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Retrospective analysis of the program Suraksha Community Based Rehabilitation of person with mental Illness and empowering the affected families' Social Justice-Psychiatry MC.TVM pilot project at a rural block Panchayat in Kerala, S. India 2019

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Abstract:
Background: Psychosocial Rehabilitation of Persons with Mental Illness (PMI) is a challenging practice and the life of the people is limited in the rehabilitation centres lifelong. It results in limitation of their social life and community involvement. In 2016 Govt. of Kerala approved a pilot project proposal of Psychiatry Department of Govt. Medical College, for Community Based Rehabilitation (CBR) of PMIs and empowering their families to care the persons with Mental illness. It was a model to care PMIs at their community and develop mental health system at rural areas through Local self Governments. It is implemented at Chirayinkeezh Block Panchayat in its six Grama Panchayats. The Mental health services existed in the project area were service of One Psychiatrist at Taluk level Hospital and a visiting Psychiatry team once in a month in one of the Grama Panchayat Health centre. The project was finished by March 2019. This study was conducted as an evaluation of the pilot project to submit to the State Government. **Materials and methods:** Analysis of the Project proposal, action plans and five finger approach used for the fulfilment of the objectives, Interview with leaders of Local Self Governments, visiting primary Health Centres, Suraksha Clinics and the homes of the beneficiaries were used for the study. Secondary data of Documents, Registers, Action plans, Intervention Protocols, Reports and observational visits were used to evaluate the programme implementation, Functions of Suraksha Clinics, Service provided, Out-reach and sustainability. Interview with key persons and Focus Group Discussion of stake holders and beneficiaries were also conducted to assess sustainability of the programme.
Results: The project analysis showed that Community Based Rehabilitation of persons with mental Illness and empowering the affected families' is satisfactorily done through Local Self Governments with the Technical Support of Psychiatry Department at Govt. medical college
Conclusion: The Suraksha Community Based rehabilitation of the Person with Mental Illness and empowering the affected families is a locally sustainable model of Rehabilitation of PMIs under Local Self Governments utilizing the provisions under Panchayat Raj act 1992 and RPWD act 2016
Key Words: Person with mental Illness, Community Based Rehabilitation, Local Self Government, primary health care

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I. INTRODUCTION

Mental Illness and its management is an important Global Public health issue. According to World Health Organization, more than 250 million people are suffering from mental illness and in which 24 million people suffer from schizophrenia. The World Bank studies revealed that mental illness is a major cause of lost years of quality life in the world.[1]

The notions on mental illnesses and its management practices are passed through many changes from the dark ages to modern era. In the pre historic period (8000 BC to 500 BC) management of mental illness was unscientific and inhuman like trepanning, that is drilling the skull to drive alien spirits from the body to treat insanity. Curse of God or possession of demons were believed as causes of mental illness and stated that man behaving like animals should be handled like animals. Torturing the mentally ill was justified as not torturing the man but the possessed evil force.

The remarks about mental illness are dates back to ancient Egyptian medical text Eber Papyrus (1550BC). Mental disorders, depression and dementia are detailed in the Chapter Book of Hearts.[2] Faith healing and exorcism was prevailed as the treatment for mental illness. [3] In 6th century BC Greek temple of Asclepius treated psychosomatic illness.[4] Greek sanctuary at Epidauros is considered as the earliest form of mental hospitals.[5] Hippocrates(460 BC- 370 BC) the ancient Greek philosopher proposed that mental illness have natural origin as in any other disease and described melancholy, psychosis and phobias. He asserts that brain is the destination of mind and intelligence. [6]

Apart from western belief of Demons, evil forces and treated by exorcism. The Muslim scholars of that time including IBn Sina and Avisenna, the founder of modern medicine rejected such notions. The first Mental Hospital built in AD 705 by al Razi in Bagdad was followed by Cairo in AD 872 and in Damascus in 1270.[7]

The St. Mary Bethlehem hospital started at London in 1247 admitted mentally ill patients in 1377. It was nick named as 'Bedlam' and it became the most notorious with its infamous history. Patients were used for public amusement. In 15th century Hospitals started at Spain and France. The living conditions were neglected at these hospitals and hall marked with unhygienic conditions, mal nutrition, poor clothing, overcrowding. Patients were restrained and treated equivalent to criminals and were kept with them. Attempts for treatment were crude, strange and abusive till 19th century.[8]

The asylums and so called hospitals denied the freedom and dignity by incarceration without clothes and food but instead gave brutal physical abuse and showcasing. This pathetic scenario roared attention for compassion to the mentally ill and need for humanitarian approach. In 1797 William Tuke started the 'York retreat' treatment centre at Lame Hill in England and proposed humanitarian approach.[9] In 1801 Philp Pinel in France initiated 'moral treatment' by banning the use of chains and shackles of patients at Bicetre insane asylum.[10] This 'moral treatment' for patients emphasized on open ward settings, pleasant surroundings, minimal restrain, regular activity and a familial relationship between the healers and the patients in the hospitals. During 1841-45, Dorthea Dix freed mentally ill patients cared at Jails and Government established facilities for the care of the insane in USA.[11] The Mental patients were treated inhumanly, denied their Rights and were always discriminated. Compulsory sterilization of these patients were prevailed for a long time in USA and by 1940 a total of 18552 patients were surgically sterilized to prevent the progeny.

The drug chlorpromazine developed at France in 1955 made a revolutionary change in Psychiatric treatment. The cure rate increased but the continuance of the stabilized at the hospitals were increased, as their family abandoned them and accumulated at the hospitals. A movement against drug alone management and the economic recession prevailing at the time lead to deinstitutionalization movement of mentally ill persons and caused the evolution of the Community Psychiatry in USA propagated to different parts of the world. But the community and family of the affected were not equipped to manage them and mostly abandoned. It raised reverse issues and reinstated institutional care. This pendulum swing phenomenon expressed everywhere in the world.[8]

In ancient India, patients were managed at temples and shrines. The treatment of diseases was an extension service of the priests. Priests treated the mentally ill with magico-religious rituals. Exorcism, incantations, prayer, atonement and other various mystical rituals were used to drive out the evil spirit. Water, soil and solaced materials were used. Wearing such cord and rings as a remedy for mental illness is existed and still existing at various degrees. Patients were managed at temples and shrines. Ayurveda emphasized on prevention of Mental Illness and for healthy lifestyles, as in Charaka Samhitha.[11] The Chronic mentally ill patients were cared for in various temples and religious institutions in South India. The Islamic mythology of "Jinn" is concerned with the hallucinations and Psychoses. It is used to treat by religious heads using the solaced water, cord, soil and pleasing things to mosques and infiltrated in the culture.[12]

The earliest record of institutions for the care of mentally ill in India can be traced back to the-reign of Md. Khi|ji in the 15th century. There existed at that time, such an institution at Dhar, near Mandu in Madhya Pradesh (Varma.1953). Mental hospitals or asylums were entirely a British conception. Therefore, the evolution of mental hospitals in India was greatly influenced by British psychiatry and catered mostly to European soldiers posted in India at the time. [8]

The English started mental asylums; Surgeon Kenderline started one of the first asylums in Calcutta, in 1787. In 1795, a lunatic asylum was established at Monghyr of Bihar for insane soldiers. The first mental hospital in South India was opened at Kilpauk, Madras in 1794. The guiding principle behind these asylums was to separate mentally ill persons from the mainstream of the society. The Bangalore Lunatic Asylum was started in 1847at the time of British Commissioner Sir Mark Cubbon, was a model with higher standards of care freedom and Occupational Therapy. The Lunatic Asylum Act 36 of 1858 which was later modified to form Indian Lunacy Act 4 of 1912 aimed at establishment of new ones and improvement of old ones. The Central Institute of Psychiatry established in 1918 at Ranchi. In 1920 the name lunatic asylum was changed to mental hospital. The hospitals were remained as custodial care centres and were over crowded.[8]

In 1946 Bohr Committee suggested for the improvement of Mental Hospitals, The Indian Lunacy Act 1912 replaced with mental Health Act 1987 with the technical support of Indian Psychiatric Society. [13, 14]

National Mental Health Program was launched in 1982 to address the heavy burden of Mental illness and inadequate mental health infra structure by assuring minimum mental health care, application of mental health knowledge in general health care and social development and to promote community participation. The merging of State Mental Hospital Bangalore and All India Institute of Mental Health clubbed together and formed National Institute of Mental Health in 1974, which was a milestone in the history of Indian Psychiatry. In 1996 District Mental Health Program was launched under NMHP in order to attend early detection and treatment, Training to general physicians for primary management of mental illness, and to create public awareness and monitoring.[15]

The Mental Health Centres followed modern treatment and occupational therapy for addressing psychological health. But the means for community participation and social integration were not planned. The Chronic patients, who were staying for a long period in the treatment centres, resulted in stagnation with overcrowd. The patients discharged from mental hospitals were unprotected. Admission of new cases were challenged and forced to limit to Outpatient service. More and more patients were detained at home without treatment or abandoned. Guptha et.al study in 1968 on Rehabilitation needs among the psychiatric patients stayed for a period longer than two years at a stretch at Hospital for Mental Diseases in Ranchi, found that 60 % of the beds occupied by chronic patients and among them only 6.5 % were needed to stay at hospital. 71.5% needed limited hospitalization and were capable of productive work under supervision and 22 % patients were staying at hospital only for social reasons and hospitalization was not necessary.[16] it pointed out the need of Psychiatric Rehabilitation.Nagaswamy et al assessed rehabilitation needs of schizophrenic patients and posed occupational training as part of Psychiatric Rehabilitation to enable the life at community.[17] The Rehabilitation Centres in India were satisfied only the minimal needs-Level 1 and 2 of Maslow's hierarchy of Needs.[18]

By the end of 19th century, Christian Missionaries and rehabilitation Groups started its work in India. Catholic and Protestant Christians have established numerous homes throughout India for the abandoned, the abused and the exploited. The mentally ill were cared at Mental Hospitals. Those who were come out of the hospitals were accommodated in the destitute homes and restrained.[19]

In south India Mentally Ill were kept restrained at homes or at 'Worship centres such as Ervady, Beema Pally and Chottanikkara Temple . The special centres for destitute mentally ill were started in Kerala followed by the socio political developments and decline of poverty. The centres for Road side destitute started at different parts of the country by Christian Missionaries. The foreign organizations like Congregation of the Hospitaller Sisters of the Sacred Heart of Jesus started centres in India and at Kerala. These groups and congregations started to admit the destitute mentally ill at their orphanages and other charitable homes. Sister Dr. Mary Litty follower of Saint Guiseppe Benedetto Cottolengo started Little House of Divine Providence at Kunnanthanam Thiruvalla in 1978. This home cared persons with Disabilities including Mental illness. [20]

In 1980s Churches in Kerala initiated special centres for destitute mentally ill. Priests were assigned this purpose. The works of 'George Kuttiykkal Achan' a priest started centres for destitute mentally ill persons from the street and named Akasha Paravakal. Many of these centres are still working at a good level. Chronic Psychotic people were either in the Mental Health Centres, under home custody or were straying wayside. In these years the charismatic movement started in the country and especially in the Southern state of Kerala. Apart from missionaries more and more lay man called 'Almeyan' followed the path of Biblical treat and care of the destitute and mentally ill. The beginning was difficult and struggled to provide shelter and food timely. Many persons convert their own homes as the home for the mentally ill. In the mean time, a group of people from Kerala who were with mother St. Theresa returned to Kerala and started homes for destitute mentally ill at the places Senkulam in Idukki, Waynad and Marayoor.[21]

These Rehabilitation centres were heterogeneous in nature with inmates of multiple disabilities but the management was common. The infrastructure was poor especially at the centres started by individuals at the beginning. The psychiatric management was not followed strictly or there were no such management and these centres were mostly overcrowded. The Police also used to put the straying people in these centres; as there is no other means. [22]

In Kerala, the conditions of mentally ill patients were pathetic at the Mental Health Centres. In 1980s, the Human Rights activists organized under the leadership of Poetess Sugatha Kumari Teacher. The Human Rights movement agitated the public conscious and court ordered for enquiry. Justice Narendran was appointed for the enquiry and for submits recommendations. Government acted favourably and quickly, and brought the human face of the Mental Health centres. NGOs and Companies were also in support. The stable and recovered patients have no means to send to their family, as most of them were abandoned from their families.[23] The interventions resulted the starting of Rehabilitation Centres for cured mentally ill persons under Government Sector and three Ashabhavan at Thiruvananthapuram, Kozhikode and Thrissur were started under

Social Welfare Department. In the NGO sector The Psycho Social rehabilitation centre "Abhaya" under the leadership of poetess Sugattha Kumari Teacher was also started with Government support.

In order to attend the Human Rights of mentally ill persons and to improve mental health services, the **United Nations General Assembly** adopted the principles for the protection of persons with Mental illness and notified them in 1991.[24] The emerging needs for rehabilitation and supportive suggestions paved the way for planned Psycho Social Rehabilitation of the mentally ill all over the world. Government of India assimilated these principles and incorporated Mental Illness as a Disability in the Persons with disabilities Act 1995.[25]

The conditions of the Mental Hospitals in the country were pathetic. According to National Human Rights Commission Report, 38 % of the Hospitals were similar to Jails.[26] World Health Organization and World Association of Psycho Social Rehabilitation done initiatives of finding the International Practices in Psycho Social/Psychiatric Rehabilitation published best practices in 1999.[27]

The custom of keeping mentally ill at the faith based mental asylum is being continued at different parts of the country. In 2001 August 6, occurred the 'Ervadi Moideen Badusha' mental home fire accident in which 26 mentally ill patients in chain were died in Tamil Nadu. It raised human right agitation, and Government stopped all such homes. Supreme Court appointed N Ramadas Commission in this regard and the commission suggested immediate measures to improve the Rehabilitation system in the state and as a result the Psycho Social Rehabilitation Rules under the PWD Act 1995 was formulated in the state of Tamilnadu. [28]

The World Association of Psychosocial Rehabilitation Indian Chapter was formed and the leadership was vested in Representatives from Kerala. Dr. T. Murali Psychiatrist at NIMHANS and Dr. Radha Krishnan were strived to coordinate and strengthen these centres. Government of Kerala appointed Dr. Radhakrishnan and Dr. Jayaram Committee to frame Guidelines for Registration of Psychosocial Rehabilitation Centres in accordance with Person with Disabilities Act 1995.[29]

The Kerala Registration of Psycho Social Rehabilitation Centres of the mentally ill persons Rules was framed in 2012. It assimilated major recommendations of experts on Psycho Social Rehabilitation and set standards for establishment and service of these centres. The Rules 2012, Standardization and Training Imparted a new momentum in the rehabilitation scenario but there were many hurdles before the centres to standardize and update these centres. In this background this study is planned to explore scope and limitations of the Psycho Social rehabilitation Centres in Kerala using a validated Check List, Interviews and by focus group discussions (FGD).[30]The centres for psychosocial rehabilitation in the state is now standardised with infrastructure and services. All the centres initiated pharmacotherapy and regular psychiatric examination. The lives of the inmates at these centres are away from social stream. The patients reaching at these centres are from streets wandered without any medication for long time or those who are sent from psychiatric hospitals, reached there, only in the later years of their life. Families of these patients are used to fail, to identify the mental illness in the beginning and seeking faith healing or denied treatment due to stigma and fear existing in the society. At the end they are become depended and put in Psychiatric Hospitals. This practice is inhuman and denial of rights of persons for treatment and right for living in the society with all civil rights and human rights (RPWD Act2016). It pointed out the need for a sustainable model of Community Based rehabilitation of PMIs.[31]The Panchayat Raj Act 1992 of India introduced Democratic Decentralization, to hand over power to local self governments to address the basic needs of the people at their premises and to take policies and schemes by peoples participation at local level. These two acts are opening great opportunity to Panchayats to plan and implement mental health programmes and provide community based rehabilitation to the Persons with Mental Illness. But there are no such initiatives as yet in the country. [32]

As part of psychosocial interventions, Department of Psychiatry developed an action plan for community based rehabilitation of the persons with mental illness and empowering the affected families. The model was examined by state Planning Board for feasibility and ethical aspects and was approved. As per the order GO (RT) 468/2016 SJD sanctioned fund for implementing the model Suraksha as a pilot project at Chirayinkeezh Block Panchayat. The pilot project implemented in 6 Grama Panchayats from 2016 October 10 to 2019March.The results and sustainability of the programme implemented is analysed in this study to submit to Government of Kerala for its state level application[33]

II. MATERIAL AND METHODS

This study was a retrospective analysis of the Suraksha CBR in terms of Organization, Service Components, outreach and sustainability of the model. The organization, service components, Resources and action plans of Suraksha CBR were studied. Evaluation of each component was done by analysis of secondary data-Documents and Registers, Reports, Check list based on objectives of the programme, and Interview schedule Focus Group Discussion were used for evaluation of the system and its sustainability.

Study Design: Retrospective analysis study
Study Duration: Period of study was from October 10th 2019 to March 2020.

Study Location:6 Grama Panchayats of Chirayinkeezh Block Panchayat consists of 51000 houses and 1.83 Lakhs were coming under the Pilot project.

Procedure

The Government order of Suraksha CBR instructed Monitoring and evaluation as pilot project. The monitoring committee assigned the analysis and evaluation to the researchers of this study in 2018. The project proposal, documents, Action plans and reports were permitted for the study. Interview schedule regarding the feedback of the project from stake holders, check lists based on objectives of the project, Tabulation forms for assess quantity of services provided, Observational visit for evaluating services at the clinics were carried out. Descriptive analysis used for data of services and targets accomplishment. Qualitative methods used to elicit feed backs and sustainability factors of the project. The conceptual frame works were examined. The project design, organizational structure, Technical support, Service components, mental health system developed under the project and measures taken to sustain the programmes were examined and analysed

Project Objectives

Suraksha Community Based rehabilitation and empowering the affected families- Model envisages Rehabilitation of the Persons with mental illness at their community and empowering care givers. It presents strategies and system development for Treatment and free medicine and other mental health services at Primary health centres and first referral Psychiatric Unit at the project area. Community level interventions- plan and strategies were given in the proposed model. The Community support was assigned through ward level CBR committees. Infrastructure development and expenses for medicines and human resources were assigned to LSGDs, the Panchayats. It conceived Community Based Rehabilitation and mental health services through Local Self Governments, by conglomerating the rights entrusted in Panchayat Raj Act 1992 and RPWD act 2016

Organizational structure

The Organizational structure as per the project design was as a Block level Body includes all elected members of the Block and Presidents of individual Grama Panchayats as the members. Block Panchayat President as chair man of the monitoring committee. The Block level task force was framed under the health standing committee and Block Level Medical officer was its Convenor. The Medical officers of PHC in each Panchayat, ICDS Supervisor, and Circle Inspector of the area, Assistant Education officer of the area and leaders of NGOs working in the area were also the members of the Block level task Force. The organization at Grama Panchayat is also in the similar members at Grama Panchayat and its President was the Chairman of the Monitoring Body. Implementation at Grama Panchayat was convened by Medical Officers of the PHCs utilizing all Health and ICDS resources.

Technical Support in Mental Health Services

The head of the Department of Psychiatry lead the project as its Director and the Social Scientist at psychiatry was the Nodal officer to act between Block Panchayat and Department of psychiatry. Training to Medical officers, targets, Action Plans, materials for training and service providing were developed by the Technical team. Two psychiatric Social Workers and One Coordinator having qualification at Graduation level were provided by the Block and Grama Panchayats for implementing the programme

Training

Capacity Building was the major objective of the programme to impart rehabilitation at primary health care. Medical officers were trained at psychiatry Department Medical College Thiruvananthapuram. The training modules used were WHOs training manual for primary care doctors and NIMHANS module.

Training was given to all ICDS supervisors and Anganwadi workers to identify the Persons with mental illness at their charge area. A handbook on mental health and mental health problems, role of field staff in Community based rehabilitation was developed and introduced. A basic Performa for as check list was used to enrol the beneficiaries.

Health Filed staff and ASHA workers of the project area was given on the basis of the hand book and specific roles of each category was developed by focus Group discussion and included in the handbook.

The psychiatric Social Workers and Grama Panchayat Coordinators were trained in supervising, service providing and link the services. Hand book and registers were introduced by Group discussion mode.

Service Components in Suraksha CBR

1. Identification of chronic PMIS at community
2. Psychiatric Examination
3. Training to Care Givers and Family

4. Free Medicines from PHC Suraksha Clinics
5. Psychosocial Interventions and psychological Support Services
6. Disability Certificate for Mental Illness
7. Suraksha mental health clinic at Taluk Head Quarters Hospital for follow up
8. Formation of Self help Association of patients and Care Givers
9. Assurance of Social avenues to the Psychiatric patients with Bench Mark Disability

Action Plan

Weekly action plans were prepared based on targets and field reports at the Nodal office. Supervision, monitoring and feedback were mandatory. Honorarium and remuneration were given as motivation for volunteer works.

Data Collection

Secondary data of Documents, registers, Action plans, Intervention Protocols, reports , observational visits were used to evaluate the programme, its implementation, Functions of Suraksha Clinics, Service provided, Out-reach and sustainability. Interview with key persons and Focus Group Discussion of stake holders and beneficiaries were also conducted

Table no1: Shows Sources of Data

Sl. No	Evaluating Component	Source of data
1	Organization and structure	Minutes and Records
2	Monitoring of the programme	Minutes
3	Identification of cases	Protocol Registers
4	Psychiatric medical Camps	Action plans and Case Registers
5	Training to Care Givers And empowering affected Families	Protocol Registers and Documents
6	Availability of Medicines from PHC Suraksha Clinics	Minutes Documents and Registers Observational visits
7	Psychological Services Counselling and Guidance	Documents and Registers Observational visits
8	Disability Certificate for Mental Illness	Protocol Documents Registers Observational visits
9	Suraksha mental health clinic at Taluk Head Quarters Hospital for follow up	Documents Registers Reports Observational visit
10	Formation of Self help Association of patients and Care Givers	Minutes Registers Visual Documents Report
11	Assurance of Social avenues to the Psychiatric patients with Bench Mark Disability	Applications Documents Registers Reports
12. SUSTAINABILITY ASSESSMENT (01.04.2019- 31.03.2020)		
1	Identification of new cases need Rehabilitation	Cases Registers Reports
2	Suraksha Clinics at PHCs	Cases Registers Reports
3	Suraksha Clinics at THQ Hospital	Monitoring Reports

4	Support to affected families and care givers by Home based services	Monitoring Reports
5	Regularity of Funding	Documents and Reports
6	Adverse Practices to sustainability	Observed outputs Interviews Focus Group Discussion

Data analysis

Descriptive statistics was used to compile and interpret system development and service output. Qualitative analysis was done for the information collected in interviews and feed backs

III. RESULTS

Suraksha – CBR of PMIs and empowering the affected families'- analysed the Programme in accordance with project proposal. The objectives and its satisfaction were cross checked. Observations in the project phase and in post project phase (sustainability phase) were analysed. Interviews and FGD Results used to elicit sustainability factors. Finding sand results are given below

The programme implemented in 6 Grama Panchayat under Chirayinkeeezh Block Panchayat as planned in the project Outreach population was 1.83 Lakhs, a total of 839 persons with mental illness identified and it was more than estimated in the project proposal. The project analysis showed that it completed its objectives successfully and established a sustainable mental health care system at Panchayat level. The major objective of identifying Persons suffering from Chronic Mental Illness and rehabilitated at their homes by giving training to the care giver at family. 839 PMIs identified are rehabilitated at their community. Community support is established with the help of 103 ward level Suraksha Committees under the elected representatives as chairman. 119 Elected members participated in orientation training programme. The Five Finger Approach used to provide Food, Shelter, Care Giver, Treatment and Medicine and Social avenues and Rights at their premises. Mental Health Clinics at 6 Primary Health centres started at these Grama Panchayats under LSGDs with the Technical Support of Psychiatry Department at Government Medical College, Thiruvananthapuram. 12 Doctors, 2 Psychiatric Social workers, 194 Health Field Staff, 174 Anganwadi workers and 6 Grama Panchayat Coordinators were trained. 1281 cases of common mental health problems identified and linked to Suraksha Clinics to prevent mental disability during the project period and continuing. The programme is running by the Panchayats and blocks Panchayats with their own fund and sustains locally.

System developed under the Suraksha CBR in the project area

1. Identification of Chronic PMIS at community

The action plan of the programme explained in the programme for identification of Chronic Mentally Ill Persons need rehabilitation at community. Trained Anganwadi workers visited house of known cases and collected details of service needed using a rehabilitation check list- covers food, proper housing, care giver at home, treatment& medicine, disability certificate, Disability pension and other social avenues endorsed.

2. Psychiatric Examination

Psychiatric examination of the identified persons was designed and conducted as psychiatric Medical Camp at Panchayat Level, with the support of Psychiatry department, Medical College Thiruvananthapuram.

3. Training to Care Givers of the patients

The Care givers of the patients needs training on care and management of the patients at home, medication, symptoms to be noticed, activities to be engaged, their rights and social avenues. It was planned in the programme as Training camps at Panchayat level & Direct Home based training

4. Free Medicines from PHC Suraksha Clinics

Availability of free medicine was a crucial issue. The mental Health team visit is only once in a month and in one of the Panchayat among six Panchayats and its accessibility was a problem. It was addressed in the programme by weekly Suraksha clinics started at each PHC under trained Medical officer and free medicines by Panchayats. Symptoms were monitoring at these clinics and referred to higher centres if it needs.

5. Psychosocial Interventions and psychological Support Services

The patients and care givers needs motivation and stress release support. The programme introduced the service of a Trained Psychiatric Social worker at Suraksha Clinics at PHCs, In addition to counselling and guidance. The Grama Panchayat Coordinators takes the Social worker to the homes of marked cases and providing Guidance and Counselling. The Psychosocial problems are addressing by a Psychologist at family Facilitation Centre under the Block Panchayat.

6. Disability Certificate for PMIs

Mental Illness is one of the Disability deserves for Disability and other rights reserved in RPWD act and for other social avenues. These provisions are based on Bench mark Disability (40%) and Disability certificate. The programme planned issuance of Disability Certificate at Disability Board at Taluk Head Quarter Hospital. Provision of a Voluntary Psychiatrist as part of the Programme was also assured in the programme

7. Suraksha mental health clinic at Taluk Head Quarters Hospital for follow up

The weekly Suraksha Clinic set at THQ Hospital is the first referral centre. Services of a Psychiatrist and psychologists are available at this centre.

8. Formation of Self helps Association of patients and Care Givers

The formation of self -help Association of patients and their care givers was imagined as part of the programme. It was focused for stigma reduction, community participation and act as a body to represent their needs and grievances to the LSGD and Government

9. Assurance of Social avenues to the Psychiatric patients with Bench Mark Disability

The RPWD act affirms that there will be special rights, schemes and programmes for the disabled population and it is the responsibility of appropriate Governments. A training Programme for ministerial staff at Block level was conducted as part of the programme and Grama Panchayat Coordinators were equipped to facilitate care givers in that level

Output of the project found in the Study

Table no 2: Shows mental health system developed under Suraksha CBR

Sl. No	Infra structure Developed	Number
1	Block Level Suraksha Clinic at THQH	1
2	Panchayat level Suraksha Clinic at PHCs	6
3	Family Facilitation and Preventive Clinic	1
4	Suraksha Nodal office at Block Office	1

Table no 3: Shows Human Resource developed under Suraksha CBR

Sl. No	Human resource Developed	Number
1	Trained Primary Care Doctors	12
2	Trained PSWs	2
3	Trained Health Field Staff	194
4	Trained Anganwadi Workers	174
5	Trained Graduate level coordinators (GPC)	6

Table no4: Shows Services rendered under Suraksha CBR

Sl. No	Services	Number	Self reliant*	Total
1	Identification of Chronic PMIs	673	61	839
2	Psychiatric treatment of PMIs assured	673	61	839
3	Free Medicines to PMIs	795	39	839
4	Training to care Givers-Group Mode	522	0	522
5	Training to Care Giver -Home Based training	312	0	312
6	New Disability certificate- issued	175	67	301
7	Community Care of Homeless PMIs	27	0	27
8	Application for Disability Pension registered	163	0	167
9	Palliative Psychiatry Cases attended	27	0	27
10	No of psychosocial Interventions for facilitating social Avenues	804	30	834
11	No of cases attended Suraksha clinics at PHCs	1281		
12	No of cases attended Suraksha clinics at Block Level Clinic(THQH)	432		
13	No of cases attended Suraksha Family Facilitation and Child Clinic	97		
14	Disability Certificate distribution (New)	175		

*Patients and families declared financially self reliant are taking private resources

Table no 5: Shows Sustainability of Suraksha CBR in the Post project Phase

Sl. No	Components	Status
1	Budgetary allocation for continuation of Suraksha CBR under LSGD	Allotted
2	Service of health field staff in monitoring old cases and directing new cases	Continuing
3	Service of Anganwadi workers reporting new cases and facilitating social avenues	Continuing
4	Ward level Monitoring Committees &Task Force	Slow progress
5	Panchayat level Committee & Task Force	Progressing
6	Block Level Committee & Task Force	Progressing
7	Suraksha Clinics at PHCs	Running
8	Block level Suraksha Psychiatric Clinic at THQH	Running
9	Palliative Psychiatry for Bed Ridden patients	stagnant
10	Block level Family Facilitation and Preventive Clinic	Running
11	Mental Health promotion and Prevention of Mental Illness in the community	Progressing
12	Early Detection of mental health problems	Progressing
13	Social welfare measures under LSGDs	progressing

Table 6 Adverse factors identified to the Sustainability of the Suraksha CBR and measures to be taken

Sl. No	Services	Preventive measures
1	Lethargy of administrative system	Orientation Programmes Time being Planning and Implementation
2	Change in Leadership in LSGDs	Orientation Programmes
3	Lack of transmission of vision and mission to successors	Role modelling and leadership
4	Personal interests	Build Team work and Group Dynamics
5	Local, internal and external influences	Follow strict guidelines in Education, Qualification and skills of the persons appointing
6	Lagging in funding process	Follow RPWD act 2016
7	Multi centred directives	Define roles and responsibilities and stipulate to practice
8	Degradation of quality in services	Utilize the service of a Nodal agency in Mental Health
9	Lack of capacity in performing roles	Training , Find new Hands
10	Deficit in materials	Seek Corporate Social Responsibility and NGO support

IV. DISCUSSION

The programme was designed with an average estimation of about 700 cases on the basis of prevalence of Chronic mentally ill patients found in state disability census in 2015. While implementing the programme, a total of 839 persons with chronic mental illness identified in the target population. The training to ICDS Anganwadi workers gave a definite path for identification of cases at grass root level.

The project aimed at training of 150 health staff, but given training to 161 health field staff and 12 primary care medical officers. The vision of WHO to integrate mental health to primary health is being a hurdle. Suraksha training and Suraksha Clinics started at PHCs under Panchayats delivered a novel strategy for this and resolved treatment gap effectively in the project area.

The conceptual frame work of the programme was deliver mental health services through local self governments was a vision applied and succeed in Suraksha CBR, The existing health system at the Panchayat level developed to occupy mental health services with the technical support of a Nodal agency in Psychiatry, and it is a replicable model anywhere in the world.

The care of mentally ill persons in homes is highly challenging as it needs special skills and many resources. Suraksha CBR enabled families to care and treat their family member at their home with local support and local resources. The Suraksha clinics at nearby Primary Health centres and free medicines

positively changed their life. The homeless PMIs were accommodated in the houses of relatives and assured community support by ward level Suraksha Committees.

The Suraksha CBR provided scientific and rightful involvement of Panchayats to guard the mental health of the people locally with a minimum budget.

The lessons of previous successful social experiments in the state of Kerala, as literacy movement and neighbourhood movement incorporated in the model helped to reduce stigma towards mental illness through health education. The ward level Suraksha committees formed under the leadership of Panchayat Member of the ward and task force lead by JPHNs and ICDS Anganwadi workers. The involvement of Kudumbasree Workers in the committee is taking the care and protection of patients, having no care givers. Those having no houses were accommodated at the homes of the relatives and providing all support by the ward committees.

V. CONCLUSION

One in every four persons in the world is suffering from any one mental illness in their life time. And 75 % of this population do not taking treatment. This debilitates the skills and life of the affected. They become a burden to their family and society, become abandoned and finally reached at Rehabilitation centres. It is a global social problem and searching for prevention of mental illness, early detection and timely rehabilitation but an integrated approach is rare in practice. In Indian context we have many scopes with Panchayat Raj act 1992 and RPWD Act 2016 but the essences have been used in one direction to make the life of mentally disabled possible at their own community. Suraksha Community Based Rehabilitation is the simplest and effective model.

The pilot project succeeded to meet its objectives in identifying the chronic mentally Ill patients in a systematic procedure. The estimated was 700 cases but it identified 839 cases. Psychiatric evaluation, free medicines, psychological services are delivered to these target population by developing clinics at Panchayat Level and Block level. Technical support of the nodal agency Psychiatry Department enabled to develop Human Resources through Training to Doctors, Health and ICDS field staff and psychiatric social workers as designed in the project proposal. The trained ICDS staff helped to identify cases at grass root level and facilitated application for disability pension and guidance for Social welfare measures available to Person with disabilities. The mental health system developed under Local Self Government were Weekly Suraksha mental health clinics at PHCs under trained Medical officer in all Panchayat in the project area, Block level first referral Psychiatry Clinic at Taluk Head Quarter Hospital, Family Facilitation centre to address psychosocial problems of the affected population. The project ceased in March 2019 and the transition phase to Panchayats supported by extended support of Psychiatry department. The FFA- Five finger approach of Suraksha CBR ensures food, shelter, care giver, treatment and medicine, Social avenues and ensures Comprehensive Rehabilitation at Community in a sustainable design

During the retrospective analysis, the programme found sustainable with the services of the mental health system developed under Panchayats. Human resources are updating with the consultation and support of Nodal agency.

Analysis and overall evaluation concludes that Community Based rehabilitation of Persons with mental illness and empowering the affected families through Local Self Government is a promising one in the new horizon of Psychosocial rehabilitation.

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