Mental Health Task-Sharing at Community Level

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A practice-note Health & Nutrition

Published: April 2026 · Last reviewed: —

In India, there is approximately one psychiatrist per 100,000 people nationally. In Odisha's tribal districts, the figure is dramatically lower — most interior blocks have no mental health professional of any category within reasonable reach. Psychiatric services are concentrated in urban district hospitals, in Bhubaneswar and Cuttack, in settings that are inaccessible to the communities with the highest mental health burden.

The standard policy response to this gap — train more psychiatrists, build more facilities — is correct and insufficient. It is correct because specialist care is needed for severe conditions. It is insufficient because the timelines for producing adequate numbers of specialists are measured in decades, while the mental health burden is present now.

Task-sharing is the evidence-based alternative that works within this constraint. Task-sharing means training non-specialist health workers — community health workers, nurses, primary care physicians — to deliver specific, structured psychological interventions under specialist supervision. The specialist's role shifts from direct patient care to training, supervision, and oversight of a larger workforce. This expands the reach of effective mental health care by orders of magnitude without requiring the production of more psychiatrists.

The global evidence on task-sharing for common mental health disorders — particularly depression and anxiety — is among the most robustly validated in

implementation science. A 2017 Lancet RCT by Sangath (the Healthy Activity Programme, or HAP) found that lay health counsellors trained to deliver a structured 6–8 session behaviour activation intervention produced significant reductions in depression severity compared to enhanced usual care. At three months, 73% of patients in the HAP group achieved recovery from depression versus 50% in the control group.

What the EMPOWER programme then tested — beginning in 2021, published in full in 2025 — was whether this same intervention could be delivered by ASHAs (not lay counsellors, but the government's own frontline health workers) at scale in rural districts, using digital training tools rather than in-person training from Sangath specialists.

The EMPOWER Results: What Was Demonstrated

The EMPOWER (Expanding Mental Health Care Capacities and Outcomes With Research) project, a Harvard-Sangath collaboration, trained 1,001 ASHAs in three rural districts of Madhya Pradesh using a smartphone-based Learning Management System — a digital curriculum covering depression identification using validated screening tools, the HAP behavioural activation protocol, safety assessment, and escalation criteria.

The results, published in BMC Primary Care in August 2025, are striking:

As of 2023, over 1,000 ASHAs completed the HAP training, and detected close to 2,900 persons with depression. Of those persons, approximately 90% completed the treatment, with over 87% remitting by the end of treatment. Overall, ASHAs delivered 15,300+ counselling sessions for adult depression.

The implementation model included fortnightly supervision of ASHAs by the project team, referral linkages with the state's Mann Kaksh (district mental health) programme and the DMHP, and concurrent training of health system stakeholders through a digital leadership course designed to build institutional support. The project

also recruited community volunteers — village elders, panchayat members, teachers, social workers, and college students — trained to conduct community-level screening for depression.

The EMPOWER project demonstrated that high-quality mental health services can be embedded within existing health systems using current human resources, requiring minimal investment, and delivered in a non-stigmatizing and acceptable manner to ensure sustainability.

What this means for Odisha NGOs is specific: the human resources for task-sharing already exist in Odisha's ASHA cadre. The intervention protocol (HAP) has been validated in India and implemented in comparable rural conditions. The training methodology (digital LMS with fortnightly supervision) has been demonstrated at scale. What does not yet exist in Odisha's tribal districts is the NGO facilitation layer that connects these elements — helping block health systems activate the ASHA mental health role, establishing the supervision structure, and building the referral linkages that the EMPOWER model required.

Understanding Depression in Tribal Communities — The Cultural Dimension

Before any programme can work, practitioners need to understand how depression presents and is understood in the specific communities they are working with. The biomedical category of "depression" does not automatically map onto how distress is experienced or expressed in Odisha's tribal communities.

In many tribal communities, symptoms that the PHQ-8 (the screening tool used in EMPOWER) would capture as depression — persistent sadness, loss of interest, sleep disturbance, fatigue, feelings of worthlessness — are expressed through somatic complaints (body pain, headache, stomach problems), through withdrawal from social roles and festivals, or through idioms of distress that reference spiritual causes or social violations rather than psychological states.

This is not a barrier to effective treatment. Behavioural activation — the mechanism through which HAP works — does not depend on the patient adopting a biomedical understanding of their condition. It works by helping people re-engage with activities that are meaningful and pleasurable to them, which produces improvement in mood regardless of whether the person understands their experience as "depression." But it does require that screening and assessment be conducted sensitively, that the ASHA uses language that connects with the person's own experience, and that the intervention be adapted to the specific cultural context of the community.

The EMPOWER training explicitly included modules on cultural adaptation of the screening and intervention. Any Odisha replication must do the same — specifically addressing: the vocabulary of distress in each tribal language being used; the cultural appropriateness of the activities proposed in behavioural activation (activities must be from the community's own repertoire, not externally suggested); and the role of traditional healing practices in the person's existing coping system.

Alcohol and Substance Use: The Parallel Problem

Alcohol use disorders are the other major untreated mental health condition in tribal Odisha. The evidence base on alcohol use in tribal communities in eastern India consistently documents high prevalence — both traditional and commercial alcohol — with documented associations with domestic violence, economic instability, and poor health outcomes.

ASHAs trained in the EMPOWER model are taught to identify alcohol use disorders alongside depression and to make appropriate referrals. In Odisha's context, the referral system for alcohol treatment is even thinner than for depression — de-addiction services are scarce even at district level.

For communities with high rates of alcohol use disorders, the NGO programme needs to: address the alcohol problem explicitly in community engagement (not in a moralistic frame but in an economic and health frame — how much household income

goes to alcohol, what health consequences follow); build peer support structures (men's groups or mixed groups that provide social support for behaviour change); and connect to whatever de-addiction resources exist at block and district level, while simultaneously advocating for those resources to be strengthened.

Brief intervention for alcohol use — a structured conversation about drinking patterns and their consequences, delivered by trained community workers — has evidence from multiple Indian contexts and is simpler to train and deliver than the full HAP protocol. It can be a standalone programme component or an add-on to an ASHA mental health training initiative.

What the NGO Does: The Facilitation Role

The EMPOWER model was implemented by a research organisation working directly with the health system. For NGOs, the role is different and specific: NGOs do not train ASHAs directly — that is the health system's role, supported by NIMHANS-linked district mental health teams. NGOs facilitate the conditions that make ASHA mental health task-sharing possible in their operational areas.

Facilitation activity 1: Engage the District Mental Health Programme

Every Odisha district has a District Mental Health Programme team — psychiatrist, psychologist, social worker, and programme manager — funded under NHM. The DMHP is mandated to support ASHA mental health training and community outreach. In practice, DMHP teams are understaffed, under-resourced, and focused on district hospital functions. Their community outreach — including ASHA training and supervision — is limited.

The NGO's first step is to visit the DMHP team, understand what ASHA mental health training has happened in the blocks where the NGO works, and offer to support the extension of that training into specific communities. This is not replacing the DMHP — it is extending its reach into communities where it cannot currently operate.

Facilitation activity 2: Support screening at community level

Community-level screening for depression using the PHQ-2 (a two-question pre-screener that takes under a minute) can be conducted by trained community volunteers — teachers, VHSNC members, SHG members — who then refer positive screens to the ASHA for full assessment. The EMPOWER model used this community volunteer layer and found it significantly expanded detection rates beyond what ASHAs could achieve through their household visits alone.

The NGO trains and supervises these community volunteers, maintains a record of screenings and referrals, and provides the DMHP with data on detection rates that supports the case for strengthened DMHP resources in the block.

Facilitation activity 3: Establish the referral chain

The referral chain for mental health in tribal Odisha — from community screening through ASHA intervention to DMHP support for severe cases — does not currently function as a chain. It functions as a series of disconnected nodes. The NGO facilitates the connections: ensuring ASHAs know the DMHP contact; ensuring the DMHP knows which ASHAs in which villages are conducting mental health work; and monitoring whether referrals made by ASHAs are actually received and acted on by the DMHP.

This is unglamorous coordination work that produces functioning systems rather than individual service events.

Facilitation activity 4: Stigma reduction

Mental health stigma in tribal communities — the social consequences of being identified as mentally ill — is a significant barrier to both help-seeking and programme participation. Public community events (gram sabha discussions, school sessions, SHG meetings) that address mental health in non-stigmatising, normalising frames — connecting mental health to experiences everyone has, not to a category of people who are different — reduce the stigma that would otherwise prevent people from accepting ASHA support when it is offered.

The EMPOWER model used public engagement events alongside clinical programme delivery. Without addressing stigma, screening and referral rates are suppressed by the fear of labelling.

Practical First Steps for Odisha NGOs

Identify your district's DMHP programme manager. They are the entry point into the formal mental health system. A meeting with the DMHP programme manager — to understand what ASHA mental health training has happened in your block, what screening tools are being used, and what the referral pathway to Mann Kaksh looks like — takes one morning and establishes the relationship that everything else depends on.

Get trained in PHQ-8/PHQ-2 administration. The Patient Health Questionnaire screening tools are the standard instruments for depression screening in India's ASHA programme. They are freely available, have been translated into multiple Indian languages, and can be learned in a half-day. If your NGO staff understand the tools, they can support both ASHA training and community volunteer training.

Start with SHG platforms. The most accessible entry point for community mental health engagement in Odisha is the Mission Shakti SHG meeting infrastructure. A trained facilitator running a structured session on stress, emotional wellbeing, and when to seek support — at a monthly SHG meeting that women are already attending — reaches women who would never attend a dedicated mental health event. The session normalises the conversation, identifies women who may benefit from ASHA follow-up, and generates referrals naturally.

What Success Looks Like

At 18 months, an NGO-facilitated ASHA mental health programme in a block should demonstrate:

- ASHAs in the operational blocks trained in PHQ-8 screening and the HAP protocol (or equivalent) — through DMHP training, facilitated by the NGO
- A fortnightly supervision structure for trained ASHAs, with the DMHP psychologist or social worker providing oversight
- A documented number of persons screened, identified as depressed, and completing HAP treatment
- At least one functioning referral pathway to the DMHP for cases requiring higher-level support
- Reduction in community stigma — assessed through simple before/after questions in community surveys

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Related Knowledge Commons content: Health & Nutrition Sector Primer (Sector 08) · Practice Note: ASHA Programme — How NGOs Can Strengthen the Last Mile · Practice Note: Mobile Health Clinics — Design for Remote Tribal Contexts

Evidence Grade: A/B — The HAP Lancet RCT (Patel et al. 2017) and the EMPOWER implementation study (BMC Primary Care, August 2025; medrxiv preprint October 2024) are the primary evidence sources. Grade A for the RCT evidence on HAP effectiveness; Grade B for the implementation research on ASHA-delivered task-sharing at scale. Last reviewed: April 2026.

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