A STRENGTH AND GAPS ANALYSIS OF THE PROJECT IMPLEMENTATION PLAN OF THE TAMIL NADU “PUDHU VAAZHVU” MENTAL HEALTH PROGRAM (TNPVMHP)

VARSHA RAMAKRISHNAN
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<tr>
<td>ANM</td>
<td>Auxillary Nurse Midwife</td>
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<td>ASF</td>
<td>Amudha Surabhi Fund</td>
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<td>AWW</td>
<td>Anganwadi worker</td>
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<td>BDFAs</td>
<td>Block Level Disability Facilitating Agencies</td>
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<td>BLCP</td>
<td>Block Level Clinical Psychologist</td>
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<td>BLP</td>
<td>Block Level Physiotherapists</td>
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<td>BMHP</td>
<td>Block MentaL Health Professional</td>
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<td>CB</td>
<td>Capacity Building</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<td>CBR</td>
<td>Community Based Rehabilitation</td>
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<td>CBT</td>
<td>Cognitive Behavioral Therapy</td>
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<td>CC</td>
<td>Cluster Coordinator</td>
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<td>CDD</td>
<td>Community Driven Development</td>
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<td>CDF</td>
<td>Community Disability Facilitator</td>
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<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CLF</td>
<td>Cluster Level Federation</td>
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<td>CLG</td>
<td>Common Livelihood Groups</td>
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<td>CMHIF</td>
<td>Chief Minister’s Health Insurance Fund</td>
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<td>COM</td>
<td>Community Operational Manual</td>
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<td>CP</td>
<td>Cerebral Palsy</td>
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<td>CRP</td>
<td>Community Resource Persons</td>
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<td>CRS</td>
<td>State Nodal Officer for MHP in Tamil Nadu</td>
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<td>DDRO</td>
<td>District Disability Rehabilitation Officer</td>
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<td>DMH0</td>
<td>District Mental Health Officer</td>
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<td>DMHP</td>
<td>District Mental Health Program</td>
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<td>DRI</td>
<td>Differential Rate of Interest</td>
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<td>DS</td>
<td>Disability Specialist</td>
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<td>GH</td>
<td>Government Hospital</td>
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<td>GMHI</td>
<td>Government Mental Health Institution</td>
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<td>GS</td>
<td>Gram Sabha</td>
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<td>HBP</td>
<td>Home Based Training Program</td>
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<td>IEC</td>
<td>Information Education Communication</td>
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<td>MR</td>
<td>Mental Retardation</td>
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<td>MRT</td>
<td>Multiple Rehabilitation Therapy</td>
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<td>MI</td>
<td>Mental Illness</td>
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<td>NGO</td>
<td>Non-Government Organization</td>
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<td>NIEPMD</td>
<td>National Institute for empowerment of persons with Mental Disabilities</td>
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<td>OAP</td>
<td>Old age pension</td>
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<td>OBC</td>
<td>Other Backward Classes</td>
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OT  Occupational Therapist
PF  Project Fund
PFT  Project Facilitator
PHRD  Policy and Human Resource Development (Government of Japan Fund)
PIP  Participatory Identification of the Poor
PLF  Panchayat Level Federation
PMI  Persons with Mental Illness
POP  Poorest of the Poor
PRI  Panchayat Raj Institutions
PT  Physiotherapist
PTM  Participatory Training Methods
PVP  Pudhu Vazhvu Project, Tamil Nadu
PVMHP  Pudhu Vazhvu Mental Health Program
PWD’s  Persons with Disabilities (Adults with limb defects, Visual/hearing impairment
PwMD  Persons with Mental Disabilities (children with MR, CP, autism)
PwMI  Persons with Mental Illness
RRA  Regional Resource Agency
SAC  Social Audit Committee
SC  Scheduled Caste
SE  Special Educator
SGF  Special Group Facilitator
SSA  Sarva Shiksha Abhinaan
SHG  Self Help Groups
SLRA  State Level Resource Agencies
SSHG  Special Self Help Group
SW  Social Worker
TL  Team Leader
TLM  Teaching and Learning Materials
TNEPRP  Tamil Nadu Empowerment and Poverty Reduction Project
TNPVMHP  Tamil Nadu Pudhuvazhvu Mental Health Program
TNSRLM  Tamil Nadu State Rural Livelihood Mission
VO  Village Organization
VPRC  Village Poverty Reduction Committee
VT  Vocational Training
WB  World Bank
**Introduction**

The Pudhu Vaazhvu project (PVP) is a poverty alleviation and empowerment initiative of the Tamil Nadu State Government; with assistance from the World Bank (WB). It was launched in the year 2005 and implementation started in August 2006. The underlying principle of the program is implementation of programs using the Community Driven Development (CDD) approach. This entails empowering community members to identify specific needs pertinent to the community and deliver project services at the grass root level with the funds being transferred and handled by the communities themselves. The intention of this approach is to enable capacity building and ownership among the community that the initiative is attempting to reach.

The Pudhu Vaazhvu Project has a special component that has attempted to address the needs of Persons with Mental Disabilities (PWMD’s). It is a special initiative that builds on the institutional and implementation experience of the Tamil Nadu Empowerment and Poverty Reduction Project (TNEPRP) that envisions empowering Persons with Mental Disabilities (PwMD). Pudhu Vaazhvu Mental Health Project is a new initiative that envisions the inclusion of Persons with Mental Illness (PWMI) into the PVP sphere. PVMHP is to be implemented in the Block 1 districts of the PVP space, where the TNEPRP has been functional since 2006. The individuals that were targeted in Phase 1 of PVP were individuals with all categories of disabilities. More specifically, adults and children with physical disabilities (e.g. – locomotor disabilities, visually impairment, speech and hearing impairment etc.) as well as children with mental disabilities- namely cerebral palsy, congenital anomalies, ADHD and autism were targeted in this program. The identification of these individuals was carried out through the Participatory Identification of Poor (PIP) process, community members who were trained by mental health and physical rehabilitation specialists’ and medical and need assessment camps arranged by the Village Poverty Reduction Committee. The Multiple Rehabilitation Therapy (MRT) training for the Community Disability Facilitators (CDFs) was for a period of 36 days and imparted the baseline skills to identify children with mental health needs and help in their rehabilitation process and rehabilitate other PWMD’s.
The next Phase of the project aims to include children, youth and adults with mental illness; with a special focus on the elderly and women. It will be implemented over four years. The first phase of screening will be carried out through the months of October 2013 to December 2013. The successive phases will be implemented on a quarterly basis.

The vision of PVMHP is to accurately identify patients with mental illness at the grass root level with the help of grass root level workers and Regional Resource Level Agencies (RRA’s). The main goal of engaging RRA’s in this program structure is to augment and include technical support and mentorship to community workers on the field. With an aim to reduce ignorance at the community level and increase identification of individuals, the project will link individuals to rehabilitation services with the goal of facilitating medical interventions, livelihood empowerment measures and more importantly Community Based Rehabilitation (CBR) measures.

The key objective of this preliminary report is to identify strengths, challenges and gaps in the existing PVP special component for PWMD’s structure. The existing structure deals primarily with PWMD’s and associated conditions. The expansion to work with PWMI envisions utilizing the PVMHP workers at all levels to work with MI. It builds on the institutional and implementation experience of PVP. Thus it is imperative to analyse the current structure to ensure that the next stage of the project which will work with persons with mental illness will be successful.
Key Findings

This report will attempt to elucidate the strengths and challenges of the existing PVP special component activities for PWMD’s. It will also try to analyze if theory can meet practice when considering each individual phase of a new aspect of the program that intends to work with Persons with Mental Illness (MI).

Findings of existing program structure:

**Implemented Activities of the PVP since 2006 for addressing Disability**

- Identification of motivated men and women, preferably with disabilities themselves or with a family member who is disabled to work as CDF’s to give Home Based Training Program (HBP) to PWDs.
- Initial 36 day Multiple Rehabilitation Therapy (MRT) training to CDF’s to orient them to childhood disability disorders and adult impairments.
- Identification of children and adults with disabilities – limb defects, visual/hearing impairment
- Identification of children with Mental Disabilities – autism spectrum disorders, ADHD, Cerebral Palsy via PIP process and medical and need assessment camps organised by Block Level Disability Agencies (contracted by the project) in closely coordination with Government and Private Hospitals.
- Prioritizing beneficiaries for project support in the form of individual monetary assistance via VPRC’s
- Applying for and securing national ID card, Neermaya insurance card and Chief Minister Health Insurance Fund (CMHIF) card, Old age pension, rehabilitative appliances like hearing aids, hand pedalling tricycles and maintenance grants for PWD’s
- Organizing surgical procedures for children with limb defects and individuals with visual impairment - mostly utilizing VPRC funds
- Transporting children with disabilities below the age of 14 years with the help of a van secured by VPRC funds to a day care center either setup with VPRC funds or as part of Sarva Shiksha Abhiyan (SSA)
- Initial hand-holding support activities by Block Level physiotherapists from NGO’s (Block Disability Facilitating Agencies - BDFAs) for a period of 6 months to oversee physiotherapy sessions given by CDF’s
Strengths of the PVP

• **Establishment of community level rehabilitation workers:** Through its implementation since the year 2006, the PVP has oriented and trained grass root level workers known as Community Disability Facilitators (CDF’s). Their main responsibility is to create awareness, identify children with mental and physical disabilities, provide daily physiotherapy, identify youth and adults with disabilities, and link PWDs to different services.

• **Engagement of Block Level Physiotherapist (BLP) to provide hand-holding support:** The project had adequate flexibility to address emerging needs on the field. When it was found that CDF’s required more skill transfers, training programs were imparted by the BLP’s as well as direct one-on-one field visits to monitor program activities.

• **Improvement of health-seeking behavior for children with Mental Retardation (MR) and Persons with disabilities (PWD’s) during active PVP implementation phase:** Via awareness raising and IEC methods, the stigma attached to MR, CP and autism along with hearing defects, visual impairment and Limb defects in children and adults has been reduced at the village level. It has augmented the understanding of people at all levels of the village to go to a hospital to seek health services.

• **Importance given to skill-transfer to the CDF’s:** The BDFA’S and BLP’s were entrusted with the responsibility of transferring management of disability skills to the CDF’s. This enabled capacity building of skilled community workers that could provide basic physiotherapy exercises to PWDs at the village level. This reduced the burden on employing trained personnel.

• **Possibility of PWD’s to receive loans:** Via the formation of Special Self Help groups (SSHG’s), it has been possible for PWD’s as well as PwMD’s to avail of subsidized interest rate loans with greater flexibility in repayment schemes. This has led to greater livelihood and business establishment possibilities.

• **Strong linkages of individuals to rehabilitation and government schemes:** With the help of Special Group Facilitators (SGF’s) and CDF’s, PWD’s and PwMD’s have all been successfully identified at the village level via PIP and government hospital camps. With the help of
National ID cards, they have received subsidized services, insurance cards, loans, start up seed capital as well as a monthly maintenance grant of 1000 INR from the Government of India.

- **Convergence of PVP with the Government scheme- The Sarva Shiksha Abhiyan (SSA):** With the help of the CDF’s it has been possible to motivate parents to send children with special needs to special day care centers established by the Government. This has been facilitated by arranging CDF’s to pick up children via van services (with funds from the VPRC’s) between villages to take them to the SSA schools at the Block level in the PVP districts only.

- **Special focus on community based rehabilitative counseling and therapy:** The PVP has left adequate room for individual counseling of parents as well as patients via CDF’s. This increases trust in the project structure because the CDF’s are grass root level workers. Community based rehabilitation reduces the load on specialist human resource constraint that is encountered in all districts in terms of physiotherapists and counselors.

- **Performance Based Incentivization for all additonal activities carried out by motivated CDF’s:** The PVP project special component incentivizes additional activities that CDF’s perform beyond their basic responsibilities. With a base salary of 500 INR more importance was given to additional activities performed. For example, 150 INR was paid for every additional Home Based Training Program (HBP) that was carried out by CDF’s. 150 INR was additionally paid to CDF’s every two weeks for convening a Special Self Help Group (SSHG) meeting. The more the activities that were carried out initially by the CDF, the better the pay. This helped in the initial rapid roll out of the project activities.

- **Presence of activity by the CDF’s in certain areas inspite of lack of funding:** Since the year 2011, Village Poverty Reduction Committee (VPRC) funds have been used by the project activities. There was limited to no funds for paying CDF’s. Inspite of this in certain Panchayat’s the CDF’s have carried on with intermittent activities like HBP’s once or twice in a month.

- **Increase in health-seeking behavior by parents of children in areas of PVP:** With the help of the IEC activities carried out in the villages as well as with the personalized attention given to them by CDF’s, parents
as well as their children with disabilities were motivated to seek health and educational services.

- **Adaptability of project structure to dead-end convergences and seeking alternatives to substitute the same:** It has been found in all districts that the Neermaya insurance card has proved to be redundant. The Neermaya insurance card covers a cost of up to a total of 1 lakh INR in hospital and health service expenses for a PWD. This is a form of retrospective remunerative insurance scheme whereby the PWD requires to pay the 1 lakh INR amount upfront and wait for a lengthy bureaucratic process to receive the amount 9-10 months later. The greatest impediment to this form of insurance coverage is that most villagers and VPRCs do not have 1 lakh INR funds to pay upfront for services. Also it has been found that insurance cards such as CMHIF have not been recognized in some districts in private hospitals. Thus for all practical purposes these insurance schemes have proved redundant in terms of benefit. By recognizing this during project implementation, PVP has stopped the issue of these cards to PWD’s.

**Challenges of the PVP**

- **Sustainability of funds to maintain incentives for CDF’s:** The initial amount paid to the CDF’s before the year 2010 was 500 INR per month. This was the base salary for carrying out all their activities. Additional activities such as home-based visits, personally visiting the District Disability Regional Officer (DDRO) for national ID card applications for the disabled, convening SSHG’s meetings as well as help in the Day Care on rotation with other CDF’s were important activities that were promoted via incentives. Most of the initial incentives would provide a salary of around 2500-3000 INR per month on an average. Once most cases had been identified, the salary has been noted to drop to around 15000-2000 INR. Thus the work proved to be intermittent in the years when funding at the VPRC level was completely utilized under the project. Between the year 2011-2013 it was found that the CDF activities became intermittent and not as robust as previous well-funded years because there wasn’t adequate funds to pay even the base salary.

- **Reduced motivation of parents to continue health-seeking and continued education behavior:** Although it is envisioned that this
program will empower people towards better health seeking behavior, when the funding for CDF’s was not available for two years, parents of children with disabilities who were originally bringing their children regularly for follow up therapy and to the day care centers discontinued both when CDF’s worked intermittently. This method thus holds little sustainabilty value. In addition government hospital camps are held once in 6 months and not many PWD are motivated to regularly follow up for treatment.

• **Inadequate numbers of human resources for home based visits:** The prerequisite criteria for a CDF is preferably female, preferrably disabled or has a family member who is disabled. There is one CDF to every Village Panchayat (VP). The CDF’s have voiced their concerns with respect to the difficulty in travelling between villages for home based visits for physiotherapy since in most districts a CDF caters to 5-6 small villages surrounding her own. Being women CDFs find it difficult to conduct HBP during the evenings because it is unsafe for them to travel alone later in the evening especially on foot. There are very few male CDF’s.

**Recommendations for the PVP**

• **Increase incentives for SGF and CDF’s and DA for APMs:** The current program structure has increased base salary of a CDF to 750 INR. However the fact that additional cases of mental illness will also be overseen by the CDF's’ may be important to take note of. There will be real costs to be met in terms of variance in case numbers from village to village. This should be taken into account when planning increased incentivization to maintain intial rapid momentum of project implementation.

• **Additionally recruit male CDF’s and intensify the activity of PFT’s to accompany female CDF’s in regions of need:** to rehabilitate male patients and distant villages can be covered by them: The current CDF recruits find it cumbersome to cover all the villages alloted to them for HBP. It would be useful to additionally recruit a second male CDF to carry out similar activities for male patients and in distant locations.

• **Refresher training and feedback systems after skill-transfer sessions of CDF’s:** It will be useful to incorporate refresher training sessions for
the CDF’s every 4-5 months into the program structure. This will ensure feedback systems from the CDF’s as to problems faced at the grass root level. It will also enable CDF’s to be updated on methods of management. In order to capacitate sustainability it might be useful to look at tie ups with nearby Government medical schools and Physiotherapy schools for the CDF’s to attend for a day or two..

**Need for greater attention to specific district characteristics:** Home based training programs involve traveling from one village to another to visit homes of children with disabilities to provide rehabilitation therapy by the CDF’s. This involves traveling long distances in some districts, traveling by foot in other hilly districts as well as traveling for some distance via buses. Owing to the distances in certain districts CDF’s are not as motivated to carry out HBPs. (Cuddalore, Kanchipuram, Vellore, Krishnagiri) It maybe valuable to take into account certain district characteristics when implementing this aspect of the program model

**Alternative source of maintenance funds for PWD’s and PWMI’s other than Government MG’s:** The monthly maintenance grant of 1000 INR released to all PWDs/PwMDs varies from district to district. This amount of cash is sometimes released after 7 months in bulk as 7000 INR or after 3 months. The time frame varies. This maintenance grant is the method by which PWD can empower themselves to pay for their health care services and daily needs and not be viewed as a burden by their village. With the inconsistencies in this fund it has led to inability of individuals to pay for the care they need.

**Increasing scope for PPP in addition to convergence with Government schemes** The goal of the PVP has been to allow for as many convergences with government schemes as possible. This has led to certain aspects of the program falling behind in terms of deliverables and accountability. For example, day care centers run by the Government as SSA now no longer have transport to-and-from and have discontinued Mid-Day meal schemes for Children with disabilities since March. This has led to reduced attendance of children since VPRC funds for transporting children and maintaining day care centers have thinned. Planning more PPP with surrounding Social work and Physiotherapy schools to help in both manpower and infrastructure development for day care and rehabilitation centers at the village level would be very useful.
• **Allow for greater focus on public private partnerships for community outreach services:** With the help of private medical colleges, private schools for social work and physiotherapy in local PVP areas, there lies ample opportunity to allow for PPP to deliver services at the community level.

• **Model Home Based Training Program (HBP) contextually:** It is important to implement Home Based Training Programs with consideration to local geographical and cultural constraints. Different districts require different modes of travel - reduced bus fare passes, bicycle or additional staff to cover larger distances.

**Findings of the theoretical program structure of PVMHP working with Mental Illness (MI)**

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<tr>
<th>1st quarter – Goals, deliverables and completed activities for MI (October-December 2013)</th>
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<tr>
<td>• Identification of Regional Level Resource Agencies (RRA’s), Block Mental Health Professionals (BMHPs) - completed</td>
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<tr>
<td>• Reviving the CDF structure in Phase 1 districts and deliver 5 day orientation on Mental Illness Identification and Management</td>
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<tr>
<td>• Orient Panchayat Raj Institutions (PRI) to the activities to be carried out by MI project</td>
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<tr>
<td>• Conduct awareness raising about positive mental health practices at all CBO as well as schools</td>
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<tr>
<td>• Complete identification of individuals with mental illness/emotional disturbances via primary and secondary data collection as well as a needs assessment medical camp</td>
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**Strengths of proposed Phase 1 of PVMHP for MI**

• **Utilization of services of local level NGO’s who have worked for multiple years in Mental Health:** Phase 1 of the plan has identified mental health professionals in influential NGO’s that have been working in different districts on varying mental health issues. The primary NGO’s that are involved in phase 1 are Banyan, SCARF, the Chellamuthu trust, SR Medical
College and Shanthivanam trust. They have been chosen as the Regional Level Resource Agencies (RRA’s) that will provide training to the grass root level workers already working at the VPRC level with PwMDs. They will also provide hand-holding support for a period of two years. The plan to use local district based NGO’s is extremely beneficial while delivering contextual need-based services.

- **Working within a pre-established framework and infrastructure by means of CDF’s and BMHP’s who were prior Team Leders (TL):** The existing PVP structure is strong in terms of accountability and empowerment goals and ideals. By utilizing the same individuals who are familiar with the workings of the PVP already, it reduces the time required to sensitize new individuals.

- **Inculcating Positive Mental Health Practices to reduce stigma:** By using different Community Based Organization (CBO’s) structures and grass root level workers it will be easier to help inculcate a positive environment for fostering health seeking behaviors. Currently at most village levels, mental illness is thought to be a result of a spirit possession or a punishment from God. The PVMHP will help increase awareness about causes, symptoms and management of different mental illness’.

- **Empowering individuals with mental illness to increase health seeking behavior:** The PVMHP plans to build on existing VPRC activities to extend to monitoring health-seeking behavior and the continuance of therapy. This reduces the burden of spending higher resources to track/ follow up since CDF’s are already working at the village level.

- **Adequate confidentiality maintenance for patients if they require to be placed on the PIP list:** In order to maintain accountability and transparency it is required for all those who receive special funds assistance by means of SSHG’s to be placed on a VPRC beneficiary list. The list is usually on display near the VPRC meeting room. This would lead to a breach of confidentiality of patient with MI. It has been proposed in very strong terms to add the individuals as numbers instead of names as beneficiaries. Even if it is requested as part of the Right To Information (RTI), since it is a sensitive issue – only for medical reasons will it be disclosed and under guarded privacy protocol.

- **Systematic standardized orientation and training program via RRA’s:** The 5 day orientation plan for the CDF’s is standardized RRA to RRA. Although it is important for them to impart contextual need based knowledge
to the CDF’s, it remains important for CDF’s across the board to have a standardized knowledge of mental illness. The central PVP office has delineated a specific standardized information session. This will help in assessing the understanding of the CDF’s since the knowledge imparted was standardized across the RRA’s.

• **Periodic ongoing time period for IEC activities:** The current program plan is to phase in IEC activities for a period of 3 months. It is also expected of the CDF’s to identify different ranges of mental illness within the community. This will initially target patient with severe MI. Since the project will extend for 4 years, it will ive CDF’s adequate time to sensitize villages to mild and moderate MI as well. The extended time period of the program will help in breaking cultural stigmas.

• **Structured convergence plans with district Government medical hospitals and PHC’s:** This is evident when looking at the Erwadi district VPRC’s. Erwadi is a religious region very holy to Muslims in Tamil Nadu. It is a dargah where people from all over India come and abandon mentally ill patients in the hope of a spiritual cure. Erwadi was known for the 2001 fire incident. During this time a fire in a mental institution killed 27 mentally ill patients because they had been chained to their beds. In a bid to reduce these practices, increase IEC and provide health services – the Government of Tamil Nadu has allocated funds to establish a hospital by 2013. This is modeled along the lines of the Dava (medicine)-Duha(prayers) project in Gujarat. With this the religious leaders will promote referral to medical services for severely ill patients. Currently PVP has expanded its VPRC areas to 4 Panchayats in Erwadi. PVMHP has looked at convergences with this particular hospital and the District Mental Health Professional (Dr. Periyar Lenin).

**Challenges of proposed Phase 1 of PVMHP for MI**

• **Quality of 2 day orientation of BMHP’s by the RRA’s:** The 2 day orientation of the BMHp’s by the RRA’s involved mainly showing them what facilities the RRA’s have. The first day was a very general orientation to mental illness. Since the BMHP’s will be supervising the CDF’s it is imperative they have a solid foundational understanding of mental illnesses and the approach to a patient with MI. The MRT training was a rigorous 36 day training course but the CDF training for mental illness is planned at only
5 days. This may not be adequate to sensitize and orient individuals from the community who are very new to this highly stigmatized field.

- **Pre-existing attitude of RRA’s towards management of MI:** The once in a month follow up visits planned by the RRA’s is mainly to either increase/reduce doses of medication. It may be useful to reiterate the importance of supporting villages with counseling services. The challenge with establishing counseling time is the lack of trained individuals. There is a dearth of mental health professionals in Tamil Nadu and India itself.

- **Professional attitudes of RRA’s towards medications for MI:** The RRA’s that have been identified look towards medication as the first line of management. This is a common practice in Indian mental health practice and needs to be addressed repetitively to change mindsets. Rigidity in practice beliefs have led the RRA’s to believe that if mild illness is not treated with medication it will progress to moderate. It is important for both therapy and counseling to be considered in all cases of mental illness.

- **Probability of a lack of recognition of National ID cards and redundancy of insurance cards:** Similar to the gaps encountered during the implementation of the PVMHP for PWDs, it may be the case that the national ID cards are not recognized because of a lack of communication between different departments about service information. The insurance cards may not be accepted at all hospital levels similar to the previous program challenge.

- **Convergence with Government for supply of drugs may lead to under-supply and low quality drugs:** According to the psychiatrists working at the different RRA’s, government psychiatric drugs are few and far between. Their supply is usually minimal, is extremely basic in nature and also has questionable quality. While considering the treatment of mental illness, it is imperative that the supply of good quality medications is regular without which patients may relapse.

- **Inability of patients with severe Mental Illness to travel long distances for hospital based counseling sessions:** Individuals from villages with mental illness are not well-off to be able to afford to travel to towns or cities for regular counselling sessions. Since counselling is an important requirement for all mental illnesses it becomes important to consider this challenge very carefully.

- **Potential for individuals to feel uncomfortable speaking to CDF’s during counseling sessions:** The culture of India stigmatizes mental illness.
Since the CDF is from the community, villagers may not want to openly talk about their personal issues to them. Since it is time-consuming and expensive to travel to cities for counselling and community based counsellors from the village may not be effective, this becomes an important challenge to address.

**Recommendations for proposed Phase 1 of PVMHP for MI**

**A) Recommendations for Various Aspects of Program Implementation:**

**Human Resources:**

- **Increase CDF remuneration and the number of CDF’s on the field:** An increase in incentives for the CDF’s and planning for two CDF’s, one male and one female maybe more effective for service delivery. It would be extremely important to consider male CDF’s in this particular MI program since it will be more contextually appropriate for males to handle male patients with mental illnesses.

- **Engage one individual in each village to monitor drug adherence versus having a CDF traveling from village to village:** Since the process of drug adherence check requires daily monitoring it maybe more effective to have a motivated village member (e.g. VPRC Habitation Level Forum) from each village to oversee this aspect of the program. It becomes inefficient for a CDF to travel everyday to all villages in his/her jurisdiction to check on drug adherence.

**Knowledge Attitude and Practices Monitoring:**

- **Baseline survey Knowledge Attitudes and Practices (KAP) of villagers using a PIP tool:** Using CDF’s and small focus groups, establishing a baseline understanding of existing KAP’s of MI at the village level will be important for impact evaluation. Following frequent monitoring, conducting an analysis of the KAP’s in 3-4 years will document actual KAP changes attributable to PVMHP.

- **Plan for evaluating the knowledge of CDF’s and BMHP’s at all levels:** There is currently a lack of consistency in engagement at all levels of PVMHP. There has been no evaluation of either the knowledge of the CDF’s and SGFs after implementation of PVMHP for PWD’s. It will be important
for proper engagement to develop a tool to assess the understanding of mental illness approach and management.

**Infrastructure Strengthening:**

- **Strengthen vision for sustainability of village level care centers and counseling centers:** The current plan of establishing group and individual counseling requires the establishment of day care centers or home-visits. In order to ensure sustainability of a day care center manned by a CDF, it might necessary to look at VPRC’s as a potential space to carry out these activities. This will reduce on transit time to a Block Level Federation Center and allow for CDF’s to efficiently spend their time counseling village patients locally.

- **Phase in substance de-addiction in the next cycle of program implementation:** Since adequate facilities for it have not been planned yet and convergence links are still in the process of being established, established, trying to implement this aspect of the mental illness may lead to confusion and inadequate service delivery. It maybe more appropriate to implement de-addiction initiatives once it has been planned completely since there will be an overwhelming case load. The current requirement of the PVMHP is to enroll 30% of willing individuals into de-addiction centers across the board. It maybe more apropos to contextually modify the percentage depending on the case load identified in different villages.

**B) Recommendations for Revisions in MOU with RRA’s:**

- **Increase orientation and training time for BMHP’s and CDF’s:** Mental Illness being a relatively new concept requires time to sensitize individuals working in the field. Since the BMHP’s and CDF’s are relatively new to the concept it maybe useful to increase the training time period initially and follow it up with refresher courses every few months or so.

- **Reinforcing expected protocol with the RRA’s to align professional attitudes with deliverable principles:** It is imperative for the smooth functioning of the PVMHP to address the need for village based counseling. The training that will be imparted for this is in the hands of the RRAs. It is therefore, extremely important to align their beliefs with the PVMHP vision of using both counseling and drugs for illness management. Since mental health practice in India has been entrenched for a long time in drugs as first line therapy, it will be valuable to conduct feedback sessions from the
RRA’s to analyze their attitude towards MI management. It must be stressed repeatedly that both counseling and drug therapy go hand in hand in the treatment of patients with mental illness. This needs to be accepted by agencies working to orient community level workers as well.

- **Incorporate Cognitive Behavioral Therapy in CDF training:** The methods of Cognitive Behavioral Therapy is easily understandable by a layperson. Since PVMHP is based on CDD, using CBT methods will reduce workload on professionals and increase capacity building of CBO’s. A training session of a few days in foundational CBT will strengthen the program further.

- **Addition of a standardized ICD-10 WHO checklist for Mental Health disorder screening:** This particular tool can be used by any level of worker on the field to identify mental illness. It is a very basic checklist that can be administered even by lay people in order to identify and score mental illnesses. This will increase the ability of CDF’s and BMHP’s to screen for mental illness during secondary data collection. [Refer Annexure 1]

C) **Recommendations for Program Expansion beyond Government Linkages:**

- **Promote more public private partnership methods for procuring drugs and infrastructure development:** Since there is an inadequacy in quantity and quality of drugs supplied by the Government, it maybe lucrative to look at corporate social responsibility as a way to procure drugs and develop infrastructure like day care centers for this MI program. It may also address the need for transportation of severely mentally ill patients for follow up.

- **Engage increased local NGO participation for community outreach counseling and referral for institutionalization:** Local NGO’s working close to villages need to be engaged early on in the program to strengthen service delivery; both in terms of counseling and drug therapy follow up and adherence.

D) **Recommendations for Policy Changes at the Government Level:**

- **Enable recognition of prescription given by RRA’s at the local Government Hospital:** It has been found that the local RRA’s function independent of Government facilities in their daily activities. With a major aspect of the PVMHP being convergence, it will be very important to address policies that will enable drug prescriptions handed to patients by
RRA’s to be recognized at Government hospitals. Without this measure in place, drug may have to be procured privately which will increase costs for the patients.

- **Encourage government policy for mandatory rural postings in schools of social work and mental health:** A dearth of trained individuals working at the village level is the reason for inadequate services in MI. If a policy that mandates rural posting in schools of social work and mental health, it will increase the number of individuals available as counselors and therapists.