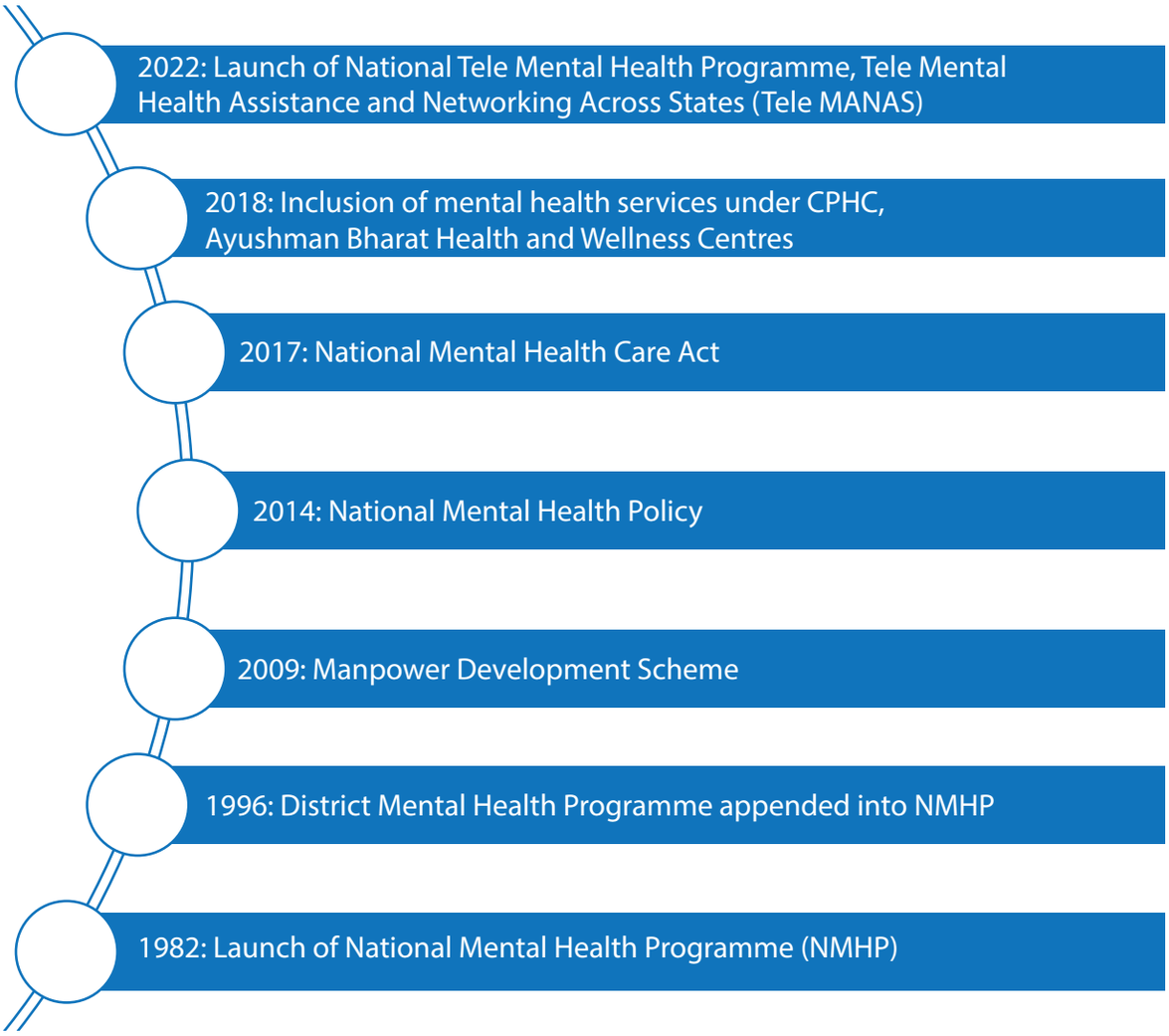
The Government of India (GoI) has taken multiple strides since the launch of the National Mental Health Programme in 1982 (Refer to Fig. 1). Notable initiatives such as the National Mental Health Policy of 2014 envisions universal access to mental health care. The National Health Policy of 2017 gave mental health a pivotal policy focus. A legislative milestone was achieved with the Mental Healthcare Act of 2017, enshrining access to mental health care as a statutory right and entitlement, including its integration into primary healthcare services. Incorporation of mental health services within the ambit of Comprehensive Primary Health Care (CPHC) under the Ayushman Arogya Mandirs (AAMs) reflected this seminal shift. This coupled with a coverage of over 90% districts under the District Mental Health Programme (DMHP) ensures access to essential mental health care through facility and community-based interventions.

3. The Global Burden of Disease Study 1990-2017. Lancet Psychiatry. 2020;7: 148–61

4. Gautham MS, Gururaj G, Varghese M, Benegal V, Rao GN NMHS Collaborators Group. The National Mental Health Survey of India (2016): Prevalence, socio-demographic correlates and treatment gap of mental morbidity. Int J Soc Psychiatry. 2020; 66:361–72.

5. Bloom, D.E., Cafiero-Fonseca E.T., Candeias V, Adashi E., Bloom L., Gurfein L., Jané-Llopis E., Lubet, A., Mitgang E, Carroll O'Brien J, Saxena A (2014). Economics of Non-Communicable Diseases in India: The Costs and Returns on Investment of Interventions to Promote Healthy Living and Prevent, Treat, and Manage NCDs. World Economic Forum, Harvard School of Public Health, 2014. Available at: https://www.weforum.org/reports/economics-non-communicable-diseases-india (Last accessed 25 August 2023)

Fig. 1: Key milestones in India's Mental Health Programme



The COVID-19 pandemic exposed and exacerbated mental health vulnerabilities. A surge of approximately 26–28% in major depressive disorder and anxiety disorders in 2020[6], underscored the pandemic's toll on mental well-being. Further, traditional avenues for mental health care delivery suffered disruptions due to resource diversions and restrictions on in-person consultations, precipitating a shift towards innovative modalities such as tele-mental health services.

Recognizing this, the Government of India unveiled the National Tele Mental Health Programme of India, Tele Mental Health Assistance and Networking Across States (Tele MANAS). In the 2022–2023 budget speech[7], the Finance Minister acknowledged the negative mental health consequences of COVID-19 pandemic and announced the launch of the Tele MANAS Programme, with a budgetary allocation of INR 1.21 billion (equivalent to over US$ 100 billion)[8].

At the core of Tele MANAS lies the aspiration to offer **free tele-mental health services**, embodying a commitment to nurture the nation's mental well-being. This visionary programme seeks to narrow the gap between mental health demand and accessible services

6. Santomauro DF, Herrera AMM, Shadid J, Zheng P, Ashbaugh C COVID-19 Mental Disorders Collaborators. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. Lancet. 2021; 398: 1700–12.
7. https://www.pib.gov.in/PressReleasePage.aspx?PRID=1866498
8. https://www.pib.gov.in/PressReleasePage.aspx?PRID=1896958

and herald a future where digital technology can be leveraged to transform lives and reshape the landscape of mental health support in India.

The term "tele-mental health" encompasses a wide range of mental health services that are delivered through the use of telecommunication or internet-based digital devices. This includes a broad spectrum of services involving varying levels of digital technology use such as telephonic calls, text messages, e-mails, and interactive audio-visual conferencing

Launched on the World Mental Health Day, 10 October 2022, the National Tele Mental Health Programme of India, Tele Mental Health Assistance and Networking Across States (Tele MANAS) seeks to function as a comprehensive, integrated, and inclusive 24x7 tele-mental health facility in each State and Union Territory.

Since its launch, the Tele MANAS programme has already grown and scaled across 34 states/UTs in one year. As part of its commitment to continuous improvement, a rapid assessment of the programme was undertaken to gain insights into implementation experience, understand its strengths and identify possible areas for improvements**.** Specifically, the rapid assessment sought to:

- Trace the programme's progress and performance, reflect on the implementation experience and effectiveness and the extent to which the Tele MANAS programme is moving towards achieving its intended goals.
- Identify success factors contributing to successful implementation.
- Pinpoint implementation challenges and barriers.
- Gather feedback from the counsellors, mental professional and other implementers and their suggestions for improvement.
- Compile a set of stories and voices from the field.
- Based on the above, provide strategic directions for the future.

Methodology and data collection process

The Ministry of Health and Family Welfare (MoHFW), organized the rapid assessment with Dr Neha Garg, Director Mental Health acting as the focal point in the Ministry. National Institute of Mental Health and Neurosciences (NIMHANS), led by its Director, Professor Pratima Murthy, coordinated the study. NIMHANS officials were integral members of the core teams conducting the rapid assessment across the identified states.

The rapid assessment employed a combination of methods to gain insights into the programme's strengths, challenges, and potential areas for enhancement. This included:

- **Desk review** of existing documents, reports, manuals, presentations related to the Tele MANAS programme.
- **Analysis of national-level data**, including utilization rates, demographic distribution of users, and key performance indicators.
- **Primary data collection** was undertaken in four states/UTs, namely, Jammu and Kashmir, Karnataka, Madhya Pradesh, and Odisha. The choice of these four states/UTs was guided by the fact that they were early implementers of the programme. Further, effort was made to reflect diverse demographics, implementation experience, call

volumes, and ensure geographical representation. Semi-structured interview guides for Tele MANAS counsellors, state mental health nodal officers and mentoring institutes, and facility observation checklist were developed. The interview guides covered topics such as programme implementation, technological support, user experience, and challenges faced. Primary data was collected through on-site visits to Tele MANAS cells and District Mental Health Programme (DMHP) through in-person interviews except in case of Gwalior where interviews and discussion were held online. Additionally, visits were organized to Tele MANAS Apex Centre at NIMHANS and International Institute of Information Technology (IIITB), which is the key agency responsible for implementing the IT platform for Tele MANAS.

- **Documentation of stories:** A template was developed to capture stories of persons who have benefited from the Tele MANAS programme. In view of ethical and privacy concerns, no personal data was directly collected from any beneficiary. These stories were compiled by four states/UTs using existing documentation of the Tele MANAS system.

The primary data was collaboratively collected by a team of experts from three levels of the World Health Organization - Headquarters, South-East Asia Regional Office and Country Office for India, and NIMHANS. A total of 46 interviews were conducted between 1–17 August 2023 across the four states/UT. The approximate duration of each visit was about 2–3 days, except in case of Karnataka where discussions were also held with NIMHANS and IIIT-B. Prior to data collection, informed consent was sought from each interviewee. Thereafter, the data collected through these various methods and tools was collated and analysed.

Certain limitations should be kept in mind when reading this report. The information presented here reflects implementation experiences, insights and observations gathered and collated based on field visits and interactions with identified stakeholders in selected four states/UTs. Where possible, this information has been triangulated with existing data as well as secondary information and general trends are presented. At no point, does this report seek to serve as an evaluation of the Tele MANAS programme - either nationally or in the four states/UTs. The fact that the four states/UT collectively contribute to over 28.7% of the total Tele MANAS call volume and have been functional for a period of about 12 months, offers insights that are relevant for other states/UTs and at the national level in terms of future programme directions. The data systems, including IT functionalities of the Tele MANAS programme continue to evolve. Available data points from the national performance dashboard have been analysed as received. While the opportunity for disaggregated and more nuanced analyses has been limited, they offer valuable pointers in terms of system readiness, programme uptake and future strategic action areas.

2. About Tele MANAS

This section provides an overview of the Tele MANAS programme. It outlines the programme vision, the nature of services offered, the underlying organizational that is pivotal to its functioning. Further, it outlines the programme's approach towards capacity building.

A. Vision

Serving as a digital component of the National Mental Health Programme, Tele MANAS aims to provide universal access to equitable, accessible, affordable, and quality mental health care through 24x7 tele-mental health counselling services across the country with assured linkages.

Tele MANAS: A comprehensive mental health care service
• Provides free 24x7 tele-mental health services • Leverages digital technology to enable anyone to access mental health services • Caters to people in remote or under-served areas and difficult to reach populations • Provides linkages with a full-fledged local mental health service network offering counselling, integrated medical and psychosocial interventions with mental health specialists • Ensures continuity of care, follow up services and links to in-person services while maintaining patient privacy

B. Services

A toll-free, around the clock (24x7) helpline number 14416 has been set up across the country, allowing callers to choose their preferred language while availing the helpline service. Additionally, helpline service is also accessible through an alternate number (1800-91-4416).

Designated Tele MANAS cells are currently in the process of establishment across different states and union territories. The calls are routed to Tele MANAS cells in the respective state and union territory. This ensures that calls are efficiently directed to the appropriate locations within the respective states and territories. **When a caller dials the Tele MANAS helpline number, basic support and counselling is provided through a centralized Interactive Voice Response system (IVRS) that is customized for use across all States and UTs.**

Recognizing that majority of users will have mental health concerns/mental distress (not mental illnesses), most of which can be effectively handled by trained non-specialists/ counsellors, **Tele MANAS is structured as a two-tier system** as outlined in Fig. 2**.** Tier 1 comprises of state Tele MANAS cells staffed by trained counsellors and mental health specialists. Tier 2 comprises of mental health specialists offering options for in-person

consultation(s) and/or utilizing the eSanjeevani platform for audio-visual consultations.

Fig. 2: Overview of Tele MANAS Services

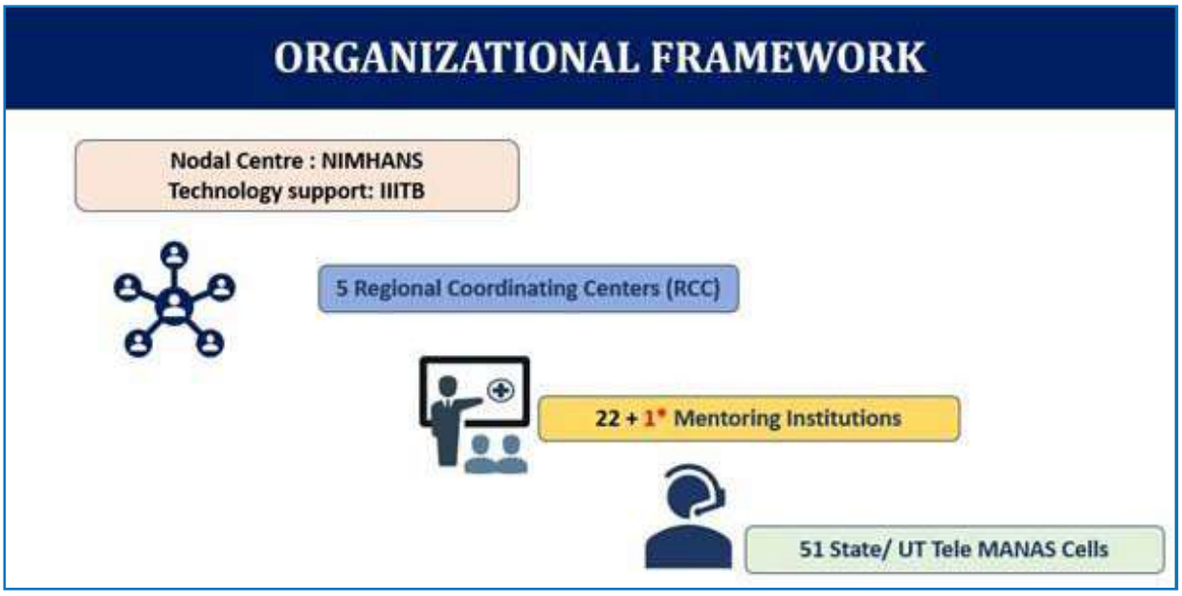
To extend comprehensive and accessible tele mental health services around the clock, Tele MANAS envisions connecting these cells with existing local mental health network and resources available at nearby centres of excellence, medical colleges, district hospitals and other mental health services. This strategy ensures timely provision of mental health care to individuals experiencing acute psychological distress. Further, it facilitates and ensures access to specialized mental health services located in proximity, depending on their convenience and gravity of their mental health needs. The National Tele Mental Health Programme ultimately seeks to align tele-mental health services with other government-led health-care initiatives, notably the Ayushman Arogya Mandirs, Ayushman Bharat Digital Health Mission, and eSanjeevani (nation-wide tele-consultation service), District Mental Health Programme amongst others. Eventually, this service is expected to cover the entire spectrum of mental wellness and illness and integrate all systems that provide mental health care.

C. Organizational framework

In terms of its **organizational framework**, the programme comprises of a network of 23 tele-mental health centres of excellence, with National Institute of Mental Health and Neurosciences (NIMHANS) at the forefront as the nodal centre and lead on mental health service delivery. The International Institute of Information Technology-Bengaluru (IIITB) works closely with NIMHANS and plays a pivotal role **by offering robust** technological support and leading on the IT Architecture. And the National Health Systems Resource Centre (NHSRC) provides technical support and leads on the health systems domain. The organizational framework is depicted in Fig. 3. The tiered organizational framework ensures provision of continued technical and operational support for the entire programme. For instance, NIMHANS plays a key role as an apex organization in review and updating of technical content, development of standard operating procedures and capacity building, provides advice on Information, Education and Communication (IEC) content, advocates on ethical and legal issues, works on integration of the programme within the larger health system and other overall co-ordination. They are ably supported by five Regional Coordinating Centres (RCC), namely - Lokpriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH),

Tezpur, Central Institute of Psychiatry (CIP) Ranchi, Institute of Human Behaviour and Allied Sciences (IHBAS) Delhi, Postgraduate Institute of Medical Education and Research (PGIMER) Chandigarh and NIMHANS Bengaluru - who serve as mentors for a group of states/UTs and other mentoring institutions and oversee training, capacity building and research.

Fig. 3. Organizational Framework



Closer to the state/UT Tele MANAS cell, 23 Mentoring Institutions[9] play a key role in standardization of the training curriculum and training and certification of Tier 1 counsellors; provide support through collaborative audio and video consultations; functional as a referral centre for complex clinical issues and for in-person consultations and conduct of implementation research.

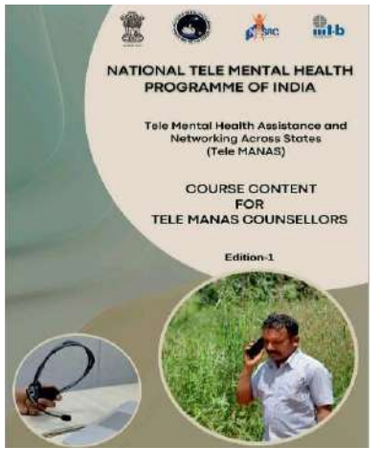
D. Empowering Tele MANAS counsellors: comprehensive approach towards capacity building

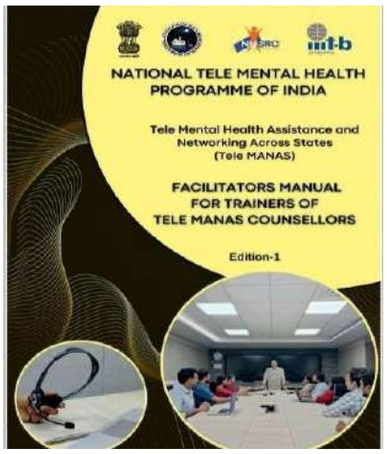
At its core, Tele MANAS centres around its dedicated professionals - the counsellors, psychologists and associated mental health professionals - who provide the services. Tele MANAS is underpinned by a meticulously crafted training and capacity-building framework, primarily aimed at Tier 1 counsellors, the first point of contact for individuals seeking solace and guidance. The essence of the training lies in its tailored approach, encompassing diverse counselling strategies fine-tuned for different callers' age groups, gender, and socio-demographic backgrounds. Notably, the entire training is conducted in local languages, enabling counsellors to communicate effectively and empathize with callers. Three foundational manuals equip counsellors to provide effective support to callers navigating the complexities of their mental health.

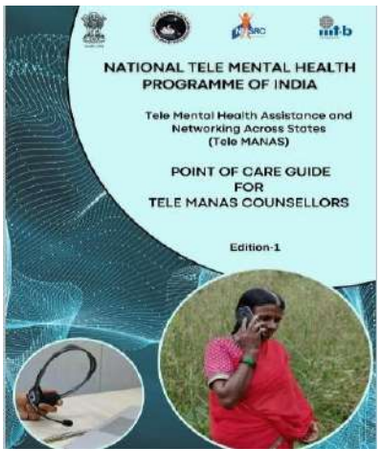
The training structure is a blend of online and onsite training - a total of 52 hours of rigorous training across a period of three months. This training covers diverse technical

9. The mentoring institutes are: IGIMS Patna, AIIMS Raipur, CIP Ranchi, AIIMS Bhopal, PGIMER, Chandigarh, Hospital for Mental Health, Ahmedabad, Gujarat, Institute of Psychiatry and Human Behaviour Bambolim Goa, AIIMS, Nagpur, KGMU Lucknow, AIIMS Rishikesh, IHBAS Delhi, IGMS Shimla, Psychiatric Diseases Hospital, Govt. Medical College, Srinagar, LGBRIMH Tezpur, NIMHANS Bengaluru, IMHANS Kozhikode Kerala, IMH Chennai, IMH Hyderabad, JIPMER and AIIMS Mangalagiri., MHI SCB, Cuttack, Psychiatry Centre, SMS MC Jaipur, Pavlov Hospital and CoE, CNMCH, Kolkata

content and skill development, ranging from identification of distressing mental health scenarios, triage, basic counselling, planning of interventions and collaboration with other mental health professionals and linkages to other resources. **To date, 31 batches of counsellors have completed the online training, a total of 2033 counsellors.** The online training is enhanced by continuous weekly training sessions led by domain experts from within the mental health field. Equally vital is the three-day face-to-face training, which offers counsellors a hands-on experience, enriching them in managing real-life scenarios. **To date, the team has provided on-site training to eight state/UT cells comprising a total of 146 counsellors. States trained include Jammu and Kashmir, Jharkhand, Tamil Nadu, Karnataka, Madhya Pradesh, Rajasthan, Ladakh and Arunachal Pradesh.**







The commitment to continued professional development is exemplified by case conferences, held every 15 days, where counsellors present unique cases, fostering collective learning. These conferences are mentored by the Mentoring Institute and overseen by Regional Coordinating Centres, ensuring a dynamic exchange of insights. Further, booster sessions, conducted in English and Hindi, on specific topics advance counsellors' skills in handling critical scenarios. To date, two booster sessions have been held, one on disaster response and psychological first aid, and the other on psychiatric rehabilitation**. In addition, 39 booster training sessions on handling the IVR system was also conducted by IITB.** Going forward, a Learning Management System (LMS) consisting of 4 modules and 16 lessons is being developed to automate training. An accreditation processes is also on the anvil, further enhancing accessibility and engagement.

Unveiling the stories

1. From darkness to light - An account of self-discovery and transformation
Madhya Pradesh

The first call from a 20-year-old young woman student to Tele MANAS helpline was characterized by crying spells and prolonged silence. Consistent efforts by the Tele MANAS counsellor paid off, unveiling the layers of her struggle - a two-month ordeal marked by panic attacks, sleepless nights, an overwhelming sense of loneliness, and the weight of traumatic childhood experiences. Relationship hurdles, lack of focus, and low self-esteem added to her burden.

The young woman's situation was evaluated by a TMC psychiatrist, leading to a referral for a face-to-face consultation at a Tier 2 facility in Bhopal. But the path to treatment was not smooth. Stigma loomed large, causing her to hesitate in seeking treatment.

The counsellor and the psychiatrist worked together, addressing her concerns. And eventually after around 7–8 sessions, the treatment began. From a flurry of daily 8–10 calls seeking validation, her communication gradually reduced to 1–2 calls per month.

The young woman was educated and equipped with healthy coping strategies, stress management techniques and problem-solving skills. Daily routines were restructured, incorporating exercise, balanced nutrition, and healthy sleep patterns. Every step was orchestrated under the watchful eye of psychiatrists and counsellors, who not only worked as one team, but the counsellors also went beyond their duty hours to empower the young woman. As a result of their collective efforts, she is now leading a happy healthy and a confident life which she always wanted.

In her own words...

"I didn't like myself in the beginning and now it is safe to say that I love myself. I have gotten a new and better perspective towards life and relationships in general. There are lot of statements that I could say were life-changing... I have become a new better version of myself."

3. Glimpses of nationwide progress

The Tele MANAS programme has been operational for about twelve months, since its launch in on World Mental Health Day, October 2022. Within this short time span, the programme has rapidly evolved. Based on available information, glimpses from its nation-wise progress are outlined in this section.

47 Functional Tele MANAS cells across 36 states/UTs

As of date, 47 out of 51 Tele MANAS cells are functional across 34 states/UTs wherein services are offered in 20 languages[10] by 1900+ trained counsellors and other staff. Two remaining states/UTs, namely Lakshadweep and Puducherry are due to go live soon.

Table 1. State-wise functional status of Tele MANAS cells

Name of the State/UT	Number of State Tele MANAS Cells to be established as per operational guidelines	Number of functional State Tele MANAS Cells
Andaman and Nicobar	1	1
Andhra Pradesh	2	1
Arunachal Pradesh	1	1
Assam	1	1
Bihar	3	3
Chandigarh	1	1
Chhattisgarh	1	1
Dadra and Nagar Haveli and Daman and Diu	1	1
Delhi	1	1
Goa	1	1
Gujarat	2	1
Haryana	1	1
Jammu and Kashmir	1	1
Jharkhand	1	1
Karnataka	2	2
Kerala	1	1
Ladakh	1	1
Madhya Pradesh	2	2
Maharashtra	3	3
Manipur	1	1
Meghalaya	1	1
Mizoram	1	1

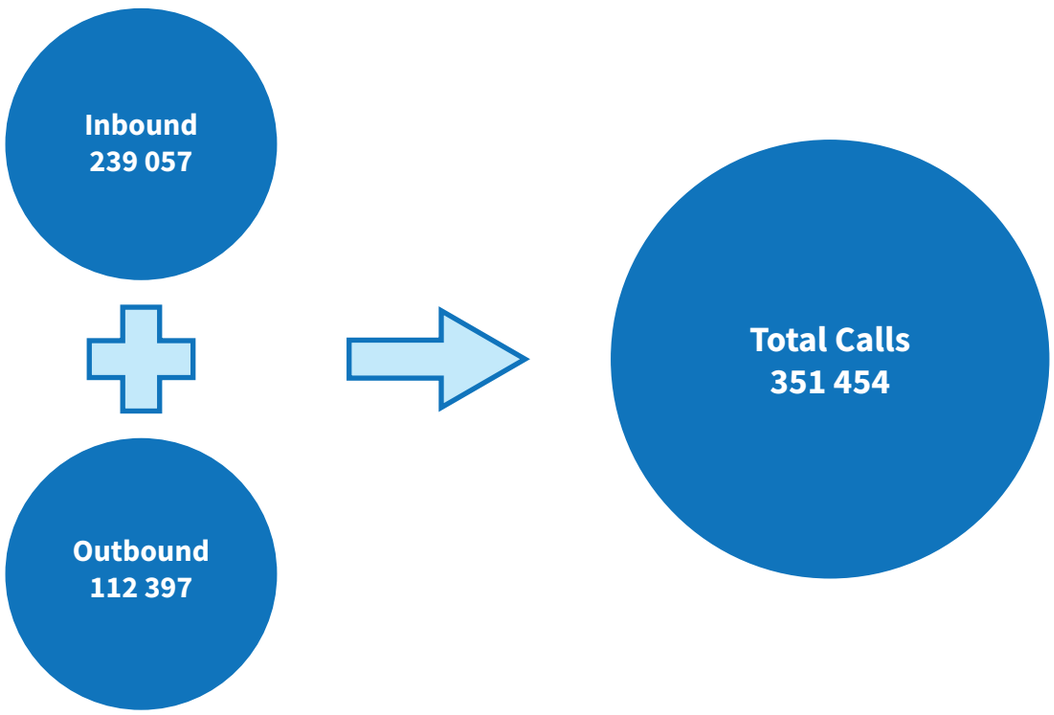
10. Hindi, English, Kannada, Telugu, Tamil, Malayalam, Konkani, Marathi, Gujarati, Assamese, Bengali, Odia, Punjabi, Kashmiri, Bodo, Dogri, Urdu, Manipuri, Mizo and Rajasthani.

Nagaland	1	1
Odisha	2	2
Punjab	1	1
Rajasthan	2	2
Tamil Nadu	2	2
Telangana	1	1
Tripura	1	1
Uttar Pradesh	4	4
Uttarakhand	1	1
West Bengal	2	2
Himachal Pradesh	1	1
Lakshadweep	1	0
Puducherry	1	0
Sikkim	1	1
Total	**51**	**47**

Total call volume: Surpassing 351 454 calls in a span of one year and counting ....

Since the programme's launch in October 2022, in a span of one year, over 351 454 calls spanning across 34 states/UTs have been received on the Tele MANAS helpline as of 9 October 2023 (Refer to Fig. 4).

Fig. 4: Total call volume



Of these, **68% constitute in-bound calls while 32% are out-bound calls.** The number of callers has steadily increased since the programme's inception (Refer to Fig. 5). Much of this increase in numbers has been attributed to promotional/IEC activities undertaken at the state level. However, overall, the Tele MANAS service is still operating significantly below capacity.

Fig. 5: Month-wise call volumes since programme launch

Fig. 6 and 7 show that the total number of calls as well as the distribution of in-bound and outbound calls vary considerably across 36 states/UTs. For example, in Tamil Nadu there have been a total of over 58 414 calls since October 2022, whereas Chandigarh has received only 320 calls in the same period. Some of this variation can be explained by population sizes of the different states. It is also notable that not all states/UTs have been fully functioning since October 2022, with some experiencing delays due to problems with recruitment. Further, variations in call volumes also suggest possible differences in awareness, promotion and unique cultural/regional factors that affect public perception of tele-mental health services and its uptake. Exploring the reasons for the wide divergence in the performance of the Tele MANAS cells across the country and how the differences could be managed constitutes an important area for further study.

Fig. 6: State-wise total calls since programme launch

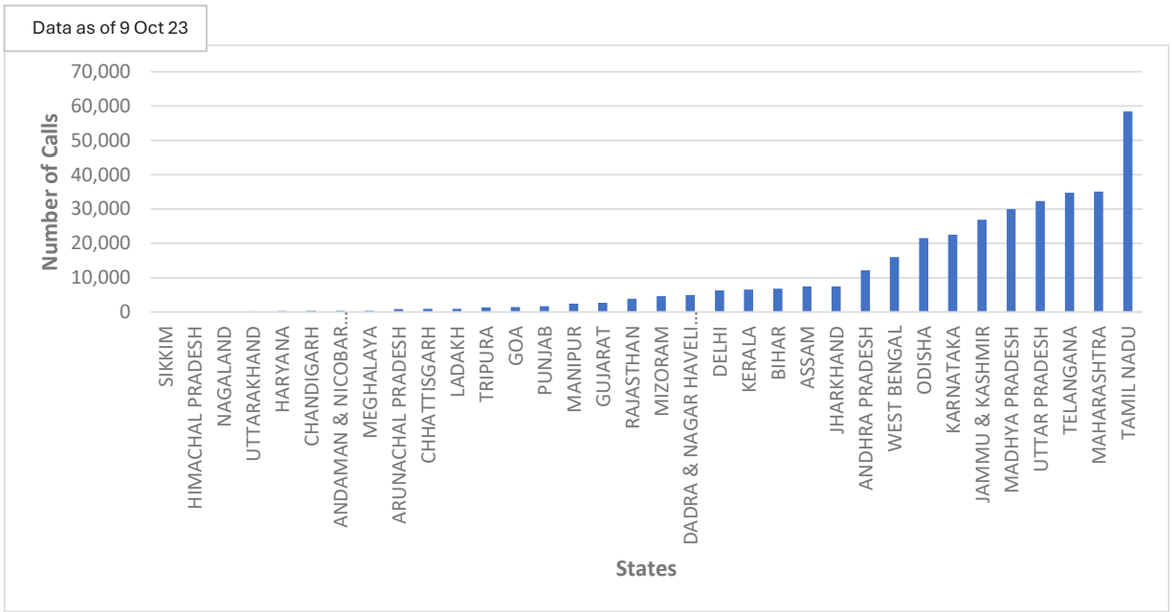
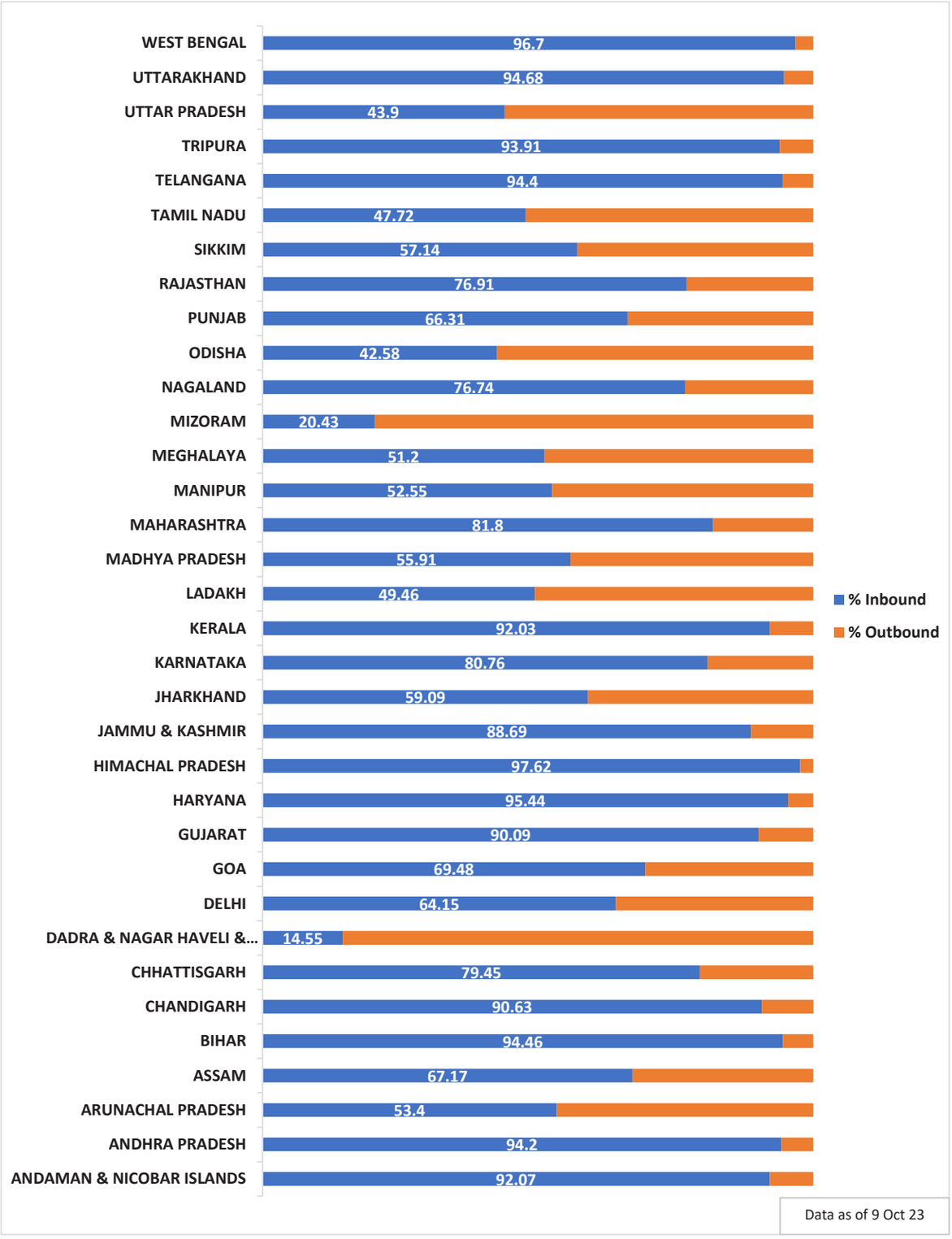


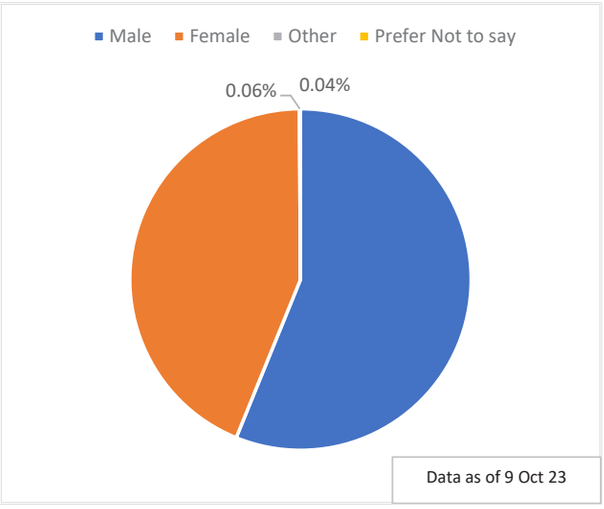
Fig. 7: State-wise distribution of inbound and outbound calls



Caller profile: Who is calling?

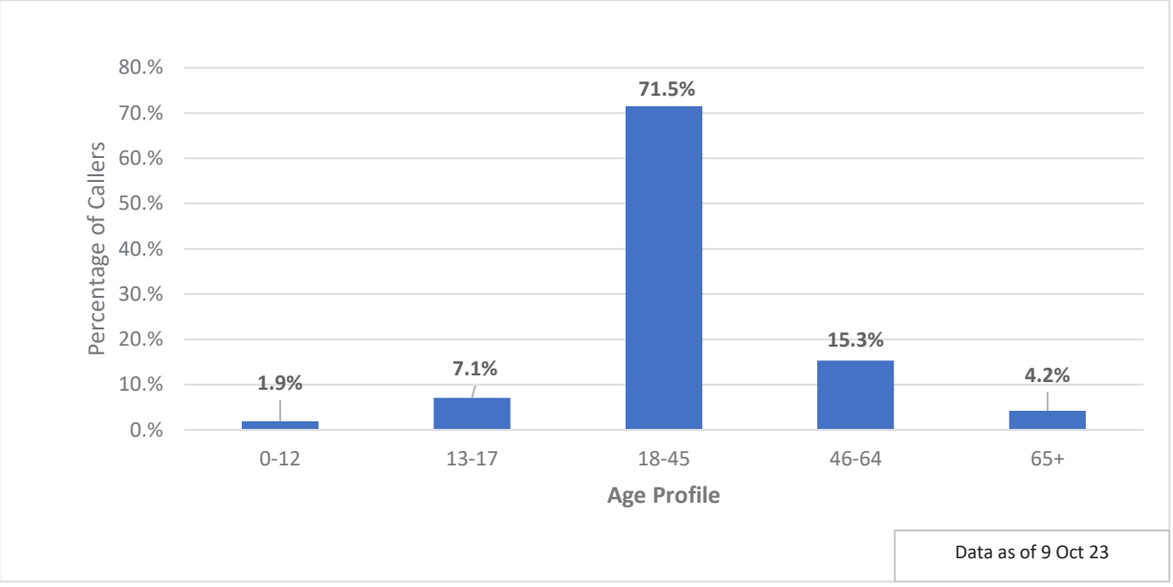
Nation-wide analyses shows that majority of the callers on Tele MANAS helpline are male (56.15%) and aged 18–45 years (71.5%) as indicated in Fig. 8 and 9 respectively. While

Fig. 8: Gender Profile



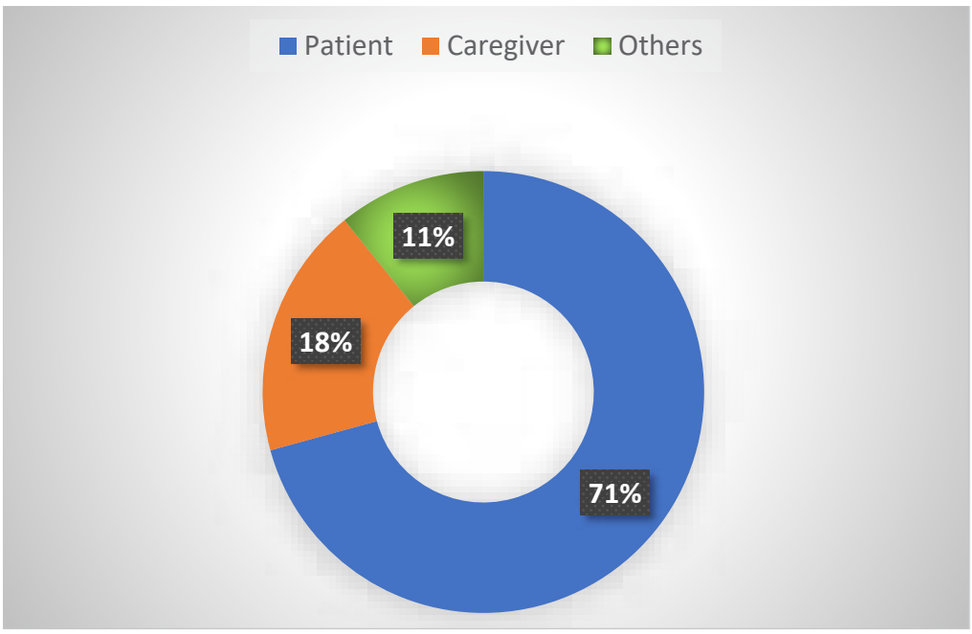
interpreting this statistic, it is important to consider the existence of gender gap in terms of mobile phone ownership, with men having better access to such technology compared to women. Given the nature of Tele MANAS, this could be one probable reason for the observed trend, but this needs to be examined further. Understanding the reasons for the observation about the male gender skew of the callers, further disaggregated analysis of available data by gender and age might help improve the community engagement plans to make it more women-focused, especially in rural areas.

Fig. 9: Age Profile Percentage



Further, most callers (71%) seek advice regarding their own mental health. 18% of callers are caregivers, calling on behalf of someone else as shown in Fig. 10.

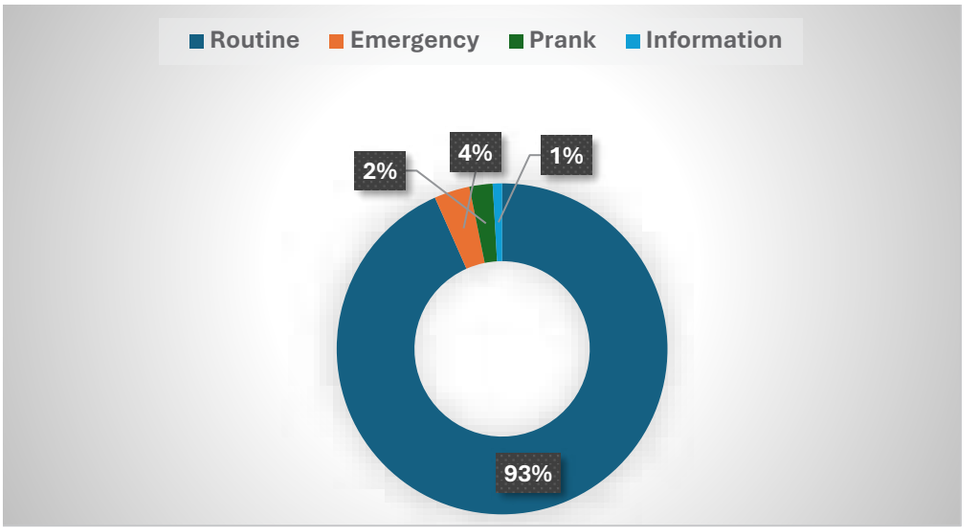
Fig. 10: Caller analysis (in %)



For what are they calling? Type of calls: routine vs emergency

93% of the calls received on Tele MANAS are classified as routine calls. 4.4% of calls are classified as emergency and escalated to a mental health specialist. 2.6% of calls are classified as prank calls. Prank calls can be distressing for counsellors as they tend to be directed at female counsellors and are either disrespectful or sexual in nature. Refer to Fig. 11.

Fig. 11: Type of calls (in %)



Type of complaints received on Tele MANAS

Fig. 12 providers an overview of the type of complaints received on the Tele MANAS helpline across 32 state/UTs. The top four caller complaints relate to:

1. Sleep disturbances - 14%
2. Sadness of mood - 12%

3. Stress-related - 11%
4. Anxiety - 9%

Analyses of type of complaints by gender reveals that these are reported by more men than women. Relationship/familial conflict are reported by more women than men. Across the types of complaints, only three types of complaints - medical issues, multiple body aches and violence or trauma are reported by more women than men.

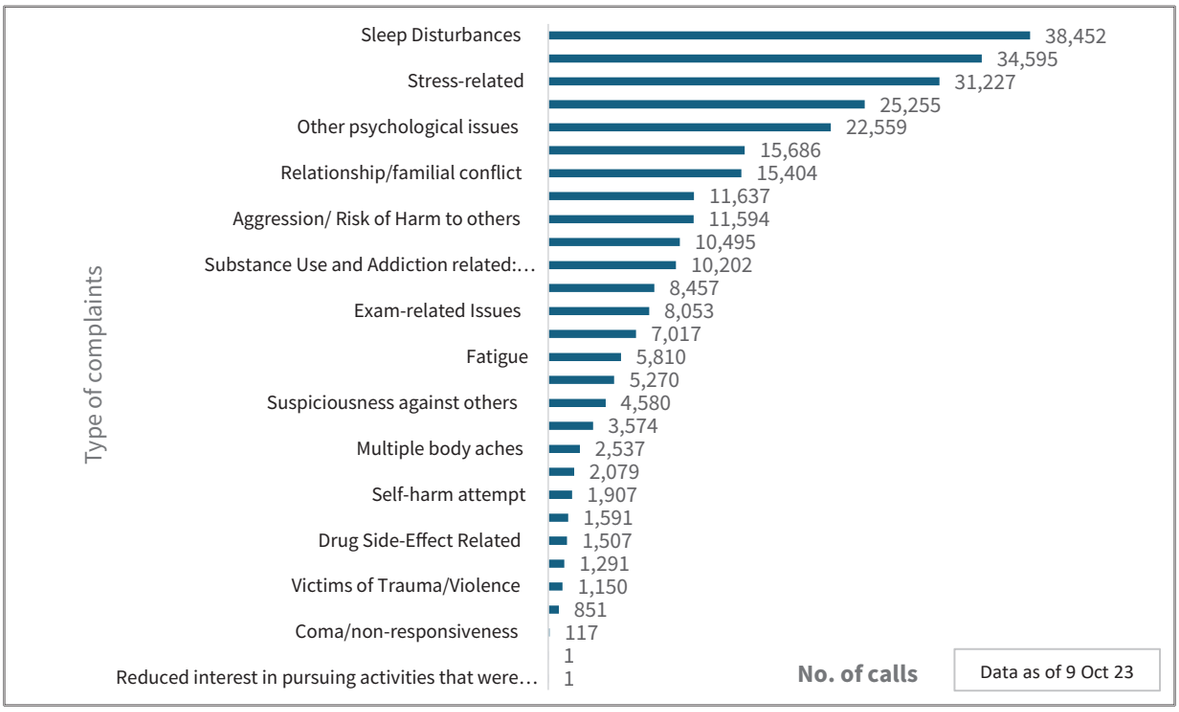
Overall profile of usage suggests that majority of the complaints received on Tele MANAS are for common mental disorders. Hence, going forward, possible use of this platform for mental health promotion and prevention activities could be explored. At the same time, while examining these trends, it needs to be borne in mind that there may be overlap of symptoms as an individual may present with multiple complaints.

Unveiling the stories

2. Conquering sleep disturbance
Odisha

A 20-year-old young female student turned to Tele MANAS for help when sleep disturbances began to disrupt her life. It emerged that she was living in a hostel with some friends, her sleep cycle had fallen into disarray due to excessive use of cell phone and laptop. Extensive use of both for late night study sessions as well entertainment, coupled with limited interactions with others had caused her sleep cycle to be disturbed. The Tele MANAS counsellor introduced her to the importance of sleep hygiene and overall well-being. She recognized the need to alter her habits, limit the use of electronic devices and screen time and restructure her daily routine. Yoga and exercise and sleep hygiene found their way into her schedule. Subsequent follow up after ten days, showed that she was able to address the sleep disturbances. The counsellor advised her to continue to implement sleep hygiene and other healthy habits that she had learnt during the counselling sessions.

Fig. 12: Type of complaints received in 1 year



Unveiling the stories

3. A young man's journey to mental wellness: addressing bipolar disorder

An 18-year-old young man, studying in 12th grade, reached out to the Tele MANAS helpline with complaints of overwhelming exam stress, the challenges of transitioning from the art stream to the biology stream, nightfall troubles, and the weight of relationship guilt concerning his girlfriend. History-taking revealed a two-year struggle with substance use involving tobacco, cigarettes, cannabis, and alcohol. Further, he experienced periods of elevated mood marked by euphoria and impulsive behaviour juxtaposed with episodes of deep sadness and hopelessness.

The interplay of mood swings, compounded by stressors and substance use, hinted at a potential diagnosis of bipolar disorder. Based on a comprehensive evaluation, a TMC Psychiatrist advocated for a referral to Tier 2 for specialized care. The young man's family held superstitious beliefs and stigmatized views about mental health, thereby creating a new challenge. In response, the Tele MANAS team not only addressed the young man's concerns but to also educated his family and dispelled myths, misconceptions, and stigma around mental illness.

The young man developed insight after taking continued treatment and thanked Tele MANAS for its services. He appreciated the counsellor for the unconditional support received throughout the process. His family members were also extremely thankful for the help they received from Tele MANAS.

Unveiling the stories

4. From crisis to recovery
Madhya Pradesh

A timely call by a doctor revealed a distressing situation involving a 42-year-old man, who was exhibiting symptoms like erratic actions, frenetic speech, and aggressive tendencies. The situation was further complicated by the man's intent, driven by religious beliefs, to harm his own daughter. The Tele MANAS team, rapidly gathered critical information from the caller, involved the TMC psychiatrist and an NGO. The NGO and the mental hospital team rescued the child and reunited her with her mother. Simultaneously, the man was admitted to the mental hospital. The Tele MANAS team did not limit itself to immediate resolution alone but also psycho-educated the man and his family about his illness and the criticality of treatment continuity. The importance of relapse prevention as also the importance of family support was emphasized. The team diligently tracked his progress, extended advice on medication adherence, the rewards of a balanced lifestyle, nourishing nutrition. All these efforts paid off. Currently, the patient is in good health, consistently attends follow-up sessions at the mental hospital and is adhering to prescribed medication. This has helped him regain control over his life.

Unveiling the stories

5. A poet finds his lost words and confidence
Madhya Pradesh

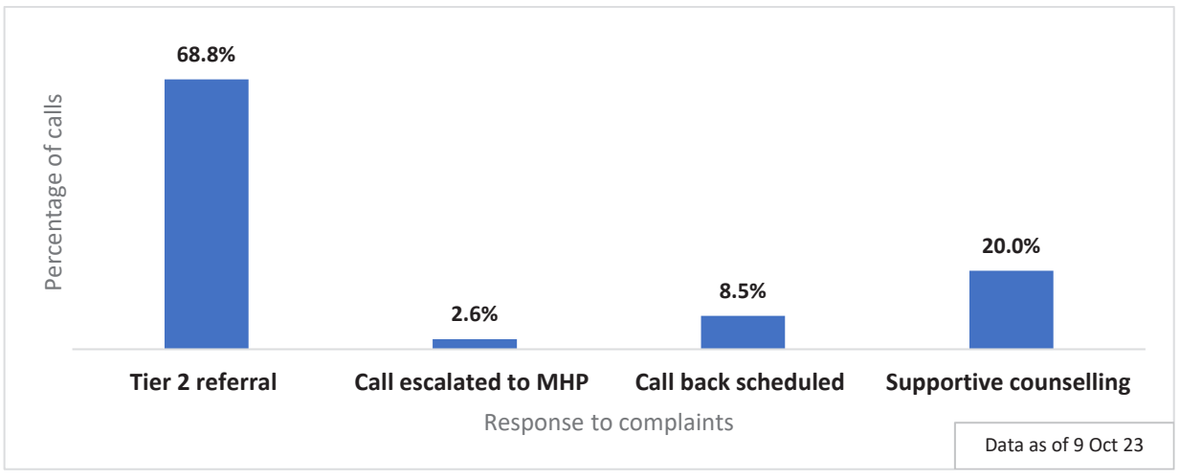
During an evening shift, a poet reached out to the Tele MANAS helpline. He was suffering from over-thinking and anxiety. He shared that before COVID-19, he was a happy, confident person and had hosted several poetry reading sessions. But after the lockdown and COVID-19, though he continued to host events, when he started to recite his poetry, he found himself to be plagued by self-doubt, and experienced loss of confidence. Anxiety, fear about the future and his ability to successfully host such events had taken root as also had social isolation. Desperation led him to consult a general physician, who emphasized importance of positive thinking and sharing with family. However, this did not solve his problem. A well-wisher took him to the District Hospital, where he also learnt about the Tele MANAS helpline. He immediately reached out to the helpline from the hospital itself.

Guided by the training offered by NIMHANS, the counsellor offered help and support. He was guided on deep breathing, the importance of exercise, a daily activity plan. Since he had a plethora of questions about his condition, medication, and treatment, he was referred to a psychiatrist who suggested that he immediately start the treatment. Alongside, he was advised to seek counselling through the Tele MANAS helpline. After psychoeducation, he commenced his treatment. He also continued with his counselling sessions. On successful completion of treatment, he called back to share that he had organized poetry reading sessions once more, had regained his self-confidence. He expressed his gratitude to the Tele MANAS team that had guided him every step of the way. In fact, he spoke about how he had shared information about Tele MANAS at his programmes and in his social network - he had become a torch bearer of the helpline's promise, sharing it with others.

Suicide related cases

Overall, less than 3% of total complaints have been identified as suicide related cases (Fig. 13). Of the 8457 cases, 68.8% are referred to Tier 2 and 2.6% are escalated to the Mental Health Provider (MHP). Almost 20% receive supportive counselling while 8.5% of cases receive a call back.

Fig. 13: Response to complaints of suicidal ideation/attempt (in %)



Unveiling the stories

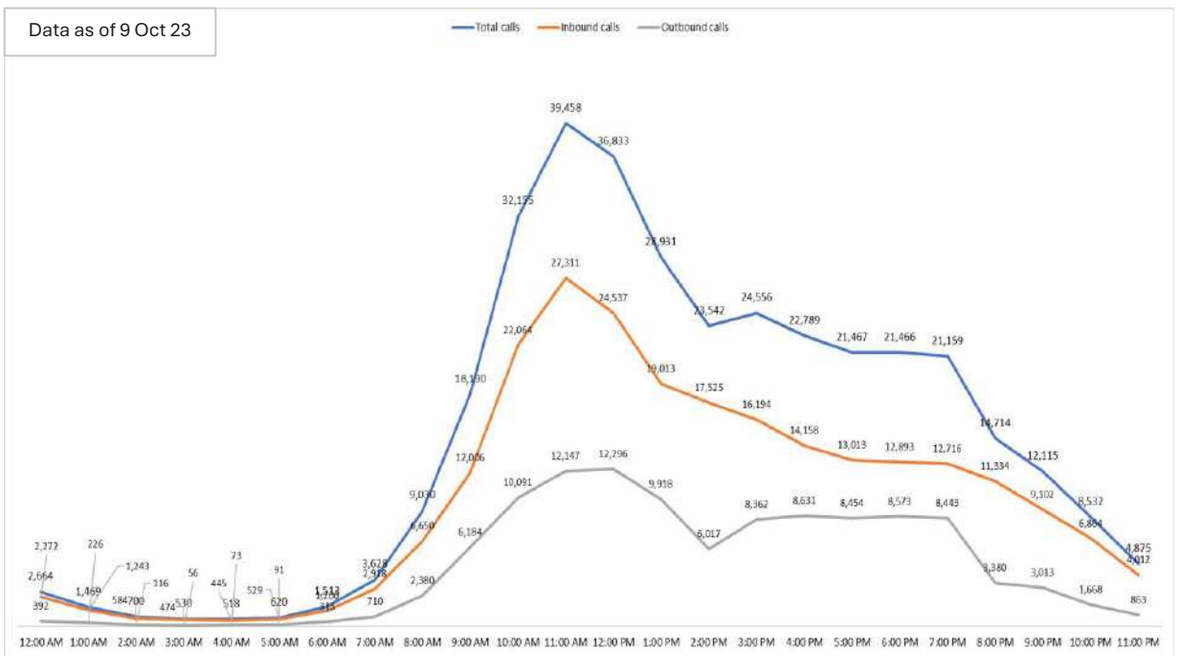
6. A glimpse into a distress call
Kashmir

A young 17-year-old girl, previously diagnosed with a mental health problem, had been undergoing therapy for a year. On this day, she reached out to the Tele MANAS helpline in distress and despair due to an upcoming class 10th board exam, scheduled for the following day. She also disclosed having a cutter or blade within reach and that she was alone at home. History revealed that she was also grappling with childhood trauma stemming from parental relationship issues and sexual abuse. There had also been previous attempt at self-harm. The guilt, and anger, together threatened to spiral out of control. The counsellor attempted to de-escalate the heightened situation and divert her attention from the blade. The counsellors' persistent effort paid off when she was successful in convincing the young girl to throw the blade.

When are people calling? Hourly call trends

Indicative cumulative hourly call patterns till date reveal that overall, counsellors receive most calls between 10 am and 2 pm as indicated in Fig. 14. Most emergency calls are received late in the evening/early morning. These trends need to be captured and examined further at a disaggregated level to better understand state and district specific trends.

Fig. 14: Hourly call trends



4. Unearthing key insights from rapid assessment in four states

This section highlights the key insights related to functioning of Tele MANAS programme in the four states/UTs: Jammu and Kashmir, Karnataka, Madhya Pradesh, and Odisha. The information presented here is derived from a combination of quantitative data from the national-level metrics and qualitative data collected during field visits and interactions, as detailed in the methodology section.

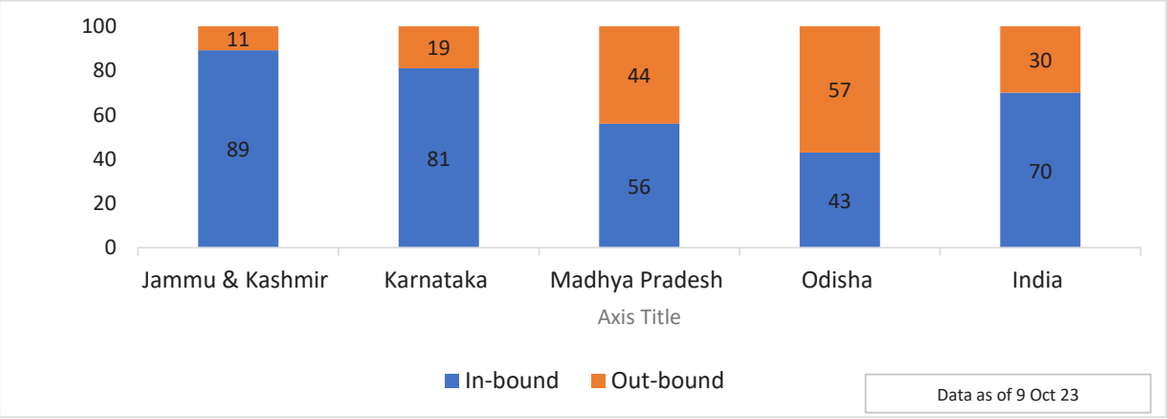
A. Overview of Tele MANAS programme

All the four states/UT introduced Tele MANAS services around the month of October-November 2022. Presently, Jammu and Kashmir has one cell at IMHANS-K, Srinagar, with further plans for establishment of another cell. The state of Karnataka has two cells at NIMHANS in Bengaluru and the Dharwad Institute of Mental Health and Neurosciences. Madhya Pradesh also has two cells in Indore and Gwalior. Odisha has two cells at Cuttack, and the Integrated DMHP/DAC unit at Berhampur. Recognizing the linguistic diversity, each state/UT offers the service in multiple local/regional languages, thereby making the service more accessible and inclusive. Referral facilities have been established to ensure that individuals in need of specialized care are able to access the same through District Mental Health Programme, state institutions, and private institutions.

India's first Tele MANAS chatbot, which leverages AI technology has been launched in Jammu and Kashmir in July 2023 to facilitate instant conversation with people in distress and offers automated responses to various mental health issues.

B. Service delivery: how is the Tele MANAS programme performing?

Fig. 15: Inbound/outbound calls



With a cumulative total of more than 100 981 calls, Jammu and Kashmir, Karnataka, Madhya Pradesh, and Odisha collectively account for 33% of the calls received on Tele MANAS, as of 9 October 2023. Distribution of in-bound vs out-bound calls varies (Fig. 15), Jammu and Kashmir and Karnataka stand out with a higher percentage of in-bound calls as compared to the national trend till date. Odisha demonstrates significantly higher out-bound call rate of 57% than the national trend of 43% due to proactive efforts in May 2023 to reach clients already engaged with the District Mental Health Team. However, on account of concerns around data confidentiality and consent, these efforts were stopped in June 2023.

Recognizing that disruption in counselling services due to poor network connectivity, internet instability and call drop were identified as one of the key challenges faced in the field, these patterns need to be examined in depth to ascertain the underlying factors that are contributing to these trends. Considering the inter-state as well as intra-state variations across the country, it is reasonable to anticipate the existence of distinct call patterns at the district level, not only in these four states/UT but also in others. As the programme, including its data systems mature, an example from Madhya Pradesh (Box 1) provides few glimpses and underscores the importance of conducting more in-depth state and district-wise analyses in the future.

Box 1: District Level Analysis - The Next Frontier, an example from Madhya Pradesh

LIST OF TELE MANAS CALLS {DISTRICT WISE} 22-06-23 TO 28-06-23

1. 20 and more calls - 2. More then 10 but less than 20 3. >5 but < 10 4. 5 or less – 5. ZERO CALLS

S.NO	MEDICAL COLLEGE	DISTRICTS	Calls
1		AGARA-MALWA	
2		ALIRAJPUR	
3		ANUPPUR	
4		ASHOKNAGAR	
5		BALAGHAT	
6		BARWANI	
7		BETUL	
8		BHIND	
9		BHOPAL	
10		BHURHANPUR	
11		CHATTARPUR	
12		CHINDWARA	
13		DAMOH	
14		DATIA	
15		DEWAS	
16		DHAR	
17		DINDORI	
18		GUNA	

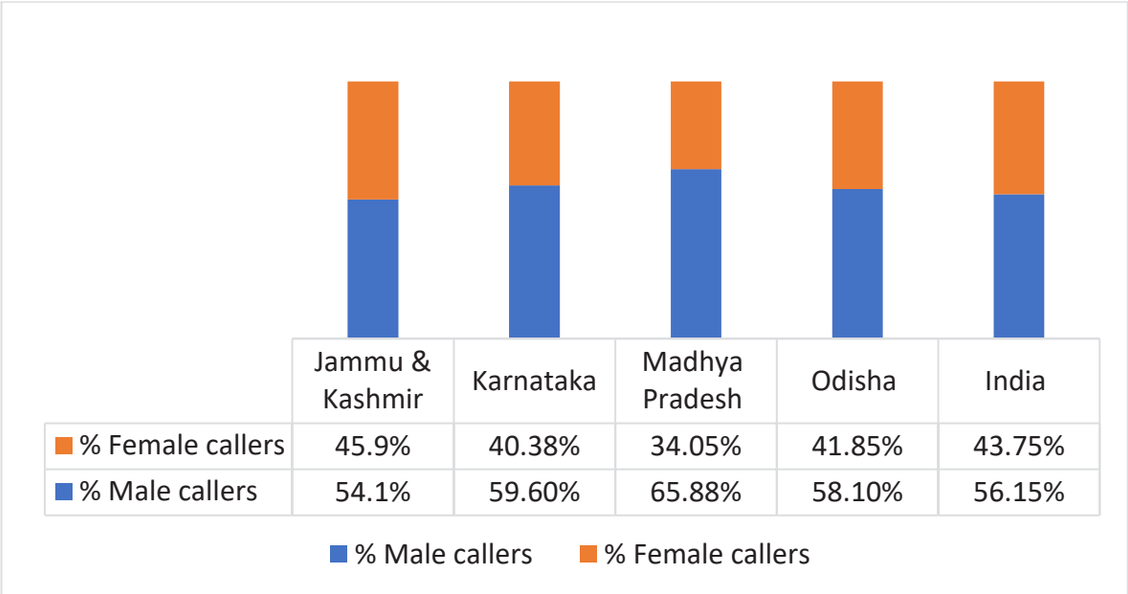
S.NO	MEDICAL COLLEGE	DISTRICTS	Calls
19		GWALIOR	
20		HARDA	
21		HOSANGABAD	
22		INDORE	
23		JABALPUR	
24		JHABUA	
25		KATNI	
26		KHANDWA	
27		KHARGONE	
28		MANDLA	
29		MANDSAUR	
30		MORENA	
31		NARSINGHPUR	
32		NEEMACH	
33		NIWARI	
34		PANNA	
35		RAISEN	
36		RAJGARH	

S.NO	MEDICAL COLLEGE	DISTRICTS	Calls
37		RATLAM	
38		REWA	
39		SAGAR	
40		SATNA	
41		SEHORE	
42		SEONI	
43		SHAHDOL	
44		SHAJAPUR	
45		SHEOPUR	
46		SHIVPURI	
47		SIDHI	
48		SINGRAULI	
49		TIKAMGARH	
50		UJJAIN	
51		UMARIA	
52		VIDISHA	
53		Other	

Caller profile

Gender distribution reveals that in Karnataka, Madhya Pradesh, Odisha and Jammu and Kashmir, majority of the callers are males, aligning with the national trend. Madhya Pradesh has the lowest female caller rate. Limited cell phone access for women in rural and traditional areas could be one contributing factor for this gender disparity. Field insights from Odisha reveal that women were less likely to use a helpline as they would not be able to find private space to call while men were more likely to use the helpline as there was still significant stigma to them seeking help and would likely prefer the confidential nature of Tele MANAS. This trend needs to be examined further.

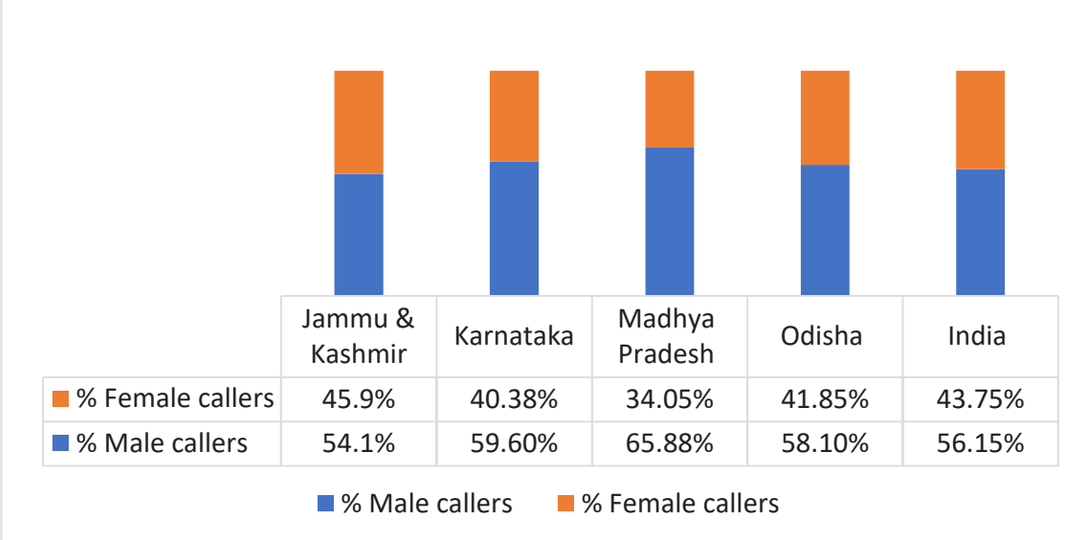
Fig. 16: Gender profile



In terms of **age distribution,** varying patterns emerge. In keeping with the national trend, majority of the callers fall in 18–45 age group. Notably, in Jammu and Kashmir, a significant 84.3% of callers belong to this age group. In 0–12 age group, Karnataka and Odisha stand out with a higher percentage of callers as compared to the national trend. Odisha reveals an intriguing trend, with near double percentage (24.3%) of callers falling into the 46–64 age group as compared to the national trend (15.3%).

In terms of **who is calling on the Tele MANAS helpline**, an impressive 94% of patients are directly calling Tele MANAS in Jammu and Kashmir, significantly higher than the national trend which stands at 71%. Madhya Pradesh reports 70% of patient directly calling followed by Karnataka. In Odisha, there is almost uniform distribution amongst patients, caregivers, and others. Interestingly, Odisha reports the highest percentage of caregivers calling on Tele MANAS as compared to any other state/UT, surpassing the national trend as well.

Fig. 17. Types of callers

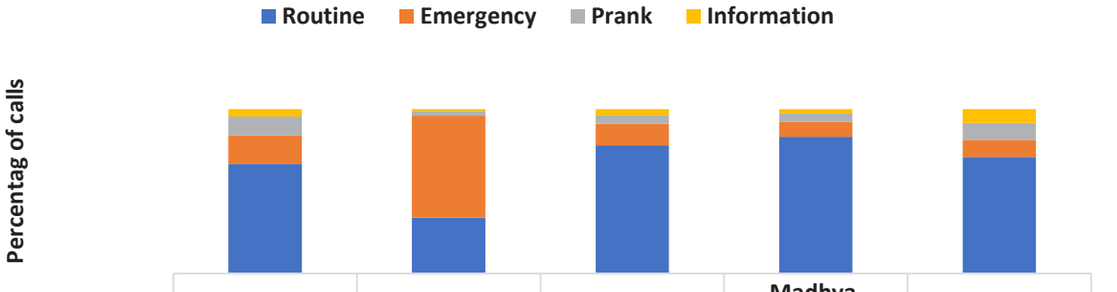


Type of calls: routine vs emergency

In all states, guidelines are in place for triaging based on different risk levels and vulnerability and referral is provided to various levels of care. The overarching trends for states of Karnataka, Madhya Pradesh and Odisha closely mirror the national pattern, with over 93% of calls being classified as routine calls as shown in Fig. 18. Notable exception is Jammu and Kashmir, which has received substantially higher number of emergency calls (12.42%) compared to the national average of 3.5%.

This section highlights the key insights related to functioning of Tele MANAS programme in the four states/UTs: Jammu and Kashmir, Karnataka, Madhya Pradesh, and Odisha. The information presented here is derived from a combination of quantitative data from the national-level metrics and qualitative data collected during field visits and interactions, as detailed in the methodology section.

Fig. 18: Types of calls across select states/UT (in %)



	India	J&K	Karnataka	Madhya Pradesh	Odisha
Information	0.91%	0.23%	0.76%	0.53%	1.69%
Prank	2.26%	0.56%	1.06%	1.03%	2.04%
Emergency	3.49%	12.42%	2.58%	1.81%	2.11%
Routine	93.34%	86.79%	95.60%	96.64%	94.16%

States

Data as of 9 Oct 23

Box 2. Triage experience from Karnataka

Calls are triaged based on operational guidelines outlined in the Point of Care manual for counsellors. Calls suitable for referral include those with a duration of problems exceeding two weeks, high-risk cases (such as suicidal ideation), vulnerable groups (for example, children, GBV cases), and individuals with severe mental health conditions. 92.1% of calls are managed solely by counsellors, with the remaining being referred to a District Mental Health Team, a mental health professional within the Tele MANAS team, or a Technical Support Coordinator.

Type of complaints

Heat map analyses (Table 2) shows the prevalence of common mental health concerns like sleep disturbances, sadness, stress, anxiety, which can be effectively managed through a tele mental health programme. While examining these trends, it needs to be borne in mind that

there may be overlap of symptoms as an individual may present with multiple complaints. As the Tele MANAS programme and data systems mature, mechanisms to capture deeper understanding of the end user could be added.

Note: Calls classified as NA - that is, calls unrelated to mental health, medical issues such as headaches, information-related calls, calls from other helplines for follow-up, pranks call, etc., are not reflected in the heatmap.

Table 2: Heatmap analysis

Complaint	Jammu and Kashmir	Karnataka	Madhya Pradesh	Odisha
Aggression/risk of harm to others	877	1018	647	487
Anxiety	2500	1806	1594	819
Coma/non-responsiveness	12	4	4	2
Drug side-effect related	33	280	196	147
Exam-related Issues	367	716	462	189
Excessive cheerfulness of mood	191	83	85	48
Fatigue	997	312	408	79
Hearing voices/muttering to self	102	707	515	222
Hopelessness/helplessness	990	939	527	393
Worthlessness/guilt	280	77	36	37
Increased activity: pacing around, restlessness	40	126	66	29
Issues related to special groups	144	1308	701	588
Medical Issues	459	203	185	92
Multiple body aches	18	1688	2607	2177
Odd and bizarre behaviour	237	77	372	185
Other psychological issues	440	2476	1300	816
Palpitations	2101	441	255	29
Reduced interest in pursuing activities	1687	1754	1181	314
Relationship/familial conflict	1057	1333	819	457
Sadness of mood	2430	3268	2334	1468
School refusal	36	47	42	25
Self-harm attempt	351	103	123	64
Sleep disturbances	1415	3548	3506	1470
Stress-related	1658	2816	2166	1521
Substance use and addiction-related	190	1138	731	254
Suicidal ideation/attempt	688	1010	320	229
Suspiciousness against others	278	476	224	126
Victims of trauma/violence	195	44	35	21

Note: Calls classified as NA - that is, calls unrelated to mental health, medical issues such as headaches, information-related calls, calls from other helplines for follow-up, pranks call, etc., are not reflected in the heatmap

Unveiling the stories
7. Tackling depression: an aspiring medico's journey **Odisha**
A concerned mother reached out to Tele MANAS as her 22-year-old daughter, who was pursuing second year of medicine at a private college, was experiencing lack of concentration, low self-confidence, feelings of hopelessness, guilt, decreased social interaction and a sense of indecisiveness. The girl had apparently left home and messaged her mother that she did not want to live anymore. Luckily, the family members had been able to convince her to return home. After this incident, they connected her with Tele MANAS. After consultation with the clinical psychologist, a detailed treatment plan was developed, focusing on short and long-term goals. A total of five sessions have been held till date. The initial sessions centred around educating both her and her family about her condition and creation of a safe space. Thereafter, using cognitive behaviour therapy framework, her negative thoughts were challenged. She was also taught relaxation as well as decision-making techniques. Assertiveness training was used for improved communication. Daily exercises were planned to enable her to recognize and appreciate her strengths, enabling her to see herself in a new light. This led to a gradual shift in her mindset. The ongoing weekly follow-up sessions are marking her progress and guiding her on the path to recovery.

C. The people: counsellors of Tele MANAS

1. Counsellor profile

The Tele MANAS cell in each state/UT comprises of technical staff and other HR. The precise staffing numbers vary between category 1 and 2 of Tele MANAS cell, contingent upon population norms. Table 3 below outlines staffing pattern as per the programme guidelines.

Table 3: Details of Tele MANAS Cell Human Resources as per programme guidelines

Human resources	Category 1 (States/UTs with population >20 lakh)	Category 2 (States/UTs with population <20 lakh)
Technical staff		
1. Counsellors	20	10
2. Senior Consultant	1	1
3. Consultant	2	1
4. Clinical Psychologist/ Psychologist/ Psychiatric Social Worker/ Psychiatric Nurse	3	3
Other HR		
1. Technical Coordinators/Project Coordinators	1	1
2. Data Entry Operator	2	1
3. Attenders	2	1

At the core of Tele MANAS programme, is the counsellor, who serves as primary point of contact for the callers. Presently, the criteria for determining the number of counsellors

are population-based. Overall human resource trend shows variations in the number of counsellors in position. In some cases, the total sanctioned staff strength has not been filled as the available human resources are able to manage the existing call volumes. In Jammu and Kashmir, Madhya Pradesh and Karnataka, there is anticipated increase in demand for services in the future, necessitating an augmentation of existing workforce, including for counsellor supervisors and other staff. Going forward, it is also expected that more counsellors may be needed during the peak hours (for example, 6–11 pm in Jammu and Kashmir). One of the suggestions to address these emerging challenges was to transition to a call-based criteria due to increasing call volume for human resource planning. Counsellor recruitment and retention is a challenge in some states, while in state of Karnataka initially recruited counsellors continue to be in position.

In terms of gender distribution, the existing workforce predominantly comprises of female counsellors (as well as mental health professionals). Emphasis on gender diversity during recruitment will help ensure a gender balance in the workforce and will enable equitable distribution of work. This would help to better manage requests from callers requesting for counselling support from a counsellor of a particular sex, thereby promoting inclusivity and contributing to better uptake of services.

2. Counsellor renumeration

In keeping with the national guidance, the renumeration for counsellors' ranges between INR 20 000–30 000 per month (equivalent of US$ 240–360), across states/UTs. Operational challenges relating to either irregular salary payments or funding delays from the national level which requires the state government make interim measures were shared. Overtime compensation mechanisms are not available in any states/UTs, except for state of Karnataka where staff working night shifts, receive an additional 25% extra pay in line with government rules. No mechanism currently exists for provision of any performance-based incentives or bonuses. However, in the state of Madhya Pradesh, incentives for good performance (for example, counsellor of the week) have been institutionalized, which can be attributed to strong leadership by mentoring institute and in the Tele MANAS cell.

It was opined that the present data access and dashboard functionality, does not allow individual counsellor performance monitoring due to data access restrictions, which may need to be addressed as the programme expands.

3. Counsellor working schedule and conditions

The duty schedules for counsellors vary in terms of shifts, working hours, and backup availability. Most states adhere to the programme guidelines (Refer to Table 4) of three shifts with rotating schedules. Few states have adapted this guidance to suit their specific requirements. For instance, given transportation and mobility challenges in Jammu and Kashmir, counsellors follow a 24-hour duty schedule followed by two days off. While on duty, they work in rotation allowing them to take time off to rest. In Madhya Pradesh, 7 counsellors are assigned to the morning shift, which is reported to be the busiest, while 5 and 3 counsellors are respectively assigned for the evening and night shifts. The rotation of counsellors occurs on a weekly basis.

Table 4: Shift-wise distribution of counsellors as per programme guidelines

Shift	Category 1 (States/UTs with population >20 lakh)	Category 2 (States/UTs with population <20 lakh)
Morning Shift (8 AM to 2 PM)	8	4
Evening Shift (2 PM to 8 PM)	8	4
Night Shift (8 PM to 8 AM)	4	2

In terms of holidays and leave, in most states, there is no provision for leave and counsellors lack backup during festivals/government holidays. It was mentioned that working during such times is a common occurrence as the Tele MANAS cell operates 24x7. Further, the same counsellors frequently work on each holiday due to scheduling process. Notably, in Odisha, counsellors get compensatory off for working on holidays. In Karnataka, counsellors get 9 days of annual leave a year. However, this creates challenges when their family live far and they need to travel to visit them.

4. Counsellor well-being and supportive environment

Burnout has emerged as a significant challenge for the counsellors. They have voiced the need for well-being activities and preventing burnout. Counsellor wellness is a priority in Madhya Pradesh, with various internal activities such as recreational outings and team-building activities like group activities, birthday celebrations, yoga are organized at the Tele MANAS cell. Feedback/counsellor redressal sessions are a frequently organized by the mentoring institute, as a practice, to address counsellor concerns and improve their overall wellness and prevent burnout. In Karnataka, the physical layout of the cell is designed in a way that all counsellors work in the same room with partitions between desks. This provides confidential space without isolating the counsellors, helping to foster a supportive environment.

5. Counsellor capacity building and training

All counsellors have received training based on standard guidelines, including online and on-site training. Fig. 19 outlines the components covered in online training while Fig. 20 depicts the modules for on-site training. Overall, feedback from counsellors suggests that they feel that this training has enabled them to perform their duties competently.

Fig. 19: Overview of Tele MANAS online training modules

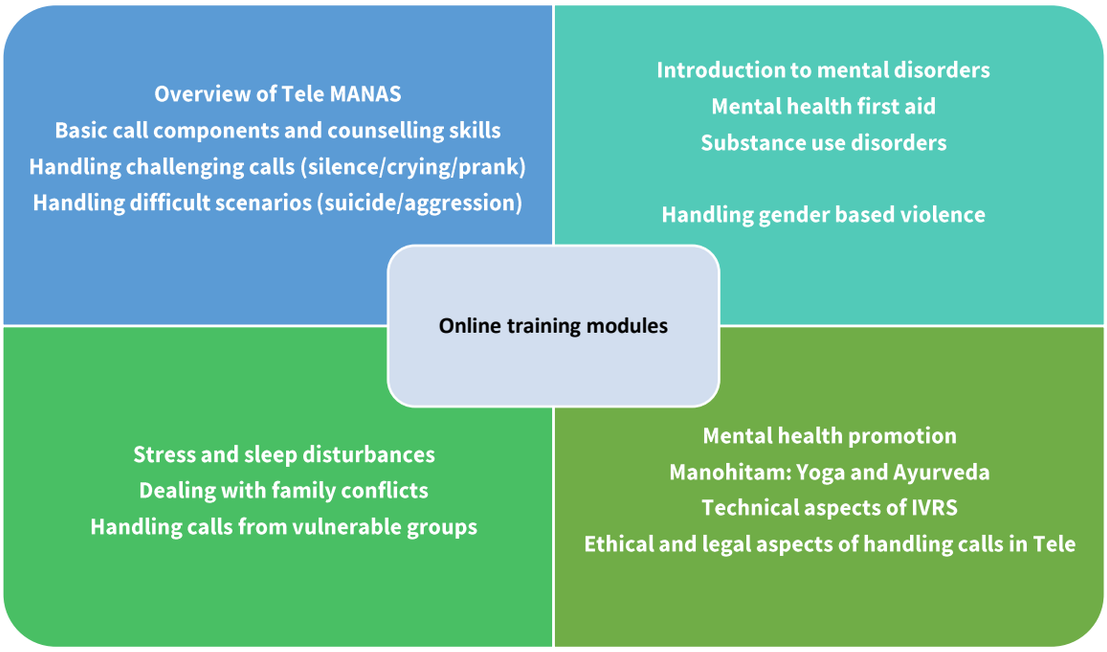


Fig. 20: Overview of Tele MANAS onsite training modules

In addition to the standard guidelines, additional capacity-building measures have been implemented by states/UT. As an example, Jammu and Kashmir has implemented case-based discussions and live case observations. In Madhya Pradesh, the mentor institution has provided additional capacity building by way of dedicated weekly sessions on requested or needed topics (in the cells), case-based discussions and live case observations, institutionalization of dummy calls to check quality and competency, targeted training

sessions at least weekly online (through the mentoring institute) and in person (through on site consultants) on requested topics, and in-person capacity building (once so far, with plans to conduct on six monthly basis). During weekly team meetings, counsellors also reflect on their role and the limits of the role and discuss challenges and opportunities. Additional training occurs through external invitees who present on relevant topics (for example, AIIMS Yoga department). In Karnataka, counsellors have access to a support network within the team, including mental health specialists and psychiatrists who offer support and advice on specific calls. Additionally, case conferences are held every 15 days as part of the training team's efforts to enhance counsellor skills and knowledge. In Odisha, the mentor institution organizes scheduled training as well as includes counsellors to in existing psychiatry and clinical psychology training programme. Counsellors have also been supported to enroll for Diploma in Community Mental Health through the Digital Academy of NIMHANS.

Counsellors requested additional training in the form of workshops, case-based discussions, experience-sharing platforms, and accredited self-paced courses. Counsellors from Jammu and Kashmir specifically requested training in thematic areas such as substance use, suicide prevention, and therapeutic interventions. While those from Karnataka felt the need for training in specific therapeutic approaches.

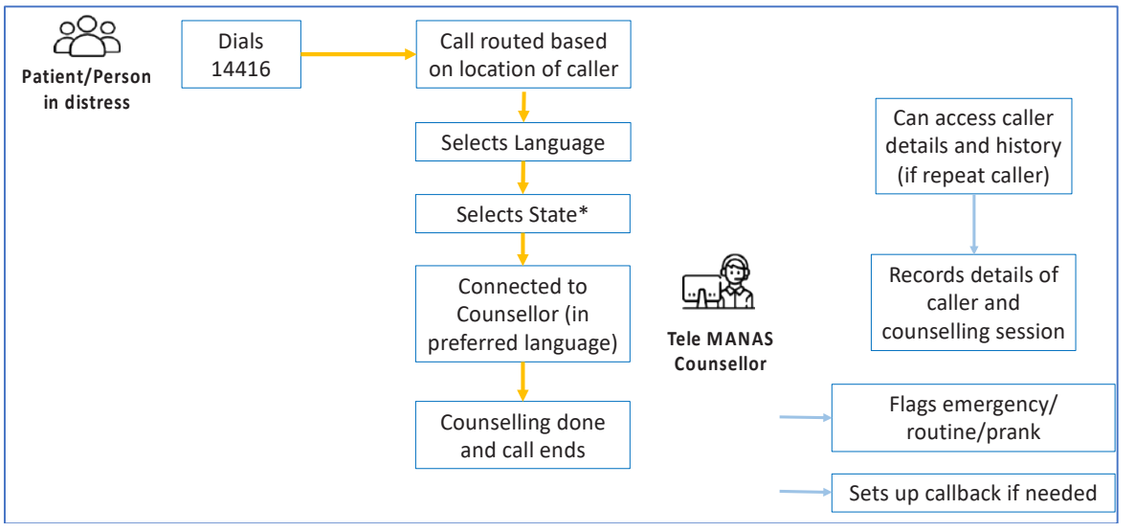
The trainers reflected that basic counselling skills training was an integral component of the counsellors' practice. Additionally, the counsellors were trained to apply five key basic psychological interventions: problem management, deep breathing, sleep hygiene, behavioural activation, and anger management. These interventions were tailored to meet caller's needs. The trainers outlined the intensiveness of the training effort, as requiring counsellors to tailor an intervention requires extensive training and support and a clear decision-making matrix to ensure that the correct intervention is applied.

As the programme further scales and matures, they suggested that it would be helpful to expand the decision-making matrix to support counsellors in the application of psychosocial interventions. Another option would be to train counsellors in existing brief, scalable psychological interventions that are designed to be delivered by non-specialists. These interventions operate on universal principles, have a strong evidence base and can be adopted with minor adaptations without requiring detailed assessment of caller needs and are known to work across problem types. The work of counsellors could be further strengthened with online self-help material that be shared with calls to reinforce the interventions.

6. Role of counsellors

The counsellors presently largely focus on screening and triaging the calls based on a brief history of the caller. Based on the type of complaint presented and caller needs, they provide basic counselling and needed care which is within their capabilities or refer the caller for care by the Mental Health Professionals (Clinical Psychologist/Psychologist/Psychiatric Social Worker/Psychiatric Nurse). Basic counselling flow chart is given in Fig. 21.

Fig. 21: Tele MANAS basic counselling flow



All states/UT follow NIMHANS Standard Operating Procedures (SOPs) for the escalation of cases to a higher level based on identified red flags. This indicates a standardized approach to handling mental health cases. Notable exception is Madhya Pradesh, which has further augmented these SOPs.

Box 3: Caller consultation and follow-up protocol: example of Madhya Pradesh

First time caller: All first-time callers are escalated for a brief consultation with consultants. This initial consultation is conducted in accordance with state devised Standard Operating Procedures (SOPs).

Follow-up procedures: Counsellors are provided with clear instructions on follow-up procedures:

- For emergency cases, follow-up is required within 24 hours.
- Regular cases necessitate follow-up within 3 days after the first consultation.
- After two follow-ups, the standard follow-up time increases to 5 days.
- After two more follow-ups, the standard follow-up time extends to 7 days.

Counsellors escalate roughly 10% of the calls to a mental health specialist. Cases of acute psychiatric emergencies and those requiring detailed in-person evaluation and management are referred to the Tier 2 mental health professionals of Tele MANAS or DMHP or mentoring institution. Criteria for referral on to a Mental Health Professional of Tele MANAS or DMHP or Mentoring Institute is based on a caller having an acute psychiatric emergency, mental health condition, being at high risk or a vulnerable group. However, current approaches to assessing caller's mental health and need for 'stepping up' are based on counsellors' judgment.

Going forward, it may be beneficial to train counsellors in brief scalable psychological interventions that are beneficial across a range of problem types, based on WHO and other existing training packages, contextualized to India's situation. The Tele MANAS programme demonstrates great potential to implement these types of interventions, beginning with less intensive guided self-help approaches (for example, DWM or SBS) and then "stepping up" to more intensive services for some callers, where indicated, like PM+ and/or specialized

referral as needed. This approach fits with the model of stepped care and conservative use of limited specialized resources for only most severe cases.

7. Counsellor challenges

Each Tele MANAS cell faces unique challenges, but there are common themes like connectivity, training needs, and the importance of staff well-being. Operational challenges related to network connectivity was seen as a key hindrance to effective counselling, thereby requiring immediate redressal across levels. In some places, the counsellors reported that they are not yet using headsets in the cells. Test calls conducted by the assessment team confirmed that the quality of the audio was not ideal in the existing physical setup. Challenges relating to frequent disruptions in calls due to connectivity issues and slow pace of internet were validated by State Programme Coordinator/Nodal officer. In one instance, it was pointed out that the amount of funds allocated for internet services was not sufficient for quality service provision required in the service.

From workforce retention and well-being point of view, counsellor burnout was identified as a widespread issue. Gender-specific call handling is another area that requires fit for purpose strategies to be designed as the programme matures. Summary of key challenges across thematic areas is summarized in Table 5.

Table 5: Thematic summary of key challenges

Theme	Key challenges
Physical Infrastructure/ Working conditions related	• Limited /low pay • Delayed payment of salaries • Lack of pay parity • No leave, in several locations • Limited annual leave, creating challenges when families live far away. • Lack of incentives • No compensation for working during holiday in many states/UT. Counsellors may work multiple festivals in a row depending on the normal rotation schedule. • Lack of backups for festivals. • Logistics and transportation challenges. • Security concerns. • Safety concerns during night shifts, recommending a minimum of 2 staff on night shifts. • Shift timings as more female counsellors are engaged under the programme. • Varying quality of equipment. • Limited privacy and quiet space for conducting effective counselling sessions. • Need for improved working conditions, equipment, and infrastructure.
Service delivery	• Low volume of calls. Stigma and discrimination regarding mental health issues limit uptake of tele-counselling service as people prefer in person services. • Managing prank calls and harassment calls (gender-related).

Service delivery	• Handling cases by female counsellors when callers request male counsellors especially for cases related to sexual problems. • Handling callers with relationship or family difficulties. • Managing callers with higher-level mental health needs, for example, those with symptoms of psychosis/suicidal tendencies. • Managing high-risk cases - slow process for releasing caller ID in case of emergencies, creating concern about meeting needs of high-risk callers. • Language issues (for example, understanding/speaking specific dialects, etc.).
System/IT related	• Regular disruption in counselling due to poor connectivity/internet issues. Network connectivity issues when handling calls leading to routing difficulties, call drop and subsequent non-connection. • Low-quality audio on some calls.
Capacity building and training	• Lack of skill in handling emergency cases, especially suicide cases. • Management of cases with diagnosis of Attention Deficit Hyperactive Disorder (ADHD), Autism Spectrum Disorders (ASD) and cases where medication is involved. • Requirement for additional on-site workshops, case-based discussions, experience sharing platforms for ongoing capacity building.
Well-being	• Burnout • Concerns about future work prospects given the project-based nature of the programme.

D. The people: mental health professionals (MHPs) of Tele MANAS

Psychiatrists and other mental health professionals play a crucial role in Tele MANAS especially in management of complex cases.

The workload of psychologists, psychiatric social workers and psychiatric nurses hired under Tele MANAS (defined as MHPs for this document) varied across states, depending on the cases escalated for their intervention, ranging from 6–8 cases per day, with duration of 30–60 mins and follow up lasting up to 1.5 months. Insights from the field show that presently, MHPs undergo the same training as the counsellors (namely, 3-day online training from NIMHANS and one month in-person training). Experience from Karnataka shows that MHPs lacked formal training in psychological interventions but had training in structured family interventions and basic helping skills. They followed protocols for managing high-risk cases and made referrals to the same places as counsellors, including specific helplines for women. MHPs received ongoing ad-hoc supervision from the team psychiatrist and the nodal officer but lacked specific training in managing groups of counsellors or addressing their competencies. The fact that MHPs worked on a fixed schedule, unlike counsellors, was a potential area of friction with counsellors. It was suggested that ideally, two out of three MHP positions should be filled with clinical psychologists for a more effective counselling platform.

There was an expressed need by MHPs for training in psychological interventions, management of high risk calls over the phone and management of counsellors, as they lacked experience in supporting others to deliver services.

Overall, as the programme continues to expand its reach, it is evident that there is a crucial need for developing a more defined and comprehensive approach towards the role of MHPs. To ensure that the quality of care provided across the country reaches a minimum standard, a competency-based training package for MHPs may be developed. This package should include a focus on evidence-based psychological interventions as well as assessing, supervising and monitoring the work of counsellors. This would ensure that the workforce of Tele MANAS is not only knowledgeable but also proficient in applying their skills effectively, thereby elevating the overall quality of service provided.

Unveiling the stories

8. Addressing anxiety
Odisha

A 28-year-old man shared a traumatic experience from the past which was hindering his growth. Blacking out and losing consciousness during the 10th class exam had left scars and led to a two-year hiatus from studies. Today, he was pursuing his dream of becoming a Chartered Accountant. However, reminders of the past or places linked it, led him to experience fear. Symptoms of breathlessness, tightness in the chest, and a racing heart potentially hinted at an anxiety disorder and panic attack. After due assessment psychoeducation was provided. The counsellor introduced him to breathing techniques and mindfulness practices. Further, the call was escalated to a clinical psychologist, who recommended in-person treatment and therapy at DMHP. Following the guidance of the psychiatrist and clinical psychologist, he started the requisite therapy and medication. Follow up by the Tele MANAS team, shows that he has successfully been able to overcome his anxiety issues.

Unveiling the stories

9. A young woman's journey towards self-acceptance
Madhya Pradesh

A hesitant 21-year-old young woman, reached out to Tele MANAS helpline. The young woman was struggling to articulate the turmoil within her feelings that had been suppressed for far too long. Rapport building and creation of a safe space by the counsellor led the caller to finally reveal that for more than a decade she had been grappling with gender identity issues and feelings of sadness, anger, and sleep disturbances among other problems. The counsellor recognized the significance of this revelation and the emotional turbulence it brought. After Tier 1 evaluation, the caller was directed to Tier 2 for comprehensive management. The Tele MANAS team initiated a systematic approach to healing. The nature of the problem was explained to the young woman. Over a series of 7–8 follow up calls, her emotions—anger, sadness, and frustration—were addressed step by step though techniques like deep breathing and mindfulness. Anger management strategies, assertiveness training and other techniques were taught to address the pent-up frustrations that had often consumed her.

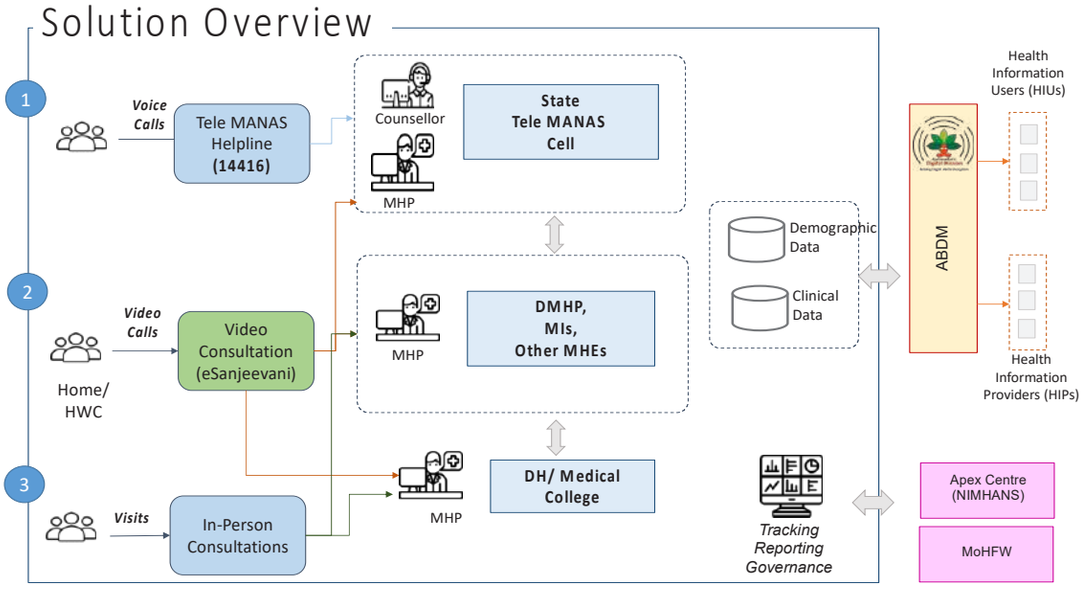
The challenges were unique—cultural perceptions, lack of emotional support, and the complexity of her gender identity. The counsellors and psychiatrists together helped her build her emotional resilience, taught her to cherish her individuality, and guided her towards wholistic well-being.

Feedback from the young woman shows the effect of Tele MANAS team's intervention. In her own words, "Today's is my 3rd follow-up. I am good because of counselling, the counsellor helped me a lot. She taught me some great exercises and techniques like grounding technique and mindfulness. I had eight counselling sessions. Now I have changed a lot."

E. Data systems: technology as the backbone of Tele MANAS

A backbone of this programme is the robust technological architecture developed by the International Institute of Information Technology-Bengaluru (IIITB). The creation of the Tele MANAS platform stands as a remarkable achievement. It was rapidly developed at scale - to offer services in more than 20 regional languages across 23 states - and under tight deadlines, for its launch to coincide with the World Mental Health Day on 10 October 2022.

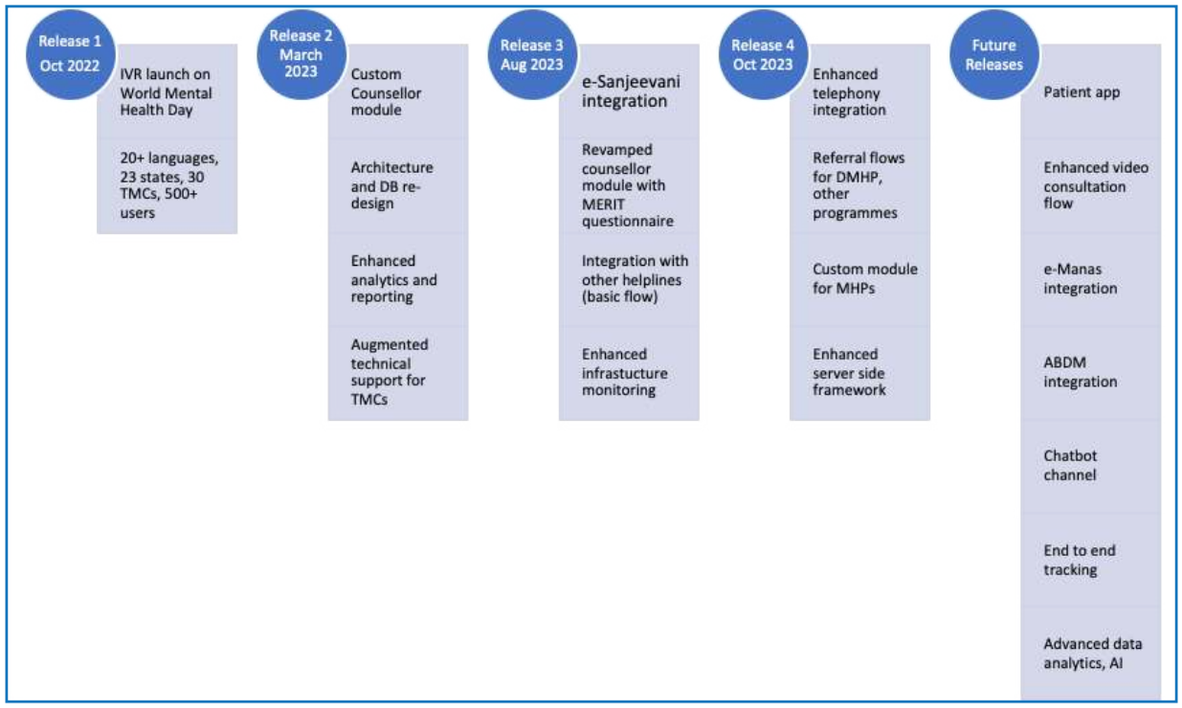
Fig. 22: Tele MANAS solution overview



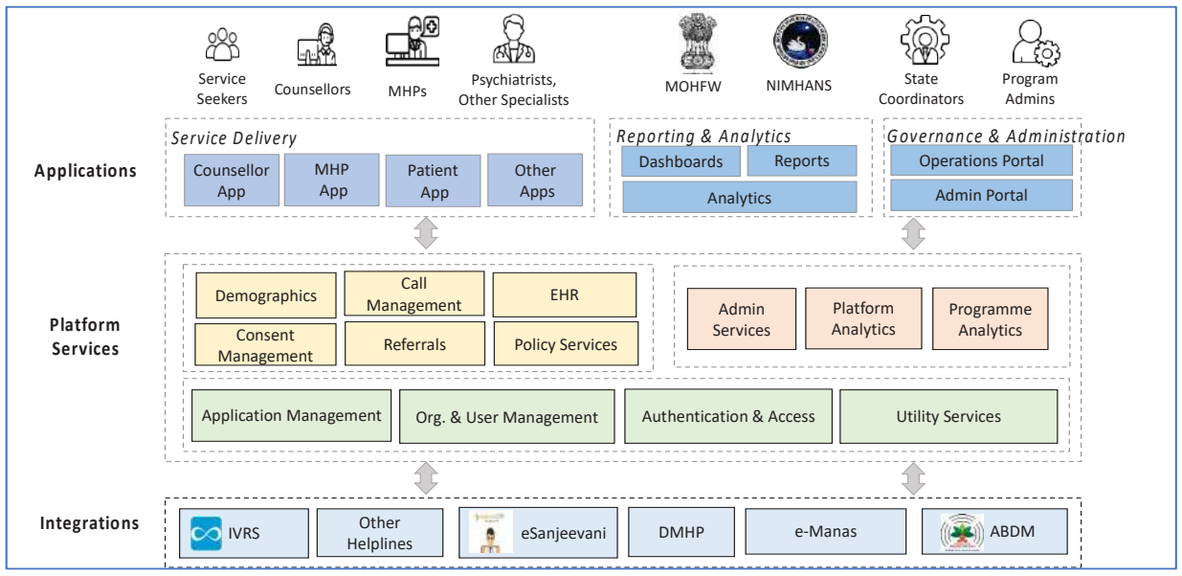
To ensure universal access across diverse phone devices, an interactive voice-based access approach was adopted and seamlessly integrated across the platform's various domains and verticals. While the Interactive Voice Response (IVR) system was procured externally, the remaining system components were designed in-house by the dedicated Tele MANAS cell at IIIT-B. The potential for open access is noteworthy, as the platform could be shared with other users under suitable agreements. An overview of the solution architecture is reflected in Fig. 22.

The platform's innovative design and operational elements, including call management, were developed through consultations with NIMHANS, and it aligns with the program training and facilitation manuals such as Point of Care and others. Informed by counsellor and TMC feedback. To date, the platform has undergone three iterative improvements, refining its user-friendliness, intuitiveness, and overall efficacy. In keeping with the overall vision of Tele MANAS, increasingly, these updates focus on linkages with district mental health programme and district hospitals and broader aspects of digital health such as eSanjeevani initiative. The platform offers the possibility of compatibility with the Ayushman Bharat system architecture and tracking across various verticals. Fig. 23 details the nature of refinements in the technology platform.

Fig. 23: Tele MANAS technology roadmap



The platform also serves as an abundant source of process data. The platform monitors system functionality, encompassing in-bound and out-bound call volumes, call durations, caller demographics, consultation reasons, problem resolution levels, and utilization patters. While cumulative national metrics provide an overarching view, granular data may be analyzed by state, TMC, and individual counsellor, empowering comprehensive evaluation, and strategic improvements. An overview of the platform architecture regarding data analytics is depicted in Fig. 24.



The Tele MANAS cell at IIIT-B shoulders the responsibility of training counsellors and TMC members in data entry and management within the system, providing ongoing technical

support, and overseeing real-time process data generation through analytics dashboards. Rigorous access controls, encryption, and role-based mechanisms safeguard sensitive data, accompanied by measures such as masking phone numbers and explicit consent for information release. Privacy considerations are threaded into the platform's operation, underscored by measures at various levels, including data storage, access controls, and caller-specific protocols.

The wide engagement from and collaboration between the many parties involved in the Tele MANAS programme is a considerable strength. These partnerships have led to a robust service. For example, the strong partnership between IIIT-B and NIMHANS has been key to the development of a platform that has already proven reliable and easy to use.

F. Oversight, monitoring and review mechanisms

Overall programme oversight and technical support is provided through existing organizational framework, supported by the National Technical Advisory Group (NTAG) and three technical advisory sub-committees. Insights from Nodal officers brought out some of the operational challenges. Common technical glitches include connectivity issues and lack of clarity/audio related challenges, with some reporting varied quality of equipment as well. Instances of data platform downtime, data loss during software updates and discrepancies between actual call number and system records in initial period were also shared. This highlights the importance of addressing these issues to ensure the effectiveness of Tele MANAS services. In terms of financial management, interruptions/delay in fund release, make regular salary payments challenging. These delays were managed delays through other available funds, which is not an ideal scenario.

All states/UT emphasized the importance of regular monitoring and supervision of their Tele MANAS programme to ensure quality service delivery. In Jammu and Kashmir and Karnataka, regular monitoring and supervision are conducted by senior psychiatrists/mental health professionals, respectively. There is variability in the frequency of supervision. Jammu and Kashmir and Odisha express the need for higher-frequency supervision, while Madhya Pradesh and Karnataka have established regular supervision mechanisms.

The state of Madhya Pradesh with its well-defined mechanism for monitoring and internal review (Box 4) and Karnataka with its "See-Try-Do" method (Box 5.) offer good practices and learnings for other states/UT.

Box 5. Use of "See-Try-Do" method in Karnataka

The team implemented a comprehensive onboarding approach known as the **'See-Try-Do' method** for the induction of new counsellors. This structured process commenced with counsellors initially observing experienced mental health specialists as they adeptly managed calls. Subsequently, these new recruits had the opportunity to actively participate in calls under the close guidance and supervision of seasoned mental health specialists before ultimately assuming autonomous responsibility for call management. Moreover, during the recruitment phase itself, potential counsellors gauged and scored on their knowledge and skills as part of the selection process, ensuring that the most qualified and capable individuals joined the team.

Box 6. A spotlight on Madhya Pradesh's District Mental Health Programme

India's healthcare system, the DMHP is positioned at the secondary care level. In the districts of Bhopal and Indore of the state of Madhya Pradesh, the DMHP serves large populations, approximately 3.2 million and 3.3 million, respectively. Bhopal's DMHP attends to around 250 new patients per month, while Indore's DMHP handles approximately 150 new patients each month. Both DMHPs are staffed with mental health professionals, including at least one psychiatrist in Bhopal and two in Indore, along with a clinical psychologist and 1–2 psychiatric nurses. Their operational framework involves a schedule of 3 days of outpatient services at the DMHP facility and 3 days of outreach activities. These outreach activities encompass raising awareness, conducting group-based psychoeducation sessions, providing outpatient clinics at Community Health Centres (CHC) and Primary Health Centres (PHC), and enhancing the skills and knowledge of general health providers and community workers. Integration with other initiatives within the health sector are in progress (e.g., with district NCDs clinics) are also being established.

Key elements:

- Organization of regular orientation sessions for DMHP staff.
- Consultants periodically make telephonic contact with DMHP staff.
- Patients are referred to nearest DMHP for Tier 2 mental health services. Assessment of Tier 2 status (visit to DMHP) in follow up calls.
- Staff at DMHP assists patients in making their first call to Tele MANAS.
- A separate classification "Patient referred from Tele MANAS" is included in reporting format.
- Awareness activities by Tele MANAS team along with DMHP Staff in the community.
- Telephonic assistance to DMHP staff for expert opinion regarding treatment by Tele MANAS Cell Consultants (where Mental Health Provider is not available).

G. Partnership and linkages

Tele MANAS is designed to serve as the 'digital arm' of the District Mental Health Programme (DMHP) and supplement and complement the services of DMHP. The DMHP personnel delivers Tele MANAS services at the Tier 2 level as needed. Urgent cases requiring in-person care are referred to nearby healthcare facilities, ranging from Ayushman Arogya Mandirs to tertiary care centres, which are part of DMHP. Alternatively, patients receive audio-visual consultations with specialists via eSanjeevani. It is envisaged that DMHP specialists operating from their district headquarters, shall leverage the audio-visual calling facilities to ensure seamless collaboration with Tele MANAS services.

In terms of linkages with DMHP, Madhya Pradesh (refer to Box 6), Karnataka and Odisha have strong and well-established linkages with their respective DMHPs. Jammu and Kashmir, on the other hand, is actively working on progressively strengthening its linkage with the DMHP.

Linkages with eSanjeevani. Efforts are underway across all states/UT to establish Tele MANAS linkages with eSanjeevani. This would be one of the key factors contributing to further take-up of the service.

Elaborate resource mapping of referral networks across the state and country was seen as one critical pathway to enable effective linkages of Tele MANAS with other health and non-

health initiatives. Specific suggestions were to explore the possibility of making follow-up calls (with informed consent) by Tele MANAS counsellors to People with Mental Illness (PwMIs)/database of Cancer care/database of persons with Chronic and critical illness/ students appearing examinations/caregivers having children with profound disability.

Unveiling the stories

10. Helping a family navigate a tapestry of troubles in remote Karnataka

A 62-year-old male called the Tele MANAS helpline from a remote part of Karnataka with complaints that people were observing him, someone is following him and trying to harm him and his family members. The same caller repeatedly reached out with the same complaints on multiple occasions. The Tele MANAS team observed that there were instances of anger outbursts, irrelevant speech, paranoia, delusion of reference, delusion of persecution and crying spells. Family history revealed a blind and deaf wife and a daughter living with schizophrenia who was being treated at a mental hospital for seven years without apparent improvement in her condition. The family had been kept outside the village due to the stigma around mental illness. The Tele MANAS team offered prompt reassurance and validation. They highlighted the nuances of mental illness, addressed misconceptions, emphasized the vital role of consistent medication and timely follow-up. Recognizing the need for a more comprehensive approach, the Tele MANAS team expanded their reach and acted as a bridge between the district mental health hospital and this family. A home visit was organized by the district mental health team, treatment and disability assessments were undertaken for the daughter as well as his wife. Treatment modalities were established for the caller himself. Simultaneously, the team facilitated referral, co-ordinated with the ASHA worker for home visits, infusing rays of hope in this situation. In liaison with the psychiatrist of the DMHP, treatment was started for this 62-year-old man by the TMC psychiatrist. Through the collective efforts of Tele MANAS team, the district mental health hospital, district mental health team and ASHA, the family found their path to healing. Continuity of care was assured, including by the district administration facilitating IEC activities with a view to re-integrate this family back into the village.

Unveiling the stories

11. Addressing PTSD: A young girl finds help Madhya Pradesh

One evening, a distressed 18-year-old girl reached out to TMC in Madhya Pradesh. In trembling words, she narrated how every night she hears strange sounds - of bells ringing and insects quivering. For two months, her hands and feet tremble, she gets dizzy and the world spins into darkness as she faints. Assuring the girl of utmost confidentiality, the counsellor was able to unearth that two months ago, an incident with her mother had unfurled these symptoms. More worryingly, this was not the first time they had occurred; her past revealed that she had witnessed a road accident as a child and experienced these very symptoms. Seeking solace, her parents had turned to a faith healer to find answer, with no avail. The Tele MANAS number was shared by a friend, who like her, was appearing for competitive exams. As their conversation unfolded, the counsellor recognized the depths of her disturbance and the clutches of fear that held her close. She was provided psychoeducation and assured that her condition is treatable. With her consent, she was connected to a psychiatrist, who informed her as well as her parents that she could be suffering from post-traumatic stress disorder (PTSD). They were referred to nearest hospital for evaluation and treatment.

A follow-up calls by the counsellor after two days, revealed that the girl and her parents had begun the treatment. 4–5 follow-up sessions revealed that she was feeling a lot of relief. And then, few days ago, she herself called, to share that she was healed and feeling happy. She profusely thanked the counsellor and Tele MANAS team.

In conclusion, while there are varied implementation experiences across the four states/UTs visited, common elements of a well-functioning programme could be observed. These are:

- States/UT which are front-runners have been implementing the programme since its launch in October 2022.
- There is presence of multiple cells in one state/UT, as per the operational guidelines, thereby catering to the population of the state.
- Adequate and effective human resources comprising of 10–20 counsellors and four mental health specialists are in place and operating on 24x7 basis.
- Close handholding is undertaken by MHPs at different levels.
- Robust and ongoing promotional activities are undertaken with active involvement of state programme coordinators and NHM.
- Active and on-going handholding is undertaken by the mentoring institutes and RCCs.

5. Key takeaways and recommendations

Globally, Tele MANAS is one of the largest deployment of a digital, phone based mental health initiative in a country.

Key takeaways

- **High priority accorded to mental health by the government:** Introduction of Tele MANAS is a reflection of the government's commitment and prioritization of mental health as a key concern.

- **Scale and complexity:** The scale and complexity of the initiative is exceptional. Tele MANAS has already been scaled across 32 states/UTs, offers service in 20 languages by 1900+ trained and paid counsellors.

- **Multi-layered system with strong support mechanism:** The two-tiered structure at state level, comprising of trained counsellors and mental health professionals at Tier 1 and mental health specialists at Tier 2 is uniquely supported with ongoing technical support and handholding by mentoring institutions and regional collaborating centres across the country. These mentoring institutions and regional centres in turn leverage the institutional expertise of apex institutions like NIMHANS and IIIT-B.

- **Significant progress:** In less than one year since its launch in October 2022, the programme has already received over 230 000 calls which continue to increase day on day, thereby indicating that the programme is meeting a hitherto unaddressed need.

- **Integral part of the health system:** The evolving linkages with the larger health system is one of the hallmarks of this initiative, which distinguishes it from other such telephone-based services.

- **Effective training and capacity building approach:** Overall, the counsellors were well trained through the blended methodology and supervised. Based on the available data, the stepped care process is being managed without major technical or process difficulties.

- **Stable IT platform, safety and privacy assured**: Overall the IT platform has been stable, though challenges around connectivity have been reported. The system design and architecture ensure a clear focus on safety and privacy measures.

- **Financial commitment:** The programme is well-resourced, both in terms of technical and financial resources.

- **Immense potential to link with non-health sectors:** The programme offers hitherto unexplored potential to create referral pathways and linkages with other non-health sectors.

Given the global importance of the initiative, the following aspects could be further strengthened:

- **Augmenting national level support for promotional efforts:** Augmenting national level on promotion activities would help to further raise awareness of the Tele MANAS service and increase uptake. In wide scale introduction of mental health services in other countries enlisting the help of marketing and communications professionals to develop a clear and targeted strategy to raise awareness has been found to be essential. The Tele MANAS programme utilizes the services of such professionals and has organized several events to showcase the Tele MANAS initiative. Select states also organize IEC campaigns to create awareness about the programme. These efforts may be further augmented through national level support to ensure Tele MANAS has the widest reach possible.

- **Training and capacity building:** Tele MANAS training approach is already comprehensive and emphasizes several key areas of importance for tele-counsellors. The model can be further strengthened by including competency-based training and supervision approaches to support ongoing capacity building.

- **Introduction of a screening tool:** As Tele MANAS develops it would be helpful use a brief measure to screen callers and establish a more objective approach to understanding their needs and the circumstances under which they are stepped up from counsellors to MHPs. This would also support the introduction of scalable psychological interventions.

- **Addressing operational challenges:** Addressing the operational challenges such as IT connectivity would further improve the caller experience and increase service uptake.

- **Deeper understanding of the end user and programme impact:** There is a need for a more detailed and nuanced understanding of who is using the Tele MANAS service. Presently, data for Tele MANAS is centrally stored and only an overview is provided. The data systems could be further developed to provide capability for disaggregated analyses, including by unique callers. A robust monitoring and evaluation framework would support further detailed understanding of the impact of Tele MANAS and support future developments ensuring that the service it reaches the broadest possible user base and that decisions are data driven.

Overall, the foundational aspects of the Tele MANAS programme are sound and there is every reason to be optimistic about its progress in the coming years. Key recommendations across specific thematic areas (Table 6) that could contribute towards further strengthening the programme are outlined below.

Table 6: Key recommendations

Theme/Sub-theme	Recommendation	Responsible stakeholders
Support and strengthen the Tele MANAS Workforce		
Workplace enhancement for improved service delivery	Increase the comfort and functionality of the physical workspace (for example, placement of dividers between desks for enhanced privacy, door locks, use of headsets, etc.)	• Central Government • State Government • Tele MANAS Cells
Human Resource Planning and Recruitment	Work to ensure gender balance among existing workforce, especially counsellors to meet needs of diverse callers. Inclusion of middle-aged and senior citizens as counsellors may be helpful.	
Human Resource Management	Introduce a rotational or incentive-based schedule for counsellor and consultants, especially during holidays to ensure fair distribution of work.	
	Implement a system of recognized certification for both counsellors and supervising psychiatrists (for example, by the medical council) to support retention of existing staff and recruitment of new staff to positions that are currently vacant.	• Central/State Government
	Strengthen initiatives and establish a system to provide psycho-social support and prevent burnout among counsellors.	• State Government • Mentoring Institutes • Tele MANAS Cells
Augment Service Delivery		
Supporting Triage	Consider implementing a brief screening tool such as K6+ to provide clearer information on caller needs to support triage and the application of psychological interventions	• National Tele MANAS Programme, MOHFW, GOI • State Government • Apex Mentoring Institute -NIMHANS • Mentoring Institutes • Tele MANAS Cell • WHO
Consider structured interventions and stepped care	Consider implementing interventions/using tools like WHO's Problem Management Plus (PM+), WHO's Step by Step (SBS), WHO's Doing What Matters in Times of Stress (DWM) to move towards the model of stepped care and conservative use of limited specialized resources for only most severe cases.	

Role of Mental Health Professionals	Enhance the role clarity and required competencies of Tier 1 Mental Health Professionals supporting the team of counsellors.	• National Tele MANAS Programme, MOHFW, GOI • Apex Mentoring Institute-NIMHANS • State Government • Mentoring Institutes • Tele MANAS Cell
	Examine options to ensure availability of psychiatrists for referral – for example, on call; deputation of psychiatrists from government cadre as an interim measure.	Central/State Government
Build on existing capacity development strategies		
Competency based training and supervision	Introduce competency-based training and supervision approaches to further emphasize ongoing capacity building (for example, WHO-UNICEF's Ensuring Quality in Psychological Support – EQUIP, an evidence-based tool for building competencies of mental health and psychosocial support providers in providing both basic psychosocial support and specific counselling techniques and interventions).	• Apex Mentoring Institute-NIMHANS • Tele MANAS Cells • WHO
	Consider introducing a focused training and ongoing supervision programme for MHPs.	
Enhance the supervision structure	Integrate more structured methods of supervision, including standard and regularly scheduled individual and group-based supervision of counsellors, as well as within-cell case conferences.	• State Governments • Mentoring Institutes • Tele MANAS Cells
Enhance the mentoring structure	Develop a training calendar based on a needs assessment. Introduce organized and phased training programmes for continuous translation of knowledge to practice.	
Task-sharing in training and mentoring	Explore task-sharing opportunities in training and mentoring to reduce the burden on consultant psychiatrists and increase the role of experienced peer counsellors.	

Continue to strengthen data systems, monitoring and evaluation aspects		
Enhancing data systems and implementation research	Support disaggregation of data and make data more readily available to the Mentoring Institutions for evidence-based programming.	• National Tele MANAS Programme, MOHFW, GOI • Apex Mentoring Institute-NIMHANS • IIIT-B • Mentoring Institutes • Tele MANAS Cells • WHO
	Allocate dedicated resources to create an inbuilt M&E cell that can drive the process and collaboratively set the research agenda and monitor implementation.	
	Identify key priorities and create an implementation research agenda for the programme.	
Continue to strengthen linkages and partnerships		
Linkages within the community, beyond the health sector	Map local resources beyond the health sector (for example, social welfare programs, employment and livelihood supports), and enhance referral to holistically support the client populations' needs. This information could be made available and regularly updated.	• National Tele MANAS Programme, MOHFW, GOI • State Governments • Tele MANAS Cells
	Consider introducing focused awareness and sensitization programmes among community to address barriers in accessing tele services and improve programme uptake.	• National Tele MANAS Programme, MOHFW, GOI • State Governments • Tele MANAS Cells
Linkages and integration within the existing health system and other Departments/Ministries	Strengthen the integration of Tele MANAS into the 'Ayushman Arogya Mandirs' - Mental, Neurological and Substance Use Disorders' package.	• National Tele MANAS Programme, MOHFW, GOI • State Governments • Tele MANAS Cells
	Prioritize operationalizing the integration of Tele MANAS and eSanjeevani telemedicine system	
	Invest additional efforts to improve bi-directional flow from DMHP to include people who might benefit from brief psychosocial interventions being referred more systematically to Tele MANAS from OPDs and services in district hospitals	
	Strengthen linkages with district hospitals to provide follow up support of people being discharged after admissions (like after suicide attempt) for continued support, information and to ensure timely follow up	

Linkages and integration within the existing health system and other Departments/Ministries	Establish/strengthen linkages of Tele MANAS with relevant programmes and initiatives of Departments/Ministries such as Women and Child Development, Education, Social Justice and Empowerment amongst others to address mental health issues amongst their beneficiaries.	
Knowledge Sharing	Facilitate sharing of tools, learnings, and innovation	• National Tele MANAS Programme, MOHFW, GOI • Apex Mentoring Institute-NIMHANS • WHO
	Implement an exchange programme to facilitate sharing between counsellors and mentors across districts/states, MHPs, both remotely and in-person to encourage learning across the programme.	
	Develop a national case study on Tele-MANAS programme to share learnings and innovations with other countries.	

Annex 1: Rapid assessment teams and key interactions

Rapid assessment - Jammu and Kashmir (1–2 August 2023)

Team members:

- Dr Andrea Bruni, Regional Advisor, Mental Health, WHO SEARO
- Dr Atreyi Ganguli, National Professional Officer, Mental Health and Substance Abuse, WHO India
- Dr Madhuri H N, Assistant Professor, NIMHANS
- Dr Qazi Haroon, State Program Coordinator, Mental Health
- Dr Arshad Hussain, Psychiatric Diseases Hospital, Srinagar

Key interactions:

- Secretary, Health
- Divisional Nodal Officer
- HoD, Psychiatry, Institute of Mental Health and Neurosciences
- Medical Superintendent, Budgam District Hospital
- Senior Consultant, Tele MANAS
- Tele MANAS counsellors

Rapid assessment - Madhya Pradesh (3–5 August 2023)

Team members:

- Dr Yutaro Setoya, Team Lead, NCDs and Comorbidities, WHO India
- Dr Brandon Gray, Mental Health Officer, WHO HQ
- Dr Suchandra HH, Assistant Professor, NIMHANS
- Dr Sharad Tiwari, State Program Coordinator, Mental Health
- Dr Vijendra Singh, In charge, All India Institute of Medical Sciences, Bhopal

Key interactions:

- Deputy Director and State Programme Coordinator, Mental Health, National Health Mission
- Executive Director, All India Institute of Medical Sciences, Bhopal
- Head of Department of Psychiatry, All India Institute of Medical Sciences, Bhopal
- Senior Consultant Psychiatrist, Tele MANAS, All India Institute of Medical Sciences, Bhopal
- Consultant Psychiatrist, Tele MANAS, All India Institute of Medical Sciences, Bhopal
- Dean, Mahatma Gandhi Memorial Medical College, Indore
- Professor and Head, Dept. of Psychiatry, Mahatma Gandhi Memorial Medical College, Indore
- Senior Consultant and Consultant Tele MANAS Indore
- Mental Health Professionals, Tele MANAS Cells
- Tele MANAS counsellors

Rapid assessment - Karnataka (7–11 August 2023)

Team members:

- Dr. Sudipto Chatterjee, Mental Health Specialist, WHO HQ
- Dr. James Underhill, Consultant, WHO HQ
- Dr. Manjunatha N, Additional Professor, Psychiatry, NIMHANS
- Dr. Swati Ravindran, Assistant Professor, Psychiatry, NIMHANS
- Dr. Rajani Parthasarathy, State Program Officer, Mental Health
- Dr. Ranganath Kulkarni, Dharwad Tele MANAS Cell

Key interactions:

- Director and Senior Professor of Psychiatry, NIMHANS
- Professor of Psychiatry, Head of Telemedicine Centre, NIMHANS
- Professor of Psychiatry, NIMHANS
- Associate Professor of Psychiatry, NIMHANS
- Assistant Professor of Psychiatry, NIMHANS
- Assistant Professor of Psychiatry, Tele MANAS, NIMHANS
- Senior Resident, Department of Psychiatry, NIMHANS
- Senior Resident, Department of Psychiatry, NIMHANS
- Deputy Director,Mental Health, Department of Health and Family Welfare
- Head of Programs, E-Health Research Centre, International Institute of Information Technology, Bangalore
- Mental Health Professionals, Tele MANAS, Dharwad Cell
- Counsellors, Tele MANAS, Bengaluru Cell
- Counsellors,Tele MANAS, Dharwad Cell
- DMHP teams and DHO at Chikkaballapur and Dharwad
- District Hospital staff at Chikkaballapur
- Community Health Officers and ASHA workers at AAM in Chikkaballapur

Rapid assessment - Odisha (16–17 August 2023)

Team members:

- Dr. James Underhill, Consultant, WHO HQ
- Ms. Maitreyee Mukherjee, Consultant, Mental Health, WHO India
- Dr. Rakesh Chander, Assistant Professor, NIMHANS
- Dr. Prameela Baral, State Program Coordinator, Mental Health
- Dr. Ajay Mishra, In charge, Mental Health Institute, SCB MCH, Cuttack

Key interactions:

- Mission Director, National Health Mission
- Director, Mental Health Institute, Sriram Chandra Bhanja Medical College, Cuttack
- State Project Officer, National Mental Health Programme
- Senior Consultant, Tele MANAS, Cuttack
- Nodal Officer, District Mental Health Programme/De-addiction Centre and Tele MANAS Cell, Ganjam
- Medical Officers, Community Health Officers of Primary Health Centre and Community Health Centre

- Mental Health Professionals of Tele MANAS Centres, District Mental Health Programme Units
- Tele MANAS Counsellors
- ASHAs of Sub Health Centre

Annex 2: Rapid assessment - photographs

Jammu and Kashmir (1–2 August 2023)

Madhya Pradesh (3–5 August 2023)

Karnataka (7–11 August 2023)

Odisha (16–17 August 2023)

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