
Brainstorming on Prioritization of Mental Health Research

**Indian Council of Medical Research
New Delhi
2016**










Report of the Brainstorming on Prioritization of Mental Health Research

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Report of Brainstorming on Prioritization of Mental Health

Background

According to NIMHANS estimates, India has more than 7 crores persons with mental health problems. In 2004, UNODC and the Ministry of Social Justice and Empowerment, jointly released the report of National Survey on the Extent, Pattern and Trends of Drug Abuse in India. It showed that the number of chronic substance-dependent individuals were as follows: 10 million (alcohol), 2.3 million (cannabis) and 0.5 million (opiates). In India person with mental health problems especially women are highly stigmatized. There are only 43 government-run mental hospitals and approximately 3500 psychiatrists serving a population of 1.2 billion. There is need to bring evidence based preventive and management strategies to take care of huge number of persons with mental health problems. ICMR has a role to provide research based solutions and other inputs to the National Mental Health Programme. It was proposed to bring together the mental health professionals to discuss these strategies. For this purpose, ICMR organized a Brainstorming on the “Prioritization of Mental Health Research” on May 12, 2016 at Conference Room, ICMR Headquarters, New Delhi. The objectives of the meet were to appraise mental health and substance abuse research supported by ICMR in the last 10 years & the results/impact of it on policy and practice, to suggest priority areas for research on mental health and substance abuse for India for the next 5 years & a process of consultations with policy makers to validate these; and to suggest the process for involving research institutions/individuals in leading research on these areas, keeping in mind the (limited) resources likely to be available.

The agenda was drafted in consultation with Dr Soumya Swaminathan, Dr. Shekhar Saxena, and Dr. R. Srinivasa Murthy. It was suggested that the delegates may bring in the presentations on Mental Health Research at ICMR & Draft Document on Mental Health Research Priorities in India; WHO Global Priorities on Mental Health; WHO Regional Priorities on Mental Health; Burden of Mental Health & Substance Abuse; Research directions on prevention of mental disorders & promotion of mental health; Research directions on early identification, diagnosis & clinical management; Assessing outcomes of health care services for mental health problems; Developing guidelines for consensus among Psychiatrists; Research directions on feasibility & effectiveness of mental health service models; Research through NGOs & CBOs; Matching research priorities with NMHP; and Research on task sharing & collaborative care. The purpose of the presentations was to share the current scenario and the views of the eminent scientists working in the related area at national and international level. Accordingly, the topics were assigned to the researchers/scientists working on these topics for fairly long period of time and those who have been recognized by national and international funding agencies. It was assumed that researchers would suggest the priorities ranging from preclinical questions into the aetiology, treatment of mental health problems, implementation and policy needs to scale up effective interventions using a life-course approach. As the suffering caused by mental health problems extends beyond the patient to family members and communities, changes at health care settings are crucial, together with attention to social exclusion and discrimination. At the same time, research into systems interventions, such as integrating care for mental health problems into chronic disease care, could transform health services and reduce costs of its management drastically.

Inaugural Session

Dr. Rakesh Kumar, IAS, Senior Deputy Director General (Administration) welcomed the delegates and shared his views on the mental health problems, care and research in India. Mental health care in India in last 25 years has been a period of growth and innovation. Prior to the formulation of the NMHP in 1982, the major initiatives included setting up of mental hospitals during 1950s and early 1960s and general hospital psychiatric units in the 1960s and 1970s. Simultaneously, involvement of the families in care of the mentally ill was also initiated in a number of centres. Another major step in mental health care was to integrate mental health care with general health services. Followed by the initial demonstration projects at Chandigarh and Bangalore. The district model of mental health (DMHP) care was developed by National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore during the latter part of 1980s, which is an integral part of National Mental Health Programme.

Dr. Soumya Swaminathan, Secretary, Department of Health Research and Director General, Indian Council of Medical Research, in her inaugural address, shared that the National Health Policy clearly spells out the place of mental health in the overall planning of health care. These developments have occurred against the over 25 years of efforts to integrate mental health care with primary health care (from 1975), replacement of the Indian Lunacy Act 1912 by the Mental Health Act 1987, and the enactment of The Persons with Disabilities Act 1995 focusing on the equal opportunities, protection of rights and full participation of disabled persons. A registry of serious psychiatric problems seen in psychiatry departments of hospitals should be developed. Present brainstorming may suggest that what minimum data to collect, how to develop a central database. Such a registry would obviously have several benefits and allow international comparisons as well as facilitate cohort development. We may promote Implementation research around the DMHP. Evaluation of NMHP should be done by independent agency. Strategies to improve NMHP functioning should be identified. Maternal depression and prevention of suicide should be focussed. The MD and DNB students should start collecting data on high priority

topics to be decided by ICMR. This would allow large scale national data collection. This will be discussed further with the national board. I would very much like this group to brainstorm (through email and telecons) and develop these ideas. We can then discuss with MOH about implementation as well as funding.

Dr. Ravinder Singh mentioned that mental health research was initiated at ICMR approximately six decades ago. Commencing with the first epidemiological studies at Bangalore in the 1950s and at Agra in the early 1960s, the Indian Council of Medical Research (ICMR) has been in the forefront of mental health research. The other major studies include the multi-centered research cum intervention project titled “Severe Mental Morbidity” at four centres across India. The “Strategies for Mental Health Research”, based on six task forces that identified research priorities in mental health in 1980s was a major milestone. Two of these task force projects focused on acute psychosis and course and outcome of schizophrenia. Findings of the studies have not only influenced mental health care in India, but contributed to the inclusion of acute psychosis as a separate diagnostic category in International Classification of Diseases (ICD) 10th Edition of the World Health Organisation.

In 1980s, the Council set up Advanced Centers for Research on Community Mental Health at Bangalore; Mental Health of Aged at Madurai; and Biological Psychiatry at Lucknow – all of which demonstrated how research support can help develop mental health services. The ICMR also supported research into the mental health aspects of disasters like the Bhopal Disaster in the 1980s, the Marathwada earthquake in the 1990s, Gujarat earthquake 2001, fire tragedy in Delhi and Tamil Nadu Tsunami in 2004. It is largely the result of these efforts that following any disaster in India, psychosocial support is readily provided to the survivors along with other services.

Scientific Programme

Dr. Alok Mathur shared his views on “Matching Research Priorities with National Mental Health Program”. He informed that National Mental Health Programme (NMHP), which is now part of National Health Mission, have the objectives to ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future; to encourage the application of mental health knowledge in general healthcare and in social development; to promote community participation in the mental health service development; and to enhance human resource in mental health sub-specialties. District Mental Health Program (DMHP), which is part of NMHP, provides financial support to NGOs for up to Rs. 5 lakhs per NGO on PPP Mode. It also provides financial support for Day Care Centre (@ 50,000 per centre per month); Residential Continuing Care Centre (financial support @ 75,000 per centre per month); Long Term Residential Continuing Care Centre (financial support @ 75,000 per centre per month); Community Health Centres; Primary Health Centres; Mental Health Services and Mental Health Helpline. Tertiary care level activities include manpower Development Schemes (Co-E & Scheme-B); Up-gradation of two Central MH Institutes to provide Neurological and Neuro-surgical Facilities on the pattern of NIMHANS (CIP, Ranchi & LGB, Tezpur); Support to Central and State Mental Health Authorities; Research & Survey; Monitoring & Evaluation; Central Information, education and communication; Central Mental Health Team; Mental Health Information System; and supporting Training programmes/Workshops. Priority areas for research with respect to NMHP include Promotion of mental health; Community awareness; Stress management & Suicide prevention (School, College, Work-place etc.); Universal access to mental health services; Models of DMHP (Urban, Semi-urban, Rural & Tribal); Integration of mental health with other CD & NCD Control Programs; and Development of Human Resources (including Training material & schedule and Training mode/model). Other research areas are Development of Community Mental Health mechanism for those patients who are fit to be discharged but their families don't claim them (Day-care & Residential Continuing Care); Monitoring & Surveillance; Effective Governance and Accountability mechanisms for mental health; CMHA/SMHA; and Mental Health Economics & Finance.

Dr. Ajit Avasthi shared his experiences on development of “Clinical Practice Guidelines for Psychiatrists in India”. The Indian Psychiatric Society (IPS) constituted a Task Force on Clinical Practice Guidelines (CPGs) in 2004 to formulate guidelines for management of various psychiatric disorders in an Indian setting. Purpose of these guidelines was to develop a framework for Evaluation, Treatment and Follow-up of the persons with mental health problems under treatment. It was expected to be evidence based, but at places these were based on opinion of experts. The Task force brought out 5 volumes of CPGs from the year 2005-2009, which are under revision now. The Task Force identified psychiatrists from different parts of the country to formulate guidelines on specific conditions. Psychiatrists from various teaching institutes (both faculty members and trainee psychiatrists) and those working with non-government organizations (NGOs) and those in private practice, were included. The Task Force also identified psychiatrists from different parts of the country to formulate guidelines on specific conditions. For each guideline, a lead author was identified and was asked to formulate the draft of the guideline on the assigned topic along with the help of other psychiatrist(s). Once the drafts were prepared, these were discussed in the Task Force meetings at Jaipur every year. The draft was initially read by a group of 5-9 psychiatrists, who gave their inputs. Later, the revised draft was presented to a group of 50-60 psychiatrists, who gave their comments, which were incorporated. A modified draft was supposed to be put up on the website for 4-6 weeks for comment from members, however, this did not happen consistently. The draft of the first volume was sent to all the members by the Editor of the Indian Journal of Psychiatry for their comments. *All* the comments received were securitized by the Chairman and Convenor of the Task Force and, wherever it was felt necessary, guidelines were modified in consultation with the authors.

Presentation of Guidelines was divided into three parts i.e.

- Part-I - Review of international literature,
- Part-II - Review of Indian literature, and
- Part-III - Proposed Guidelines. Local Issues were taken into consideration while formulating the guidelines.

Following Guidelines were prepared:

- Volume-1: Schizophrenia, Bipolar Disorder, Depression, OCD, Generalized Anxiety Disorder and Panic Disorder
- Volume-2: Substance use disorders, sexual dysfunction, Sleep disorders
- Volume-3: CPG for management of various psychiatric disorders in elderly
- Volume-4: CPG for management of various psychiatric disorders in Children & Adolescents
- Volume-5: CPG on Forensic Psychiatry
- 2014: Speciality section of substance use disorders updated the CPGs for management of various substance use disorders
- 2015: CPG on Treatment of Psychiatric Disorders in pregnant and lactating Women

In 2015, IPS again formed a Task Force to revise the CPGs. Basic mandate of this Task Force was to overcome the limitations of previous guidelines, which were lengthy, not suitable to local conditions, and were poorly disseminated. On Behalf of IPS, a survey was conducted to understand the needs and expectations of the members for the CPGs. More than 500 members participated. Basic suggestions were that these Guidelines should be brief and succinct with more tables/flow charts and local prevailing conditions should be considered in formulating the guidelines. The first issue of revised CPGs on Schizophrenia; Bipolar Disorder; and Depression is in the process of developing.

Dr. Johann Ebenezer elaborated his Project Shifa (the Community Mental Health Project at Padhar Hospital). Padhar Hospital is a charitable rural Lutheran mission hospital in Betul district of Madhya Pradesh. The psychiatry department at Padhar Hospital has been running a community mental health project covering 75 surrounding villages for patients with various psychiatric disorders and epilepsy since more than a year. One of the central aims, apart from clinical care, is to facilitate pragmatic community-based research work to improve service delivery in remote rural areas such as ours. Some of our relevant research work and suggestions include: Padhar Community Mental Health Screening Instrument (PaCoMSI): This is our new family-level screening tool for psychiatric disorders and epilepsy, designed to be asked by any non-specialist (lay) worker to one person per household (preferably head of family if available). It incorporates local terms and concepts.

Currently we are evaluating its effectiveness in the field; our latest data indicated sensitivity of 93% and specificity of 94% for picking up cases in the community. We shall continue to update data as it gets added on. The strengths of this project are: a) uses locally relevant terms and concepts; b) easy to train workers (verbatim tool) and reduces time taken to train workers; c) easy to administer (less than 10 min per household, family level not individual); d) single tool to pick up wide variety of psychiatric disorders & epilepsy; e) can easily be modified for local situations/cultures by substituting relevant terms; and f) makes screening of entire villages possible in short periods of time. The Weaknesses of this project are: a) Does not include a question on substance issues; and b) Does not (at least in present form) include specific question for dementia. We have also developed Outcome evaluation tool. This is also a newly created tool designed so that any non-specialist worker can easily fill it up using available field and clinical records, and therefore saves time by avoiding individual patient interviews (though it can be done that way as well). Outcome data thus generated is in 4 domains (compliance, symptom reduction, occupational/functional recovery & community reintegration). It can be modified easily to suit other program's requirements and is thus flexible. Other research being attempted from preventive angle include Post-encephalitic syndromes, where we are hoping to identify a list of possible pathogens responsible for the many post-encephalitic

neuropsychiatric syndromes we are encountering in the field; these efforts might hopefully lead to targeted strategies for primary prevention in the field. The work on suicides includes an evaluation of suicide attempters presenting to Padhar during last 2 years. The data from this study is now being analyzed. We hope that this would yield some suggestions on areas of primary preventive strategies in the field.

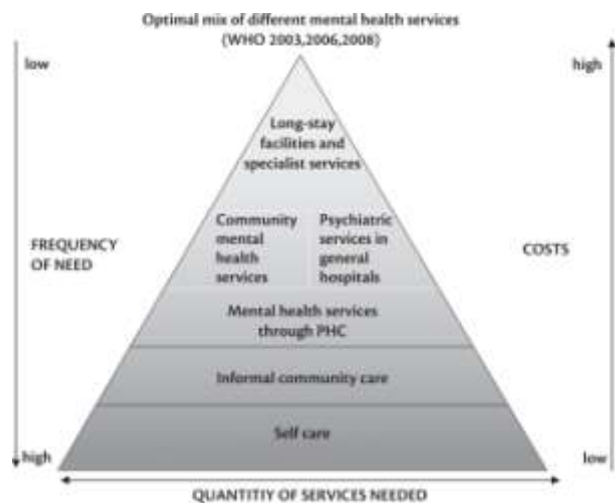
Dr. R. Srinavasa Murthy presented his views on “Research Priorities in Mental Health Promotion and Prevention of Mental Disorders”. He shared that most of his views were included World Health Report 2001, theme of which was “Mental Health: New

Understanding, New Hope”. The 2001 report focuses on the fact that mental health – neglected for far too long – is crucial to the overall well-being of individuals, societies and countries. The report advocates policies that are urgently needed to ensure that stigma and discrimination are broken down and that effective prevention and treatment



are put in place. Mental health is as important as physical health to the overall well-being of individuals, societies and countries. All over the world, approximately 450 million people are suffering from a mental or behavioural disorder, while only a small minority of them are receiving treatment. The latest studies undertaken in neuroscience and behavioural medicine have shown that, like many physical illnesses, mental and behavioural disorders are the result of a complex interaction between biological, psychological and social factors.

The governments are as responsible for the mental health as for the physical health of their citizens. The vast majority of people with mental disorders are not violent and hence does not need prison like conditions. Only a small proportion of mental and behavioural disorders are associated with an increased risk of violence, and comprehensive mental health services can decrease the likelihood of such violence.



Management of the mental health problems include medical interventions, involvement of

communities and families. Chronic conditions require rehabilitation where social, vocational and day care supports are appropriate approaches. Spiritual needs of the persons with mental health problems can't be ignored. Optimal mix of different mental health services is required based on the frequency of need and financial implications of these services.

In recent years, new information from the fields of neuroscience and behavioural medicine has dramatically advanced our understanding of mental functioning. Increasingly, it is becoming clear that mental functioning has a physiological underpinning, and is fundamentally interconnected with physical and social functioning and health outcomes.

The scope of mental health in the new millennium should include care of the mentally ill persons, prevention of mental disorders and promotion of mental health as outlined by Dr Govindaswamy, the first Director of All India Institute of Mental Health (now NIMHANS), Bangalore over 50 yr back: "Mental health in India has three objectives. One of these has to do with mentally ill persons. For them the objective is the restoration of health. A second has to do with these people who are mentally healthy but who may become ill if they are not protected from conditions that are conducive to mental illness which however are not the same for every individual. The third objective has to do with the promotion of mental health with normal persons, quite apart from any question of disease or infirmity. This is positive mental health. It consists of the protection and development of all levels of human society of secure, affectionate and satisfying human relationships and in the reduction of hostile tensions in the community."

Three major approaches for research in mental health problems are:

(1) Research to Increase understanding of Mental Health

- Child Trauma and adult mental health
- Alcohol policies
- Gender violence

- Social change and mental health
- Mass media and mental health
- Spirituality and mental health
- Mental health of vulnerable groups
- Life course studies
- Mental health tools for measurement
- Development and mental health

(2) Research to Develop MNH interventions

- Maternal depression
- Early childhood interventions in institutional settings /Anganwadis/ Families
- Workplace mental health
- Mental health promotion of caregivers
- Mental health promotion as part of care of diabetes/ CVD/ COPD/ Cancer/ elderly care
- Fighting stigma of mental health issues
- Mobile applications for self care/ mental health

(3) Research to Evaluate the impact of MNH interventions

- Life skills education in schools and colleges
- Disaster / Conflict mental health
- Suicide Prevention
- Yoga/Meditation
- Complimentary medical approaches for MNH
- Role of non-specialists in MNH
- We need clear indicators to find out impact of the interventions.

Dr. Pratap Sharan presented “Early Identification, Diagnosis and Clinical Management”. Our populations are facing challenges in form of having poor mental health. Mental health problems are common than reported and are disabling. These cause economic and social costs. They have lifetime impact, which means that once developed, the patients need medications for whole of their lives. Recently it has been recognised that there are concurrent problems related to mental ill health and substance misuse. Co-morbidity between mental disorders, substance misuse and physical illnesses is very common. Hence, we need a life-course approach to risk reduction that takes into account risks that occur in childhood and early adulthood, and that promotes a healthy lifestyle, and early recognition and treatment of mental and substance-use disorders. There is no agreement on what constitutes best practice for health research prioritization as different approaches based on indicators of needs (e.g. Burden) or values (opinion of experts/ stakeholders) or composite indicators.

Globally efforts have been made for Priority Setting in Mental Health. Global Forum for Health Research & WHO in 2007 carried out a survey in which 812 researchers & 306 other stakeholders from 53 Low and Medium Income Countries (LAMIC) participated. The ‘Mental Health: Global Action Programme’ (mhGAP) of the World Health Organization (WHO) envisioned an active role for research in efforts to change the current mental health situation. Research-generated information was seen to be essential in determining needs, proposing new cost-effective interventions, monitoring their implementation and evaluating their effectiveness. Conceivably, such information was expected to enable LMICs to better utilize their limited mental health resources. Comprehensive picture of mental health research production in these countries was been lacking. How much (or how little) research is being conducted on mental health issues? What was the focus of such research in terms of disorders, populations, and types of studies? What do researchers and other stakeholders see as the priorities for mental health research in their countries and how do they thought such priorities should be determined? What challenges do researchers faced in conducting effective research? To what extent is research successfully translated into policy, programmes or interventions? What hinders or helps such efforts?

There was broad agreement between researchers and stakeholders, and across regions. Other such exercise was Lancet Global Mental Health Group in 2007, where 24 experts used Child Health and Nutrition Research Initiative. Similar effort was done in Brazil. Another effort was Grand Challenges in Global Mental Health in 2011. Delphi method involved 422 stakeholders from more than 60 countries. The Grand Challenges in Global Mental Health Initiative was led by the National Institute of Mental Health (NIMH) and the Global Alliance for Chronic Disease in partnership with the Wellcome Trust, the McLaughlin-Rotman Centre for Global Health, and the London School of Hygiene and Tropical Medicine. The Grand Challenges Initiative provided a critical opportunity to bring mental, neurological and substance use (MNS) disorders to the forefront of global attention and scientific inquiry. The aim of the initiative was to identify research priorities that, if addressed within the next decade, could lead to substantial improvements in the lives of people living with neuropsychiatric illnesses. A grand challenge was defined as a specific barrier that, if removed, would help to improve the lives of those affected by mental, neurological, or substance use disorders. For the purposes of the Grand Challenges Initiative, the broad category called 'mental health' referred to factors (including disorders) influencing the health of the mind, brain, and nervous system. These conditions account for approximately 10% of the global burden of disease, as indicated by disability adjusted life years (DALYs) reported by the World Health Organization and the Global Burden of Disease 2010 study. As a group, they are the leading causes of disability worldwide. MNS disorders within the Initiative's remit included depression, anxiety disorders, schizophrenia, bipolar disorder, alcohol and drug use disorders, mental disorders of childhood, migraines, dementias, epilepsy, etc. Conditions with a vascular or infectious etiology were excluded, as these were addressed in previous Grand Challenges initiatives.

Roadmap for Mental Health Research in Europe undertaken in 2015 was Multi-tiered process in which 1000 expert researchers & stakeholder organisations participated.

Global Priority Setting Exercises in Mental Health identified highly prioritized research options, which address health policy and systems research involving existing interventions, or epidemiological research to inform priority setting.

Grand Challenges in Global Mental Health (2011) identified advance prevention and implementation of early interventions as key area of research. It envisaged reduction of the duration of untreated illness by developing culturally-sensitive early interventions across settings. It supported



improvement in treatments and expanding access to care. It supported integrated screening and core packages of services into routine primary health care. It also suggested to develop effective treatments for use by non-specialists, including lay health workers with minimal training and improving children’s access to

evidence-based care by trained health providers in LAMIC.

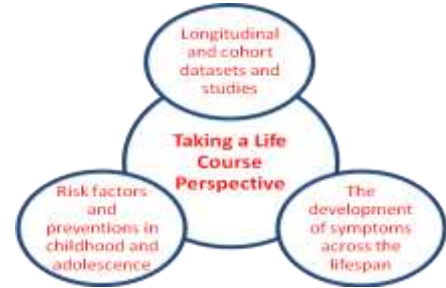
Research is needed for supporting “Mental Health for All” by applying safe innovative and effective interventions, improving access to services, empowering the users and carers, preventive & promotive factors, enhancing resilience, measuring quality across health services & systems.

Research is required into societal values and issues using economics to measure intervention efficacy, investigating wider socio-economic outcomes, effects of inequality on mental health, reducing mental health stigma.

There is need to build and enhance Research Capacities by building a strong empirical research base, sharing findings & databases, involving stakeholders in research, and maintaining inter-disciplinary research networks.



Research is also required from a Life Course Perspective by having longitudinal, cohort datasets & studies; development of symptoms across the lifespan; and identifications of risk factors & preventions in childhood & adolescence.



Finally, there is need to develop Personalised Medicine using mechanisms of psychological disorders; standardising treatment evaluation; finding the mechanisms & outcomes of co-morbidity; and improving diagnostic strategies.

Clinical Mental Health Research- there is growing gap between neuroscience research output and impact on clinical treatment for mental disorders. Some landmark studies



conducted over the last decade (e.g. CATIE, STEP-BD, and STAR*D trials) demonstrated that treatments are not as effective as was hoped. Clinical mental health research that aims to improve the health of individuals is needed to bridge this gap. Clinical mental health research requires a multidisciplinary approach because

treatment of mental disorders usually requires complex and multilevel interventions.

Horizon 2020: Challenges and Advances for Clinical Mental Health Research was an expert survey, wherein 89 experts with clinical research expertise representing most European countries participated. General challenges for clinical mental health research identified by them were: development of new treatment interventions (pharmacological, brain-related, psychotherapeutic, systemic, psychosocial, e-/m-Health or combination); exploring the mechanisms of diseases; evaluation of treatment effects; proof of concept clinical trials for

innovative treatments; and role of co-morbidity between mental disorders & somatic conditions for diagnoses, treatment decisions, and treatment & patient-related outcomes. This survey identified methodological challenges for clinical mental health research , like design of psychotherapeutic intervention studies; design of patient preference studies; design of psychopharmacological intervention studies; use of placebos in clinical research; and performing cohort studies in clinical populations.

Medical Research Council-UK in 2010 did exercise for developing therapy and suggested innovation in mental health research, e.g. cross symptom approach is required. There is need for stratified medicine; experimental medicine & phase I clinical studies to rapidly detect the efficacy of novel therapeutics, promoting recovery, including cognitive remediation & social rehabilitation; and increasing participation of service users & carers in research design & in deciding optimal research outcomes.

Recommended actions included development of large scale dataset and repository of biological and social factors for mental health research; and adding value to existing or planned cohorts.

In South Africa, Chips & Ramlall (2012) suggested locally relevant clinical studies in neuroscience, psychopharmacological & psychotherapeutic interventions; and Systematic reviews of mental health evidence for better use of already available data. Stein (2012) opined that good clinical practice & clinical research are intimately intertwined, and this intersection should be encouraged in the full range of mental health professionals and consumer organizations. He also supported that there is need to develop clinical interventions that are suitable for a resource limited context with potential to be scaled up.

Development & scientific evaluation of new interventions for mental disorders are required for effective and safe algorithms for prescription of medication; head-to-head trials of pharmacological agents for relative benefit-risk of medicines; synergistic effects of combined pharmacological & psychotherapeutic interventions; and e/m-health (risk of

health care provider withdrawal and patient disengagement), which are modern day tools to augment the process of face-to-face care.

Some methodological advances in the research include proof-of-concept trials (relatively small trials); assessment of intermediary outcomes; external validity issues in clinical trials and meta analysis; translation research: mixed-methods designs combining pragmatic randomized clinical trials with qualitative research; psychotherapy has blinding issues, neurobiological underpinnings can be used as placebo, equivalence studies, and standardization: pragmatic trials exploring adherence by patients and therapists alike.

Specific issues related to India include similarities & differences in the form, course, or manifestation of mental illness; the occurrence, incidence, & distribution of mental illness or behavioral characteristics in relation to socio-cultural factors; socio-cultural factors predisposing to mental illness or perpetuating or inhibiting recovery from mental illness; the preferred forms of treatment or methods of dealing with people defined as deviant or physically or mentally ill; and the influence of socio-cultural factors on clinical psychiatric issues (such as therapeutic approaches, progress, and diagnosis). The definitions of particular behavioural states, relationships or processes are unique to a socio-culture. The reactions, syndromes, treatment methods, perceptual styles, and reactions to stress are also culture-bound. The nature & magnitude of stigma, stereotypes, prejudices and discrimination are also culture specific.

Dr. Ravinder Singh presented the work of ICMR in last few decades and the proposed structure of priorities for mental health research. ICMR has carried studies in 7 major areas in past, viz. (1) Community mental health; (2) Phenomenology, natural history and outcome studies; (3) Mental health indicators; (4) Child and adolescent mental health; (5) Drug/substance dependence; (6) Suicide behavior; and (7) Mental health consequences of disasters.

ICMR did first large scale epidemiological study in Agra in the 1960s; study on childhood disorders in 1960s; the DST-ICMR severe mental morbidity study focusing on integration of mental health in primary health care in 1970s; the strategies for mental health research initiative of the 1980s in which new knowledge regarding acute psychosis, course and outcome of schizophrenia, psychiatric problems in old age, community level prevalence of drug abuse, human resource development for community mental health etc were focused; the setting up of the Centre for Advanced Research in Community Mental Health during 1980s to support the National mental health programme (NMHP) of the country; the study of child psychiatric problems in the community in the 1990s; initiatives on suicidal behavior and prevention of suicide; long term course and outcome of schizophrenia; study of incidence of schizophrenia; mental health effects of disasters (Bhopal, Marathwada, Gujarat, Tsunami, Orissa Super Cyclone); and Urban Mental Health Problems and Service needs. India has

research gaps in form of manpower & infrastructure shortage; evidences for management of schizophrenia & acute psychosis; relationship between Health &



behavior; models of community care; and alcohol and substance/drug abuse. World over different strategies have been suggested to carry research in mental health areas. According to one Group this can be broadly divided into two categories and there is need to (1) prevent mental disorder and disability and promote wellbeing, based on better understanding of causes, risk levels and new approaches to early preventive interventions; and (2) accelerate research and development aimed at providing new, more effective treatments for mental illness, and implement them more rapidly. The recommendations by other Group fell into three domains: (1) pursue high priority research questions as a unified agenda on sustainability; (2) advance methods for sustainability research; (3) advance infrastructure to support sustainability research.

Vision 2020 Document prepared by ICMR suggested to reduce the incidence, prevalence & burden of mental and behavioural disorders; develop & evaluate the mental health services so that they become available and accessible to the total population; enhance the positive mental health of the population; create structures to promote long-term mental health research; and involvement of Communities & Dissemination of mental health information. Strategies to research in mental health can be broadly divided into four categories:

- (1) Research at Health Care Settings- the study of systems and help seeking behavior of the people at primary, secondary and tertiary care level;
- (2) Developing New Knowledge- We need to study course of outcome of different mental health problems, research on vulnerable and special populations like women, children, older persons, and persons with disabilities. We need to develop database for the free access of students, researchers, academicians, health care providers and policy makers;
- (3) Monitoring and involving communities- indicators and burden of mental health problems needs to be focused on. The interventions at the population level involving communities are very crucial to manage problems like substance abuse or drug abuse;

(4) Capacity Building for Research-we have been constantly facing shortage of the researchers in addition to the specialists in mental health. This requires focused approach by developing institutions, course/teaching modules, trainings and knowledge enhancement. A dedicated institute for research on mental health is long pending.

Dr. Shekhar Saxena shared his views through video-conferencing. He presented on “WHO Priorities on Global Mental Health”. Mental-health disorders are the leading causes of disability worldwide. Nearly 30% of people around the world experience a mood, anxiety or substance-use disorder in their lifetime. The resources required to address these conditions are inadequate, unequally distributed, inefficiently used and static². The widespread incarceration of people with mental-health disorders persists. The burden and impacts of mental health disorders are large and widespread. Social and economic costs are high. The need and demand for mental-health care is increasing as vulnerable populations expand. Notable are the tens of millions of migrants fleeing persecution, conflict and violence, as well as the survivors of Ebola and other recent threats. Human resources are extremely limited especially in LMIC. Yet there are only 9 mental-health providers per 100,000 people globally; an extra 1.7 million mental-health workers are needed in low-and middle-income countries alone. Stigma and discrimination is a serious barrier. Financial allocations are very low. Innovations are the key to move forward. Grand Challenges in Global Mental Health initiative, called for an equitable and global approach to reducing the burden of mental disorders. The visibility of the issue has come a long way since then. And although there continue to be problems with the delivery of mental-health services, funding for research and innovation in mental health in low- and middle-income countries has increased substantially (albeit from a small base).

Top five challenges as identified by Grand Challenges in Global Mental Health (Nature, July 2011) are:

- (1) Integrate screening and core service packages in PHC;
- (2) Reduce the cost and improve the supply of medications;
- (3) Provide effective and affordable community based care;
- (4) Improve children's access to care; and
- (5) Strengthen mental health component in training of health personnel.

Evaluate the outcomes of treatments. Globally, we lack adequate information on the impact of services because clinics and health systems often lack the funding, capacity, motivation and protocols for monitoring and evaluation. Rarer still is a mechanism for using the results of evaluation to improve services. So people need to be trained to monitor and evaluate new and established approaches. Collaborative research networks can facilitate this kind of capacity building. The WHO Mental Health Action Plan sets out six global targets to achieve by 2020. For example, it calls for a 20% increase in service coverage for severe mental disorders and a 10% reduction in suicide rates globally. Mental-health advocates, clinicians and patient groups in each country must track progress towards these targets.

Internationally, there are some developments for inclusion of mental health and wellbeing in SDGs. There is visible increase in international funding for research in mental health. Political support is now available in many countries. World Bank has also extended its support for funding in mental health research. User movements are happening across different places and forcing governments to take appropriate actions.

“WHO mhGAP Intervention Guide” launched in 2010 based on systematic review of evidence. It nats for support for for non-specialized staff in low resource settings. Actions includes pharmacological & psychosocial interventions. It is now used in more than 80 countries in 19 languages. Electronic (e) and Mobile (m) versions will be available before end 2016.

Comprehensive Mental Health Action Plan 2013-2020
Vision A world in which mental health is valued, promoted and protected, mental disorders are effectively prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigma and discrimination.
Cross-cutting Principles

Universal health coverage	Human rights	Evidence-based practice	Life course approach	Multi-sectoral approach	Empowerment of persons with mental disorders and psychosocial disabilities
<p>Goal To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders</p>					
<p>Objectives and Targets</p>					
<p>1. To strengthen effective leadership and governance for mental health</p> <p><i>Targets 1.1 and 1.2</i></p>	<p>2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings</p> <p><i>Target 2</i></p>	<p>3. To implement strategies for mental health promotion and prevention in mental health</p> <p><i>Targets 3.1 and 3.2</i></p>	<p>4. To strengthen information systems, evidence and research for mental health</p> <p><i>Targets 4</i></p>		

Dr. Smita Deshpande shared her views on “Assessing outcomes of health care services for mental health problems: Role of DHR-ICMR”. According to Murthy (2004), the ICMR has contributed in the areas of Drug dependence; Public interest litigation to address the human rights of the mentally ill; Setting up of community mental health care facilities; Disaster mental health care; Movement of family members (care givers) of mentally ill individuals; Suicide prevention; and Research in depression, schizophrenia and child psychiatric problems. Government of India has launched National Mental Health Policy in 2014. The Policy’s objective is to provide universal access to mental health care by enhancing understanding of mental health and strengthening leadership in the mental health sector at all levels. This policy does not reduce mental health interventions to merely disease and disability prevention and it takes into account the need for all stakeholders to work synergistically and achieve common policy goals. The long term Vision and Goals of this policy document are: - promoting quality of life of the mentally ill persons (PWMI) and carers – towards a sensitized society, respectful of the dignity and personhood of the PWMI – access to quality, equitable and affordable mental health services–interventions towards prevention of mental illness and their disabilities and promotion of positive mental health–strengthening professionals capacities–strengthening people’s roles in mental health. The Policy document has attempted to broad-base the perspectives on mental health–the variety of determinants, the needs of diverse vulnerable populations, the requirements for a variety of care models to respond to these needs and the particular lacunae present in the public health system, in the context of a system level response required. National Mental Health Programme (NMHP) was launched by the Government of India in 1982. NMHP strives to ensure availability and accessibility of minimum mental health care for all in the near foreseeable future, particularly to the most vulnerable sections of the population; to encourage mental health knowledge and skills in general health care and social development; to promote community participation in mental health service development and to stimulate self-help in the community.

Among various goals, one of the goals of research by DHR-ICMR should be review of the National Mental Health Policy and National Mental Health Program. Specific measurable

outcomes should be identified and some external agency should be given this task. At present there is no nodal agency to assess/evaluate outcomes.

DHR-ICMR should also undertake Implementation Projects as ‘ongoing evaluations’ and as clinical trial mode with defined outcomes. Research training should be imparted and research partnerships needs to be created. There should be research incentives for the institutions as well as individuals.

Effective intervention programs from all over India need to be compiled as Best Models. Cafeteria approach should be adopted for different regions and communities as one size cannot fit all in this diverse country.

Collaborations are required for sharing resources and knowledge. Site specific models need to be made and evaluated. Industry can be involved through partnerships and corporate social responsibility (CSR). Foster partnership with Ministry of Ayurveda, Yoga, Unani, Sidhha and Homeopathy (AYUSH). Clinical trial models should be developed for non-medical interventions.

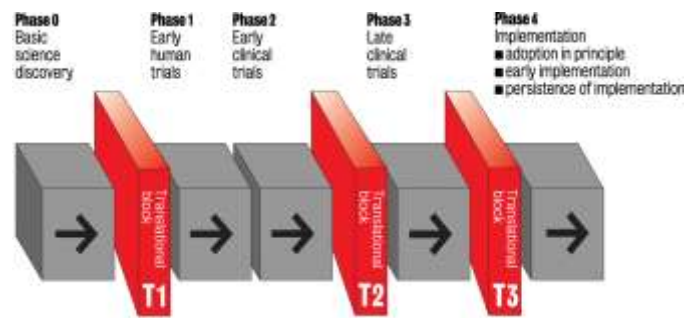
Smaller skill development programs to be initiated. Internet based programs may be launched for good mental health practices with ongoing evaluations. Graduates or family members of mentally ill can be trained for minor problems. Mental health should be promoted in the community. Reintegrating mentally ill persons into job market is huge task and suitable jobs should be identified for such persons through Government-Industry interactions.

DHR-ICMR should support and fund registries and long term follow-ups of the research project at the larger level. Specific registries should be developed for suicide, road trauma and children’s issues.

Top 5 challenges ranked by disease-burden reduction, impact on equity, immediacy of impact and feasibility.	
Challenge	
1	Integrate screening and core packages of services into routine primary health care
2	Reduce the cost and improve the supply of effective medications
3	Improve children’s access to evidence-based care by trained health providers
4	Provide effective and affordable community-based care and rehabilitation
5	Strengthen the mental and neurological health component in the training of all health-care personnel

Dr. Vikram Patel shared his experiences on implementation research in mental health in India. A recent initiative, led by the Global Forum for Health Research and the World Health Organization (WHO), was aimed to assess research resources and capacity and describe the current research agendas, priority-setting, and impact of research on policy. Six regional teams implemented a common protocol; the South Asian team was led by Dr. Vikram Patel and included partners in Pakistan, Sri Lanka, Bangladesh and Nepal. This study concluded that the South Asian region suffers from very inadequate mental health research resources in terms of both financial support (funding for individuals and institutions) and professional support (e.g. involvement in research networks, access to the literature, training in research methodology). Though some examples of research impacting policy are available, in general there is little interface between research and policy. The project has identified the major mental health research priorities and resources for the region, which are shared by both researchers and stakeholders; this agenda needs to be implemented through a concerted effort to build research capacity, improve the communication of findings to a wide range of stakeholders (in particular policy makers), and advocate for research resources in the region.

The best developed framework describing the development of new therapeutic interventions is that which refers to pharmacological drug discoveries. By combining these various formulations we propose a



single overall schema, which consists of five phases (0–4) and three translational blocks (T1–T3), as shown in the figure here (Thorncroft 2011). The overall purpose of translational medicine is ‘to test, in humans, novel therapeutic strategies developed through experimentation’ (Marincola, 2003).

To fill the gap for quality research, the non-governmental and not-for-profit organisation called Sangath was founded in 1996. It is headquartered in Goa, and operating in 6 states.

Sangath has expertise in development and evaluation of task-sharing and collaborative care for mental disorders. It is ranked in the top 5 public health research institutions in India (RCUK) and awarded 2016 Public Health Champion of India award by WHO.

Sangath is committed for improving health across the lifespan by empowering existing community resources to provide appropriate physical, psychological and social therapies. Its primary focus areas include child development, adolescent and youth health, and mental health and chronic disease. It began as Goa's first multi-disciplinary child development clinic based in Porvorim through the voluntary contributions of its seven founder-members. Sangath has now stretched its reach to become one of the state's most influential health NGOs garnering local, national and international recognition. Over the years, it has shifted to a public health model to increase the coverage of basic interventions for child development, adolescent health and mental health. The major barriers to accessing healthcare include an emphasis on providing care in medical settings, the lack of specialists and high costs of medical care. A key element is to strengthen state and private sector services by integrating affordable and effective interventions to ultimately scale up through sustainable health systems. Sangath is empowering low-cost human resources with knowledge and supervision to improve access to healthcare for children with developmental disabilities, adolescents and young people, or people with any form of mental disorder. Training and supervising low-cost human resources is one of the inventive strategies, and examples its work using this method include: (1) Training lay people, called as health counsellors, to deliver psychosocial treatments for depression in adults attending primary healthcare centres or for schizophrenia in community settings; (2) Training lay people or teachers, called as school health counsellors, to deliver a package of interventions to promote the health and educational outcomes of adolescents in schools; (3) Integrating learning resource rooms and remedial education in mainstream schools to promote inclusive education for children with learning disabilities (such as LEL and Prayas); and (4) Training community outreach workers to promote the mental health of people living with HIV and their caregivers.

Guiding principles of Sangath are: (1) Multi-disciplinary interventions - a mix of social, psychological and medical interventions is needed to improve the health of our community. The collaboration of diverse academic and health disciplines is likely to generate the most effective treatments; (2) Linking services with research - Sangath insists that its work be based on the best evidence available, which is thoroughly evaluated and then disseminated; (3) Participatory methods - beneficiaries are engaged and involved to work actively; (4) Inter-sectoral collaboration - Sangath believes that existing community resources, especially those in the public sector, provide the most sustainable setting for delivering interventions. Collaborative framework involves key partnerships with government health services, department of education, schools, other NGOs and the Goa Medical College; and (5) Scaling up - Sangath has dream to develop a model of care which can be scaled up through government machinery. Sangath engages constantly with policy-makers right from developing our projects to disseminating our findings to achieve this goal.

Sangath is a nodal agency for the National Trust for the Welfare of Persons with Autism, Mental Retardation, Cerebral Palsy and Multiple Disabilities. Sangath has been awarded the MacArthur Foundation's International Prize for Creative and Effective Institutions in 2008 in recognition of our work. Notable studies conducted by Sangath include:- the Home Care Trial: Community based carer support intervention for families affected by dementia (PLoS One 2008); MANAS: Collaborative stepped care for depressive and anxiety disorders in primary care (Lancet 2010); COPSI: Community based psychosocial intervention package for chronic schizophrenia (Lancet 2014); PASS: Parent mediated communication intervention for autism (Lancet Psychiatry 2015); and PREMIUM: Two novel brief psychological treatments for severe depression and harmful drinking in primary care attenders (under review). Ongoing trials are:- SHARE: peer delivered cognitive behavioural intervention for maternal depression; DIL: indicated prevention of depression in high risk older people; CONTAD and SAFE: Two novel interventions for community based detoxification and supporting families affected by alcohol dependence; PASS Plus: modular intervention for autism, including management of co-morbidities; SEHER: Health promoting schools intervention to improve school social capital; SPRING: Integrated

package for promoting growth and development in newborns; and PRIDE: Trans-diagnostic psychological treatment for adolescents with emotional and behavioural disorders.

Some of the studies, which has been adopted by different states for their service care are: (1) PRIME - Collaborative care to DMHP across Madhya Pradesh; (2) INCENSE: community based care to rehabilitation of people discharged from mental hospitals in Pune and Tezpur; and (3) VISHRAM: low intensity psychological treatments for rural community in Vidarbha.

Sangath has the capability to carry out research, as it has established its place in implementation science looking at the priority and growing acknowledgment of importance of chronic diseases/NCDs/mental health. Increased funding for health research with stronger local players (e.g. DBT-Wellcome Alliance, DHR) can further strengthen the evidence base. Wider range of institutional players, many outside the traditional university/medical college sector, has been involved and would help in multi-disciplinary approach. There are increasing opportunities for capacity building.

Sangath is looking forward to support a network of advanced centres for population mental health research with agendas of epidemiological surveillance and implementation research. It can support technology innovations across the continuum of care. It can also help organizations from delivery to discovery science, in particular related to the development of novel interventions.

Recommendations of the Brainstorming

(1) Actions to be taken at ICMR Level:

- a. Development of a national level Mental Health Research institute under ICMR.
- b. Initiation of Research Training Programmes and development of Research Modules for Mental Health Professionals and Para-Medical Staff.
- c. Development of Softwares for Data Archiving at point of contact level and Registries.
- d. Status Paper on research in last five years for Annotated List of the potential study areas for researchers and fellows.
- e. Sharing of the ICMR Tools/Reports/Research Papers/Manuals/Modules on open platform.
- f. Collaboration of ICMR with MoHFW/WHO/World Bank for ongoing review of NMHP, Regional Priorities and Social Determinants.

(2) Specific Research Areas

- a. Intervention/Implementation Research to address unmet public health needs.
- b. Standardization of outcome measures at Individual and Community level.
- c. Integrating the Yoga Lifestyle for preventive and promotive mental health.
- d. Mental health intervention for non-communicable diseases.

Annexure I**Agenda**

Timing	Topic	Speaker
10.00 am-10.05 am	Welcome	Dr. D.K. Shukla
10.05 am-10.10 am	Inaugural Address	Dr. Soumya Swaminathan
10.10 am-10.15 am	Introduction	Dr. Bela Shah
10.15 am-10.20 am	Mental Health Research at ICMR & Draft Document on Mental Health Research Priorities in India	Dr. Ravinder Singh
10.20 am-10.30 am	WHO Global Priorities for Mental Health	Dr. Shekhar Saxena (Through Video-Conferencing)
10.30 am – 10.40 am	WHO Regional Priorities on Mental Health	Dr. Nazneen Anwar- WHO
10.40 am-10.50 am	Research directions on prevention of mental disorders & promotion of mental health	Dr. R.S. Murthy
10.50 am-11.00 am	Research directions on early identification, diagnosis & clinical management	Dr. Pratap Sharan
11.00 am-11.10 am	Assessing outcomes of health care services for mental health problems	Dr. Smita Deshpande
11.10 am-11.20 am	Developing guidelines for consensus among Psychiatrists	Dr. Ajit Avasthi
11.20 am-11.30 am	Research directions on feasibility & effectiveness of mental health service models	Dr. S.C. Tiwari
11.30 am-11.40 am	Research through NGOs & CBOs	Dr. Thara Srinivasan

Brainstorming on Prioritization of Mental Health Research

11.40 am-11.50 am	Matching research priorities with NMHP	Dr. Alok Mathur
11.50 am-12.00 noon	Research on task sharing & collaborative care	Dr. Vikram Patel (Through Video-conferencing)
12.00 noon-12.10 pm	Sharing the Views	Dr. Vishwajit Nimgaonkar (Through Video-conferencing)
12.00 noon-01.30 pm	Discussions	
01-30 pm-2.00 pm	Recommendations	

Annexure II**Delegates who participated in Brainstorming**

Sr. No.	Name	Organisation
1.	Dr. Soumya Swaminathan	Secretary, Deptt of Health Research (DHR) & Director General, Indian Council of Medical Research (ICMR), Ministry of Health and Family Welfare, New Delhi
2.	Dr. Rakesh Kumar IAS	Sr. Deputy Director General (Administration) Indian Council of Medical Research, Ansari Nagar, New Delhi
3.	Ms. Ritu Dhillon IAAS	Sr. Financial Advisor Indian Council of Medical Research, Ansari Nagar, New Delhi
4.	Dr. Bela Shah	Head (NCD) Indian Council of Medical Research, Ansari Nagar, New Delhi
5.	Dr. D.K. Shukla	Scientist G Indian Council of Medical Research, Ansari Nagar, New Delhi
6.	Dr. Shekhar Saxena	Director Department of Mental Health and Substance Abuse World Health Organization CH-1211, Geneva, Switzerland e-mail saxenas@who.int Phone- 41 22 7913625 http://www.who.int/mental_health/en/
7.	Dr. Nazneen Anwar	Regional Advisor World Health organization SEARO

		anwarna@who.int
8.	Jorge A. Coarasa	Economist, World Bank
9.	Dr. Tripti Khanna	Division of NCD Indian Council of Medical Research (ICMR), Ansari Nagar, New Delhi
10.	Dr. Ravinder Singh	Division of NCD Indian Council of Medical Research (ICMR), Ansari Nagar, New Delhi
11.	Dr. Deepika Saraf	Division of NCD Indian Council of Medical Research (ICMR), Ansari Nagar, New Delhi
12.	Dr Vikram Patel	Professor of International Mental Health at London School of Tropical Medicine, Wellcome Trust Senior Research Fellow in Clinical Science, Co-Director of CCCI & Director CMH, PHFI
13.	Dr Thara Srinivasan	SCARF (NGO)
14.	Dr R S Murthy	NIMHANS/WHO
15.	Dr Pratap Sharan	Professor Deptt of Psychiatry All India Institute of Medical Sciences (AIIMS) Ansari Nagar, New Delhi
16.	Dr. B. N. Gangadhar	Director and Vice-Chancellor National Institute of Mental Health and Neurosciences (NIMHANS) Hosur Road, Bengaluru (Karnataka)
17.	Prof. Ajit Avasthi	Professor and Head Deptt of Psychiatry Post-Graduate Institute of Medical Education and Research (PGIMER)

		Sector-12, Chandigarh
18.	Prof. S.C. Tiwari	Professor and Head Deptt of Geriatric Mental Health King Georges's Medical University (KGMU) Lucknow
19.	Dr. Deepak Kumar	Acting HOD, Deptt. Of Psychiatry, Institute of Human Behaviour and Allied Sciences, Dilshad Garden, Delhi
20.	Dr. N.G. Desai	Psychiatrist, Delhi
21.	Dr. K.S. Jacob	CMC Vellore
22.	Dr. Smita Deshpande	Professor and Head Deptt of Psychiatry RML Hospital and Post-Graduate Institute of Medical Education and Research (PGIMER) , New Delhi
23.	Dr. Alok Mathur	Chief Medical Officer Directorate General of Health Services (MoHFW) Nirman Bhawan, New Delhi
24.	Dr. Johann Ebenezer	Padhar Hospital, Betul Distt. MP
25.	Dr. Vishwajit Nimgaonkar	Pittsberg University, US
26.	Dr. Hamid Dabholkar	Parivartan Trust, Satara and Pune

Annexure III

Discussion Note:

Prof. R.Srinivasa Murthy, Email: smurthy030@gmail.com

Sub: Research Direction on Prevention of Mental Disorders and Mental Health Promotion

Research to Increase understanding of Mental Health	Research to Develop MNH interventions	Research to Evaluate the impact of MNH interventions
Child Trauma and adult mental health	Maternal depression	Life skills education in schools and colleges
Alcohol policies	Early childhood interventions in institutional settings /Anganwadis/ Families	Disaster / Conflict mental health
Gender violence	Workplace mental health	Suicide Prevention
Social change and mental health	Mental health promotion of caregivers	Yoga/Meditation
Mass media and mental health	Mental health promotion as part of care of diabetes/ CVD/ COPD/ Cancer/ elderly care	Complimentary medical approaches for MNH
Spirituality and mental health	Fighting stigma of mental health issues	Role of non-specialists in MNH
Mental health of vulnerable groups	Mobile applications for self care/ mental health	
Life course studies		
Mental health tools for measurement		
Development and mental health		

Annexure IV

**Suggested Topics for the Mental Health Research
(Brainstorming on Prioritization of
Mental Health Research on 12-05-2016)**

Dr Deepak Kumar,
Acting HOD Psychiatry
& DMS, IHBAS, Delhi

- Suicide Prevention and Assessment of Preventive strategies customized to the local needs.
- Child abuse and its Neuro-Psychiatric impact and preventive strategies in this regard
- Suitability of e Systems (Digital health services) for the Mental Health Services Delivery in India
- Preventive strategies for Neuropsychiatric disorders like Dementia with specific focus on Lifestyle changes and Nutritional factors
- Peri-natal Psychiatry: Focus on maternal and child health related preventive strategies as part of Rural Mental Health programme
- Focus on socially relevant issues like Domestic violence, Road rage, farmers suicide etc
- Workplace Stress- sources, impact and the management as part of Occupational safety