Tilak Maharashtra Vidyapeeth, Pune.

Enactment of Community Mental Health & Development Model In Tribal Area

(Specific Emphasis on Yavatmal District of Maharashtra)

A Thesis Submitted to

Tilak Maharashtra Vidyapeeth, Pune.

For the Degree of Doctor of Philosophy (Ph.D.)

In Social Work Subject

Under the Board of Social Work Studies

Submitted By

Siddharth Kamal Gangale

Under the Guidance of

Dr. Vijay J. Shingnapure

January 2015.

DECLARATION

I do hear by declare that this thesis **“Enactment of Community Mental Health & Development Model In Tribal Area”** (Specific Emphasis on Yavatmal District of Maharashtra) is the result of investigation carried out by me under the guidance of Dr. Vijay Shingnapure, associate professor, Tirpude College of Social Work, Nagpur and register guide under Tilak Maharashtra Vidyapeeth, Pune**.** I am submitting the same to the Tilak Maharashtra Vidyapeeth for the award of the degree of Doctor of Philosophy in Social Work.

Further I declare that this work has not been submitted before by me or anybody else, in part or whole to this or any other university for the award of any diploma or degree.

Date: 14th January 2015. Signature of the candidate

Place: Pune. Siddharth K. Gangale

FORM 'C'

C E R T I F I C A T E

This is to certify that the thesis entitled **“Enactment of Community Mental Health & Development Model In Tribal Area”** (Specific Emphasis on Yavatmal District of Maharashtra) which is being submitted herewith for the award of the Degree of Vidyavachaspati (Ph.D.) in **Department of Social Work** of Tilak Maharashtra Vidyapeeth, Pune is the result of original research work completed by **Shri. Siddharth Kamal Gangale** under my supervision and guidance. To the best of my knowledge and belief the work incorporated in this thesis has not formed the basis for the award of any Degree or similar title of this or any other University or examining body upon him.

Research Guide

Dr. Vijay Shingnapure

Place: Nagpur

Date: 14th January 2015.

// ACKNOWLEDGEMENT

At the culmination of this thesis, it is time to acknowledge the contribution of all those who have helped me in this endeavour. The success of this effort is but because of many people who shouldered a kind word, support and encouragement. I express my deep sense of gratitude and heartfelt thanks to my guide Dr. Vijay Shingnapure for the valuable guidance throughout the study. He has been instrumental in inspiring me through my research, encouraging me constantly to complete this work. I am thankful to the authorities of Tilak Maharashtra Vidyapeeth, Pune especially the Vice- chancellor, the registrar and others for giving me an opportunity to work on my research related Community Mental Health and Development Model in Tribal area.

I am grateful and it is a wonderful feeling to Dr. Jacintha Mascarenhas, Project Director, Sangath organisation, part of my journey, was often there to boost me with discussions and deliberation. I am thankful to her to help me in the data analysis that is integral to my research and also help rendered in editing my research drafts.

My heartfelt thanks go to the entire persons with mental illness and their caregivers from the community who have share their positive and negative experiences being a mentally ill person or a caregiver.

The acknowledgement would be incomplete without mentioning my wife Dr. Dipali who has been a great support and stood by me throughout this endeavours and my son Neel who have always been a great inspiration for me throughout my study.

I acknowledge many more who have helped during the course of my study directly or indirectly are duly acknowledged.

Date: 14th January 2015. Siddharth K. Gangale

Place: Pune.

CONTENT INDEX

Sr. No.	Details	Page No.
1.	Declaration	1
2.	Certificate	2
3.	Acknowledgement	3
4.	Content Index	4
5.	List of Tables	5
6.	List of Figures	8
7.	List of Abbreviations	9
8.	Chapter-1 : Introduction	11
9.	Chapter-2 : Review of Literature	31
10.	Chapter-3 : Research Methodology	47
11.	Chapter-4 : Profile of the Study area	60
12.	Chapter-5 : Data Analysis and Interpretation	64
13.	Chapter-6 : Findings, Conclusions and Recommendations	170
14.	Chapter-7 : Appendixes	189

Table Content

Sr. No.	Title of the Table	Page No.
1.	Section A: Social, Educational and Economic aspects of Person with Mental Illness and their Caregivers.	65
2.	5A. 1. Age Distribution among the Person with Mental Illness	67
3.	5A. 2. Educational status among the Person with Mental Illness	68
4.	5A. 3. Type of Mental Illness and Education of PWMI	70
5.	5A. 4. Age and type of Mental Illness of PWMIs	71
6.	5A. 5. Sex and Type of Mental Illness of PWMI	73
7.	5A. 6. Age and Sex of Caregivers	75
8.	5A. 7. Age and Relationship with the person with mental illness	79
9.	5A. 8. Sex and Marital Status with Type of Mental Illness	81
10.	5A. 9. Occupation and Type of Mental Illness	84
11.	5A. 10. Number of Family members and Earning members in the Family.	85
12.	5A. 11. Family Incomes and Type of Mental Illness	87
13.	5A. 12. Income and Occupation of Caregivers	89
14.	Section B: Understanding Treatments & Stigma Associated with Mental Illness.	91
15.	5B. 13.Type of Mental Illness and Years of Treatment	98
16.	5B. 14. Period of Treatment by Sex	99
17.	5B. 15. Action taken in the initial period and Type of Mental Illness	101
18.	5B. 16. Accessed Treatments in the Initial Period By Sex	103
19.	5B. 17. Treatment taken from and condition after treatment	105
20.	5B. 18. Method for Fast Recovery	106
21.	5B. 19. Religious treatment and Type of Mental Illness	109
22.	5B. 20.Religious treatment and Impact of the treatment	110
23.	5B. 21. PWMI access Treatment from Spiritual Healers& type of treatment provided	111
24.	5B. 22. Usefulness of Type of Treatment provided by Spiritual Healers	113
25.	5B. 23. Place and Accessed treatment from Spiritual Healers	114

26.	5B. 24. Useful Treatment and Status of Daily Life	115
27.	5B. 25. Action taken in the initial period of Mental Illness and Advised Sought	117
28.	5B. 26. Reason for Mental Illness by Sex	118
29.	5B. 27. Negative Feeling about PWMI and reasons for the feeling	120
30.	5B. 28. Type of Mental Illness and Stabilization	121
31.	5B. 29. Period of Treatment and Stabilization	123
32.	5B. 30. Number of PWMI Approach Spiritual Healers by Their Location	124
33.	5B. 31. Advice given by and Type of Mental Illness	125
34.	5B. 32. Reason for Hiding Mental Illness and Type of Mental Illness	127
35.	5B. 33. Usefulness of Treatments and Type of Mental Illness	128
36.	5B. 34. Type of Mental Illness and Advice given by to take Mental Health Treatment	130
37.	5B. 35. Type of Mental Illness and Villager Know about Your illness	131
38.	5B. 36. Reason for Mental Disorder and Type of Mental Illness	132
39.	5B. 37. Duration of Stability of PWMIs and Efforts for Livelihood	134
40.	5B. 38. Time spent on caring by Sex	136
41.	5B. 39. Type of Care provided by Caregivers	137
42.	Section C: Impact of Myths on the Lives of Person with Mental Illness & Caregivers.	138
43.	5C. 40. Type of Mental Illness and Impact on Family	141
44.	5C. 41. More Impact on by Type of Mental Illness	143
45.	5C. 42. More Impact of Mental illness on by Sex	144
46.	5C. 43. Impact of Mental Disorders on Family by Type of Mental Illness	145
47.	5C. 44. Reason for Feeling Threatened from the Community	147
48.	5C. 45. PWMI Lived Isolated from the Society by Sex	150
49.	5C. 46. Impact of Fear	151
50.	5C. 47. Impact of the Fear by Sex	152
51.	5C. 48. Type of Mental Illness and PWMIs Presently involved in the Activity	153
52.	Section D: Impact of Community Mental Health & Development Module in Community Setting.	155
53.	5D. 49. Encouraged by to Start Work	159
54.	5D. 50. Information Providers about CMHD Program	159

55.	5D. 51. Usefulness of CMHD Program	160
56.	5D. 52. Type of Helps Offered	161
57.	5D. 53. Number of Meeting Participated by Sex	162
58.	5D. 54. Number of Meeting Participated and It's Use	163
59.	5D. 55. Impact of CMHD Program and Improvement among PWMI.	165
60.	5D. 56. Impact of Mental Health Program in the Community	166
61.	5D. 57. PWMIs Opinion on CMHD Program	167
62.	5D. 58. Suggestions about the Program	169

Figure Table

Sr. No.	Name of the Figure	Page No.
1.	Figure No. 5A. 2.1 Educational status among the Person with Mental Illness	69
2.	Figure No. 5A. 3.2 Type of Mental Illness and Education of PWMI	70
3.	Figure No. 5A. 4.3 Age and type of Mental Illness of PWMIs	72
4.	Figure No. 5A. 6.4 Age and Sex of Caregivers	77
5.	Figure No. 5A. 8.5 Sex and Marital Status with Type of Mental Illness	83
6.	Figure No. 5B. 13.6 Type of Mental Illness and Years of Treatment	99
7.	Figure No. 5B. 18.7 Method for Fast Recovery	108
8.	Figure No. 5B. 28.8 Type of Mental Illness and Stabilization	122
9.	Figure No. 5C. 43.9 Impact of Mental Disorders on Family by Type of Mental Illness	147
10.	Figure No. 5D. 54.10 Number of Meeting Participated and it's Use	164
11.	Figure No.5D.56.11 Impact of Mental Health Program in the Community	167

List of Abbreviations

Sr. No.	Abbreviation	Full Form
1.	ADL	Activity of Daily Living
2.	AIDS	Acquired Immune Deficiency Syndrome
3.	BNI	Basic Needs India
4.	CBO	Community Based Organisation
5.	CHC	Community Health Centre
6.	CHV	Community Health Volunteers
7.	CHW	Community Health Worker
8.	CMD	Common Mental Disorder
9.	CMH&D/CMHD	Community Mental Health & Development
10.	CRPD	Convention or the Rights of Person with Disabilities
11.	DALY	Disability Adjust Life Year
12.	DMHP	District Mental Health Program
13.	ECT	Elector Conversion Therapy
14.	FGD	Focus Group Discussion
15.	GHPU	General Hospital Psychiatric Unit
16.	GNP	Gross National Product
17.	GP	General Practitioner
18.	HC	Health Counsellor
19.	HIV	Human Immunodeficiency virus
20.	IADL	Instrumental Activities of Daily Living
21.	IASC	Inter-Agency Standing Committee
22.	ICDS	Integrated Child Development services
23.	ICESCR	International covenant on Economic, Social and Cultural Rights
24.	ICMR	Indian Counsel of Medical Research
25.	IPS	Indian Psychiatric Society
26.	ITI	Industrial Training Institute
27.	MDD	Major Depressive Disorders

28.	MDG's	Millennium Development Goals
29.	MHGAP	WHO Mental Health Gap Action Program
30.	MNS	Mental Neurological and Substance use Disorders
31.	MPW	Multipurpose Health Workers
32.	NA	Not Applicable
33.	NCS	National Co-morbidity Survey
34.	NGO's	Non-Government Organisation
35.	NHP	National Health Policy
36.	NHRC	National Human Right Commission
37.	NIMHANS	National Institute of Mental Health and Neuroscience
38.	NMHP	National Mental Health Program
39.	NREGA	National Rural Employment Guarantee Act
40.	OCD	Obsessive Compulsive Disorder
41.	PHC	Primary Health Centre
42.	PRI	Panchayat Raj Institution
43.	PSW	Psychiatric Social Worker
44.	PWMI	Person with Mental Illness
45.	RH	Rural Hospital
46.	SMD	Severe Mental Disorder
47.	SRPB	Spiritual, Religious and Personal Beliefs
48.	TOT	Training of Trainers
49.	UDHR	Universal Declaration of Human Right
50.	UN	United Nation
51.	UNCRPD	Universal Nation conversion on the Right of Person with Disability
52.	UNDP	United Nation Development Programme
53.	UNESCO	United Nation Education Scientific and Cultural Organisations
54.	UNFPA	United Nation Population Fund
55.	UNICEF	United Nation Children's Fund
56.	UNU	United Nation University
57.	WHO	World Health Organisation
58.	WHOQOL	WHO Quality of Life

Chapter-1.

Theoretical Background

Mental health is a vital component of health, defined by the WHO as “a state of well-being in which every individual understands his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.” Mental health problems is a term that refers to a set of medical conditions that affect a person’s thinking, feeling, mood, ability to relate to others and daily working. This includes a comprehensive range of conditions such as depression and anxiety, drug and alcohol abuse and schizophrenia. Mental health problems are enormously common in all countries of the world. In most parts of the world, persons with mental illness are deprived of the basic human right of access to treatment, rehabilitation and appropriate mental health care. Person with mental illness (PWMI) and their families experience discrimination and exclusion from social and economic activities (Murthy, 2000). Lack of access to information about their rights propagates and deepens on a situation of misery for large numbers of people who are not in a position to assert them. As a result, they face chronic ill health, and families experience social and economic problems, in certain cases leading to poverty (Murthy, 2000). Many persons with mental illness are restricted to their houses without any treatment, either because their family members do not distinguish the illness or else find it embarrassing to be associated with mentally ill relatives, who are commonly called ‘mad’. The stigma is so remarkable that people feel ashamed and deny the illness. The discrimination is seen from the family members’ right up to the policy makers and the state authorities (Lefley, 1987; Johnson, 1990).

The World Health Report 2001 evidently pointed out that mental and neurological conditions cause a significant amount of morbidity all over the world. It is projected that about 450 million people are affected by mental, neurological and substance-abuse disorders. A large amount of these people live in developing countries, including the WHO (World Health Organisation) South-East Asia Region. It is estimated that the burden of disease from neuropsychiatric conditions measured by DALY’s (disability adjusted life years) will increase from 9% of the total disease burden in 1990 to 14% in 2020. It is also known that a substantial proportion of people with neuropsychiatric conditions, particularly in developing

countries, do not get proper treatment. This is referred to as the mental-health gap or treatment gap for mental health. It is very unfortunate that the treatment gap in developing countries can be as high as 80-90%. Traditionally, neurological and psychiatric services have been concentrated in tertiary-care hospitals. Thus, large segments of the population, particularly those who live in rural and remote tribal areas, have been deprived from such services. This is despite the fact that both neurological and psychiatric conditions are common in these communities.

Mental Health: - Mental health is more than just the absence of disease (WHO 2001b). It includes being able to think clearly and solve the problems faced in everyday life being able to enjoy good relationships with other people feeling at ease spiritually and being able to bring happiness to people around you (Patel 2003).

Mental health definitions are more holistic meaning that mental health covers much more than just the absence of illness. "Mental health means striking a balance in all aspects of your life: social, physical, spiritual, economic and mental. Reaching a balance is a learning process, your personal balance will be unique and your challenge will be to stay mentally healthy by keeping that balance." Mental health is an important part of our overall health and mental health aspects:

- How we feel about ourselves,
- How we feel about others,
- How we are able to meet everyday demands, and
- How we make choices in life.

Mental health is about how you feel, how you think and how you see the world around you. Without good mental health it is difficult to do the things you need to do each day to have a full and happy life.

Mental illness:- Any illness experienced by a person which affects their emotions, thoughts or behaviour, which is out of keeping with their cultural beliefs and personality and is producing a negative effect on their lives or the lives of their families (Patel 2003). Mental illnesses occur in all cultures and populations throughout the world (World Health Organization 2001). Differences in prevalence between cultures are minimal and probably often due to differences in diagnosis and reporting (WHO & Wonca 2008). Mental illness has profound negative impacts on an affected person's capacity for feeling, thinking, relating to

others, and coping with life's stresses. It increases the risk of premature death due to suicide, accidents or substance abuse (Murray & Lopez 1996).

Global Burden of Mental illness: - The global burden of mental illness is increase to grate extend. Four of the ten most disabling disorders globally are mental illnesses (World Health Organization 2004). The impact of mental illness is sensed not only by the affected individual but also by his/her family. A person's mental illness can damagingly affect their family emotionally and financially. The financial problem due to accessing treatment is added to by the person with mental illness reduced capability to work and the loss of work opportunities for family members who care for the individual with mental illness (World Health Organization 2001). Despite the high burden of mental illness, mental health services remain inadequate and at least two thirds of people with mental illness receive no treatment (Lancet Group for Mental Health 2007). Stigma and discrimination, insufficient provision of services, the costs of treatment, the perception that treatment is ineffective distance from services and the fear of possible side effects are all obstacles to mental health care (World Health Organization 2001; James 2002). Raising awareness of the incidence of mental illnesses the fact that they are treatable the recovery process and the human rights of people living with mental illness are effective strategies in reducing barriers to treatment (World Health Organization 2001).

Mental health is a neglected arena: - All among several non-communicable diseases that people suffer, mental health is an area ignored by an individual and families because of the stigma attached to pursuing care and the traditional beliefs that are held. Further the available health services are insufficient. The World Health Survey (2003) had also probed into problems of 'worry or anxiety' in the last 30 days in Maharashtra. The survey found that 50% males and only 39% females reported that they have no worries and anxieties. Higher proportion of women, individuals belonging to rural areas, of low levels of education, of higher ages and lower incomes reported moderate to severe levels of worry or anxiety. These findings do indicate the general existence of distress linked to issues of employment and growing agrarian distress in the countryside. In Maharashtra the non-communicable disease load coupled with communicable disease load will have serious impacts for the poor in general and women in particular. In rural and remote tribal areas small populations are geographically dispersed across large distances with varying access to health services. Isolation, socio-economic disadvantage and mobility and transport limitations are key issues

in the delivery of community mental health services to rural and remote tribal communities. Natural disasters such as drought or floods can also have a significant impact on the mental wellbeing of rural and tribal communities and require targeted responses. Mental health service delivery needs to be locally focused and build on the capacity of existing community services. The challenges of mental health service delivery in rural and remote tribal communities require the development of personalized, innovative strategies and effective service models. Such solutions should be developed in collaboration with the broad range of community services involved in supporting rural and tribal areas. These innovations aim to provide better and more accessible care across the full range of community mental health services. In most rural and remote tribal areas, the numbers of health and specialist mental health staff are limited. Recruitment, retention and ongoing professional development and support are key issues for community mental health staff working in isolated settings and geographically isolated teams.

Rural and remote tribal mental health services generally operate on a primary health care model founded on strong capacity building and partnerships with primary health and community services.

Scenario of Mental Health Resources: - Resources for mental health include policy and infrastructure within states mental health services, community resources, human resources and finical resources. We discuss here the over-all availability of these resources especially in low-income and middle income countries. Government spending on mental health in most of the relevant countries is far lower than is needed based on the proportionate burden of mental disorders and the availability of cost effective and affordable interventions. The poorest countries spend the lowest percentages of their overall health budgets on mental health. Most treatment care is now institutionally based and the conversion to community care would require additional financial resources that have not been made available in most of the countries. Human resources available for mental health care in most low income and middle income countries are very limited and scarcities are likely to persist. Not only the resources for mental health limited they are also inequitably distributed between countries, between states/regions and within communities. Populations with high rates of socio-economic deprivation have the highest need for mental health care and the lowest access to it. Stigma about mental disorders also constrains use of available resources. PWMIs are also vulnerable to abuse of their basic human rights. Inefficiencies in the use of available resources for mental health care include allocative and technical inefficiencies in financing mechanisms and

interventions and an overconcentration of resources in big institutions. Scarcity of available resources, disproportions in their distribution and inefficiencies in their use pose the three main difficulties to better mental health especially in low-income and middle-income countries. Mental health is an integral and essential component of health. Human, financial and social resources will be needed to achieve the World Health Report objective of adequate access to effective and humane treatment for those who suffer from a mental disorders. These three themes of scarcity, inequity and inefficiency are connected and often seem to emphasize each other. For example, countries with fewer mental health resources commonly distribute them less equitably because they rely on private rather than collective financing mechanisms. In turn the general neglect of mental disorders in under resourced health systems cans affect not only national productivity but also individual quality of life.

Policies and Services Related to Mental Health: - The de-institutionalization movement in the late 1950's early '60s was the single most important reform of the 20th century. Today medical progresses, restriction in involuntary hospital admission, shorter hospital stays, limited discharge planning and extension of home care technology have placed increased costs as well as increased care accountabilities on families who are being asked to shoulder greater care burdens for longer periods of time. The WHO has acknowledged the need for action to reduce the burden of Mental, Neurological and Substance use (MNS) disorders worldwide and to improve the capacity of member states to respond to the increasing challenge. In 2001, national and international establishments and organizations, the public health community and other stakeholders were reminded of the issues of mental health. The WHO Mental Health Gap Action Programmes (MHGAP) provides a comprehensible approach to for bridging the gap between what is urgently needed and what is available to reduce the burden of mental disorders worldwide to strengthen the commitment of governments, international organizations and other stakeholders to increase the allocation of financial and human resources for care of mental disorders; to achieve higher coverage with key interventions in the countries with low and middle incomes that have a huge proportion of the global burden of mental disorders and to promote the human rights of people suffering from mental disorders through innovative policies and service organizations (Saraceno, 2009). Despite recent developments in medical technology, SMD remains a serious disease and a global burden. There is growing recognition within the international community that mental health is one of the most neglected yet essential development issues in achieving the Millennium Development Goals (MDGs). According to the United Nations report, persons

with mental and psychosocial disabilities represent a significant proportion of the world's population.

About 4 out of 5 people in low and middle-income countries who need services for mental disorders do not receive them (WHO, 2010), the reasons for which have not been scientifically studied. In India over 25 million people suffer from mental disorders. Mental health has been on a low importance and has been completely neglected in India. The economic effect it creates has never been understood by policy makers. The burden it creates on family members is least understood, as they are uninformed about their symptoms. In the past several decades, there have been steady improvement in mental health policies and services in Asia. They are:

1) Broadening the scope of psychiatry.

2) Changes from biological psychiatry model to a bio-psycho-social model.

3) Development of community based services.

4) Modification of manpower in psychiatry.

5) Participation of users, caregivers and family members in the development of mental health services.

6) Increase international collaboration in the mental health field.

Mental health needs of the population have figured in the different health surveys and special committees set up in the last 5 decades. They offer an understanding of the hopes and failures in accomplishment in the area of mental health care in the last 50 years. One of the earliest references the turn of the period of this review is the report in the Indian medical review (1938). At that time it was noted that there are 17 mental hospitals in British India with an accommodation for 8425 patients, but the number of patients actually confined in the hospitals in 1936 was 11,792. There was overcrowding in almost all the hospitals but was more acute in Madras, Bombay and the united provinces. Various reports state the situation-

1. **Bhore Committee Report (1946):** If the proportion of mental ill patients be taken as 2 per thousand populations in India, hospital accommodation should be available for at least 800000 mentally ill patients as against the existing provision for a little over 10000 beds for the country as a whole. In India, the existing number of mental hospital beds is in the ratio of one bed to about 40000 of the population while in England, the corresponding ratio is approximately one bed to 300 populations.

2. **Mudaliar Committee (1962):** "Reliable statistics regarding the incidence of mental morbidity in India are not available. It is believed that huge number of patients

requires psychiatric assistance and service as against the total need of the number of beds available in the mental hospitals in India is only 15,000. There is hardly any provision for the mental health education. Provision for the treatment of psychosomatic diseases in general hospitals is inadequate."

3. **Srivastava Committee (1974):** The document plan for immediate action does not contain any specific proposals for developing mental health care programs. One of the important outcomes of this committee's recommendation was the CHV (community Health Volunteers) scheme. Out of the total training of 200 hours, one hour was kept for mental health. One of the 12 chapters in the CHV manual was also devoted to the recognition and management of mental health problems.
4. **Alma Ata Conference (1978):-**Mental health as part of primary health care by this conference, as one of the eight essential components of PHC (Primary Health Center) is important.
5. **National Health Policy (NHP) (1983)**:- Special well coordinate programs should be launched to provide mental health care as well as medical care and also the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, and infirm and the aged.
6. **National Level Initiatives for Mental Health Program:-**The Mental Health Advisory Committee constituted in 1962 met in 1963, 1965 and 1966 to consider the various aspects of mental health needs in the country. The areas that received considerations were
    a. The mental health bill,
    b. Training of mental health personnel,
    c. Improvement of mental hospitals,
    d. Standardized recording system of mental health services and
    e. Regular supply of drugs (Ministry of Health, 1964-66).

As mentioned in various reports, the need for a comprehensive plan to organize nationwide services has been often expressed. The need for a clear plan led to the formation of a group of 3 psychiatrists to assist the president of IPS (Indian Psychiatric Society) to prepare a blue print for national level planning of mental health WHO collaborating Centre, PGI, Chandigarh, April, 1977. However, it was only during 1981, that the Directorate General of Health Services organized a National level workshop to consider a draft mental health plan.

This was held at AIIMS, New Delhi under the convenership of Prof. N.Wig. in July1981. The essential aspect of the suggested plan following the workshop is to stimulate services both in the periphery and the Centre. This is planned to be achieved by suitably integrating mental health care at all levels of health services. The national mental health program is one such program in the country.

The National Mental Health Programme, Government of India 1982 (NMHP) is the outcome of the improvements in providing mental health care through different methods as well as the overall goals of health care in general. The first concerted effort to formulate a national programme was held in July 1981. Over 70 mental health and related professionals met at New Delhi and reviewed the needs in the area of mental health and the possible approaches. The result of this workshop was a draft NMHP for further consideration. On 2 August 1982, a small group of experts met to consider the revised document and finalize the same. This document was presented to the Central Council of Health and Family Welfare at its meeting between 18 and 20 August 1982. This body the highest policy making body in the realm of health, recommended the NMHP for implementation.

The Objectives of the program are:-

- To ensure availability and accessibility of minimum mental health care for all in the foreseeable future particularly to the most vulnerable and under privileged sections of the population.
- To encourage application of mental health knowledge in general health care and in social development.
- To promote community participation in mental health services development and to stimulate effort towards self-help in the community.

At the district level as well there has been a program that is designed to provide mental health care facilities. The District Mental Health Program (DMHP), which operates as part of the National Mental Health Programme was launched in 1996-97 in four districts. By 2000 the DMHP was extended to 22 districts in 20 States and Union Territories and by 2002 the DMHP further extended to 27 districts in 22 States and Union Territories, providing for services to over 40 million of the population. In the current 10th plan period (2003-2007) the government has announced the programs extension to 100 districts across the states with a total budget outlay of 200 Core rupees (286000 pounds). The DMHP promotes a community mental health approach providing training of primary health staff, awareness, detection and treatment in the community.

Emphasis on community mental health care: Mental disorders figure among the leading causes of disease and disability the world over. Depressive disorders are already the fourth leading cause of the global disease burden; they are expected to rank second by 2020. Mental disorders affect 1 in 4 persons. The year 2001 was a landmark in the development of mental health services. Since the problem of mental health problem is a global problem, WHO has chosen the theme: “Mental Health: stop exclusion Dare to Care” during the year 2001, to focus worldwide attention on the issues related to mental health. The past in the history of mental health services has been a gloomy but nevertheless it has taught us many lessons. Past experience of mental health built a strong myth and perception in the community and the common man perceived mental illnesses as stigma, admission in asylum or mental hospital, electric shocks and confinement in institution with sub-human conditions. The picture has changed significantly and the modern mental health care goes far beyond the institutions and in a way it is trying to restore and build confidence of common man and by changing his/her perception through educational programme. Mass media continues to focus on miserable conditions of asylums and mental hospitals and sub-human conditions of these hospitals, to draw the attention of authorities for improving these conditions. Directives of Honourable Supreme Court have made considerable contribution in the area of mental health programme. Similarly the derogatory Indian Lunacy Act of 1912 which was based on earlier English Lunacy Act of 1890 has been replaced by 1987 Mental Health Act with a focus to improve the quality of amenities/care and protect the rights of mentally ill person. Mental health act has been a very important milestone in the development of modern psychiatric services in the country, optimistically, the act is made patient friendly. The State Governments took a long lead time to establish mental health authority and to implement this act.

National mental health programme initiated in 1982 has ultimately come out with community based approach for sustainability of actions as also enhanced accessibility. Development of district mental health programme is a step in the right direction but the progress and coverage is too slow to make any mark on enhancement of the problem. Nodal agency has been identified in each state to undertake in-service training programme of the medical officers and paramedical workers as also to arrange for technical support to district training programme; it adheres to recommended manual by NIMHANS, Bangalore. Two weeks training programme is being scrutinised at the level of medical college by the department of psychiatry (a tertiary level of care). This decision undermines the capacity of district health agencies or district training teams established recently as a training institution for continuing education programme of medical and paramedical personnel. It is acknowledged that

effective delivery of primary health care including mental health care would largely depend upon the nature of education and appropriate orientation towards community health of all categories of medical and health personnel and their capacity to function as an integrated team. Basic training courses of all categories should incorporate adequate time for building essential skills of medical and paramedical staff so that they are able to deal with the problem of mental health within the framework of primary health care. In general we must address the issues of quality of medical education for undergraduates and specifically to the training of students in the discipline of psychiatry to lay firm foundation for development of mental health services at primary health care level. This should be considered as real investment in development of psychiatric health services in the community. Training of Trainers (TOT) is essential to impart need based and relevant training on the key areas of mental health and counselling. Training needs assessment and pursuing the hands on the training with case material and community should become the primary focus with trainers of medical and paramedical personnel. Focus of the training of essential should be on the methods of interviewing and contact with the individuals and families, skills of listening to clients, assessing their needs, counselling and identification of high risk families and clients as also group meetings and dynamics besides community organization and mobilization of resources. Ongoing education should be part of routine meetings. Health teams (Multipurpose Health Workers, Anganwadi workers, Gram Sewikas and Health Guides) should be trained together for better empathetic of each other's role and responsibility. Awareness generation and mental health literacy drives at the level of community through active involvement of Panchayati Raj Institutions, influential groups, non-formal leaders and other organized groups on regular basis can be most productive. Awareness generation campaign must have the support of district mental health services, Community Health Centre, Primary Health Centre and Sub centres system. Ownership of the programme by district health organization and the area is essential for sustainability and endurance. Even the available services for mental disorders are being poorly utilized. Nearly two third of persons with known mental disorders never seek help from health professionals and most patients utilize the services of other agencies and resort to harmful practices and keep on visiting faith healers and delay the treatment till the condition deteriorates which compels them to seek the treatment from established government institutions. Stigma, discrimination and neglect prevent care and treatment reaching people. Mental health literacy needs to be built strongly in the community to scale up the utilization of available mental health services. In the first instance, the amenities and infrastructure for mental health services in public sector are insufficient and

mostly confined to bigger cities and hospitals. DMHP Services for all can be best delivered through primary health care system. Preventive and promotive programme along with awareness generation can be commenced on sustainable basis through this infrastructure. System of Integrated Child Development Services (ICDS) which is composed for universal coverage has played an essential role for mother and child development in rural, urban and tribal areas.

Government or public mental services is just one source for mental health services, Private sector and Non-Governmental Organizations, as also varied health care providers such as practitioners of Indian System of Medicine should be considered as potential resource for primary health care including mental health services. Resource mapping for primary health care as also mental health care should not lose sight of other available organizations contributing to the care or services related to mental health programme. Partnership between government and private sector is an important area for development of mental health services programme at community level. It is widely acclaimed that community care is more effective as well as more humane than in-patient stays in mental hospitals therefore essential to develop mental health services in the community settings as an integral part of primary health care; to root out stigma, myths and misconceptions and discrimination against mental disorders. The World Mental Health report 2001 advocates' community based mental health programmes and active involvement of families and consumers and community in the delivery of programme. People and the community are the biggest resources available in India. Many of the problems in the area of mental health can be effectively dealt with by the people and within resources available close to them. Large-scale dissemination of knowledge and simple skills to people and health volunteers should be addressed through primary health care. Capacity of family must be built and primary health care infrastructure should support the family to build their capacity to prevent and manage the mental health problems within the available resources.

Mental Health and Development: Mental health as an emerging development issue:- Including mental health as an integral part of development is relatively new to the United Nations and its development partners. There is growing recognition within the international community that mental health is one of the most neglected yet essential development issues in achieving the Millennium Development Goals (MDGs).

Mental health signifies a critical indicator of human development, serves as a key element of well-being, quality of life, and hope, has an impact on a range of development

outcomes, and is a basis for social stability. The adoption of the Convention on the Rights of Persons with Disabilities in 2006 by the United Nations General Assembly provided momentum to highlight the importance of the connection between disabilities and mental health in the context of human rights, humanitarian activities and in development work. In addition, the Ministerial Declaration on Implementing the Internationally Agreed Goals and Commitments in Regard to Global Public Health, in the high-level segment of the substantive session of the Economic and Social Council in July 2009, highlighted the importance of integrating mental health into the implementation of the MDGs and other internationally decided development goals and commitments, in order to reduce poverty, promote better health, and accomplish other development outcomes. Poor mental health is both a cause and a consequence of poverty, compromised education, gender inequality, ill-health, violence and other global challenges. It impedes the individual's capacity to work productively, realize their potential and make a contribution to their community. On the other hand, positive mental health is linked to a series of development outcomes, including enhanced productivity and earnings, better employment, higher educational achievement, improved human rights protection and promotion, better health status and improved quality of life.

Persons with mental and psychosocial disabilities represent a significant proportion of the world's population. Millions of people worldwide have mental health conditions. An estimated one in four people globally will experience a mental health condition in their lifetime. Almost one million people die due to suicide every year, and it is the third leading cause of death among young people. Depression is the leading cause of years lost due to disability worldwide. Mental health problems, including alcohol abuse, are among the ten leading causes of disability in both developed and developing countries. In particular, depression is ranked 3rd in the global burden of disease, and is projected to rank 1st in 2030. Even now, depression is the leading cause of disease burden for women in high, low and middle-income countries. The economic cost of mental health problems is vast, while reasonable investment in mental health can contribute to better mental health for people.

Mental health and the Millennium Development Goals:- "Accomplishing the Millennium Development Goals (MDGs): Does Mental Health Play a Role?" We agree with their concern that "**there is No Health without Mental Health.**" However, we do not feel mental health is ignored in the health agenda, nor do we share their pessimism about the potential to reach the MDGs in general.

MDG 1: Eradicate Extreme Poverty and Hunger: Mental health issues should be integrated into all larger development and poverty eradication policies and programs as a key indicator of human development.

MDG 2: Accomplish Universal Primary Education: Education programs should integrate mental health and psychosocial perspectives in efforts to increase quality of education and confirm accessibility for persons with mental and psychosocial disabilities and intellectual disabilities.

MDG 3: Promote Gender Equality and Women Empowerment: Mental health and psychosocial issues should be incorporated into all efforts to promote gender equality and empowerment of women including efforts to fight against gender-based violence.

MDG 4: Reduce Child Mortality: Child development, education, health and protection policies, programmes and services must integrate mental and psychosocial aspects.

MDG 5: Improve Maternal Health: It is essential to integrate mental health into sexual and reproductive health, and maternal health policies and programs. This will contribute to better access to sexual and reproductive services, child and maternal health services, enhancement in child and maternal morbidity and mortality rates and quality of life for women.

MDG 6: Combat HIV/AIDS, Malaria and Other Diseases: Health system reform needs to integrate the mental and psychosocial aspects of health.

MDG 7: Ensure Environment Sustainability: Sustainable development requires that policies and programmes related to climate change, disaster reduction and response, and slum and urbanization integrate the mental health and psychosocial perspective.

MDG 8: Develop a Global Partnership for Development: Cooperation efforts must ensure the participation of persons with disabilities including those with mental and psychosocial disabilities. Efforts to improve information and communication technologies need to integrate the mental health and disability perspectives.

In addition to this, several bilateral agencies have funded some activities to support mental health and psychosocial programmes in countries, such as research programme consortia on improving mental health services in low income countries, activities to strengthen mental health systems and capacity development, programs to improve mental health outcomes in

children, and initiatives to support the integration of mental health into national policies, systems, and programmes.

NGOs Perspectives on Mental Health and Development:- Until recently development programs of most NGOs did not take into account mental health as a development challenge and therefore this issue remained largely unattended especially in low and middle income countries. In relief programs that were seen as short term and focused on saving life mental health needs were often unrecognized. Similarly access to and participation in development opportunities was not considered a basic human right for vulnerable groups especially those with mental health conditions. At policy level mental health issues have not received sufficient attention in national health policies and programs. NGOs have not always prioritized such policies in their advocacy strategies.

Pathways for NGOs to further integrate mental health interventions in their programs:

- Adopt **culturally suitable methods to assess how local people perceive** and conceptualize the challenges associated with mental health and psychosocial disabilities. Field experience shows that how people understand their problems is subject to differences in culture, experiences and their environment; and this in turn impacts on their ability to contribute to and participate in their own development.
- Use **evidence-based interventions** that are culturally suitable, that build local capacity and also inform integrated programming and mental health policy development.
- Ensure **mental health services are available and accessible** as part of primary health care services in all development and emergency relief programs.
- **Strengthen advocacy for the integration of mental health into the national health policy and health delivery systems** with sufficient resources allocated for mental health services.
- Encourage **stakeholder collaboration** to build public and political support for enhanced **community based partnerships** for high profile advocacy and education to build comprehensive community mental health services as part of all development efforts.

Basic Needs India's (BNI) Community Model: - The Trust grew out of the belief that the rights of people who experience mental illnesses, especially those who are poor, must be addressed not only at an individual level, but also in the context of a wider world.

Organisation was instrumental in experimenting and promoting Community Mental Health & Development Model with a small group in India. BNI's main role is that of constructing a caring, accommodating and understanding environment to ensure fair treatment of people living with mental illnesses. The first step is developing right partnership through identifying community-based organizations (CBOs) and non-governmental organizations (NGOs) who are willing to include the needs of people with mental illness in their ongoing developmental work. The organisation works with their staff and facilitating appropriate and orientation and capacity building processes through training and handholding in the areas of mental health, economic empowerment, social inclusion etc. The organisation works with partner organizations in Maharashtra with highlighting on rights and development approaches. The consultation with affected people and family members resulted in a comprehensive strategy in addressing mental health within their own communities, economic empowerment, social inclusion and human rights violation and research in relevant areas to advocate for their own entitlements and rights. BNI’s community mental health model comprise following five aspects.

1. **Community Mental Health:** The purpose of this model is to assist individuals with mental illnesses in experiencing and acting upon their full potential as human beings in their own communities. With the assistance of professionals and BNI staff, partner organizations receive training to design and implement care programmes in the community. People living with mental illnesses attend camps to receive treatment. Community-based follow up processes are set up. These include individual home visits and group meetings. Local doctors are trained in basic psychiatry so that nearby services are available. Self Help Groups comprising people living with mental illnesses and carers are formed.

2. **Capacity Building:** builds capabilities among a range of people-people living with mental illnesses, family members, carers, staff members, staff members of CBOs and NGOs and psychiatric professionals, to adequately address mental health issues in various spheres. The trust works continuously with CBOs and NGOs as a partner. Staff members of organizations are trained in animation techniques, process reporting, participatory evaluation, and basic research which involves information gathering. The training equips them with skills to bring affected people together and to address issues both within and outside communities. The focus is on community development by working with people living with mental illnesses and their carers, recognizing that such people are discriminated against and marginalized.

3. **Sustainable Livelihoods: P**overty is both an outcome and root of mental illnesses. Thus, involving people living with mental illnesses and family members in economically viable

activities is a critical step. The programme addresses the central issues of sustainable livelihoods and poverty alleviation. The trust has developed an approach that builds the confidence of people living with mental illnesses and addresses their treatment needs so as to permit them to engage fully in economic activities. Ensuring gainful occupation is an essential part of a process that enhances confidence and facilitates integration into the family, community and society. Economic development programmes suitable for the individual and family members are designed. CBOs and NGOs are trained in identifying local resources and economic opportunities. People living with mental illnesses form their own savings and credit groups or join other such existing groups in the community. Essential links are made with micro finance organizations and with locally based employment schemes run by the Government.

4. **Research and Advocacy:** Life stories and other relevant experiential data are documented. These provide the basis for significant insights that influence the programme and are shared with other organizations. Partner organizations track changes in individuals. Factors influencing changes are recorded and made use of for people's benefit. Advocacy work involves ensuring the implementation of existing government policies, influencing formation of new policies and enabling people to directly access government facilities.

5. **Administration and Management:** A Board of Trustees comprising individuals who offer their services voluntarily as custodians of the ethos of the organization governs. Partner organizations are assisted in the areas of project management that includes finance, monitoring, evaluation and reporting. It is in this context that the decade long interventions on community mental health and development (CMHD) assume importance. In an effort to understand and intervene in mental illness and mental health from a social development and rights paradigm, trust developed the CMHD approach.

The program has sustained in its core areas in spite of fluctuations in funding resources. The work has also opened up several community level needs and dynamics yet to be engaged with. In the orientation to field staff organized an induction during the initial phase of the program for the staff of partners working in the field. The topics were on mental illness, types of illnesses, symptoms, misconceptions, and the difference between mental illness and mental retardation. This input helped them to identify the affected persons initially through door to door survey, small group meetings and referrals from other programs of partner NGOs. After identification the field staff during the visit to families, faced resistance and non-cooperation from affected persons and their families. They expressed their discomfort and fears about interacting with people on these issues. Organisation facilitated a

series of interactions with affected persons and their family members, understanding family dynamics and mobilizing community support. Family visits, being a key intervention, helped the team to develop confidence in their day to day work and laid the foundation to build relationship with the stakeholders. Many consultation meetings with affected persons and their family members helped in getting better insights to work with these people. An urgent need to educate caregivers and community on mental illnesses was felt by all those working at the ground level to address the issues of stigma and discrimination. Different strategies were adopted and they were designed to be cost effective, promoting community participation and utilizing the existing skills within the group.

1. **Poster campaigns:** - Distribution of posters on mental health issues in the community and putting them up in schools, gram panchayat office, community hall and public spaces in the communities.
2. **Street plays:** - street plays were held regularly in communities; socially relevant themes were selected to convey messages on misconceptions, beliefs and fears on mental illness and on their management. On the morning of the event, the team performing a street play would make announcements throughout the village and performances were usually held in the morning or evening. A central place within the village or common place became the venue for these events which lasted about an hour. Contact details of the team were given if people needed any further information and clarifications. Street theatre, thus served not only to disseminate the issues of mental health, but it also built rapport for the organization with the community.
3. **Wall-writings**: - The team, along with affected persons and families, sketched messages in Marathi on mental health issues on the walls of public utility buildings in the village. The team painted sketches and messages on symptoms, possible causes and treatment. In the second phase, the role of community in addressing the issues was highlighted.
4. **Groups**:- Groups like women SHGs, youth, CBOs, Anganwadi workers, school teachers and children where oriented on mental health issues through talks, display of posters, pamphlets and video shows. Sessions were conducted as part of the awareness drive focused on signs and symptoms of mental illness, causes, other options for treatment, misconceptions, and the role of community in prevention of mental illness and on various entitlements available from the government for the affected persons. Further, voluntary disclosures also increased as families and affected

persons themselves came forward to express their difficulties. Community participation and ownership of these awareness activities improved over a period of time. Many cases of human rights violations like physical abuse of affected persons were brought to notice and the team worked to reduce such incidents. Care-givers groups evolve deep rooted social fears; stigma and marginalization have pushed many affected persons into isolation and have kept them in that situation. Visit to families helped many of them to talk about their problems and helped to convince community members to question their assumptions and misconceptions about mental illness. The team facilitated residential camps, consultations and workshops for caregivers. The objectives were to educate individuals and family members on mental illness, misconceptions and cultural beliefs, anxieties related to treatment, marriage and livelihoods. When care-givers started interacting with one another during these camps they were able to empathize and relate to each other's problems. Thus it was easier to form a peer group. Care-givers met every three months with support from the field staff. They discussed treatment options, recovery and attitudinal barriers within the family and community.

5. **Advocacy: -** As people faced difficulties in accessing treatment facilities, they started to express the need for better access to doctors and medicines and information on other treatment options. The needs were prioritized. The first priority was treatment but many families could not afford the travel expense and to buy medicines. The team assisted by giving them the travel costs. Some others were supported through small income generation activities to supplement their income and to increase their self-confidence. Cognizant of the situation, the team started giving information to affected persons and their family members on their rights. This triggered the caregivers thought process and they realized that some of their basic needs were actually their right and that the government was obliged to fulfill them. With these objectives, the team along with affected persons, caregivers, representatives from women self-help groups, youth and CBOs organized a rally and a press conference on World Mental health day to raise awareness on mental health issues. The team and care givers groups presented a memorandum to various government health authority which included a list of demands like appointment of additional resources for mental health; availability of medicines at Primary Health Centers (PHCs) and in all district hospitals; rehabilitation of destitute mentally ill persons and sensitizing police personnel and judicial authorities on mental health issues, all those involved in

advocacy efforts were determined to forge ahead and strategize their moves. The rally proved the importance of hearing people's voices. Often the NGOs acting as mediators in advocacy are perceived to be soft in their approach with government officials.

Conclusion:- Social and economic impact of poor mental health is universal and far reaching, leading to poverty, high unemployment rates, poor educational and health outcomes. There is a need for a wider recognition of mental and emotional well-being as a core indicator of human development and it is necessary to integrate a mental health and psychosocial perspective into holistic development and humanitarian policies, programmes and services, particularly those related to MDGs (Millennium Development Goal). Today there is a great need of integrated studies upon poverty and mental health, because both of these are interconnected and interdependent with each other's. Therefore mental health issues need to understand from the development perspective. Accomplishing education for all requires mainstreaming and inclusion of mental health and psychosocial issues into educational programs. In addition, mental health must be considered as an integral part of all the efforts to protect and promote human rights and equality including those related to gender. Mental health issues should be included in all health policies and programmes, including prevention, treatment and rehabilitation. Integrating mental health into primary care programmes through the provision of effective evidence-based interventions will improve accessibility of care and alleviate the negative impact of these conditions. Mental health can be also promoted through a variety of social interventions. Successful and sustainable development policies and programmes require reorientation on mental health issues through improved recognition of the links between development programmes and mental and emotional well-being and the inclusion of persons with mental and psychosocial disabilities to achieve development for all.

The CMHD program brings light in the life of PWMI's (PWMI said during the interview that "*Kutrya Sarakhe Jivan Jhale Hote Amche, Ata Manasa Sarkhe Jagat Ahot*"- "earlier our life was like a dog, now we are treating as a human"), families and the communities it's also evidently address stigma and discrimination through various innovative programs for empowerment of all community stakeholders in terms of building understanding and knowledge about mental health and mental health issues.

References:

1. Basic Needs, Impact Report (2008).
2. Bhargavi V Davar Deepara Dandekar, Women and Mental Health a beginning, Pune (2002).
3. Bhore, J.Health Survey and Development Committee.1946; Government of India. New Delhi.
4. Byrne, P, Stigma of Mental Illness and Ways of Diminishing it: Advances in Psychiatry Treatment, P(2000).
5. Community Mental health News, District Mental health Programme, (1988), Issue No.11 and 12, 1-16.
6. Crisp, A. H, (1999), "The Stigmatization of Sufferers with Mental Disorders" British Journal of General Practice.
7. Gender and women's mental health factsheet. Geneva, WHO. Accessed 15 August. (2010).
8. Government of India. 'Implementation of National Mental Health Programme' Ministry of Health and Family Welfare, New Delhi. (2009).
9. Indian Journal of Community Medicine Vol. XXVII, No.4, Oct.-Dec., 2002 Moving away from Mental Institutions-towards Community Mental Health Care.
10. Janardhan & Bitopi, Introduction to India and Mental Health in India, 5th edition of E-Journal, Mental Health and Development (2006).
11. Janardhana, N. & Shravya Raghunandan, Caregivers in Community Mental Health – A Research Study, Basic Needs India, Bangalore (2008).
12. Kay, A. (2006) 'Social capital, the social economy and community development.' Community Development Journal, 41 (2) 160-173.
13. Miranda JJ, Patel V. Achieving the Millennium Development Goals: Does mental health play a role? PLoS Med. 2006; 2: e 291. doi: 10.1371/journal.pmed.0020291
14. Naidu, D.M. Putting People First, Basic Needs India, Bangalore (2006).
15. Patel V, Kleinman A. Poverty and common mental disorders in developing countries. Bull World Health Organ (2003) 609-15.
16. Patel V, Thara R, editors. Meeting mental health needs in developing countries: NGO Innovations in India, Sage (India), New Delhi, (2003).
17. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. (2007) No health without mental health. The Lancet. 370:859-877.
18. Sartorius N. Stigma and mental health. Lancet 2007 Sep 8; 370(9590):810-1.
19. Shobha Raja. The Way I Have Recovered, Basic Needs India, Bangalore.
20. WHO. World Health report 2001-Mental health-New understanding, new hope, Geneva(2001).
21. World Health Organisation, Mental Health Gap Action Programme (2008)
22. World Health Organisation, World Health Report: Mental Health, New Understanding New Hope (2001)

Chapter-2.

Review of Literature

This chapter deal with the review of literature related to the study. Review of literature is done to obtain scientific information relevant to this study. The studies reviewed have been presented under the following headings mental health, mental illness, burden on caregivers of mentally ill, awareness of mental illness among caregivers and impact of the community mental health and development model on rural and tribal area.

Brief review of theories of mental health:- The individual's mental health is determined by the family and the interactions among and promotion. Thus we have healthy persons when we have healthy family. Schizophrenic with the middle socio-economic classes showed a tendency to verbalize more, conflict, in the family as compared to those coming from low income class, who denied, hostility, and 'conflicts' and over-verbalizations' of their family members. Mental health is among the most important public health element. The mental health is the most essential and inseparable component of health. There are a number of components and dimensions that contribute to positive health. There are other related components like spiritual, emotional, vocational, philosophical, cultural, economic and educational, beside the physical, mental and social dimensions. Thus, the health is multidimensional. Mental health is defined as, a state of balance between the individual and the surrounding world, coexistence between the realities of the self and that of other people and environment.

The research suggests that certain patient factors may increase family burden. These factors include the severity of patient's symptoms, length of time in the hospital, number of hospitalizations, the length of time the patient has been ill, and the level of social functioning (Magliano et al 1998; Dyck et al 1999; Magliano et al 2000). There is evidence to suggest that positive symptom behaviours such as hallucinations and delusions along with a high degree of social dysfunction and frequent relapses are associated with greater family burden than negative symptoms of apathy and social withdrawal (Magliano et al 1998; Webb et al 1998).

Although the literature shows a moderate relationship between the level of patient disability and psychological distress of the caregiver, there is considerable variability in caregiver outcomes. This may be because of the nature of relationships between caregiver and mentally ill, pre-existing emotional resources of the caregiver, coping ability of the caregiver, availability of economic and social supports and factors, such as gender, personality, caregiving beliefs and values have been found to be significant. (Adler 2001; Songwathana 2001; Yates, Tennstedt, and Chang 1999).

A small survey conducted by Dr. R. L. Kapur (1995) in one of the villages about 14 km from Bangalore, saw a family taking care of a PWMI for the past 10 years, without any treatment. When he congratulated the family on their efforts in taking care of the PWMI, they said, "Doctor, if we had the money to take this person to the hospital, we would have gone and left him there. We just don't have the money to take the person with the hospital and that's why he is here".

WHO collaborative study (1980) on "determinants of outcome of severe mental disorders" focused on expressed emotions in cross cultural context. The study found that there are far fewer critical comments made by Indian families than by British and within the Indian families rural relatives were significantly less critical than urban relatives. Over involvement was virtually absent in Indian sample. City dwellers show a shift towards western patterns of expressed emotions. Indian families were expressing warmth at the same time they were critical.

The study on the needs of the families and the impact of the family level interventions at the community level was carried by Suman et al 1980. The psychosocial problems of the families was categorized as, high level of expectations, emotional over involvement, problems related to the long term treatment, lack of understanding of patients residual symptoms, problems related to marriage and problems related to rehabilitation. Majority of the families are not able to understand the residual symptoms of the severe mental illness. The study concluded that family members have multiple needs when living with a person with chronic schizophrenia. The needs should be understood and met to enhance the functioning of the family to provide care and thereby reduce emotional problems of the family members.

The social disadvantage for psychiatric patients in terms of unemployment, impaired relationships, social isolation and downward social drift have been well described and problems experienced by care givers have been researched. Several interventions with the

families and caregivers have been developed (Goldstein et al 1978; Leff et al 1982; Fallon et al 1984; Tarrier 1991) that combine family intervention along with neuroleptic medication as a means of preventing relapses and faster recovery of persons with mental illness. The results have shown that family psych education, care givers involvement in the treatment process would increase the level of social competences, decrease the subjective burden on relatives, change in communication pattern and change in the overall interaction within the family.

However, one research does talk about profile of the Relative/ attendant which concludes that in both experimental (80%) and control (73.3%) group, the relatives were predominantly male (Subramanya shetty et al 1995). Regarding their income, 40% of control group and 30% of the experimental group earned less than Rs. 1000 per month.

Little research has been done to understand the profile of the care givers, i.e. the people who are actually caring for the people with mental illness. This becomes important in understanding the family of the people with mental illness, presence of a secondary caregiver and the involvement of the secondary care giver in the wellbeing of people with mental illness. Also, enough information regarding what the families did to overcome their problems and what are the types of caring the caregivers give while caring for the PWMI are not available.

Mental Health: Neglected Area: - Among several non-communicable diseases that women endure, mental health is an area neglected by families because of the stigma attached to seeking care and the traditional beliefs that are held. Further, the available health services are inadequate and presumably not gender sensitive. The World Health Survey (2003) had gathered self-reported morbidity and coverage (percent of persons treated) for six non-communicable diseases. They are angina, arthritis, asthma, diabetes, depression and psychosis. The survey observed a prevalence of 27% indicated each for arthritis and depression followed by angina (18%) and asthma (5%). Highest coverage is indicated for diabetes (71%) and angina (65%). On the other hand lowest coverage is indicated for depression. A greater proportion of males have been diagnosed with angina, asthma and diabetes whereas a greater proportion of females were diagnosed with arthritis, depression and psychosis. Among all the six non-communicable diseases, depression emerges high-urban (38%) and rural (24%). However, coverage for depression seemed to be low for both males and females. The World Health Survey (2003) had also probed into questions of 'worry or anxiety' in the last 30 days in Maharashtra. The survey found that 50% males and

only 39% females reported that they have no worries and anxieties. Higher percentage of women, individuals belonging to rural areas, of low levels of education, of higher ages and lower incomes reported moderate to severe levels of worry or anxiety. These findings do indicate the general presence of distress linked to problems of employment and growing agrarian distress in the rural area. In Maharashtra, the non-communicable disease load coupled with communicable disease load will have serious consequences for the poor in general and women in particular.

Theoretical Explanations of Stigma:- Stigma is a social construction that defines people in terms of a distinguishing characteristic or mark and devalues them as a consequence (Jones el ai, 1984; Crocker el ai, 1998).

In 1963, Erving Goffman explored the phenomenon of stigma as an attribute that is deeply discrediting. Such attributes include 'physical deformities', 'blemishes of individual character', 'tribal stigma, of 'race', 'nation' and 'religion'. The stigma of mental illness can be either discrediting (when it is obvious to others) or discreditable (when it is not obvious to the others) (Goffman, 1963).

In I986, Coleman in his synthesis of "the dynamics of stigmatization" stated stigma as a dilemma of difference. It is a fact that all human beings differ from one another in a multitude of ways. Age, gender, skin colour, intellectual and social characteristics are but a few of these differences. Earlier (Goffman, 1963) had a similar idea that it is a fact that human existence has no two people who are exactly alike, certain of these attributes become defined as undesired differences or stigmas of which these differences when defined undesired to a certain extent are arbitrary.

Agarwal (2004) in his book on 'Mental Health an Indian perspective mentioned that, National Mental Health Program 1982 was the outcome of the various initiatives taken to provide mental health care to the population in India. He also mentioned that it aims to provide mental health services to the community at large. The central council of health and family welfare had recommended that mental health should be an integral part of the total health program and should be included in all national policies and programs on health, education and social welfare.

Agarwal stated that in India before independence there were no clear strategies on mental health policies for the care of mentally ill persons. There was asylums approach for custodial

care rather than therapeutic or rehabilitation centres. In 1983 the National health policy suggested that a 'special well-coordinated program' was launched to provide mental health care, as well as medical specific activities for integrated policies, include mental health policies and financing. Legislation and human rights, organization of services, prevention and promotion, education and communication to awareness, advocacy against stigma and discrimination, enhance research capability; enhance quality and effectiveness of the mental health services. Mental health act was revised and integrated into the mental health services bill mental drugs have been added in the essential drugs list. Mental health has been included as a component of the national minimum health care package, and now mental health is a part of the health ministry budget.

Related Studies on Mental Health:- Shivkumar (2001) mentioned that the mental health is becoming an integral part of our society and family development program. Mental health counselling and family counselling are the important aspects of social psychiatry. Family health is the physical, social, economic, emotional psychological and spiritual wellbeing of individual in the family; which leads to a happy and harmonious family life, clearing doubts solving information deficiencies and fully adjusted to familial and social environment. He also stated that the counselling is the social work process through guiding; helping enabling, enhancing problem solving, healing, caring, modifying and developing behaviour and personality for happy family and individual and thus the counselling provides socio-psychological and informational preparedness to the clients.

‘No health without mental health’ was the theme chosen by the World Federation of the Mental Health for 2004. According to the figures quoted at a conference held on October 2004, every year 2.5lakh of people in India are diagnosed with serious mental disorders.

Bharati et al (20o2), in her study has stated that with changing times there has been a rise in the prevalence of psychiatric disorders. Five out of 10 leading disability illnesses belong to mental illness. Probably the greatest barrier in improving the quality of life of these patients is the stigma associated with them and discrimination they face by the society. It is not only the general population who stigmatize the psychiatric patients, the general practitioner doctors stigmatize even more than them.

Nanda (2001), in his study on the Knowledge of causes of people about Mental illness in urban and rural area stated that there are no differences between urban and rural respondents concerning the behavioural and emotional dimensions. A large number of respondents have

indicated stress, anxiety, failure in life and inability to cope with problems as important reasons for mental illness. He found that myths and misconceptions do exist; and also over thirty percent respondents indicated that mental illness results from sins committed in past life.

Kulhara (2000), mentioned in his study about traditional healer were playing role in mental illness. In a study of 75 consecutive psychiatric patients at the psychiatry department of B.J. Medical College, Ahmedabad, 74.7 percent of the patients had consulted a traditional healer before coming to the hospital. Out of these 33.3 percent had consulted a tradition' healer one place only, while 17.3 percent had gone to more than ten such places.

Related Studies on Awareness:- Desai (2004) mentioned that with greater awareness and sensitivity of the public, people should accept and accommodate and make it easy for persons who have psychological, emotional and social problems in the family and community to seek the help of experts. Emphasizing the need of public awareness about illnesses, Kareer (2004) stated that treatment of mental illnesses is either delayed or it's not sought, this is because of the lack of awareness and stigma associated with it. Not only do individuals suffer as a result, but their family and friends also unnecessarily undergo the trauma.

Awareness of healthcare providers, about mental illness in the community, is very important aspect as they fail to identify these diseases. Bhagat et al (2001), study on ignorance and misconceptions about mental health in the rural tribes of the Jharkhand state. The study reports, the areas of ignorance and misconceptions about mental health in the rural tribes of the Jharkhand state. The result indicated that majority (81 percent) of the tribes believed that insanity was caused by evil spirit. About 72 percent of the tribes believed that insanity is the only cause of crime and that only pilgrimage can cure mental illnesses. The study recommended a need for intervention to remove ignorance and misconceptions and to promote the medical help.

The Evidence based on mental health has over the last decade, gained considerable currency, especially in the dial-up world with the increasing activism of consumers, as well as health policy makers. However in the developed world there has been considerable scepticism about evidence based mental health among the mental health fraternity. There has been paucity of literature regarding the awareness, attitude and barriers to the practice of evidence based mental health from developing world.

Sinha, et al (1998), in their study on Psycho-social responses of family members in pre-hospitalization stage of a mentally ill patient, stated that there are various types of psychosocial responses of family members of the mentally ill patients. Literature suggests that only when the symptomatic behaviours become unbearable and unmanageable at home do the families go for psychiatric consultation. Before that family members tried to use a number of defence oriented strategies, like denial, fear, frustration, shock and at last they accept the situation. The main areas studied were awareness about nature of patient's problems, coping with the problem and previous attempts to understand and manage the problem.

Shrinivasan (2004) stated in his study on Caregivers advocacy in mental health, that most policy decisions about mental health services were made by government officials and mental health professionals, on behalf of the largest stakeholders, but without their participation. Persons suffering from mental illness and their families become stakeholders. According to her this is social, legal and political violation of basic human rights of the affected persons and their families or caregivers.

A National family caregiver associations study mentioned that, the educational support was most beneficial to the caregivers, when they were having problems of anxiety, feeling of loneliness, isolation and depression.

Kalathil (1999), in her study on 'The family and mental health' said that the isolation that the family faced in caring the mentally ill seems to be the result of a lack of understanding leading to mental distress.

Prachi (2005) mentioned that the caregiver of the mentally ill have very limited information on the treatment of mental problems and what goes on inside a psychiatric clinic. They seldom try to empathize with the mentally ill as a 'human being, This behavior occurred because the caregiver had very limited knowledge of the mental illness and what it involves for the patient and his family. The study also mentioned that once people get information on these issues, their attitudes become more understanding and relatively positive towards people with mental illness. By doing so, the stigma attached to mental illness can also be reduced considerably, since lack of knowledge often engenders wrong ideas and beliefs.

Impact of Social Stigma on PWMIs and Caregivers:- Goffman explains that the consequences of possessing a stigmatizing attribute result into denial of acceptance in the

society, respect and regard from others. Although it may not be possible for people to conceal a mental illness, how to manage information about their condition can be a potent source of stress, anxiety and further feelings of stigma even in the absence of any direct discrimination (Goffman, 1963). The attitudes, attributes, perceptions and practices towards mental illness have had several consequences on people with mental illness including lack of respect, oppression, rejection, and denial of basic human rights. Some stigmatizing attitudes bring "internalized stigma" and its consequent effects on the person include low self-esteem, low motivation, anger, depression, heightened sense of vulnerability, social isolation and stifling of growth and productivity.

It is for these reasons that a study was carried out that would benefit MHU and other civil society organizations dealing with PWMIs.

Recovery and well-being:- The concept of recovery People outside the field of mental health may not be familiar with the passion and debate associated with the concept of recovery from mental health difficulties. When people recover from their physical ill-health, generally they are cured and their illness has gone. Bio-medical psychiatrists describe mental health problems and recovery within the same clinical framework.

In contrast, many community development (CD) practitioners favour a social model of mental health which acknowledges that our emotional well-being is affected by social and economic aspects of daily life and the social barriers or exclusions which exacerbate ill-health.

The definition of recovery adopted here fits within this social model and is provided by people who describe themselves as ‘survivors’ or ‘service users’ of the mental health system (Box 1). Recovery, as they define it, does not necessarily imply an absence of ill-health. It acknowledges the long term nature of many mental health problems, but denotes a process of change as an individual regains hope, acquires a new sense of self and purpose, takes control of their life and makes decisions about what to do and what help to call upon should this be needed. An important aspect of recovery for them is overcoming the isolation and sense of worthlessness associated with mental ill-health. Gaining good relationships and work are important milestones for many, but each individual seeks and finds recovery in his or her own way, so each person’s journey will be different. It is a continuing journey of personal growth, and there is no specific goal or endpoint (Repper and Perkins, 2003).

Box 1 Recovery

- Recovery is not the same as cure.
- Recovery is about growth.
- Recovery can and does occur without professional intervention.
- Recovery is about taking control back over one's life.
- Everyone's recovery journey is different and deeply personal.

(Repper and Perkins, 2003)

Having people around you who believe in you; and seeing and hearing other person in recovery inspires hope. Involvement in activities such as volunteering, education or work and feeling you are contributing creates a sense of worth.

(Scottish Recovery Network, Narratives of Recovery 2007)

(Source:-http://www.cdf.org.uk/wp-content/uploads/2012/Connect_and_Include.pdf)

The promotion of recovery, as defined above, is now a key principle in the re-focusing of mental health services. As a concept that is primarily about empowerment, its promotion within statutory services has led to significant discussion of its interpretation, but the policy is broadly welcomed as a step in the right direction.

Recovery and community well-being the emphasis on gaining control, good relationships and personal fulfilment makes the concept of recovery highly relevant to people who experience common mental health problems such as anxiety and depression, and to those whose daily lives are oppressed by economic, social and emotional pressures. Many people are isolated, lacking the hope, resources or connections needed to make the changes they would like (Inverarity, 2003).

Recovery is something that concerns individuals, but Wallcraft (2005) speaks of needing to address the breakdown of community life, the harmful interactions between certain groups of people, and the pressures imposed by rigid cultural expectations and values which we may not choose or be able to satisfy (Box 2). The quality of community life must improve if we are to flourish.

Box 2 Recovery and community well-being

Recovery is not specific to people with mental health problems.

(Repper and Perkins, 2003)

Ultimately, we all need to recover,, from an era in which the abuse of women and children

was kept hidden behind closed doors, from a past riven with class discrimination and racist oppression, from a work ethic that has made it hard for many people to have any quality of life. We need to heal communities where members feel lonely and isolated, where children, young people and older people are cut off from each other. We need to halt the disintegration of supportive communities.

(Wallcraft, 2005)

(Source:-http://www.cdf.org.uk/wp-content/uploads/2012/Connect_and_Include.pdf)

Mental Health and Development:- Integrating Mental Health into All Development Efforts including MDGs

Mental health as an emerging development issue:- Including mental health as an integral part of development is relatively new to the United Nations and its development partners. There is growing recognition within the international community that mental health is one of the most neglected yet essential development issues in achieving the Millennium Development Goals (MDGs).

Mental health represents a critical indicator of human development, serves as a key determinant of well-being, quality of life, and hope, has an impact on a range of development outcomes, and is a basis for social stability. The adoption of the Convention on the Rights of Persons with Disabilities in 2006 by the United Nations General Assembly provided momentum to highlight the importance of the nexus between disabilities and mental health in the context of human rights, humanitarian activities and in development work. In addition, the Ministerial Declaration on Implementing the Internationally Agreed Goals and Commitments in Regard to Global Public Health, in the high-level segment of the substantive session of the Economic and Social Council in July 2009, highlighted the importance of integrating mental health into the implementation of the MDGs and other internationally agreed development goals and commitments, in order to reduce poverty, promote better health, and achieve other development outcomes. Poor mental health is both a cause and a consequence of poverty, compromised education, gender inequality, ill-health, violence and other global challenges. It impedes the individual's capacity to work productively, realize their potential and make a contribution to their community. On the other hand, positive mental health is linked to a range of development outcomes, including enhanced productivity and earnings, better employment, higher educational achievement, improved human rights protection and promotion, better health status and improved quality of life.

Persons with mental and psychosocial disabilities represent a significant proportion of the world's population. Millions of people worldwide have mental health conditions. An estimated one in four people globally will experience a mental health condition in their lifetime. Almost one million people die due to suicide every year, and it is the third leading cause of death among young people. Depression is the leading cause of years lost due to disability worldwide. Mental health problems, including alcohol abuse, are among the ten leading causes of disability in both developed and developing countries. In particular, depression is ranked third in the global burden of disease, and is projected to rank first in 2030. Even now, depression is the leading cause of disease burden for women in high, low and middle-income countries. The economic cost of mental health problems is vast, while reasonable investment in mental health can contribute to better mental health for people.

Vulnerability of persons with mental / psychosocial disabilities:- Persons with mental and psychosocial disabilities often face stigma and discrimination due to widely held misconceptions about the causes and nature of mental health conditions. Persons with mental and psychosocial disabilities also experience high levels of physical and sexual abuse. This can occur in a range of settings, including prisons, hospitals and homes. They encounter restrictions in their exercise of socio-politico-economic rights in the majority of countries, largely due to the false assumption that they are not able to carry out their responsibilities, manage their own affairs and make decisions about their lives.

The majority of persons with mental and psychosocial disabilities in low and middle-income countries are not able to access essential income generation, education, human rights, health and other social services. For example, between 75 and 85 per cent of persons with mental and psychosocial disabilities in low and middle income countries do not have access to any form of treatment.

Mental health and the Millennium Development Goals:- "Achieving the Millennium Development Goals (MDGs): Does Mental Health Play a Role?" We agree with their concern that "there is no health without mental health." However, we do not feel mental health is ignored in the health agenda, nor do we share their pessimism about the potential to reach the MDGs in general.

MDG 1: Eradicate Extreme Poverty and Hunger: Mental health issues should be integrated into all broader development and poverty eradication policies and programs as a key indicator of human development.

MDG 2: Achieve Universal Primary Education: Education programs should integrate mental health and psychosocial perspectives in efforts to improve quality of education and ensure accessibility for persons with mental and psychosocial disabilities and intellectual disabilities

MDG 3: Promote Gender Equality and Empower Women: Mental health and psychosocial issues should be integrated into all efforts to promote gender equality and empowerment of women including efforts to fight against gender-based violence.

MDG 4: Reduce Child Mortality: Child development, education, health and protection policies, programmes and services must integrate mental and psychosocial aspects.

MDG 5: Improve Maternal Health: It is essential to integrate mental health into sexual and reproductive health, and maternal health policies and programs. This will contribute to better access to sexual and reproductive services, child and maternal health services, improvement in child and maternal morbidity and mortality rates and quality of life for women.

MDG 6: Combat HIV/AIDS, Malaria and Other Diseases: Health system reform needs to integrate the mental and psychosocial aspects of health.

MDG 7: Ensure Environment Sustainability: Sustainable development requires that policies and programmes related to climate change, disaster reduction and response, and slum and urbanization integrate the mental health and psychosocial perspective.

MDG 8: Develop a Global Partnership for Development: Cooperation efforts must ensure the participation of persons with disabilities including those with mental and psychosocial disabilities. Efforts to improve information and communication technologies need to integrate the mental health and disability perspectives.

NGO Perspectives on Mental Health and Development.

Issues for NGOs in integrating mental health in their development agenda:- Until recently development programs of most NGOs did not take into account mental health as a development challenge and therefore this issue remained largely unattended especially in low and middle income countries. In relief programs that were seen as short term and focused on saving life, mental health needs were often unrecognized. Similarly, access to and participation in development opportunities was not considered a basic human right for vulnerable groups, especially those with mental health conditions. At policy level, mental

health issues have not received adequate attention in national health policies and programs. NGOs have not always prioritized such policies in their advocacy strategies.

Ways NGOs can further integrate mental health interventions in their programs to improve development outcomes and contribute to achieving the MDGs

- Adopt culturally appropriate methods to assess how local people perceive and conceptualize the challenges associated with mental health and psychosocial disabilities. Field experience shows that how people understand their problems is subject to variations in culture, experiences and their environment; and this in turn impacts on their ability to contribute to and participate in their own development.
- Use evidence-based interventions that are culturally appropriate, that build local capacity and also inform integrated programming and mental health policy development.
- Ensure mental health services are available and accessible as part of primary health care services in all development and emergency relief programs.
- Strengthen advocacy for the integration of mental health into the national health policy and health delivery systems with adequate resources allocated for mental health services.
- Encourage stakeholder collaboration to build public and political support for improved community based partnerships for high profile advocacy and education to build comprehensive community mental health services as part of all development efforts.

Basic Needs India's Community Model: Dr. Janardhan & Ms. Shravya Raghunandan (2008) Basic Needs India Trust (BNI) grew out of the belief that the rights of people who experience mental illnesses, especially those who are poor, must be addressed not only at an individual level, but also in the context of a wider world. Chris Underhill, founder director, Basic Needs UK was instrumental in experimenting and promoting Community Mental Health & Development Model with a small group in Bangalore. Groundwork began in 2000 and the organization was registered as a Trust in March 2001. BNI's main role is that of creating a caring, accommodating and understanding environment to ensure fair treatment of people living with mental illnesses. The first step is developing right partnership through identifying community-based organizations (CBOs) and non-governmental organizations

(NGOs) who are willing to include the needs of people with mental illness in their ongoing developmental work. BNI works with their staff and facilitating appropriate and orientation and capacity building processes through training and handholding in the areas of mental health, economic empowerment, social inclusion etc. BNI works with partner organizations in parts 56 districts in rural Tamil Nadu, Kerala, Karnataka, Andhra Pradesh, Jharkhand, Bihar, Orissa and Maharashtra and urban poor in Bangalore City.

BNI is a mental health agency with emphasis on rights and development approaches. The consultation with affected people and family members resulted in a comprehensive strategy in addressing mental health within their own communities, economic empowerment, social inclusion and human rights violation and research in relevant areas to advocate for their own entitlements and rights. BNI's community mental health model comprise following five aspects.

1. **Community Mental Health:** The purpose of this model is to assist individuals with mental illnesses in experiencing and acting upon their full potential as human beings in their own communities. With the assistance of professionals and BNI staff, partner organizations receive training to design and implement care programmes in the community. People living with mental illnesses attend camps to receive treatment. Community-based follow up processes are set up. These include individual home visits and group meetings. Local doctors are trained in basic psychiatry so that nearby services are available. Self Help Groups comprising people living with mental illnesses and carers are formed.
2. **Capacity Building:** BNI builds capabilities among a range of people - people living with mental illnesses, family members, carers, BNI staff members, staff members of CBOs and NGOs and psychiatric professionals, to adequately address mental health issues in various spheres. BNI works continuously with CBOs and NGOs as a partner. Staff members of organizations are trained in animation techniques, process reporting, participatory evaluation, and basic research which involves information gathering. The training equips them with skills to bring affected people together and to address issues both within and outside communities. The focus is on community development by working with people living with mental illnesses and their carers, recognizing that such people are discriminated against and marginalized.
3. **Sustainable Livelihoods:** BNI believes that poverty is both an outcome and root of mental illnesses. Thus, involving people living with mental illnesses and family members

in economically viable activities is a crucial step. The programme addresses the central issues of sustainable livelihoods and poverty alleviation. BNI has developed an approach that builds the confidence of people living with mental illnesses and addresses their treatment needs so as to permit them to engage fully in economic activities. Ensuring gainful occupation is an essential part of a process that enhances confidence and facilitates integration into the family, community and society. Economic development programmes suitable for the individual and family members are designed. CBOs and NGOs are trained in identifying local resources and economic opportunities. People living with mental illnesses form their own savings and credit groups or join other such existing groups in the community. Necessary links are made with micro finance organizations and with locally based employment schemes run by the Government.

4. **Research and Advocacy:** Life stories and other relevant empirical data are documented. These provide the basis for significant insights that influence the programme and are shared with other organizations. Partner organizations track changes in individuals. Factors influencing changes are recorded and made use of for people's benefit. Advocacy work involves ensuring the implementation of existing government policies, influencing formation of new policies and enabling people to directly access government facilities.
5. **Administration and Management:** A Board of Trustees comprising individuals who offer their services voluntarily as custodians of the ethos of the organization governs Basic Needs. Partner organizations are assisted in the areas of project management that includes finance, monitoring, evaluation and reporting. It is in this context that the Basic Needs India's (BNI) decade long interventions on community mental health and development (CMHD) assume importance. In an effort to understand and intervene in mental illness and mental health from a social development and rights paradigm, BNI developed the CMHD approach.

Community mental health and development program in South India, Gururaghavendra C.E (2011). The program has sustained in its core areas in spite of fluctuations in funding resources. The work has also opened up several community level needs and dynamics yet to be engaged with. In the orientation to field staff BNI organized an induction during the initial phase of the program for the staff of partners working in the field. The topics were on mental illness, types of illnesses, symptoms, misconceptions, and the difference between mental illness and mental retardation. This input helped them to identify the affected persons initially through door to door survey, small group meetings and referrals from other programs of partner NGOs. After identification the field staff during the visit to families, faced resistance

and non-cooperation from affected persons and their families. They expressed their discomfort and fears about interacting with people on these issues. BNI facilitated a series of interactions with affected persons and their family members, understanding family dynamics and mobilizing community support. Family visits, being a key intervention, helped the team to develop confidence in their day to day work and laid the foundation to build relationship with the stakeholders. Many consultation meetings with affected persons and their family members helped in getting better insights to work with these people. An urgent need to educate caregivers and community on mental illnesses was felt by all those working at the ground level to address the issues of stigma and discrimination. Different strategies were adopted and they were designed to be cost effective, promoting community participation and utilizing the existing skills within the group.

Chapter-3.

Research Methodology

Introduction:

The present chapter is an attempt to elaborate all the methodological, procedural aspects of the problem, the field of study, field work experiences, methods of data collection and analysis and ethical considerations. The strength of any research study is in the research methodology adopted for carrying out the study. In any scientific research methodology plays a very significant and crucial role. Edwards (1971) believed that "in research we do not randomly make observation of any or all kinds, but rather our attention is directed towards those observations that we believe to be relevant to the question we have previously formulated. The objective of the research, as recognized by all sciences, is to use observation as a basis for answering questions of interest". Methodology has its own importance in scientific investigation because objectivity in any research investigation cannot be obtained unless it is carried out in a very systematic and planned manner. Scientific investigation involves careful adoption of appropriate research design, use of standardized tools and tests, choosing adequate sample by using appropriate sampling techniques, undertaking sound procedures for collecting data, its tabulation and then use of appropriate statistical techniques for analysing the data. The details of the methodological steps are as follows:

A participatory action research approach was used to assess the enactment of community mental health and development module in tribal area and its impact on the lives of PWMIs and their caregivers. BNI's CMHD program was implemented in six districts of Maharashtra. Among the six districts researcher has chosen Yavatmal district because this district is a tribal district and most of the PWMIs were from tribal community. Different research tools were applied depending on the kind of data wanted. Detailed interview scheduled were used for the PWMIs and their caregivers. On the other hand, Focus Group Discussions (FGDs) were used mainly with community health workers and the general community, where the researchers organized these discussion meetings.

Statement of the problem:

Mental health is on the threshold of developing as one of the most problematic challenges of the urban as well as rural world. While depression is estimated to be the 2nd largest cause of disease burden, in our country, the gross lack of awareness and stigma associated with mental health make it an even more frightening scenario. In the changing urban and rural society where migration, new jobs, breaking of families and old ties has become common place, loneliness and psychological distress are common. The urbanization brings harmful consequences for mental health through the effect of increased stressors and factors such as overcrowded and polluted environment, dependence on a cash economy, high levels of violence, and reduced social support. There is considerable stigma attached with mental disorders and ignorance regarding information about mental illness and available help and treatment. The mental health care services are at present limited to major cities or mental hospitals and departments of psychiatry in medical colleges. Mental health problems at an early stage remain unrecognized and untreated. There is a tendency to conceal even severe psychiatric problems due to stigma. It is proposed to develop models for mental health care in rural areas with focus on extension of mental health care to community level. Increasing the awareness levels of mental health services and reducing the stigma. Mental health is one of the most challenging tasks for mental health professionals. Worldwide, issues related to mental health require urgent attention. In India, approximately 1% of the population (10 million people) has major mental illnesses. Another 5% to 10% of the populations (50 to 100 million people) have minor mental illnesses. Human resources which include psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses are extremely inadequate. In rural areas, the situation is even more grim, with essential resources being much fewer. Women and poorer people face even greater marginalization than others. Everywhere, myths and stigma associated with mental illnesses come in the way of appropriate understanding and care. It should be important to understand the unique mental health needs of tribal and rural areas and planning of resources accordingly. Severe mental disorder is the most common and disabling mental disorder, affecting nearly one percent of the population worldwide (world health report 2001, Janardhan and Naidu 2006). The illness is characterized by delusional and confused thinking, hallucinations and social isolation. In fact, nearly one third of people with severe mental disorders have problem in participating in the structured activity on a daily basis. Constantly care should be provided for motivating people with mental illness to lead life with dignity.

Particularly for poor persons with mental illness (PWMI), it leads to extreme marginalization of the individual and the family, as both these handicaps hampers ability to be productively engaged and to access necessary resources for that. PWMI's initiative is affected by internal factors (within the individual) and external factors (due to lack of specific support facilities). The social stigma further blocks community support and access to resources (Janardhan and Naidu 2006). Poverty and gender compounds these dynamics. Being mentally ill and a female, the family's investment for care is likely to be less and so also other support needed for recovery. Consequences are unhappy lives of the individual sometimes leading to extreme crisis, poor coping abilities of the family, lost productivity and stress in the community. Family has been an essential part of the mental health care programmes in BNI programme. The emphasis on the family as the single most important source of care is fairly unique for India and contrasts with the emphasis on the professionals and institutions in mental health care in the developed countries. Because of the paucity of mental health care, families have been given more responsibilities to care their mentally ill family member. Whether it was by choice or our cultural influence or due to lack of facilities it is difficult to conclude, though there is some evidence to support that family involvement in care was and continues to be a preference of families (Kulhara and Wig, 1978; ICMR 1988). It is unfortunate that the experiences of the families have not been adequately studied and the strengths not been optimally utilized in the recovery of people with mental illness (Srinivas Murthy and Ghosh 2001).

Scope of the study:

Mental health is as important as physical well-being of individuals, societies and countries. Yet only small minorities of the 450 million people suffering from a mental or behavioural disorder are receiving treatment. Unfortunately, in most parts of the world, mental health and mental disorders are not regarded with anything like the same importance as physical health. Instead they have been largely ignored or neglected. Mental and behavioural disorders are estimated to account 12 % of the global burden of disease, yet the mental health budgets of the majority of countries constitutes less than 1 % of their total health expenditure. World health organization actively propagating community mental health for dismantling misconceptions/discrimination, stigma and in adequate services which is preventing many millions of people worldwide from receiving treatment. Many countries have accepted WHO recommendation of inclusion of mental health in the primary health care

and establishing community psychiatry departments to reach the un-reached in the community. The new innovations in modern pharmacological and behavioural medicines are creating hope to the mentally ill and their families in all countries and in all societies. It extends scope for prevention and the availability of treatment at the primary health care unit. The proposed study is emphasizing on best practices in the field of community mental health and development which is emphasize on tribal as well as rural communities in Maharashtra. It will highlight changes happen in the life of PWMIs and also address related issues with mental illness. In the general population mostly people feel or understood that mental health problem are not treatable.

The study is focus on how the community mental health and development module of BNI really work effectively and bring drastic changes in the life of PWMI as well as in the community.

Objectives of the study:

Redman and Mary define research as a “systematized effort to gain new knowledge”. Some people consider research as a movement from known to unknown. Social research tries to rediscover every aspect of man’s evolution as a social animal and every moment even adds new knowledge about the behaviour of man.

- ❖ To understand applicability of Basic Needs India’s Community Mental health and Development (CMHD) module.
- ❖ To know the changes in the lives of PWMIs (Person with Mental Illness).
- ❖ To study the importance of mental health in the development context.

Hypothesis of the study:

The hypothesis is a tentative statement about what is predicted. In other words hypothesis is assumed to true unless proved otherwise.

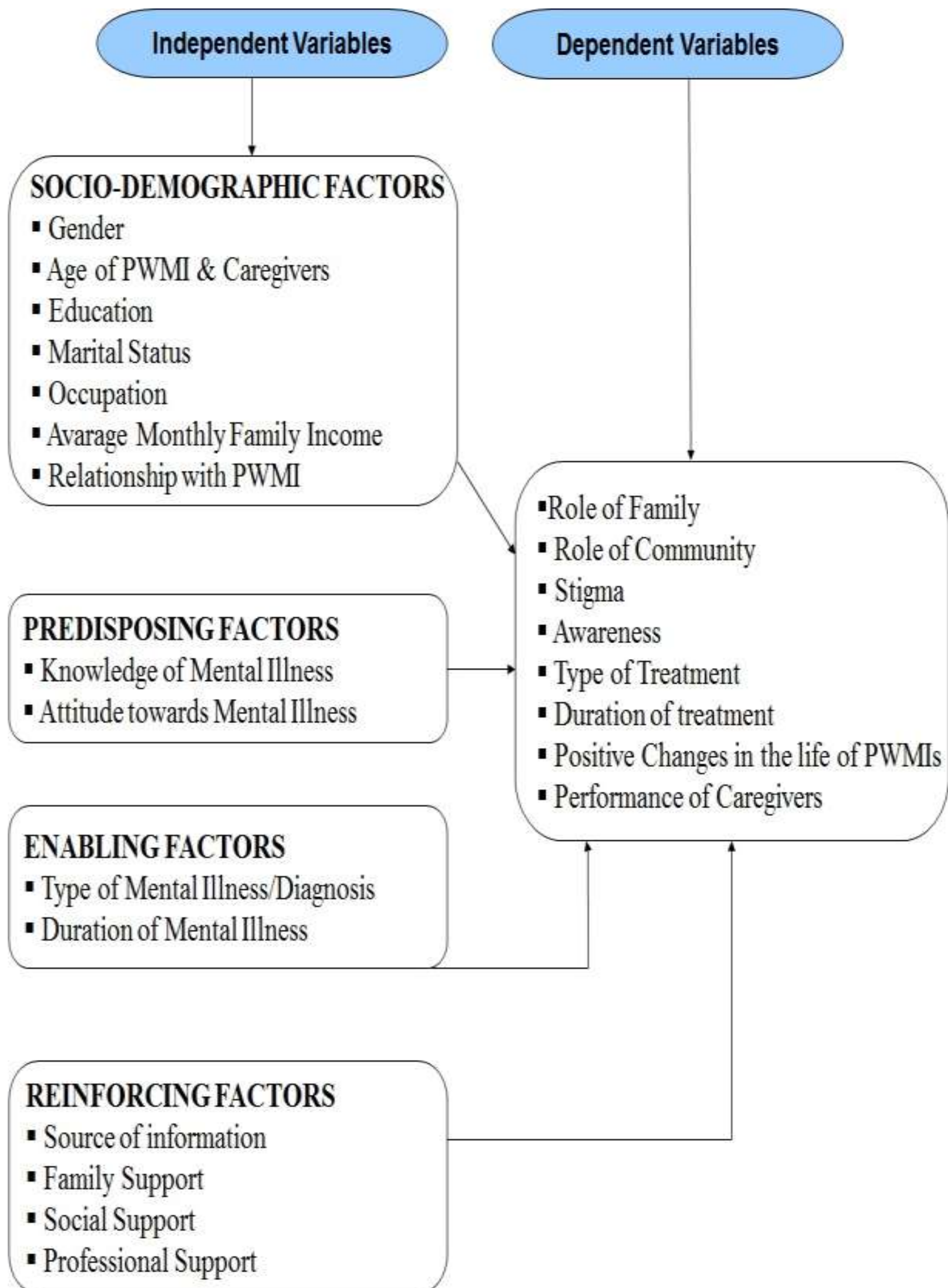
Thus, my study not only probes the area of empowerment among mentally ill person, it also searches the other different factors that are directly or indirectly connected with the condition of mentally ill person and involved in the empowerment process. Therefore, the various other hypotheses that I have also deeply delved into are as follows:

- ❖ Stigma is associated with mental illness due to lack of awareness among the tribal community.
- ❖ Positive changes among the PWMIs life is not commonly perceived due to focus on only clinical aspects.
- ❖ Lack of understanding about mental health issues due to less priority in the development sector.

Research questions:

- ▪ What are the components of CMHD model?
- ▪ How the community mental health and development model of BNI really work effectively?
- ▪ What kind of treatment PWMI received in the initial phase of mental illness?
- ▪ What are the factors playing important role in the recovery of mentally ill people?
- ▪ What level of impact CMHD model created in the life of mentally ill people and in family member and in the community?
- ▪ How mental health issues looked as a development issue?
- ▪ What is the relation between stigma and mental health?
- ▪ Why mental health is a neglected issue?
- ▪ Why stigmas associate with mental illness?

Variables:



Operational Definitions:

Health: - Health is a state of complete physical mental and social wellbeing and not merely absence from disease

Mental Illness: -Mental illness is medically diagnosable illness that results in significant impairment and imbalance in thinking, perception, emotions, moods and feeling, memory, judgment, causing distress and disability.

Mental Health: - The mental health is the capacity of an individual-

- To maintain an even temper
- To maintain a happy disposition and ability to enjoy life
- To maintain balance in life
- To maintain flexibility
- To maintain alert intelligence
- To form harmonious and health relationship
- To participate and contribute to the social environment

PWMI (Person with Mental Illness):- Person living with mental illness, including severe mental disorders and common mental disorders.

Basic Needs India (BNI) Model: - Basic Needs India model include five modules 1) Community Mental Health 2) Capacity Building, 3) Sustainable Livelihoods, 4) Research and Advocacy and 5) Administration and Management.

Severe Mental Disorders (SMD): It is a severe type of mental disorder in -which patients talk and behave abnormally. The functions of the body and mind are severely disturbed resulting in gross impairment of individual and social activities. The types of SMD are Schizophrenia, Bi-polar Affective Disorder, Psychosis not otherwise specified (Psychosis NoS).

Schizophrenia: is a severe mental illness which results in delusional thought patterns hallucinations, inappropriate affect, apathy, de-motivation, and lack of interest. These people will often suffer from social and occupational difficulties, in addition to personal disability

Common Mental Disorders: a class of mental disorder characterized by a disturbance in mood disorders in which the essential feature is severe disturbance in mood (depression, anxiety, elation, and excitement) accompanied by psychotic symptoms such as delusions, hallucinations, gross impairment in reality testing etc.

Stabilized: The indicators for **stabilization** could be seen at two levels i.e. personal level and family level.

Individual level:

- Reduction of symptoms to a large extent and this stage is consistent for not less than three months, with or without treatment.
- Attending to self-care, personal hygiene and daily activities
- Greater understanding of the situation and voluntarily taking the prescribed dose of medication.
- Regaining the insights, judgment, etc.
- Showing interest to participate/involve in the activities of family and community
- Beginning to take responsibilities voluntarily and exploring gainful occupations.

Family level:

- Carer gets relieved of the burden and finds time to engage in her/his own work
- Increased understanding of the illness and its management results in appropriate support to the affected person.

Stigma: Stigma is a negative label or mark that distinguishes people in the community it is manifested in negative attitudes, behaviour and feelings towards the identified group.

Carers: Family i.e...Partner, son, daughter, any other relative or friend who is in the role of taking primary responsibility for the mentally ill person.

Community: A community is a group of people may be linked by common social structures which provide a sense of belonging. Such structures may be derived from geographical location, cultural background, gender and political or religious beliefs. There may be sub-communities within the communities.

Faith Healer: Faith healer is a person accepted by the community for specific rituals carried out with the aim of relieving symptoms of distress. The procedures that are carried out by

faith healers include a wide range of activities like performing elaborate rituals (puja), recommending amulets (tabeez), suggestion for wearing specific rings, branding with rods, chaining in temples, exorcism of jinn and ghosts, animal sacrifices and other similar practices.

Traditional Healer: Traditional healer a person is defined largely through self-identification as indigenous in communities, Traditional healing is usually free of cost, but necessitates some kind of offering who live close to their homes and are personally known to them and their families. Traditional healers are integral parts of their communities and are so commonly sought out as a resource.

Spiritual Healer: People of diverse religions and faiths have termed this healing procedure as a process undertaken to transmit the spiritual energy provided by the Almighty. With a range of spiritual healers(saints, gurus and their ilk) getting recognition for curing people through this spiritual therapy, it is defined as the process of transmitting spiritual energy derived from the God to the patient via a healer.

Research Design:

The research design of this present study is an 'explorative' one also known as the design of descriptive studies, as it explores accurately the characteristics of a particular group or situation. It is a design that was logical and systematic. Firstly this design was chosen for deciding the mode of processing and analyzing the data and find answers to questions that were raised through the statement of objectives. Secondly, this design was concerned with planning the most optimal manner in which the data collected can be summarized and analyzed. It was a scientific and planned strategy. Under this research study, researcher was studied effectiveness of BNI's community mental health and development module hence this research study comes under 'Descriptive' study as well as research design.

Research Methods:

Due to the massive universe and large number of respondents in the research study the researcher used ‘Survey method’ as a research method.

Sampling and Sample Design:

- **Universe of the study: - Universe** of the study was 58 villages (Villages & Hamlets) of Yavatmal district in the state of Maharashtra. In these villages BNI’s partner organization (SRUJAN) implemented CMHD program that was

- **Sample size: -** In this research study the sample size was selected from the available list of PWMIs who were listed under stabilized category. All the stabled PWMIs registered in the organization and the same numbers of caregivers of the stabled PWMIs were chosen. The number of PWMI was 150 and their caregivers 150 (150+150= 300). In all the total sample size were 300 respondents including PWMIs & caregivers. Two Focus Group Discussions (FGDs) comprising of 16-20 participants of community health workers (CHW) and the general community are also included in the sample.

Methods and Techniques to Draw Sample:

In the present study researcher was fully aware about the universe of the study as well as list of respondent was made available with local organization therefore ‘Stratified Random Sampling Method’ was used under the ‘Probability’ methods of sampling method. Stratified Random Sampling also sometimes called proportional or quota random sampling; this method is generally applied when different category of individuals constitutes the population viz general. To have an actual picture of a particular population it is advisable to categorize the population on different basis otherwise some section may be under-represented or not represented at all. For drawing exact number of respondent researcher used ‘Numbering Technique’.

Method of data collection:

- **Source of data**:
    1. **Primary data: -** In the source of primary data collection researcher used 'Interview' and observation tool in the field to collect direct information from the selected respondent.
    2. **Secondary sources of data collection: -** In the source of secondary sources of data collection researcher used secondary sources of data collection as listed following things for this research study.
        - Acts, bill, Drafts and polices documents
        - Nation Health policy of government of India
        - Academic research
        - Articles and news
        - Reports related community mental health.
        - Government resolutions and reports on mental health.
        - Reports and discussions papers by the NGOs and forum working on mental health issues in India.

Data Processing:

After the collection of data the next step involved was arrangement of the data for processing and analysis, after which inferences were drawn, which resulted in findings. The careful and systematic processing thus gradually led itself for statistical treatment. There were two types of data that was collected, qualitative and quantitative. The processing of this data involved the following steps.

Part 1. Quantitative Analysis included:

- Statistics
- Chi square
- Coefficient of Contingency
- Probability
- Simple tables
- Cross tables
- MS Excel and Word
- Statistical Package for Social Sciences (SPSS)

Part 2. Quantitative Analysis included:

- Editing
- Coding
- Tabulation
- Analysis and Interpretation

Editing:- Editing was the first step in data processing. It involved the process of examining the data collected through the tool used i.e. Interview Schedule. The features of editing consisted of accuracy, consistency with other facts secured, uniformly entered, as complete as possible and acceptable for tabulation and arranged to facilitate coding and tabulation which were borne in the mind by the researcher. These were thus carefully adhered to by the researcher.

Coding:- Through coding process the data was organized into sections/categories and thus it was possible to give numerals to each item according to the class in which it belonged. Coding eliminated much of the information in the raw data, as it was important to set them in the proper category to utilize the data more fully. This was the immediate step to tabulation.

Tabulation:- In tabulation the procedure was adopted to summarize the collected data into some convenient and manageable forms. It enabled the researcher to dispense with the schedules when they were cumbersome to handle. It entailed the process of displaying the data in a compact form for further analysis. Tabulation for this study was done through the SPSS package which was convenient, reliable and scientific.

Analysis and Interpretation:- Analysis and Interpretation are central steps in the present research process. In the analysis of the data material was studied carefully in order to determine inherent facts of meanings. It involved breaking down existing complex factors into simpler parts and putting the parts together in new arrangements for the purpose of interpretation. It also involved summarizing the collected data and organizing them in such a manner that helped in yielding answers to the research questions.

Through Interpretation the meanings and implications of the study became clear. Analysis thus became complete with interpretation. The task of Interpretation thus helped find out a link and position of the study in the whole analytical framework. In other words it helped

building relationship between the theoretical data of the study and between the study findings and other scientific knowledge base.

Chapterization:

The present study has been presented in the form of subsections of the proposed chapters such as have been organized under the following sections:

- Section A: Social, Educational and Economic aspects of Person with Mental Illness and their Caregivers.
- Section B: Understanding Treatments & Stigma Associated with Mental Illness.
- Section C: Impact of Myths on the Lives of Person with Mental Illness & Caregivers.
- Section D: Impact of Community Mental Health & Development Module in Community Setting.

Chapter one presents an introduction of the study. In chapter two the review of literature in chapter three the research methodology has been explained in detail. In chapter four, profile of the study area where the study has been conducted. While in the fifth chapter the data analysis and interpretation have been discussed in the same manner as in chapter three and four. The sixth chapter deals wholly with major findings, conclusion and suggestions of the researcher. The seventh chapter presents appendixes with includes bibliography as well as weblography (researcher's references have been included in this), interview schedules, abbreviations and basic brief information about Basic Needs India (BNI) organisation and there community mental health and development module.

Chapter-4.

Profile of the Study Area

Introduction: - In social sciences research personnel characteristics of respondents have very significant role to play in expressing and giving the responses about the problem, keeping this in mind in this study a set of personal characteristics namely, age, sex, education occupation, income etc. of the 300 respondents have been examined and presented in this chapter.

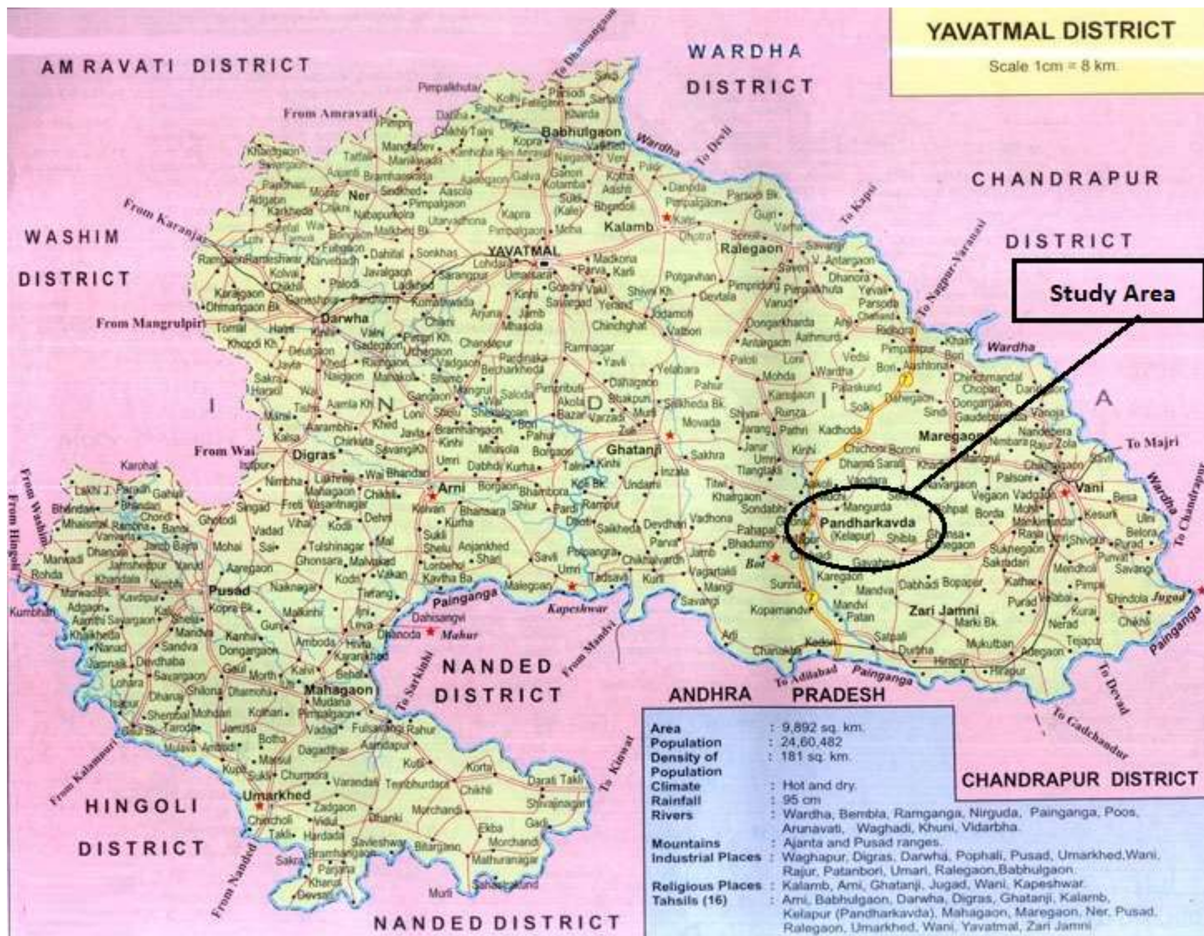
Geographical Characteristic: Yavatmal district is bounded on the north by Amravati district, to the northeast by Wardha district to the east by Chandrapur district to the south by Andhra Pradesh state and Nanded district to the southwest by Hingoli district and to the west by Washim district. Cotton and Wheat are the predominant crops grown in the district. Yavatmal district forms the southeast corner of Amravati district, which corresponds to the former British Raj Province of Berar. Yavatmal district comprises sixteen tehsil namely Arni, Umarkhed, Kalamb, Pandharkawada (Kelapur), Ghatanji, Zari Jamani, Darwha, Digras, Ner, Pusad, Babhulgaon, Mahagaon, Maregaon, Yavatmal, Ralegaon and Wani. Yavatmal district occupies a prominent place in Maharashtra part of Central Indian tribal belt. An area comprising of five taluks namely Ghatanji, Maregaon, Ralegaon, Kelapur and Zari-Jamni with 321 villages have been declares as schedule V area under clause (1) Article 244 of the Constitution of India. In Maharashtra there are 47 notified scheduled tribes, five of them namely Andh, Pradhan, Gond, Kolam and Pardhi inhabits this region. Amongst them Kolam belong to the primitive tribal group identified by planning commission of India. This community is characterized by very low level of literacy, high infant mortality, declining or stagnant population, poverty and pre-agriculture level of technology. There are 75 such tribal communities identified in the country.

Villages identified for Intervention area are situated in the extended Ajanta hill ranges, forests here is categorized as Central Indian Tropical Dry Deciduous forests with teak as dominant species. Cotton forms the major cash crops in this region, Jowar, pegion pee, gram etc. are also grown.

Demographics:- according to the 2011 census Yavatmal district has population of 2,775,457 roughly equal to the nation of Jamaica or the US state of Utah. This gives it a ranking of 141st in India (out of a total of 640). The district has a population density of 204 inhabitants per square kilometre (530/sq mi). Its population growth rate over the decade 2001-2011 was 12.9%, Yavatmal has a sex ratio of 947 females for every 1000 males and a literacy rate of 80.7% As per census of 2001, 81% of the people are Hindu, 9% Buddhist and 8% Muslim. Languages used in the district include Andh, an Indo-Aryan language spoken by 100000 people. Marathi is the major language; other languages spoken are Urdu and Hindi, Teli, Gujrati, Sindi, Banjari, Gondi and Kolami. The dialect used here is known as the Berar dialect.

Economy:- Jowar and cotton are the main produce of the district. Cotton and teakwood are the chief export of the district. Other items exported include lime, wooden furniture and oranges.

Location Map of Study Area:



Population and list of Villages:

In the study total 58 villages and hamlets were selected according the availability of persons with mental illness.

Sr. No	Village/Pod	Block	District	Population	PWMI	Caregiver
1	Ambezari	Zari-Jamni	Yavatmal	394	2	2
2	Ardhawan	Zari-Jamni		747	1	1
3	Ballarapur	Kelapur		1101	7	7
4	Bihadi-pod	Zari-Jamni		374	1	1
5	Borgaon	Kelapur		1136	1	1
6	Borgaon-kadu	Zari-Jamni		354	1	1
7	Bori	Kelapur		379	1	1
8	Botoni	Zari-Jamni		278	4	4
9	Chichapod	Maregaon		405	4	4
10	Dubhati	Zari-Jamni		1014	6	6
11	Dubli-pod	Zari-Jamni		550	3	3
12	Gao-pod	Kelapur		390	2	2
13	Gargoti-pod	Zari-Jamni		549	2	2
14	Gavrai	Kelapur		1043	1	1
15	Ghubadi	Kelapur		351	1	1
16	Gopalpur	Kelapur		1284	2	2
17	Hirapur	Zari-Jamni		783	1	1
18	Hiwra Barasa	Zari-Jamni		830	4	4
19	Indiranagar	Kelapur		892	4	4
20	Karegaon	Zari-Jamni		1124	3	3
21	Khandani	Maregaon		478	2	2
22	Kodapakhindi	Maregaon		621	3	3
23	Kondhi	Kelapur		531	2	2
24	Kondhi	Zari-Jamni		1619	5	5
25	Magurda	Kelapur		232	1	1
26	Magurla	Zari-Jamni		106	1	1
27	Mahadapur	Zari-Jamni		1263	6	6
28	Maroti pod	Zari-Jamni		201	2	2
29	Matharjun	Zari-Jamni		2964	7	7
30	Mendhani	Maregaon		1348	5	5
31	Mulgavhan	Zari-Jamni		625	6	6
32	Navapod	Zari-Jamni		646	4	4
33	Netaji pod	Kelapur		437	3	3
34	Nimani	Zari-Jamni		451	2	2
35	Pardi	Zari-Jamni		891	6	6
36	Patanbori	Zari-Jamni		205	1	1
37	Patchpor	Zari-Jamni		162	1	1

38	Pivardol	Zari-Jamni		412	3	3
39	Rajani	Shibala		212	2	2
40	Ranapratap ward	Kelapur		786	2	2
41	Renga pod	Zari-Jamni		302	1	1
42	Rohpat	Maregaon		876	4	4
43	Sakhara	Zari-Jamni		150	1	1
44	Saleipod	Maregaon		485	1	1
45	Shivnadapod	Kelapur		443	1	1
46	Sibala	Zari-Jamni		216	1	1
47	Sirametti	Kinavat		214	1	1
48	Tad Umari	Kelapur		992	2	2
49	Tandapod	Maregaon		241	1	1
50	Tembhi	Zari-Jamni		706	4	4
51	Vadgaon	Zari-Jamni		361	2	2
52	Vagdara	Maregaon		498	5	5
53	Vanjari	Zari-Jamni		257	3	3
54	vanjari pod	Zari-Jamni		383	1	1
55	Vasantnagar	Kelapur		524	1	1
56	Vrundavan takali	Zari-Jamni		679	2	2
57	Wadonabandi	Zari-Jamni		763	1	1
58	Zari	Zari-Jamni		903	3	3
	Total			37161	150	150

References:-

1. District Census 2011". Census2011.co.in. 2011. Retrieved 2011-09-30.
2. M. Paul Lewis, ed. (2009). "Andh: A language of India". Ethnologue: Languages of the World (16th edition ed.). Dallas, Texas: SIL International. Retrieved 2011-09-28.
3. Ministry of Panchayati Raj (September 8, 2009). "A Note on the Backward Regions Grant Fund Programme". National Institute of Rural Development. Retrieved September 27, 2011.

Chapter-5.

Data Analysis and Interpretation

Introduction: However valid, reliable and adequate the data may be it does not serve any useful purpose unless it is carefully processed, systematically classified and tabulated, scientifically analysed, intelligently interpreted and rationally concluded. After the data was collected, it was processed and tabulated using SPSS-16.0 (Statistical Packages for Social Sciences) data analysis software. The data collected on different variables and then the data were analysed separately for PWMIs (Person with Mental Illness) and Caregivers with reference to the objectives and hypotheses by using descriptive statistics, differential analysis including Pearson chi-square test, one way analysis and Pearson's correlation coefficient analysis by using SPSS 16.0 statistical software and the results obtained thereby have been interpreted. It was also the intention of the investigator to find out differences in between the independent variables namely age groups, sex, relationships, marital status, educational qualifications, occupations, income groups, type of mental illness, treatment and coping pattern about mental illness and impact of community mental health and development module in the life of PWMI. Further, same technique was used for, the different characteristics of Caregivers of PWMIs namely gender, age groups, relationships, educational qualifications, occupations, income groups, role of caregivers, stigma associated with mental illness and impact of mental disorders in the family.

Presentation of Data: For the purpose of convenience, data is presented in different chapters titled, Introduction, Review of Literature, Research Methodology, Profile of the Study area, Data Analysis and Interpretation, Conclusion, Findings and Recommendations. More focused on core component of study is the chapter 5th which divided in to different sections as mention in the study as mention below.

- Section A: Social, Educational and Economic aspects of Person with Mental Illness and their Caregivers.
- Section B: Understanding Treatments & Stigma Associated with Mental Illness.
- Section C: Impact of Myths on the Lives of Person with Mental Illness & Caregivers.
- Section D: Impact of Community Mental Health & Development Module in Community Setting.

Section A: Social, Educational and Economic aspects of Person with Mental Illness and their Care givers.

This chapter is focused on various aspects of person with mental illness (PWMI) such as social, educational and economical. Mental illness is growing cutting across several groups in society. This becomes severe with vulnerable groups. The gravity of the issue for the poor, the dalits, the tribal and persons with disability often need far greater support to help them through the conditions. Health including mental health is a fundamental right. Availing treatment is a right and today the situation is most critical. Mental health is described as something more than a mere absence of mental disorders. Mental health refers to a state of mind which is characterized by emotional well-being, relative freedom from anxiety and disabling symptoms, and a capacity to establish productive relationships and cope with the ordinary demands and stresses of life (Bhagi, 1992). Mental health as defined by Kornhauser (1995) means those behaviours, perceptions and feelings that determine a person's overall level of personal effectiveness, success, happiness and excellence of functioning as a present also depends on the development and retention of goals that are neither too high nor too low to permit realistic successful maintenance of belief in one's self as a worthy, effective human being. He further states that since, employees spend roughly one third of their time in their workplace, mental health is of particular importance. The rise in magnitude of mental disorders, affecting millions of people all over the world has become a problem of grave-concern. World Health Organization in its world health report (2000-2001) has stated that 20-25% of the world population is affected by mental problems at some time during their life. Prevalence rate of mental disorders in India is reported to be 58.2 per thousand populations (Reddy and Chandrasekhar, 1998). Incidence of mental disorders is on rise. In 1990, mental and neurological disorders accounted for 10% of the total patients of all disease and injuries which rose to 12% in 2000 and by 2020; it is projected that the burden of these disorders will increase to 15 percent. Factors associated with the prevalence, onset and course of mental and behavioural disorders include poverty, gender, age, conflicts, and disasters, major physical disease and the family and social environment.

Among several non-communicable diseases that women endure, mental health is an area neglected by families because of the stigma attached to seeking care and the traditional beliefs that are held. Further, the available health services are inadequate and presumably not gender sensitive. The World Health Survey (2003) had gathered self-reported morbidity and

coverage (percent of persons treated) for six non-communicable diseases, depression emerges high urban (38%) and rural (24%). The survey had also probed into questions of 'worry or anxiety' in the last 30 days in Maharashtra. The survey found that 50% males and only 39% females reported that they have no worries and anxieties. Higher proportion of women, individuals belonging to rural areas of low levels of education of higher ages and lower incomes reported moderate to severe levels of worry or anxiety. These findings do indicate the general existence of distress linked to issues of employment and growing agrarian distress in the countryside. In Maharashtra, the non-communicable disease load coupled with communicable disease load will have serious repercussions for the poor in general and women in particular. Gender roles are critical determinants of mental health that need to be considered in policies and programs. They govern the unequal power relationship between men and women and the consequences of that inequality. They affect the control men and women have over socioeconomic determinants of their mental health, their social position, status and treatment in society. They also determine the susceptibility and exposure of men and women to specific mental health risks.

Economic well-being is one of the key elements to dignified living. This section looks at the finer indicators of livelihood opportunities, income, employment that directly influences the wellbeing of persons. Economic wellbeing is one of the key elements to any individual realizing his/her full potential. It becomes critical for a person with disability, mental illness or for any individual born into poverty. This often impedes the potential for growing to one's full potential. A few indicators for the economic well-being of an individual are employment, income, wealth, occupation, along with the access to social security. While there is increasing evidence of an association between poor mental health and the experience of poverty and deprivation, the relationship is complex. We discuss the epidemiological data on mental illness among the different socio-economic groups look at the cause effect debate on poverty and mental illness and the nature of mental distress and disorders related to poverty. Issues related to individual versus area based poverty, relative poverty and the impact of poverty on woman's and child mental health are presented. This review also addresses factors associated with poverty and the difficulties in the measurement of mental health and illness and levels impact of poverty. The relationship between poor mental health and the experience of poverty and deprivation has been well studied and an association between the two factors has been established. The World Health Organization report on mental health states 'Mental disorders occur in persons of all genders, ages and backgrounds.

No group is immune to mental disorders but the risk is higher among the poor, homeless, the unemployed and persons with low education' the link is however complex and is influenced by numerous factors. Psychiatric epidemiological surveys since the late 1930s have reported higher rates of mental illness in low-income communities. A large community survey in the United States indicated that the lowest socio-economic group manifested twice the risk of major depressive disorder (MDD) than the highest income group. The National Co-morbidity Survey (NCS) concluded that individuals with low socio-economic status demonstrate higher risk for major depressive disorder than individuals who are economically well-off.

5A. 1. Age distribution among the person with mental illness

Age of onset is a key clinical epidemiological variable, which has only recently become the focus of major study and interest. It is critical, as Kessler pointed out, firstly because it enables us to calculate the projected lifetime risk of disorder and secondly in capturing the topography of onset so that primary prevention, prevention of secondary disorders and early intervention strategies can be targeted in an efficient, timely and cost-effective manner. We have lacked solid data to draw this map and epidemiologists have been forced to rely upon two problematic sources: firstly, retrospective reports from community based surveys, typically of an incomplete range of disorders and secondly, retrospective measures of treated incidence samples, which even for psychotic disorders are known to be incomplete. Certainly for the mood, anxiety, substance use and personality disorders in which treated incidence and prevalence are low as a proportion of the total age of onset data ascertained this way is of uncertain accuracy.

The age of onset approach has surprised both researchers and policy makers in showing that the full lifetime risk for mental disorders approaches 50% meaning that mental ill health is a reality most of us will increasingly have to confront either in ourselves and or in our families. This review provides an update of the recent studies of age of onset and especially those which relate onset to the prospects for prevention and early intervention. For psychotic disorders, this involves special attention to treatment delay and early quality of care whereas in other domains a three way focus upon maximizing treated incidence, reducing delay and enhancing early quality of care is necessary. Timing of onset across the lifespan and its relationship with treatment delay will also be considered. Finally, the implications for preventive and early intervention will be discussed.

Table No. 5A.1

Age Distribution among the Person with Mental Illness

Age Distribution				
Valid	Frequency	Percent	Valid Percent	Cumulative Percent
18 – 27	49	32.7	32.7	32.7
28 – 37	30	20.0	20.0	52.7
38 – 47	41	27.3	27.3	80.0
48 -57	18	12.0	12.0	92.0
Above 58	12	8.0	8.0	100.0
Total	150	100.0	100.0	

Mean= 2.43, Median=2.00, Std. Deviation= 1.276

The above table depicts that 32.7% of the respondents belonging to age group 18-27, 20% of them belong to 28-37 years of age, 27.3% between 38-47 years age group, 12% between 48 - 57 and 8% above 58 years of age.

From these findings we can infer that the respondents were mostly 32% a young group between 18-27 years of age who are mentally ill. In overall 80% 18 to 47 year age group has higher prevalence of mental illness. This young adult age group is a productive age group and they faced lot of stress in most of the roles and responsibilities.

5A. 2. Educational status among the Person with Mental Illness

Illiteracy or poor education is a consistent risk factor for mental disorders. Some studies have also demonstrated a dose response relationship between educational level and the risk of such disorders. Reverse causality is unlikely to be a factor, since primary education occurs in early childhood when mental disorders are uncommon. The relationship between low educational level and mental disorders may be confounded or explained by a number of pathways: these include malnutrition, which impairs intellectual development, leading to poor educational performance and poor psychosocial development. The social consequences of poor education are understandable; lack of education represents a diminished opportunity for persons to access resources to improve their situation and low levels of education have been implicated as a risk factor for mental disorder. Higher levels of education may reflect optimal brain development in childhood, which in turn protects from pathological processes that lead to cognitive impairment (or in the case of this review, common mental disorders) in later life.

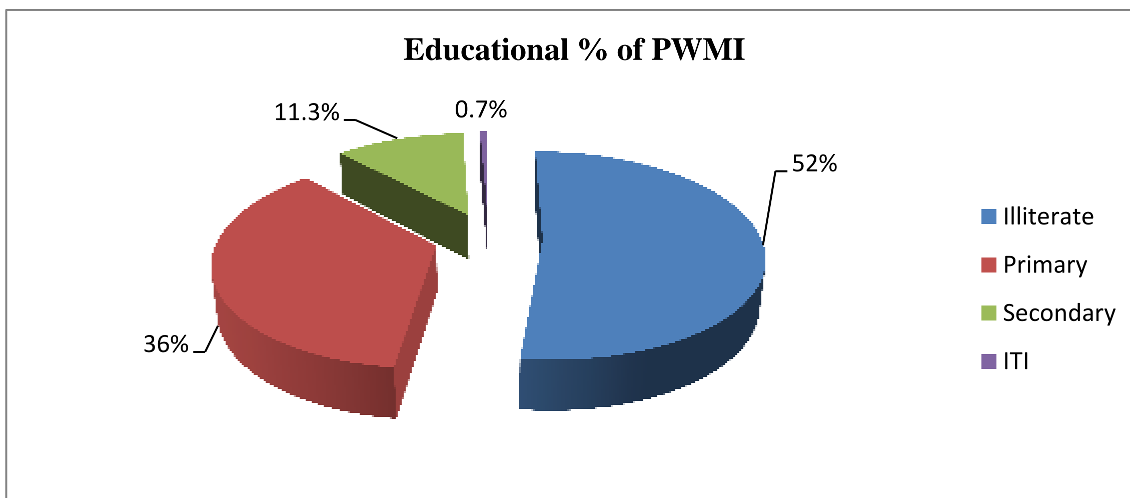
Table No. 5A. 2.
Educational status among the Person with Mental Illness

Education				
Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Illiterate	78	52.0	52.0	52.0
Primary	54	36.0	36.0	36.0
Secondary	17	11.3	11.3	63.3
ITI	1	0.7	0.7	100.0
Total	150	100.0	100.0	

Mean=2.57, Median=1.00, Std. Deviation=1.866

Figure No. 5A. 2.1

Educational status among the Person with Mental Illness



The above values in the figure suggest that 36 percent of the respondents who are mentally ill have education up to primary level, 11.3 percent have education up to secondary level and 0.7 percent have learned an ITI course and 52 percent are illiterate.

From these findings we can interpret that a very large number (52%) of the mentally ill respondents are illiterate. Their illness could possibly be one of the causes for them not being able to perceive education. This also suggests that one of their basic fundamental rights has been infringed due to their illness.

5A. 3. Type of mental illness and education of PWMI

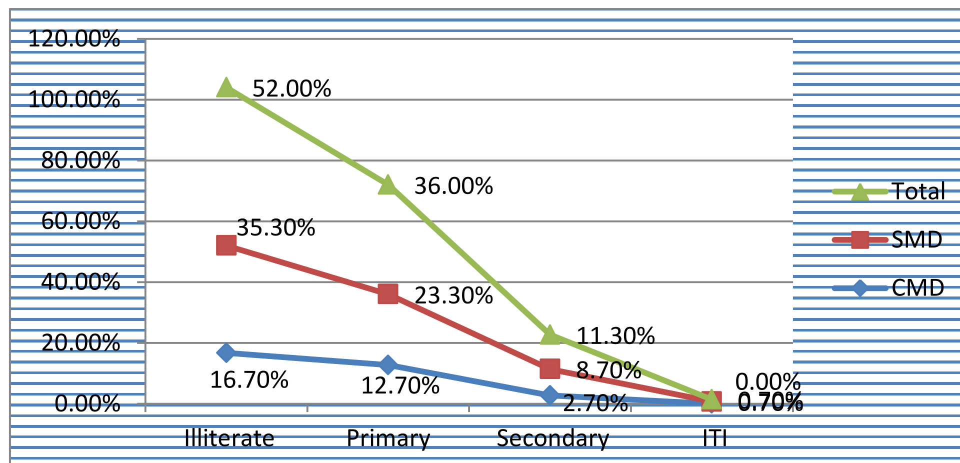
Poor mental health in childhood is strongly linked to poor mental health later in life and has been shown to have a serious impact on life changes (Richard and Abbott, 2009) Mental health problem may impact on human capital accumulation by reducing both the amount of schooling and the productivity level, which may in turn have lifelong Consequences for employment, income and other outcomes. Although poor mental health has often been correlated with poor educational attainment and or dropping out of education.

Table No. 5A. 3.
Type of Mental Illness and Education of PWMI

Education		**Type of Mental Illness**		Total
		CMD	SMD	
Illiterate	Count	25	53	78
	% of Total	16.7%	35.3%	52.0%
Primary	Count	19	35	54
	% of Total	12.7%	23.3%	36.0%
Secondary	Count	4	13	17
	% of Total	2.7%	8.7%	11.3%
ITI	Count	0	1	1
	% of Total	.0%	.7%	.7%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =106.0543, df=3, No. of valid cases = 150, Contingency Coefficient = 0.644, P>0.05)

Figure No. 5A. 3.2
Type of Mental Illness and Education of PWMI



The above figure reveals that 16.7 percent of the CMD and 35.3% SMD respondents are illiterate.12.7 percent CMD and 23.3 percent SMD have education up to primary level, 2.7 percent CMD and 8.7 percent SMD have education up to secondary level and 0.7 percent SMD respondent has learned an ITI course. (Pearson chi-square =106.0543, df=3, No. of valid cases = 150, Contingency Coefficient = 0.644, $P>0.05$)

From these findings we can interpret that a very large numbers (35.3%) of the mentally ill respondents are illiterate those having severe mental illness. Their illness could possibly one of the causes for them not being able to perceive education. It also states since the p-value is more than 0.05% , the null hypothesis is accepted because there is no enough evidence to prove against the null hypothesis

Educational level of individuals seems to play a role in individual's status in society. The graph here depicts the educational level of PWMI according to the types of illnesses. Figure 5A.3.2 on PWMI based on categories of illness and education shows that the majority of identified PWMI (in all the types of illness) were illiterate. Identified PWMI with higher education were in small percentage. Here again the focus is on the vulnerable section of the people with little or no education. Education has strongly correlated with poverty. Education is an important determinant of present and future life opportunities which promote mental health in later life. In any case it is important to realize that the socioeconomic variables beloved by epidemiologists might have different meanings and significance in different societies.

5A. 4. Age and type of mental illness of PWMIs

In the human life in any stage of age mental illness can be accrued. Mental illness does not have any specific age which we can finger out for early intervention or early diagnosis. But some studies emphasize that the adolescent age is a high risk age group where stress factors are more than other age group. Different age group has different psychological characteristic which is also reflect when they performed roles.

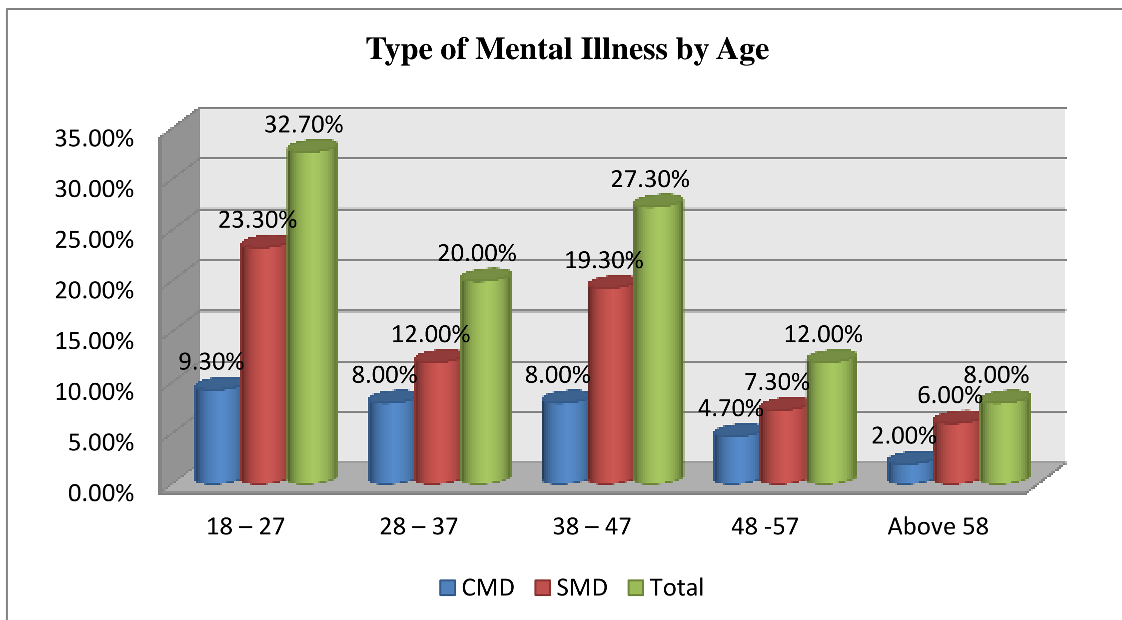
Table No. 5A.4.

Age and type of Mental Illness of PWMIs

Age		Type of Mental Illness		Total
		CMD	SMD	
18 – 27	Count	14	35	49
	% of Total	9.3%	23.3%	32.7%
28 – 37	Count	12	18	30
	% of Total	8.0%	12.0%	20.0%
38 – 47	Count	12	29	41
	% of Total	8.0%	19.3%	27.3%
48 -57	Count	7	11	18
	% of Total	4.7%	7.3%	12.0%
Above 58	Count	3	9	12
	% of Total	2.0%	6.0%	8.0%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square = 1.95, df=4, No. of valid cases = 150 Contingency Coefficient= 0.113, P>0.05)

Figure No: 5A.4.3



The table above depicts two variables age and Type of Mental Illnesses. In the age category between 18-27 years, 9.3% of the people are living with common mental disorders (CMD) and 23.3% with severe mental disorders (SMD). In the age group between 48-57 years the percentage is of common mental disorders and severe mental disorders are 4.7 % and 7.3%.

While in the higher age category (above 58 years) there are 2% with common mental disorders and 6% with severe mental disorders, the number of persons with mental illnesses is very low as it can be observed in this age category.. Both the variables do not significantly affect each other's degrees of change. At any age people are likely to having mental illnesses. Chi-square tests: Pearson's Chi-square = 1.95, df=4, no of valid cases = 150. P>0.05. The test reveal that since the p-value is more than 0.05 Thus from these findings it can be inferred that age and mental illnesses do not have a significant relationship and so the null hypothesis is accepted.

Out of the identified people majority are in the age group of 18 to 47.The prevalence of mental illness in the program area seems to be quite high during the most productive years of life, i.e, between 18 to 47 years. The Community Mental Health & Development (CMHD) program covered all the aspects of the PWMI and caregivers which include socio-economic and psychosocial components which provide all attention to help them improve the quality of their lives. Most youth are healthy, physically and emotionally, yet one in every four to five youth in the general population meet criteria for a lifetime mental disorder that is associated with severe role impairment and distress. A national and international literature review found that an average of 17 percent of young people experience an emotional, mental or behavioural disorder. Substance abuse or dependence was the most commonly diagnosed group for young people followed by anxiety disorders, depressive disorders and attention deficit hyperactivity disorder. Overall it seems that severe mental illness is higher in the age group of 18 to 27 year age than any other age group over 18.

5A. 5. Sex and type of mental illness of PWMI

Sex and type of mental illness has correlation in terms of Indian scenario women has more work load than men. Most of the women worked more than 8 hours in and out of the house. Women are more likely to have been treated for a mental health problem than men (29% compared with 17%).

- Depression is more common in women than men. 1 in 4 women will require treatment for depression at some time, compared with 1 in 10 men. The reasons for this are unclear but are thought to be due to both social and biological factors.
- Doctors are more likely to treat depression in women than in men, even when they present with identical symptoms.

- Women are twice as likely to experience anxiety as men. Of people with phobias or OCD, about 60% are female.

The socially defined role of women in many societies exposes them to greater stresses, which, together with other factors including family violence and abuse, leads to higher rates of CMD.

Table No. 5A. 5.

Sex and Type of Mental Illness of Person with Mental Illness

Sex		**Type of Mental Illness**		Total
		CMD	SMD	
Male	Count	31	58	89
	% of Total	20.7%	38.7%	59.3%
Female	Count	17	44	61
	% of Total	11.3%	29.3%	40.7%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square = 0.649, df=1, No. of valid cases = 150, Contingency Coefficient = 0.518, P>0.05)

From the respondent sample 59.3% were males and 40.7% were females. Of the 59.3% males 20.7% were persons having common mental disorders and 38.7% having severe mental disorders. From amongst the females, 11.3% have common mental disorders and 29.3% are severe mentally ill. The tests (Pearson chi-square = 0.649, df=1, No. of valid cases = 150, Contingency Coefficient = 0.518, P>0.05). With this p-value it is evident that there is no significance between the two variables and so null hypothesis of no difference is rejected and the alternate hypothesis is accepted which states that women do have greater rates of prevalence of mental disorders.

In the above table overall in both the mental health conditions were men percentage is higher than women due to unavailability of equal number of male and female respondent. But most of the studies show that the common mental disorders were higher number in women than in men. Here this difference came due to cultural context and gender difference ruling out in the society were usually women hide their illness in the family but more caring for men. Therefore the basic difference we can see in the identification also (89 male & 61 female).There is a gender gap for mental illness with females being up to 40.7 percent more likely to develop some type of mental health condition than their male counterparts. A new study to be published by Oxford University Press finds that women are nearly 75 percent more likely than men to have suffered from depression and approximately 60 percent more

likely to report an anxiety disorder. Dr. Freeman said that because the conditions most affecting women were more common than those affecting men, overall mental health conditions were more common in women than in men by a factor of 20 percent to 40 percent. Sex differences are seen most graphically in the prevalence of common mental disorders like depression, anxiety and somatic complaints. These disorders, most prevalent in women, represent the most common diagnoses within primary health care settings and constitute serious public health problems. In particular, depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women as in men across most societies and social contexts; it may also be more persistent in women than men. Reducing the disproportionate number of women who are depressed would significantly lessen the global burden of disability caused by mental and behavioural disorders.

The researcher suggests that, in the mental health intervention women should be given priority as a vulnerable group than men.

5A. 6. Age and sex of caregivers:

Traditionally, women are central to caring of families and communities and have played a major part in the care-giving role. Today there is a growing concern about the diminishing numbers of women caring for the increasingly large numbers of persons with chronic mental. Male caregivers are growing in number, as the frequency of spouse caregiving rapidly increases. Vijayalakshmi and Ramana (1987) found that due to the patient’s illness and inability to perform their respective roles in the family, spouses often took over the breadwinner’s role. The immediate family members are a source of support for the acutely disturbed mentally ill person. It is the caregivers who play a key role in the rehabilitation of person with mental illness. Their caring starts from bearing the violent behavior to attending for their physical needs motivating the person to involve in productive work and continue to care even after recovery. The caregiver often suffers from severe mental and emotional drain feels utterly defeated and has feelings of anxiety, resentment and anger with stress being cumulative over time. A study of unresolved grief in families of persons with severe mental illness found that levels of grief increased over time (Hatfield 1978; Noh and Turner 1987; Miller et al 1990).The ABS 2003 Survey of Disability, Ageing and Carers estimated that approximately 13% of people or more than one in ten adults were carers. One in five of these were primary carers 3 and 71% of primary carers were women (ABS, 2004). Two aspects of caregiving relate specifically to mental health. The care involved in looking after a person with a mental illness and the impact of caring on the mental health of the caregiver. The

second type may occur in the caring of a person with a range of physical and intellectual disabilities as well as mental illness. Caring may not always lead to mental health problems for the carer but caring experiences are often talked about in terms that may relate to mental health (e.g., stress levels) without expressly being defined as such. It is therefore difficult to clearly distinguish from the literature under what circumstances a carer's mental health is or isn't affected. The mental health status and needs of carers may also go unidentified by families and professionals as they focus on other's needs; carers may avoid self-identification of mental health problems due to their lived reality that the ill family member cannot afford for them to be sick or not coping. As such, the mental health needs of carers may remain unidentified and unaddressed which may have long-term ramifications for both their own wellbeing and the wellbeing of the care recipient. One of the key aspects of caring that can impact on the mental health of carers is the level of burden involved in the caring role. Similarly to other caring roles, two types of burden associated with caring for a person with a mental illness are highlighted in the literature: objective burden and subjective burden. Objective burden relates to the specific tasks associated with caring, for example managing finances or doing housework and subjective burden relates to the feelings and cognitive appraisals associated with caring, such as finding particular behaviours embarrassing, worrying about the future and dealing with excessive demands (Baronet, 1999; Williams & Carthy, 2006). The degree of burden is most often related to the degree of impairment or severity of the disability and symptoms associated with the illness of the care recipient (Wittmund, Ulrich Wilms, Mory & Angermeyer, 2002). It is important to state however that caring has positive elements for some caregivers and is not necessarily universally harmful to carers' psychological wellbeing (Choi & Marks, 2006). The caring relationship is often thought of as involving only caregiving and care receipt.

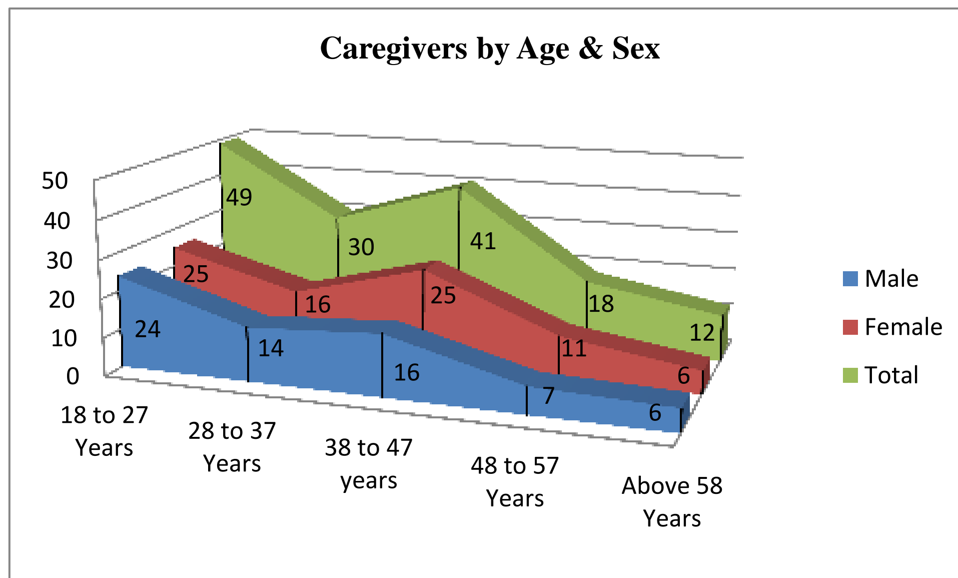
Table No.5A. 6.

Age and Sex of Caregivers

Age		Sex		Total
		Male	Female	
18 to 27 Years	Count	24	25	49
	% of Total	16.0%	16.7%	32.7%
28 to 37 Years	Count	14	16	30
	% of Total	9.3%	10.7%	20.0%
38 to 47 years	Count	16	25	41
	% of Total	10.7%	16.7%	27.3%
48 to 57 Years	Count	7	11	18
	% of Total	4.7%	7.3%	12.0%
Above 58	Count	6	6	12
	% of Total	4.0%	4.0%	8.0%
Total	Count	67	83	150
	% of Total	44.7%	55.3%	100.0%

Chi-square test: (Pearson chi-square = 1.327, df=4, No. of valid cases = 150 Contingency Coefficient= .094, P>0.05)

Figure No: 5A.6.4



The above table reveals that 32.7% caregivers were between ages 18-27 year of which 16% were male and 16.7% were females. 20% caregivers between ages 28-37 years of which 9.3% were males and 10.7% were females. 27.3% were ages 38-47 years of which 10.7% were males and 16.7% were females. 12% caregivers were above 48 years and 8% above 58 years. In all 44.7% were males and 55.3% females in caregiver's role. (Pearson chi-square = 1.327, df=4, No. of valid cases = 150 Contingency Coefficient= .094, P>0.05). The null hypothesis is rejected as there is a difference between caregiving by a male and female family member.

From the able findings we can infer that women outnumber men in providing care to mentally ill person irrespective of their gender, women have always played a major role in the family as a care provider in general also.

The provision of assistance and support by one family member to another is a regular and usual part of family interactions and is in fact a normal and pervasive activity. Thus, caregiving due to chronic illness like mental illness and disability represents something that, in principle, is not very different from traditional tasks and activities rendered to family members. This is especially true for women, across cultures, have traditionally shouldered a disproportionate amount of family caregiving responsibility (McGoldrick 1989; Lefley 2001; Olson 1994). The difference, however is that caregiving in chronic illness often represents an increase in care that surpasses the bounds of normal or usual care.

The structure of the family providing care for a mentally ill relative as well as the life stage of the family e.g., elderly parents caring for an adult with severe mental illness, former family breadwinner, incapacitated by mental illness can present different challenges to caregivers (Pot et al 2001). Female caregivers show higher levels of caregiver burden than males (Miller and Cafasso 1992).Most carers are women, care for close relatives and provide limited hours of care. More than one in ten adults (family and friends) is involved in informal typically unpaid caregiving defined as providing help with personal care or basic activities of daily living (ADL) to people with functional limitations. Carers are more likely to be female but more males become carers at older ages.

There is strong evidence that women are more involved in caregiving than men. This includes the proportion of women involved in caregiving, the greater likelihood that women will be primary caregivers and the hour's women spend on their caregiving tasks. Women also bear greater financial costs of caregiving as it often further interrupts their working life and reduces their opportunity to save for retirement which in many cases is longer than that of men. There is some evidence to suggest that women react to caregiving with a greater tendency to become depressed, distressed and to feel burdened by caregiving. This has been attributed to women experiencing more caregiving stressors, such as higher social expectations and lower social support for women than men. Gender differences in caregiving may be slightly decreasing. New evidence shows that both men and women are experiencing similar experiences of caregiving tasks.

5A. 7. Age and relationship with the person with mental illness

Mental health disorders are a common occurrence in society and affect people of all ages, gender and socio-economic status. Mental health problems and illnesses can have a considerable effect on families and relationships, with issues such as a lack of diagnosis, treatment use and efficacy, chronicity and propensity all impacting on a family's experience of mental illness. Likewise, relationship and family problems can have a significant impact on mental health. Both living with and or caring for someone under these circumstances not only impacts on the wellbeing of the person with the illness but those around them. Considering the circumstances under which many clients would access family relationship services, it would seem likely that mental health and wellbeing would play a prominent role in their reasons for seeking help. Responding to mental health issues will depend on the level of practitioners' understanding, knowledge and skills, as will the extent to which they can intervene, assist and or incorporate such issues into service provision. Whilst providing mental health treatment to a person who has a mental illness may be outside of the scope of the practitioner's role and or knowledge and skill base, working with the family surrounding the person, or working with the person with a mental health problem regarding their relationships and family, may still be an option.

Both men and women experienced a greater increase in depression and decline in happiness, compared to non-caregivers, when transitioning into spouse care. The needs of carers and family members who are impacted upon by a member's mental illness should be attended to in their own right. This is in contrast to many current responses in the mental health service systems that only consider these needs in relation to how they may benefit their unwell family member. There is also a public health opportunity within family relationship services to help ameliorate the stigma associated with mental illness and intervene early to prevent and reduce the risk and onset of mental health problems.

The Burden of care has been defined as "the presence of problems, difficulties or adverse events which affect the life (lives) of the psychiatric patient's significant others. These occur as a result of challenges involved in caring for the mentally ill patients. Burden of care affects family's daily routine, caregiver's emotional, psychological and physical health and has economic implications in addition to distressing notions such as shame, embarrassment, feelings of guilt and self-blame. The caregiver is usually a relative of an ill person and the care given is invariable continuous. He or she often has additional responsibilities in the family and many of the care recipients do not acknowledge or even recognize the assistance and help them are receiving. The care is given because of emotional

bonding, duty, guilt and or the lack of other available services in the community. Dimensions of burden of care giving include the symptom specific burden impact of the disability associated with the illness itself, both in terms of the demands for assistance and supervision, and regarding the potential stigma associated with the illness; the social burden impact on family and other social relationships; the emotional burden impact on mental and emotional wellbeing; and the financial costs of care giving. Since the burden has been found to be dependent on the characteristics of the people with mental illnesses and their caregivers, the relationship between them, and their environment; hyperactivity, irritability, sadness and withdrawal in people with mental illness have been reported to be perceived as the most distressing behaviours by the caregivers, affecting their emotional health and life in general. Thus, it is important to assess various characteristics of caregivers' burden and its adverse effects on care giving, so that appropriate actions can be taken to manage the problem. It is also important to understand caregiver's coping strategies for tackling burden, because it affects not only caregiver's day-to-day functioning and is a constant source of stress, but how this stress is managed also has a bearing on the course of person's illness and prospects for improvement. If maladaptive coping styles are identified, caregivers can be helped to adopt healthier coping styles, so as to continue in a healthy care giving role.

Table No. 5A. 7.

Age and Relationship with the person with mental illness

Age		**Relationship with the person with mental illness**						Total
		Mother	Father	Brother	Sister	Wife	Husband	
18 to 27 Years	Count	21	12	0	4	11	1	49
	% of Total	14.0%	8.0%	.0%	2.7%	7.3%	.7%	32.7%
28 to 37 Years	Count	14	6	1	0	7	2	30
	% of Total	9.3%	4.0%	.7%	.0%	4.7%	1.3%	20.0%
38 to 47 years	Count	25	7	1	3	3	2	41
	% of Total	16.7%	4.7%	.7%	2.0%	2.0%	1.3%	27.3%
48 to 57 Years	Count	11	2	0	0	4	1	18
	% of Total	7.3%	1.3%	.0%	.0%	2.7%	.7%	12.0%
Above 58	Count	6	2	1	0	2	1	12
	% of Total	4.0%	1.3%	.7%	.0%	1.3%	.7%	8.0%
Total	Count	77	29	3	7	27	7	150
	% of Total	51.3%	19.3%	2.0%	4.7%	18.0%	4.7%	100.0%

Chi-square test: (Pearson chi-square = 17.275, df= 20, No. of valid cases = 150 Contingency Coefficient= .321,P>0.05)

The above table shows that 51% are mothers who are caregivers, 19.3% are fathers, 2% are brothers, 4.7% are sisters, 18% are wives and 4.7% are husbands. Tests show (Pearson chi-square = 17.275, df= 20, No. of valid cases = 150 Contingency Coefficient= .321, $P>0.05$)

From these stated findings we can infer that women are 74% (mother, sister and wife) who are caregivers. Thus women play an important role in caring of the person with mental illness. But most is shown un-productive services where as they contribute productively indirectly. There is no significant evidence to accept the null hypothesis and hence it is rejected

Family has been an essential part of the mental health care programs in Basic Needs India. The emphasis on the family as the single most important source of care is fairly unique for India and contrasts with the emphasis on the professionals and institutions in mental health care in the developed countries. Because of the scarcity of mental health care, families have been given more responsibilities to care their mentally ill family member. Whether it was by choice or our cultural influence or due to lack of facilities it is difficult to conclude, though there is some evidence to support that family involvement in care was and continues to be a preference of families (Kulhara and Wig, 1978; ICMR 1988). It is unfortunate that the experiences of the families have not been adequately studied and the strengths not been optimally utilized in the recovery of people with mental illness.

5A. 8. Sex and marital status with type of mental illness

Marital status of an individual is socially important for both men and women in the Indian scenario after marriage roles and responsibilities of men and women are increased. They have to perform additional tasks including previous ones. Sociologists have debated about the consequences of marriage for men's and women's mental health. The married have lower rate of mortality, morbidity and mental disorders than the unmarried (Goldman, Korenman and Weinstein 1995; Gove1972; Kobrin and Hendershot 1977). Among the unmarried, there are several patterns of health differentials. When self-reported health status and health conditions are used the divorced and separated have the highest rates of poor health, followed by the widowed (Verbrugge 1979). The rates of mental illness are lowest for the married and never married, followed by the divorced, widowed and finally, the separated (Warheit et al 1976). Since Gove's publication, dozens of studies have examined gender differences in mental health by focusing on self-reports of emotional problems in the non-treated (i.e., the general) population. Most of this research is based on cross-sectional data from community samples of individuals who report the frequency or intensity in which they experience psychological

symptoms such as nonspecific distress, anxiety, and depression. Overall, the past 30 years of research has produced three main findings regarding the relationships among gender, marital status, and mental health.

First, the marriage is beneficial for men's mental health and detrimental for women's.

Second, women report more mental health problems than men irrespective of marital status. Studies that have focused on gender differences in psychological well-being among the married and among the unmarried find that women report greater distress than men.

Third, research has been less consistent with regard to the interaction between gender and marital status and whether the mental health advantage of marriage is greater for men. While several studies suggest that men derive more emotional benefit from marriage (Kessler and McRae 1984; Menaghan 1989), others imply that women are the true mental health beneficiaries of marriage (e.g.,Thoits 1986). However, here again, because most of these studies are based on cross-sectional data and types of psychological problems typically experienced by females, they provide limited insight into whether marriage (or the lack thereof) actually has different emotional consequences for women and men.

Table No: 5A.8.

Sex and Marital Status with Type of Mental Illness

<table>
<tr><th colspan="4" rowspan="2">Type of Mental Illness</th><th colspan="4">Marital Status</th><th rowspan="2">Total</th></tr>
<tr><th>Unmarried</th><th>Married</th><th>Widowed</th><th>Deserted</th></tr>
<tr><td rowspan="6">CMD</td><td rowspan="4">Sex</td><td rowspan="2">Male</td><td>Count</td><td>7</td><td>23</td><td>0</td><td>0</td><td>31</td></tr>
<tr><td>% of Total</td><td>14.6%</td><td>47.9%</td><td>.0%</td><td>.0%</td><td>64.6%</td></tr>
<tr><td rowspan="2">Female</td><td>Count</td><td>3</td><td>14</td><td>1</td><td>0</td><td>17</td></tr>
<tr><td>% of Total</td><td>6.3%</td><td>29.2%</td><td>2.1%</td><td>.0%</td><td>35.4%</td></tr>
<tr><td colspan="2" rowspan="2">Total</td><td>Count</td><td>10</td><td>37</td><td>1</td><td>0</td><td>48</td></tr>
<tr><td>% of Total</td><td>20.8%</td><td>77.1%</td><td>2.1%</td><td>.0%</td><td>100.0%</td></tr>
<tr><td rowspan="6">SMD</td><td rowspan="4">Sex</td><td rowspan="2">Male</td><td>Count</td><td>17</td><td>38</td><td>0</td><td>0</td><td>58</td></tr>
<tr><td>% of Total</td><td>16.7%</td><td>37.3%</td><td>.0%</td><td>.0%</td><td>56.9%</td></tr>
<tr><td rowspan="2">Female</td><td>Count</td><td>12</td><td>28</td><td>5</td><td>2</td><td>44</td></tr>
<tr><td>% of Total</td><td>11.8%</td><td>27.5%</td><td>4.9%</td><td>2.0%</td><td>43.1%</td></tr>
<tr><td colspan="2" rowspan="2">Total</td><td>Count</td><td>29</td><td>66</td><td>5</td><td>2</td><td>102</td></tr>
<tr><td>% of Total</td><td>28.4%</td><td>64.7%</td><td>4.9%</td><td>2.0%</td><td>100.0%</td></tr>
</table>

Chi-square test: (Pearson chi-square CMD=.771(a), df=2, CC = .126 Pearson chi-square SMD=4.337(b), df=3 No. of valid cases = 150, Contingency Coefficient = .202), $P<0.05$.

Figure No: 5A.8.5
Marital Status of PWMI

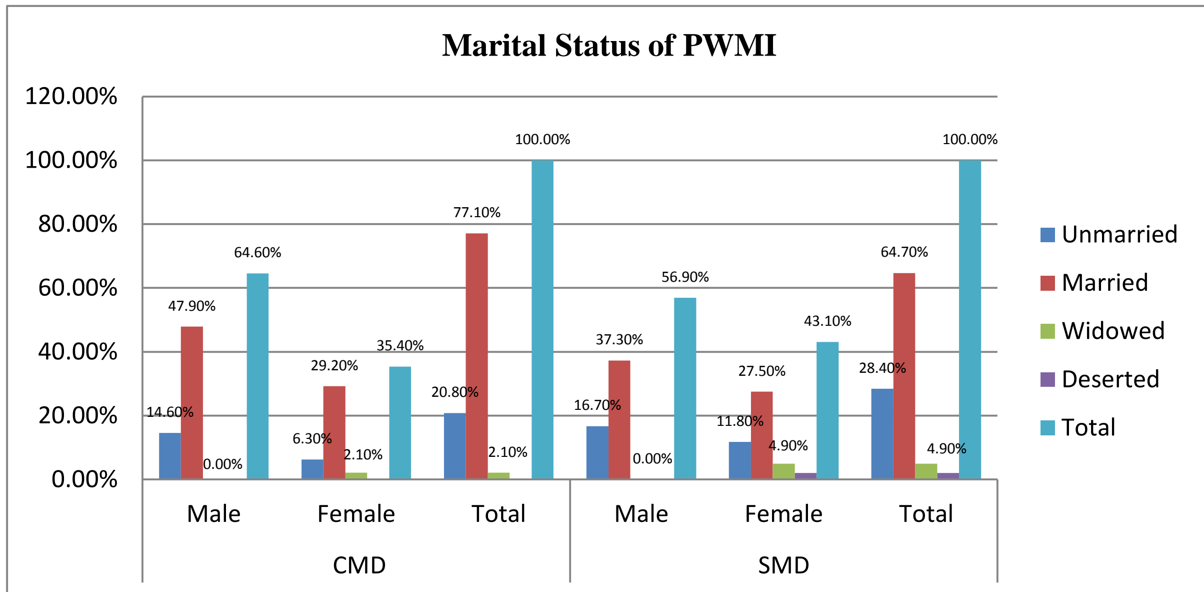


Figure 5A.8.5 show the percentage distribution of identified PWMI based on their marital status according to the types of mental illness. The prevalence of both severe and common mental illnesses was high with persons who are married (77.1% [out of 48=100%] and 64.7% [out of 102=100%] respectively) than those who are unmarried. The reason could be due to the stresses the family responsibilities and issues bring to the married persons. The data for the unmarried indicate nearly 28.4% with severe mental disorders and nearly 20.8% with common mental disorders. The persons widowed though smaller in number and percentage, a total of 1 person (2.1%) suffered severe mental illnesses; and 5 persons (4.9%) were with common mental disorders. The sex-wise distribution of PWMI based on marital status shows that married men have a higher prevalence of mental illness (47.9%) CMD and (37.3%) SMD as compared to the women with mental illness who are married (29.2%) CMD and (27.5%) SMD. The study shows that a higher percentage of unmarried men suffer from common mental illness 14.6% and 16.7% severe mental illness in comparison with unmarried women (6.3% and 11.8%).

The data on PWMI according to sex and marital status show that a higher percentage of married men were with mental illness, it is not merely the stresses of family responsibilities that marriage brings to men.

5A. 9. Occupation and type of mental illness

The right to work and the right to "just and favourable conditions of work" are human rights recognized in Articles 6 and 7 of the International Covenant on Economic, Social and Cultural Rights and Article 27 of the Convention or the Rights of Persons with Disabilities. Work is also a major determinant for good mental health and for recovery from mental health problems. It is thus inextricably linked with the human right to the highest attainable standard of mental health.

Satisfactory work is good for people's mental health and can help people experiencing a mental health problem to recover not only their health, but also their self-confidence and self-esteem. Unemployment not only creates economic disadvantage but also decreases self-esteem and increases isolation and marginalization. Article 27 of the CRPD sets out a wide range of areas for government action to protect and fulfil the right of persons with disabilities to work on an equal basis with others. All individuals with experience of a mental health problem have the potential to make a valued contribution to their own and the wider community. The reality that many people with this experience are being denied their right to work or are inadequately supported to avail of this right is a loss not only to the Irish economy, but to a society that needs the creative talent and determination of all of its members.

Table No: 5A.9.

Occupation and Type of Mental Illness

Occupation		Type of Mental Illness		Total
		CMD	SMD	
Agricultural	Count	30	61	91
	% of Total	20.0%	40.7%	60.7%
Daily wage Labour	Count	4	15	19
	% of Total	2.7%	10.0%	12.7%
Household work	Count	8	12	20
	% of Total	5.3%	8.0%	13.3%
Not working	Count	6	14	20
	% of Total	4.0%	9.3%	13.3%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =1.711, df=3, No. of valid cases = 150, Contingency Coefficient = 0.106, $P<0.05$)

The PWMI identified in the CMH&D Program based on occupation shows the varied nature of occupation of PWMI (Figure 5A.8.1). They were involved in agriculture, agriculture

labour, daily wage labour, and household work. Majority of PWMI identified were in agricultural work. The daily wage earners also partake in agricultural activates. Daily wage earners work in agricultural fields, construction work, carpentry, weaving and NREGA. The study shows that a total of 20 (13.3%) persons (women and men) are not involved in any productive work. It was observed that the PWMI who were in the symptomatic state, had poor family support, little or no enthusiasm of the community to integrate the individual, stigma and hence were unemployed. Poor occupational functioning is nearly a universal characteristic of SMD, with competitive employment rates typically in the range of 10% -20 % (Mueser et al. 2001b). The majority of the unemployed were in the age group of 26 to 30 years. This is in keeping with Western studies (Strauss et al., 2000) which show that most of employed and unemployed persons with SMD belonged to this age group. Unemployment of PWMI could be the result of the presence of persistent symptoms (negative symptoms and general psychopathology), loss of acquired skills or due to cognitive decline during the course of the illness.

From the above table finding shows that 9.3% unemployed (not working) and 8% household work among the PWMI is higher in the category of SMD than CMD. It has relationship with their employment and illness category. In the severe mental illness people need lot of time to stabilize and back to the work.

5A. 10. Number of family members and earning members in the family.

Although many Indians still live in joint families, which of course deviate in various ways from the ideal joint family, others live in nuclear family set ups and in some other situations a couple lives with their unmarried children, as is the most common pattern in the West. These changes in family structure are amply reflected by the national census data. According to the 1981 census, the population growth was higher than the growth rate of households, a phenomenon which saw a turnaround in 1991 census which showed that the number of households grew at a faster pace than the population and this trend gathered further strength in 2001census data. This perhaps indicates that nuclearization of families is growing in the society which is more evident in urban areas than in the rural, although happening in both the settings. The changes in family system may pose a host of unique advantages as well as disadvantages vis-à-vis the older pattern of Indian families, when it comes to mental health. Reviewing the impact of these on an individual member's mental health in nuclear families the concept is 'me my wife and my children' with no place for others was alarming. This disappearance of emotional ethos has affected the socio-psychological environment of the

individuals. Person feels alienated. The community is disappearing. Modern progress brings individualistic way of thinking; this causes increasing frustration and low tolerance level among the younger generation. These are some common features seen in contemporary urban society in India. The advantages of nuclear families are: increased personal freedom and space to grow, expression and exploration, much needed privacy to the couples and avoidance of unnecessary meddling by others, financial stability, ease of adjusting to the work, educational demands, and thus reduction in the levels of stress and dependence.

Since the individualism is emerging, economic resilience can be expected to be higher with women working, and increasing sources of income. However, individualism, urbanization can be expected to impact emotional resilience. The disadvantages of the nuclear families are: lack of support to take care of things children in absence or emergency of one member, limited social interactions close relationships, considerable erosion of traditional support systems and increased stress and pressure on nuclearized families, leading to an increased vulnerability to emotional problems and disorders, increased demands on finances to replace the traditional joint family support systems by hiring services like concierge, crèche, etc.

Table No.5A. 10.

Number of Family members and Earning members in the Family

Earning Member Family		**Total Member in Family**				Total
		2 to 3	4 to 5	5 to 6	More than 6	
1	Count	12	24	56	8	100
	% of Total	8.0%	16.0%	37.3%	5.3%	66.7%
2 to 3	Count	11	8	28	1	48
	% of Total	7.3%	5.3%	18.7%	.7%	32.0%
More than 3	Count	0	0	2	0	2
	% of Total	.0%	.0%	1.3%	.0%	1.3%
Total	Count	23	32	86	9	150
	% of Total	15.3%	21.3%	57.3%	6.0%	100.0%

Chi-square test: (Pearson chi-square = 6.770, df= 6, No. of valid cases = 150 Contingency Coefficient= .518, P>0.05)

The above table reveals 66.7% families with a mentally illness person have one earning member. 32% have 2-3 earning members in the family 1.3% have more than 3 earning members in the family. (Pearson chi-square = 6.770, df= 6, No. of valid cases = 150 Contingency Coefficient= .518, P>0.05). There is no enough evidence to accept the null hypothesis and so null hypothesis is rejected with no significance between the variables.

From the above findings we can infer that 66.7% families have only one earning members because even if there is another adult in the family s/he would have to stay back at home to look after the mentally ill person.

5A. 11. Family incomes and type of mental illness

Poverty was one issue that cut across all the other concerns. Families of persons with mental illness resorted to what they believed were cost-effective methods of healing, like superstitious practices, to avoid going all the way to the institute. They assumed that such treatment would be a one-time affair, but eventually spent a lot of money and time at these faith-healing centres. Many families lost all their financial resources in their search for cures for their ill members. There is now a substantial body of evidence, which demonstrates the relationship between poverty and socioeconomic inequalities with CMD. In the United Kingdom there is good evidence showing an association between low standard of living (not owning a car and or a house) and the prevalence of CMD. British data also suggest that socioeconomic measures appear to delay recovery rather than increase the onset of new episodes. However it is also possible that those with poor mental health have a reduced capacity to earn, and this might account for some or the entire observed socioeconomic gradient. This explanation has been called social selection. There is some evidence for social selection but it does not appear to be able to explain the whole socioeconomic gradient. There is evidence from a longitudinal study in the USA that low income is associated with CMD. The World Health Organization estimates that the cost of mental health problems in developed countries is between 3 and 4% of Gross National Product. The 'hidden' costs of mental illness have a significant impact on public finances: it has been estimated that the costs of CMD through lost working days are 23 times higher than the costs to the health service.

Especially for poor persons with mental illness, it leads to extreme marginalization of the individual and the family, as both these handicaps hampers ability to be productively engaged and to access necessary resources for that. PWMI's initiative is affected by internal factors (within the individual) and external factors (due to lack of specific support facilities). The social stigma further blocks community support and access to resources (Dr. Janardhan and Naidu 2006). Being mentally ill and a female, the family's investment for care is likely to be less and so also other support needed for recovery. Consequences are unhappy lives of the individual sometimes leading to extreme crisis, poor coping abilities of the family, lost productivity and stress in the community. Poverty and associated conditions of

unemployment, low educational level, deprivation and homelessness are all strong markers for mental illness. These adverse conditions prevail in the populations of many rich as well as poor countries. Mental illness and poverty are considered to interact in a negative cycle; that is, not only is the risk of mental illness among people who live in poverty higher, but so too is the likelihood that those living with mental illness will drift into or remain in poverty. The relationship between poor mental health and the experience of poverty and deprivation has been well studied and an association between the two factors has been established. The World Health Organization report on mental health states 'Mental disorders occur in persons of all genders, ages, and backgrounds. No group is immune to mental disorders, but the risk is higher among the poor, homeless, the unemployed, persons with low education'. The link is however, complex and is influenced by numerous factors. Poor PWMI are not only vulnerable due to their condition, but also the vulnerability brought about by poverty, which is a consequence and to some extent cause of their condition. One of the main reasons that people find it hard to accept PWMI as equal, is that they do not see them as capable of contributing to the household or the community. For decades, researchers have shown that poverty and mental illness are correlated; the lower a person's socioeconomic status, the greater are his or her chances of having some sort of mental disorder. Poverty exacerbates mental illness.

Table No. 5A.11.
Family Incomes and Type of Mental Illness

Family Income		**Type of Mental Illness**		Total
		CMD	SMD	
Less 10000	Count	8	12	20
	% of Total	5.3%	8.0%	13.3%
10000-20000	Count	4	15	19
	% of Total	2.7%	10.0%	12.7%
20001-30000	Count	14	31	45
	% of Total	9.3%	20.7%	30.0%
40001-50000	Count	9	13	22
	% of Total	6.0%	8.7%	14.7%
Above 50001	Count	13	31	44
	% of Total	8.7%	20.7%	29.3%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =2.575, df=4, No. of valid cases = 150, Contingency Coefficient = 0.130, P>0.05)

From the table we can observe that 13.3% of the people living with mental illness earn an income less than Rs. 10000/- p.a. 12.7 % earn between Rs. 10000-20000, 30% up to 20000, 14.7% up to 50000 and 29.3% more than 50000 p.a. 32% people living with common mental disorders of which 5.3% earn less than 10000/- and 8.7% above 50000/- p.a. 68% are people living with severe mental disorders of which 8.0% earn less than 10000/-p.a. and 20.7% above 50000/-p.a.

From the above findings with (Pearson chi-square =2.575, df=4, No. of valid cases = 150, Contingency Coefficient = 0.130, P>0.05), we can infer that there is no significant relationship between both the variables and the null hypothesis is rejected. People who belong to any income group can be affected by mental illness. It is evident that poverty and mental ill health are linked together in a complex manner. Insecurity, low educational levels, inadequate housing and malnutrition, which are the correlates of poverty are recognized as contributing to CMD and SMD. Mental disorders envisage costs in terms of long-term treatment and lost productivity. Health policy makers and planners must recognize the needs of the vulnerable and focus on the psychological as well as social aspects of health in order to be truly effective. 30% of the PWMIs which is the higher number among the total number of PWMIs full under the income group 20001 to 30000 annually.

5A. 12. Income and occupation of caregivers

The family care giving burden of persons with severe mental illness includes financial responsibilities, missed work, disturbance of domestic routines, constraints on social and leisure activities and reduced attention to other family members (Kreisman and Joy 1974; Hatfield 1987) Family caregivers are more likely to have lower income and lower self-reported health problems than the population at large. Reduced earnings and decreased employment potential put caregivers of mentally ill individuals at an increased risk of poverty. Mental illness and poverty "interact in a negative cycle", in which poverty acts as a risk factor for mental illness and mental illness increases the risk that individuals will "drift into or remain in poverty". This negative cycle may also contribute to high rates of homelessness among individuals with mental illness.

Table No. 5A.12.
Income and Occupation of Caregivers

Income		**Occupation**				Total
		Agricultural	Daily wage Labour	Household Work	NA	
Less 10000	Count	18	6	20	0	44
	% of Total	12.0%	4.0%	13.3%	.0%	29.3%
10000-20000	Count	12	24	10	0	46
	% of Total	8.0%	16.0%	6.7%	.0%	30.7%
20001-30000	Count	20	11	5	0	36
	% of Total	13.3%	7.3%	3.3%	.0%	24.0%
30001-40000	Count	4	4	2	2	12
	% of Total	2.7%	2.7%	1.3%	1.3%	8.0%
40001-50000	Count	2	5	0	0	7
	% of Total	1.3%	3.3%	.0%	.0%	4.7%
Above 50001	Count	3	1	0	1	5
	% of Total	2.0%	0.7%	0.0%	0.7%	3.3%
Total	Count	59	51	37	3	150
	% of Total	39.3%	34.0%	24.7%	2.0%	100.0%

Chi-square test: (Pearson chi-square = 54.984, df=15, No. of valid cases = 150 Contingency Coefficient= .518, P<0.05)

The above table reveals that 39.3% of caregivers are farmers, 34% are agricultural labourers and 24.7% are labourers who also engaged in all local activities. The table states that 29.3% earn less than 10,000 a year, 30.7% between 10,001-20,000 24% earn between 20,001-30,000, 8% between 30,001- 40,000 4.7% between 40,001-50,000 and 3.3% above 50,001.

From the findings we can infer that there is a significant relationship between income and type of occupation with these test results (Pearson chi-square = 54.984, df=15, No. of valid cases = 150 Contingency Coefficient= .518, P<0.05). Null hypothesis is accepted.

Most of the respondents' are in the category of 10,001-20,000 and are agricultural labourer who earns a moderate income. Mental illness which is chronic deteriorates the economic condition of caregivers. However, one research does talk about profile of the relative attendant which concludes that in both experimental (80%) and control (73.3%) group, the relatives were predominantly male (SubramanyaShetty1995). Regarding their income, 40% of control group and 30% of the experimental group earned less than Rs. 1000 per month.

Section B: Understanding Treatments and Stigma Associated with Mental Illness.

This chapter examines the diagnosis, impact of treatment and stigma associated with mental illness. Mental illness can be treated. When someone first starts to develop symptoms of mental illness, it is important to contact a doctor or a community mental health service for help. The correct treatment can help a person's condition to improve or help a person to live well, despite the presence of ongoing symptoms. Psychological treatments are often the most helpful for people more sever affected by mental illness. Sometimes, the symptoms can be so confusing for the person that they do not realize they are not realizes they are ill. In this case, family or friends can visit the doctor to seek support and advice about how they can help the person. Mental disorders are estimated to account for 12% of the global burden of disease, but only a minority of persons affected receives basic treatment. Whereas there is evidence from industrialized countries that not all people with mental disorder received adequate treatment, in developing countries mental health services area totally lacking and large segments of the population do not have ready access to health facilities, which tend to be based in hospitals and oriented predominantly towards urban conditions. In an attempt to strengthen the health care system and achieve low cost but effective and efficient health services, attention is being increasingly focused on the development of a primary health care strategy.

Extraordinary advances have been made in the treatment of mental illness. Understanding what causes some mental health disorders helps doctors tailor treatment to those disorders. As a result, many mental health disorders can now be treated nearly as successfully as physical disorders. Most treatment methods for mental health disorders can be categorized as either somatic or psychotherapeutic. Somatic treatments include drugs, electroconvulsive therapy, and other therapies that stimulate the brain (such as transcranial magnetic stimulation and vagus nerve stimulation). Psychotherapeutic treatments include psychotherapy (individual, group, or family and marital), behaviour therapy techniques (such as relaxation training or exposure therapy) and hypnotherapy. Most studies suggest that for major mental health disorders, a treatment approach involving both drugs and psychotherapy is more effective than either treatment method used alone. Psychiatrists are not the only mental health care practitioners trained to treat mental illness. Others include clinical psychologists, advanced practice nurses, social workers and some lay health counsellors.

However, psychiatrists (and psychiatric nurse practitioners in some states) are the only mental health care practitioners licensed to prescribe drugs. Other mental health care practitioners practice psychotherapy primarily. Many primary care doctors and other types of doctors also prescribe drugs to treat mental health disorders. Following are the mental health care practitioner and their expertise from the training they received.

Types of Mental Health Care Practitioners		
Practitioner	**Training**	**Expertise**
Psychiatrist	Medical doctor with 4 or more years of psychiatric training after graduation from medical school	Can prescribe drugs, use electroconvulsive therapy, and admit people to the hospital may only practice psychotherapy, only prescribe drugs, or do both.
Psychologist	Practitioner who has a master's or doctoral degree but not a medical degree Often have postdoctoral training and usually have been trained to administer psychological tests that are helpful in diagnosis.	May practice psychotherapy but cannot do physical examinations, prescribe drugs (in most states), or admit people to the hospital
Psychiatric social worker	A practitioner with specialized training in certain aspects of psychotherapy, such as family and marital therapy or individual psychotherapy. Often trained to interface with the social service systems in the state may have a master's degree and sometimes a doctorate as well	Cannot do physical examinations or prescribe drugs
Advanced practice psychiatric nurse	Registered nurse with a master's degree or higher and training in behavioural health	May practice psychotherapy independently in some states and may prescribe drugs under the supervision of a doctor
Psychoanalyst	May be a psychiatrist, psychologist, or social worker who has many years of training in the practice of psychoanalysis (a type of intensive psychotherapy involving several sessions a week and designed to explore unconscious patterns of thought, feeling, and behaviour)	Practices psychoanalysis and, if also a psychiatrist, may prescribe drugs and admit people to hospitals

(Source:http://www.merckmanuals.com/home/mental_health_disorders/overview_of_mental_health_care/treatment_of_mental_illness.html)

Now a day’s mental health care scenario has been slightly changed and modern science added different therapies to treat mental disorders.

Drug Therapy: A number of psychoactive drugs are highly effective and widely used by psychiatrists and other medical doctors. These drugs are often categorized according to the disorder they are primarily prescribed for. For example, antidepressants are used to treat depression.

Electroconvulsive Therapy: With electroconvulsive therapy, electrodes are attached to the head, and while the person is sedated, a series of electrical shocks are delivered to the brain to induce a brief seizure. This therapy has consistently been shown to be the most effective treatment for severe depression.

Psychotherapy: In recent years, significant advances have been made in the field of psychotherapy. Psychotherapy, sometimes referred to as talk therapy, works on the assumption that the cure for a person's suffering lies within that person and that this cure can be facilitated through a trusting, supportive relationship with a psychotherapist. By creating an empathetic and accepting atmosphere, the therapist often is able to help the person identify the source of the problems and consider alternatives for dealing with them. The emotional awareness and insight that the person gains through psychotherapy, often results in a change in attitude and behaviours that allows the person to live a fuller and more satisfying life.

Psychotherapy is appropriate in a wide range of conditions. Even people who do not have a mental health disorder may find psychotherapy helpful in coping with such problems as employment difficulties, bereavement, or chronic illness in the family. Group psychotherapy, couples therapy, and family therapy are also widely used. Most mental health practitioners practice one of six types of psychotherapy: supportive psychotherapy, psychoanalysis, psychodynamic psychotherapy, cognitive therapy, behavioural therapy, or interpersonal therapy.

Psychoanalysis is the oldest form of psychotherapy and was developed by Sigmund Freud in the first part of the 20th century. The person typically lies on a couch in the therapist's office 4 or 5 times a week and attempts to say whatever comes to mind a practice called free association. Much of the focus is on understanding how past patterns of relationships repeat themselves in the present. An understanding of how the past affects the present helps the person develop new and more adaptive ways of functioning in relationships and in work settings.

Psychodynamic psychotherapy: like psychoanalysis, emphasizes the identification of unconscious patterns in current thoughts, feelings, and behaviours. However, the person is

usually sitting instead of lying on a couch and attends only 1 to 3 sessions per week. In addition, less emphasis is placed on the relationship between the person and therapist.

Cognitive therapy: helps people identify distortions in thinking and understand how these distortions lead to problems in their lives. The premise is that how people feel and behave is determined by how they interpret experiences. Through the identification of core beliefs and assumptions, people learn to think in different ways about their experiences, reducing symptoms and resulting in improvement in behaviour and feelings.

Behavioural therapy: is related to cognitive therapy. Sometimes a combination of the two, known as cognitive behavioural therapy, is used. The theoretical basis of behavioural therapy is learning theory, which says that abnormal behaviours are due to faulty learning. Behavioural therapy involves a number of interventions that are designed to help the person unlearn maladaptive behaviours while learning adaptive behaviours. Exposure therapy, often used to treat phobias, is one example of a behavioural therapy

Religious treatments: Places of worship to Hindus, Muslims and Christians, are still important centres for the treatment of mental illness (Thara et al, 1998). Here the focus of control is placed outside the sufferer and problems may be attributed to black magic, a curse, divine wrath, or karma (determinism) of a previous life. The explanatory model therefore largely influences the type of help sought. Treatments at religious centres range from performing a series of rituals such as bathing in the temple tank and circumambulation the temple, to prayers at specified times. Physical restraint by chaining patients to a pole or a tree is not uncommon. Belief in the efficacy of religious treatment has led to the growth of unauthorized shelters housing mentally ill patients around such centres of worship. In August 2001 a gruesome event occurred when fire broke out at one such shelter, in Yerwadi, in which 26 mentally ill people burnt to death because they had been chained to prevent them from escaping. This disaster led to a rethink of the mental health scene and some governmental action followed.

Alternative healing practices, especially religious healing, are still the first resort and can be attributed to misconceptions about mental disorders and the stigma attached to them. A significant population in India cannot afford private hospital care. The rehabilitation of psychiatric patients has not been given much importance in the existing mental health framework (Thara K. et. al., 2004). In another study (Kulhara, Avasthhi, Sharma 2000) found that relatives attributed mental illness to the influence of supernatural phenomena although many denied personal conviction in magical religious beliefs, and yet 74% had

sought some kind of magical religious treatment for their patients. However, contrary results were reported in a study by Srinivas and Thara (2001) where only 12% reported the cause to be supernatural but a majority cited psychosocial stressors, personality defects and heredity. Previous studies have reported that families also attribute other causative factors for being inflicted with mental illness. An Indian study by Kavitha (2003) reported that the views held by both patient and caregivers were that psycho-social factors caused mental illness. Similar findings were reported in a Turkish study by Karanci (1995) where caregivers attributed schizophrenia mainly to psychosocial causes, including stressful events, family conflicts and disruptions of family live, subjective burden and the financial cost of illness. A study by Adebowale and Ogunlesi (1999) from Nigeria reported that twelve (17.1%) patients and respondents gave 'medical causal explanation; 16 (22.9% patients and 13 (18.6%) relatives gave 'psychosocial causal explanation; 27 (38.6%) patients and 38 (54.3%) relatives were 'uncertain' about the cause of their relatives illness. Relatives reported a greater relevance of 'heredity' and 'supernatural' factors as other possible causal factors, than patients. Patients with previous psychiatric hospitalization reported higher prevalence of 'psychosocial' and 'supernatural' causal beliefs than those without.

Understanding Stigma Associated with Mental Illness:

"Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger and or avoidance. Stigma leads others to avoid living socializing or working with renting to or employing people with mental disorders especially severe disorders. It reduces access to resources and opportunities (e.g. housing, jobs) and leads to low self-esteem isolation and hopelessness. It deters the public from seeking and wanting to pay for care in its more overt and egregious form stigma results in outright discrimination and abuse. More tragically it deprives people of their dignity and interferes with their full participation in society" (U.S. Department of Health and Human Services, 1999, p.6). If stigma represents the feelings, reactions and stereotypes that people experience when they encounter mental illness and adults and children who face it discrimination is action taken to deprive people of their rights based on those feelings and reactions. Stigma demonstrates a lack of understanding compassion and knowledge of mental illness and the people it affects.

Not all of us have direct experience of being treated differently because of the stigma associated with mental illness but a substantial number of us do, especially if we include the unease that can be associated with the "embarrassment" of having a mental illness.

Stigma is experienced and seen by many of us as:

- Being seen as different.
- Being regarded as socially unacceptable.
- Being alienated.
- Being discriminated against and abused.
- Being verbally harassed.
- Worrying too much about what other people will say.
- Being the subject of a set of unreasonable generalizations that may be passed from generation to generation.
- Being the subject of a range of negative views and perceptions by other people (for instance that we are always 'down' and unhappy).
- Being seen as an unknown quantity as another species.
- Being a group that other people do not know how to talk to or act with.
- Not being normal.
- Feeling ashamed and weak because we cannot cope.
- Being avoided.
- Being seen as failures and as weak.
- Having a condition that we have to hide and lie about.
- Being seen as unpredictable.
- Not being seen as part of social conversations. People often don't speak about illness, as the intensity of emotion is not acceptable to them.
- Being seen as 'mad' or 'pagal'.
- Being labelled and stereotyped and defined by our illness.
- Not being understood.

The stigma attached to mental illness may be experienced at individual, family, community levels and the social interactions to the family with person with mental illness. There is a lot of ignorance and myth associated with the mental illness. Individuals and families are isolated, rejected, and sometimes excluded from the social settings.

On the individual level, a person with mental illness, in some instances is rejected isolated and sometimes hidden from being seen by the community. Most of the people with mental illness has interacted with had experienced various episodes of violence testify of being mistreated, harassed, beaten, ridiculed and tied up because of the social stigma attached to the condition. There is emotional, physical and sexual abuse too directed towards these PWMIs.

People with mental illness are called all sorts of names in different cultures like "Mad" or “Pagal" in Maharashtra and other names in other cultures because of the nature of the problem. PWMIs suffer a lot of physical torture in trying to control them in one place for those with hallucinations and delusions. Because of stigma PWMIs are discriminated in many ways ranging from denial of human rights like education, marriage, and right to take decisions on the kind of treatment and also concerning their property. Because of this state of affairs PWMIs also self-stigmatize themselves due to the lack of self-confidence and self-esteem, empowerment and ability to take control of their lives.

At a family level, stigma is also experienced more or less like at the individual level. There is great fear by the community that associating with a family with a PWMI may also expose them to contract the illness which is shameful. Families with a PWMI live in a world of social isolation people fear to get married or to marry from such a family. Mental illness is usually associated with witchcraft. There is likelihood of not inviting such a family to social functions because of the negative connotations attributed to mental illness. Such perceptions, attitudes or beliefs may be beheld to all family members.

At community level, people who tend to associate themselves with a family of PWMI have a risk of being isolated too because the society tends to reason that birds of the same feathers flock together and are therefore mentally ill themselves. Stigma is also seen as a sign of human frailty. Most of us know that stigma is illogical damaging and unjustified and yet it still exists. Some of our members feel that some of the acts of discrimination come from people who are frail themselves. Only by putting down those that they believe are worse off than themselves do they manage to create feelings of self-worth for themselves. The stigma experienced by a PWMI or a caregivers at any level mentioned above it impacted on the different aspects as following.

Impact on Help-Seeking: Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment. Stigma surrounding the receipt of mental health treatment is among the many barriers that discourage people from seeking treatment. The stigmatization of mental illness and the lack of information on the symptoms of mental illness are seen as the main barriers to seeking help for mental health problems.

Impact on Employment: Stigmatization is generally associated with decreased employment. Results of National Survey was the first to focus on the experience of individuals with SMD and details pervasive discrimination in the workplace that prevents them from reaching their full professional and personal potential. Seven out of ten said they have been treated as less competent by others when their illness is revealed. Three out of four said they avoid

disclosing their illness to anyone outside their immediate families, we know similar fears exist about disclosure to employers for those who experience more mild forms of mental health problems as well.

Impact on Families: Stigma affects not only people with mental illnesses but their families as well. Families commonly report 'stigma by association' resulting in discriminatory and prejudicial behaviours towards them.

5B. 13.Type of mental illness and years of treatment

In the treatment of mental disorders specifically in severe mental disorder people need very regular and long term treatment than the common mental disorder. In the tribal area there were no health facilities available than thinking of having mental health treatment facilities is a miracle. Most of the mentally ill people don't received regular treatment therefore their period of treatment is shown as longer more than seven years. Psychiatric treatment is available in the district place or in a metro city which is very far from the tribal area therefore most of the people who had taken treatment from private psychiatrist were very irregular or stop the treatment in between consequently their severity of mental illness has been increased. The psychiatric symptoms and disabilities of many people living with mental illness can be significantly improved by various psychiatric and psychosocial treatments. Unfortunately, although each year approaching 30 percent of the population worldwide has some form of mental illness, at most only one third of them receive mental health treatment (Kessler et al., 2003; Alonso et al., 2004; Kohn et al., 2004; Kessler et al., 2005; Wittchen & Jacobi, 2005). Generally people with severe mental illness do not participate in treatment more often than those with common mental disorders (World Health Organization 2005).

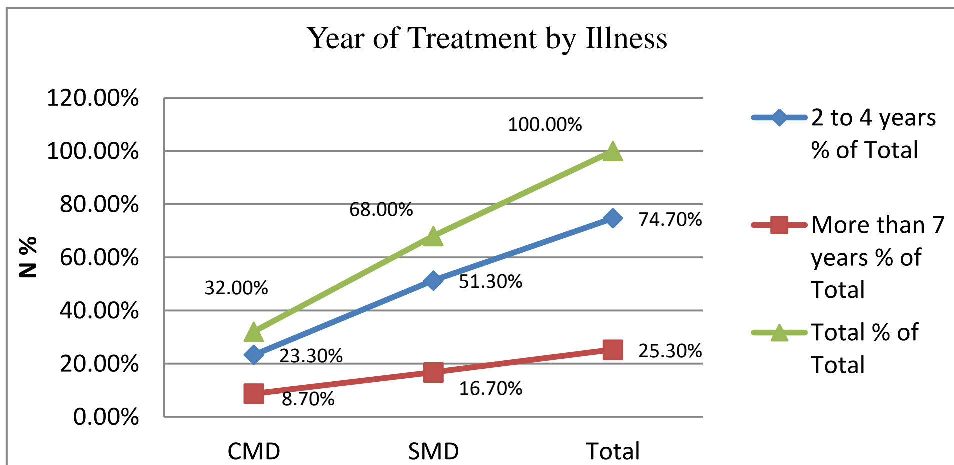
Table No. 5B.13

Type of Mental Illness and Years of Treatment

Years of Treatment		**Type of Mental Illness**		Total
		CMD	SMD	
2 to 4 years	Count	35	77	112
	% of Total	23.3%	51.3%	74.7%
More than 7 years	Count	13	25	38
	% of Total	8.7%	16.7%	25.3%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =.114, df=1, No. of valid cases = 150, Contingency Coefficient = 0.028, P>0.05)

Figure No: 5B.13.6



From the above figure it can be observed that chronic mental illness requires treatment for a longer period of time. The table shows that 25.3% of PWMIs have taken treatment for more than 7 years of which 8.7% were diagnosed with common mental disorders and 16.7% PWMIs with SMDs. The figure 16.7% also shows that SMDs who required more number of years for treatment than the CMDs. Pearson chi-square =.114, df=1, No. of valid cases = 150, Contingency Coefficient = 0.028, P>0.05) hence null hypothesis is rejected.

Regular and long term treatment is necessary in the lives of PWMIs in both the conditions (CMD & SMD). In common mental disorder early treatment plays crucial role in total recovery from the illness and back to the productive life.

Findings draw from above table that severe mental disorders need long term treatment than the common mental disorder. 16.7% PWMIs who has severe mental disorder had taken more than 7 years of treatment for their illness.

5B.14. Period of treatment by sex

Gender refers to "the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Gender is relational gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationships between women and men, girls and boys". Simply put, sex refers to biological differences, whereas gender refers to social differences. In the last decade, a considerable amount of research has been conducted in the area of gender and mental health, including gender differences in vulnerability to, and the impact of, specific mental health conditions. Gender has been shown to influence how health policies are conceived and implemented, how biomedical and

contraceptive technologies are developed and how the health system responds to male and female clients. A study on gender and mental health in China that combined historical, epidemiological and qualitative data found significantly higher rates of SMD among women than among men, a finding contrary to western studies in which men suffer more from SMD. Interestingly, however men occupied more hospital beds than women in psychiatric hospitals, in which at least three quarters of patients were suffering from SMD, indicating that hospital bed occupancy did not reflect the male-female ratio of people affected by the disease. While several possible reasons for this imbalance were cited, significant gender differences in ability to pay were noted. Men were much more likely to have health insurance from their employers than women, who tended to be treated more as charity cases. Reports from other parts of the world show that women constitute the large majority of individuals seeking psychological services. Given this gender imbalance, services are not positioned to respond adequately to their female clients. The links among mental health, gender and economic status were clear in several aspects. Women had about twice the incidence of poor mental health indicators than men and the mental health problems increased as income declined. This is also true of other studies.

Table No. 5B.14.

Period of Treatment by Sex

Sex		**Years of Treatment**			Total
		Less than 1 year	2 to 4 years	More than 7 years	
Male	Count	7	63	19	89
	% of Total	4.7%	42.0%	12.7%	59.3%
Female	Count	28	22	11	61
	% of Total	18.7%	14.7%	7.3%	40.7%
Total	Count	35	85	30	150
	% of Total	23.3%	56.7%	20.0%	100.0%

Chi-square test: (Pearson chi-square =30.340, df=2, No. of valid cases = 150, Contingency Coefficient = 0.410, P<0.05)

The table shows comparison between male and female and the period of their treatments. Above table describe that 40.7% female were in treatment within that 18.7% female took treatment less than 1 year and very less 7.3% of females took treatment more than 7 years. This also show that more number of males under treatment for a longer time. Most of the PWMIs (56.7%) were taken treatment in the period of 2 to 4 years. 23.3% PWMI taken treatment less than 1 year. Most of the males were under treatment than female and also for a

longer period. (Pearson chi-square =30.340, df=2, No. of valid cases = 150, Contingency Coefficient = 0.410, $P<0.05$).There is no significant association as p-value is less than 0.05.

Findings draw from above table that 20% male and female both received more than 7 years of treatment for their illness but within this more number of male (12.7%) were received long treatment than the (7.3%) female.

5B. 15. Action taken in the initial period and type of mental illness

The types of treatment and services available for adults with mental health issues vary depending on how severe their need is. Many older adults get all of their treatment primarily through their family doctor. Medical care can address mild forms of anxiety, depression and other common mental health problems. Many individuals may feel comfortable keeping their primary care physician as the only one involved in their care. If you have any symptoms or concerns about the way you are feeling, talk to your doctor. If you have questions about your medication, you can talk to your doctor. There may be times that the family doctor needs to make a referral for more specialized mental health care, just as they might for other kinds of disorders. Depending on the need, these types of specialists may include:

- Psychiatrist (a medical doctor with a specialty in psychiatry)
- Geropsychiatrist (a psychiatrist with a specialty in working with older adults)
- Clinical psychologist
- Clinical social worker
- Pastoral counselor
- Clinical nurse specialist
- Nurse practitioner
- Physician’s assistant

People affected by mental illness may benefit from a range of treatment. Medical treatment (or referral to other health services) can be provided by: A local doctor (general practitioner or GP) can make an assessment and prepare a mental health plan to help the person get treatment and support. This may include referral for psychological therapy from an appropriately qualified health professional, which may be largely covered by Medicare. A doctor can also provide ongoing treatment for many people some undertake further training to specialize in this area. Doctors also play an important role in making sure that the physical health of a person with a mental illness is not neglected. A psychiatrist is a medical doctor who specializes in the study and treatment of mental illness. Most people affected by mental

illness will have contact with a psychiatrist at some stage of their illness. Those more seriously affected will have more regular contact.

Table No. 5B.15.
Action taken in the initial period and Type of Mental Illness

Action taken in the initial period		Type of Mental Illness		Total
		CMD	SMD	
Nothing	Count	7	12	19
	% of Total	4.7%	8.0%	12.7%
Faith Healer	Count	5	14	19
	% of Total	3.3%	9.3%	12.7%
General practitioner	Count	3	15	18
	% of Total	2.0%	10.0%	12.0%
Psychiatrist	Count	5	13	18
	% of Total	3.3%	8.7%	12.0%
Faith Healer, General Practitioner & Psychiatrist	Count	20	37	57
	% of Total	13.3%	24.7%	38.0%
Home Remedies & General Practitioner	Count	8	11	19
	% of Total	5.3%	7.3%	12.7%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =3.721, df=5, No. of valid cases = 150, Contingency Coefficient = 0.156, $P<0.05$)

The above table shows that 4.7% of CMD and 8.0% of SMD didn`t take any action for treating their mental illness. 3.3%of CMD and 9.3% of SMD patient goes to Faith Healers for the treatment of their mental illness. 2.0% of CMD and 10%of SMD prefer to go to the General Hospital for the cure of their mental illness. 3.3% of CMD and 8.7% of SMD only directly goes to the psychiatrics for treatment. 13.3% of SMD and 24.7% of SMD went to various institutions for treatment including psychiatrist. 5.3% of SMD and 7.3% of SMD took Home Remedies and went to General Hospital. (Pearson chi-square =3.721, df=5, No. of valid cases = 150, Contingency Coefficient = 0.156, $P<0.05$) With a $P<0.05$ there is no significant association between variables and hence we can reject the null hypothesis.

Overall 38% PWMIs were taken treatment from faith healer, general practitioner and psychiatrist. It shows that people firstly access faith healer than general practitioner and finally to the mental health specialist (psychiatrist). Psychiatrist treatment comes very late in to the picture, in the initial period of mental illness people try to take treatment from local faith healer. In the severe condition people preferred to take treatment from psychiatrist.

5B. 16. Accessed treatments in the initial period by sex

In the today's scenario in the Rural and Tribal area, mental health services not available in terms of requirement. Forty years ago, the mental health field did not have the tools for successful community care. There was an evident need for more effective mental health treatment, improvements in the system and provision of community support. But those in the field were quite unaware of this. It would not be surprising if the field of long-term care still has much to learn. In severe mental disorder like schizophrenia, usually first appears in a person during their late teens or throughout their twenties. It affects more men than women and is considered a life-long condition which rarely is "cured," but rather treated. The primary treatment for severe mental disorders is medication. Unfortunately, compliance with a medication regimen is often one of the largest problems associated with the ongoing treatment of schizophrenia. Because people who live with this disorder often go off of their medication during periods throughout their lives, the repercussions of this loss of treatment are acutely felt not only by the individual, but by their family and friends as well. Successful treatment of schizophrenia, therefore, depends upon a life-long regimen of both drug and psychosocial, support therapies. While the medication helps control the psychosis associated with schizophrenia (e.g., the delusions and hallucinations), it cannot help the person find a job, learn to be effective in social relationships, increase the individual's coping skills and help them learn to communicate and work well with others. Poverty, homelessness, and unemployment are often associated with this disorder. In the initial recovery from the first symptoms of schizophrenia can be an extremely lonely experience. Individuals coping with the onset of schizophrenia for the first time in their lives require all the support that their families, friends, and communities can provide.

Table No. 5B.16.
Accessed Treatments in the Initial Period By Sex

Accessed Treatments in the Initial Period		Sex		Total
		Male	Female	
Nothing	Count	12	7	19
	% of Total	8.0%	4.7%	12.7%
Faith Healer	Count	10	9	19
	% of Total	6.7%	6.0%	12.7%
General Practitioner	Count	11	7	18
	% of Total	7.3%	4.7%	12.0%
Psychiatrist	Count	13	5	18
	% of Total	8.7%	3.3%	12.0%
Faith Healer, General Practitioner, Psychiatrist	Count	34	23	57
	% of Total	22.7%	15.3%	38.0%
Home Remedies, General practitioner	Count	9	10	19
	% of Total	6.0%	6.7%	12.7%
Total	Count	89	61	150
	% of Total	59.3%	40.7%	100.0%

Chi-square test: (Pearson chi-square =2.861, df=5, No. of valid cases = 150, Contingency Coefficient = 0.137, P<0.05)

The above table shows that 8% of the male and 4.7% of females did not access any type of treatment action for treating their mental illness. 6.7% male & 6% of females sent to faith healers, 7.3% of male and 4.7% female took treatment from general practitioners, 8.7% of males and 3.3% of females took treatment from psychiatrist treatment. 22.7% of males and 15.3% of females went to various institutions for treatment including a psychiatrist. 6% of male and 6.7% of females took home remedies and went to a general practitioner. From the above findings we can infer that 14% males and 10.7% females still have not accessed proper treatment for mental illness which is matter of concern. (Pearson chi-square =2.861, df=5, No. of valid cases = 150, Contingency Coefficient = 0.137, P<0.05)In these cases, stigma along with ignorance is a major factor which prevents the mentally ill to access treatments and so the null hypothesis is rejected as there is no significant relationship.

Findings drawn from above table that 12.7% male and female both does not received any kind of treatment in the initial phase of illness. 8.7% male and only 3.3% females PWMIs who were received psychiatric treatment in the initial phase of their illness it shows that more number males got psychiatric treatment than the female PWMIs.

5B. 17. Treatment taken from and condition after treatment

Faith healers are helpful especially in the initial stages of illness. It was reported over 98% of PWMIs first consult Faith healers. Besides even when they are given western medical treatment they still combine it with the herbs because when they come to the hospitals they want the psychiatric practitioner to accord them proper psychosocial attention. Sometimes, required drugs are not available in the hospitals and at times a family is told to go and buy them and yet they are very expensive. This is a reason why Faith healers are consulted because they are easily accessible, offer comfort and counselling and time to the clients and payment for the treatment they offer may not necessarily be only in monetary terms.

Table No. 5B.17.

Treatment Taken From and Condition after Treatment

Treatment Taken From		**Condition After Treatment**				Total
		Better	Quite better	Not improved	Become worst then previous	
Faith Healer	Count	0	0	19	19	38
	% of Total	.0%	.0%	12.7%	12.7%	25.3%
General Practitioner (GP)	Count	20	0	18	0	38
	% of Total	13.3%	.0%	12.0%	.0%	25.3%
Psychiatrist	Count	0	55	0	0	55
	% of Total	.0%	36.7%	.0%	.0%	36.7%
Faith Healer, GP & Psychiatrist	Count	0	19	0	0	19
	% of Total	.0%	12.7%	.0%	.0%	12.7%
Total	Count	20	74	37	19	150
	% of Total	13.3%	49.3%	24.7%	12.7%	100.0%

Chi-square test: (Pearson chi-square =227.027, df=9, No. of valid cases = 150, Contingency Coefficient = 0.776, P>0.05)

From the above table it can be observed that the 37.7% PWMIs who have received treatment from a psychiatrist shows quite better improvement in their condition. 25.3% did not improve who took treatment form the faith healer and among that 12.7% PWMIs condition become worse than previous. 25.3% who have taken treatment from general practitioners amongst them 13.3% PWMI feel better after the treatment and 12% said that they don't feel any improvement from the treatment. 12.7% PWMIs tried all type of treatment including faith healer, general practitioners and psychiatrist after which they feel quite better than previous.

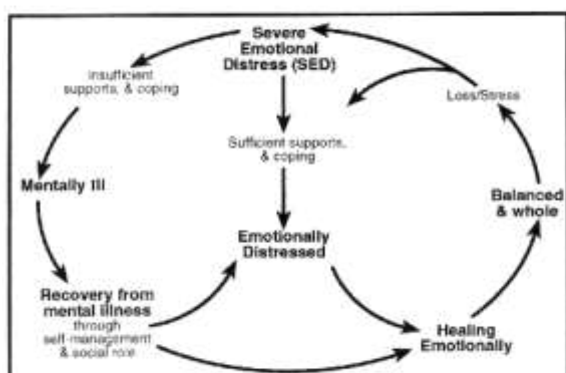
Findings drawn from above table that highest number of (37.7%) PWMIs who have received treatment from a psychiatrist after which they feel quite better improvement in their condition. (Pearson chi-square =227.027, df=9, No. of valid cases = 150, Contingency

Coefficient = 0.776, P>0.05).There is no significant relationship. The alternate hypothesis is accepted.

5B. 18. Method for fast recovery.

Research carried out at the National Empowerment Centre has shown that people can fully recover from even the most severe forms of mental illness. In depth interviews of people diagnosed with SMD have shown that these people are capable of regaining significant roles in society and of running their own lives. Though they have recovered from their mental illness they, as everyone, continue to heal emotionally. In most cases they no longer need medication and use holistic health and peer support to continue their healing. Our findings are consistent with long term studies carried out in this country by Dr. Courtenay Harding and colleagues, and in Europe by Dr. Manfred Bleuler and Dr. Luc Ciompi. These workers have shown that over a 20-30 year period a majority of people recover from even the most severe forms of mental illness. In addition, cross cultural and historical studies indicate that chronic mental illness is recent phenomenon of westernized countries. Recent studies by the World Health Organization show that the rate of recovery from severe mental illness is much better in third world countries than in Western industrialized countries. Historical evidence points out that the rates of recovery were much higher during the 1830-40s in this country when there was a much more optimistic view of recovery.

In spite of all this evidence, most people in this country still believe that when a person has been labelled with mental illness they can never fully recover. Even most rehabilitation professionals believe that mental illness is a permanent condition. We believe that fear is a large factor in perpetuating the myth of no recovery. Those persons who are temporarily labelled normal are afraid that they too could enter the realms of madness. They are more comfortable thinking that those of us who have displayed severe emotional distress are qualitatively different than they are, that somehow we have a genetically based brain disorder that they don't have. This myth could not be continued if people labelled with mental illness fully recover and no longer need medication. In fact, if we are to better understand recovery from mental illness we need to see that anyone could be labelled mentally ill. We need to see the connection between recovery and healing. (See the expanded diagram of our empowerment model.) If you look at the right



Empowerment Model of Recovery from Mental Illness
by Daniel B. Fisher, M.D., Ph.D. and Laurie Ahern

side of the diagram you will see the state of being balanced and whole. This is an idealized state, which may exist in utero and may be a goal we strive much of our life to return to. We needed to believe in our own capacity to do so. We needed to believe in ourselves. We need others along the road who believe in us and believe in our capacity to live our own life. We need others who are not threatened by our leaving because they have a full life of their own. We all need to develop an inner soothing, an inner cooing, an inner whoosh and whoosh. However, life is filled with many losses, conflicts and traumas, as shown in the diagram. They can lead to varying degrees of emotional distress.

The challenge we all face is how to integrate after loss or conflict and return to a greater wholeness of self. This is accomplished through social supports, coping and other resources. This we call the process of emotional healing and appear in the lower right side of the recovery diagram. Some people's losses may be greater and or their inner resources more limited. Instead of healing, those people may enter into a state of severe emotional distress seen at the top of the diagram. They still are in a major, accepted social role, but they may need to go through a state of severe emotional distress to experience the self-renewal which Dr. John Weir Perry has written of in The Far Side of Madness. There may be a state of social withdrawal. Their thoughts become more personalized. If the person's social, cultural, economic and psychological worlds are able to support him as he goes through this deep reintegration process, his thoughts will return to shared reality. Then he can maintain his social role. The person's emotions calm down and he can proceed with the healing we all go through. If on the other hand, there are not sufficient outer and inner resources, and the person is no longer able to maintain a major social role, he is placed in the role and assumes the identity of mental patient. In the role of mental patient, he is no longer seen as a valid member of society. In fact he is an invalid.

With the label of mental illness, a whole new set of discriminations and problems must be overcome. There is a loss of rights. People can lose property, lose custody of children, lose privacy and lose due process before the law. They are basically taken out of the traditional legal system and placed in the extra-legal psychiatric system. The major task then in recovering from mental illness is to regain social roles and identities which are recognized as valid by one self and the people in one's community. This may mean getting a job, being a volunteer or becoming a student. It also means regaining rights, a process which the Americans with Disabilities Act of 1990 have greatly accelerated. Recovery often depends on finding someone who believes in you. That type of relationship can help a person to dream again. People who have recovered from mental illness often do not believe that they have

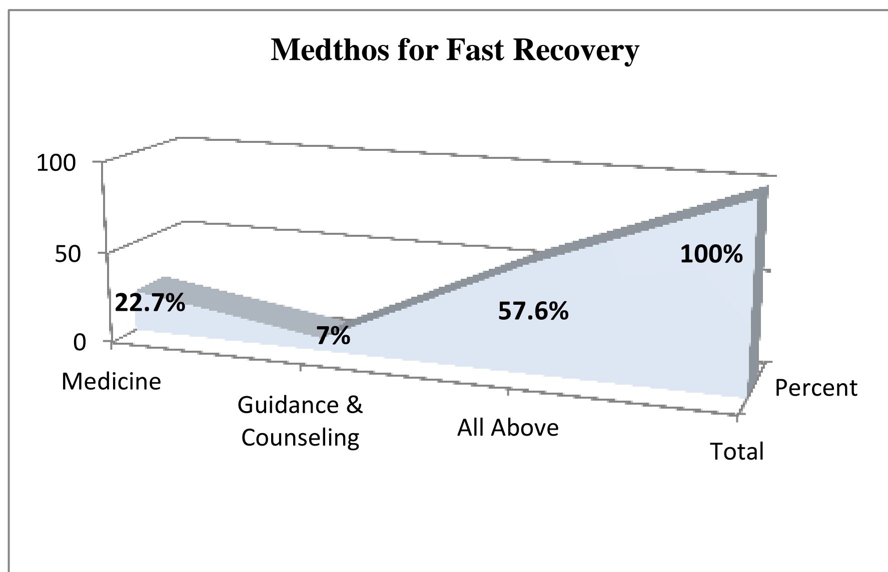
recovered. A case related that she had been diagnosed with schizophrenia in her early twenties. However, she has been out of the hospital for 10 years, has been off all medication for several years and has contributed positively to the community through her full-time job and community service. When we said we thought she had recovered, she disagreed. She said she knew she had not recovered from mental illness because she still has periods when she gets very angry. These periods were never intense enough for her to lose her job or result in hospitalization. We pointed out to her that getting angry like that was a normal part of most people's life. Unfortunately, the label and identity of mental patient is so deep that we and the people around us continue to interpret life's normal swings of emotion as symptoms of continuing illness. After people have recovered from mental illness they still go through the emotional healing that everyone else is involved in. That is why the diagram shows that recovery is usually followed by the emotional healing.

Table No. 5B. 18.
Methods for Fast Recovery.

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Medicine	39	22.7	26.0	26.0
Guidance & Counselling	12	7.0	8.0	34.0
All Above	99	57.6	66.0	
Total	150	100.0	100.0	100.0

Mean=3.14,N=150, Std. Deviation=1.301

Figure No. 5B. 18.7



The above table illustrates that 22.7% get better due to medicines, 7% due to proper guidance and counselling for effective treatments. 57.6% PWMI feel that both medicine and counselling have been effective in treatments of the mentally ill person.

From the above findings we can interpret that counselling and pharmacotherapy both are an important methods for treatment of mentally ill person. Even though 22.7% PWMIs feel that the medication is the best methods for recovery from mental illness, this is true in case of severe mental disorder they first need medication and then the counselling or psychosocial intervention. In case of CMD they can be treated with counselling and psychosocial interventions.

5B.19. Religious treatment and type of mental illness

In an earlier study we observed that 45% of patients presenting to a modern Westernized psychiatric facility had been to see a religious healer prior to seeking help from the psychiatrists (Campion & Bhugra, 1997). Neumann et al. (1971) reported that the stereotype of the indigenous medicine practitioner (who needs to be differentiated from religious healers but emphasizes the pluralistic help-seeking) was not upheld and this group was able to treat all types of illness and appeared to be well regarded by the users. Bhatia et al. (1975) felt that indigenous medical practitioners (who included those practicing the Ayurveda, Sidha and Unani systems of medicine) were employing a mixture of modern and traditional medicines and therefore showed a considerable degree of adaptability to fill the vacuum provided by the absence of western medical practitioners, especially in the rural areas. These authors argue that many practitioners in the older age group who continue to practice traditional medicine inherited the profession, and continue to practice merely to perpetuate the memory of their ancestors. Kakar (1988) reported that models of illness were related to the socio-economic status and religious castes of individuals. There is little doubt that education, social class and religious affiliation will play an important role but as we previously showed (Campion & Bhugra, 1997), the role of the family in determining pathways into care cannot be under-estimated. Partly for traditional reasons and partly for financial reasons, people with mental illness and their carers continue to choose religious and indigenous medical practitioners (Madan, 1969) who may also tend to believe in supernatural explanations of mental illness, thereby making help-seeking from these sources more likely.

Table No. 5B.19.
Religious treatment and Type of Mental Illness

Religious treatment		**Type of Mental Illness**		Total
		CMD	SMD	
Faith Healer from the village	Count	15	35	50
	% of Total	10.0%	23.3%	33.3%
From Temple/Darga	Count	3	14	17
	% of Total	2.0%	9.3%	11.3%
Religious or Holy person	Count	16	32	48
	% of Total	10.7%	21.3%	32.0%
Spiritual Hiller	Count	2	1	3
	% of Total	1.3%	.7%	2.0%
NA	Count	12	20	32
	% of Total	8.0%	13.3%	21.3%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square = 3.842, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.158, P<0.05)

The above table revel that 10% with common mental disorder and 23.3% with severe mental disorder took treatment from faith healers in the village. 2% with CMD and 9.3% with SMD took treatment from a healer in the temple or Darga. 10.7% CMD and 21.3% SMD took treatment from a religious or holy person. 1.3% CMD and 7% with SMD took treatment from spiritual healers. 8% CMDs and 13.3% SMDs did not take treatment from any religious persons. (Pearson chi-square = 3.842, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.158, P<0.05). There is significant difference to nullify the hypothesis.

The table also reveals that almost 78.7% people with mental illness with SMD and CMD access treatment from faith healer, spiritual healer, darga and temple, religious or holy person. It also shows that cultural beliefs are stronger and still exist in the society especially in the tribal communities. The reasons may be many. Some are affected stigma, while others don't have resources should be that can be access for treatment of mental illness and prevention and cure in Indian situations still need to go a long way.

5B. 20.Religious treatment and impact of the treatment.

Mental health care has always been influenced and determined by contemporary beliefs and India is no different. Traditionally, PWMI were often cared in temples and religious institutions, based on the principles that mental illness is a form of spiritual affliction and could thus be cured by religion. Superstition with inadequate mental health services in the community make PWMI subject to various harmful treatments. They are subjected to black-magicians, village quacks-witches and physical abuse in the name of treatment. They are kept

outside the margin of the community meaning chained, locked in the rooms, wandering in the streets, staying forever in closed wards of asylums, hospitals, etc.

Table No. 5B.20.
Religious treatment and impact of the treatment.

Religious treatment		**Impact of the treatment**			Total
		No Impact	Some extent	Good impact	
Faith Healer from the village	Count	38	4	8	50
	% of Total	25.3%	2.7%	5.3%	33.3%
From Temple/Darga	Count	0	17	0	17
	% of Total	.0%	11.3%	.0%	11.3%
Religious or Holy person	Count	25	19	4	48
	% of Total	16.7%	12.7%	2.7%	32.0%
Spiritual Hiller	Count	2	1	0	3
	% of Total	1.3%	.7%	.0%	2.0%
NA	Count	32	0	0	32
	% of Total	21.3%	.0%	.0%	21.3%
Total	Count	97	41	12	150
	% of Total	64.7%	27.3%	8.0%	100.0%

Chi-square test: (Pearson chi-square = 78.609, df= 8, No. of valid cases = 150, Contingency Coefficient = 0.586, P<0.05)

The above table reveals that 25.3% people who accessed treatment from faith healers had no impact, 2.7% had some impact form the treatment they accessed and 5.3% had good impact. 11.3% who accessed treatment from a temple/darga had a positive impact to some extent. 16.7% who accessed treatment form a religious or holy person had no impact at all, 12.7% had good impact. 21.3% did not access treatment from religious healers. **:** (Pearson chi-square = 78.609, df= 8, No. of valid cases = 150, Contingency Coefficient = 0.586, P<0.05)

From the findings we can infer that there is a significant relationship between religious treatment and its impact and so suggest that there is great need for collaboration efforts from government and NGOs to be engaged in generating awareness and sensitization. The more the people access religious treatment the lesser the impact. 67% person with mental illness said that they don't see any positive impact on the treatment from religious treatment which includes faith healers, spiritual healer's darga/temple and religious or holy person.

5B. 21. PWMI access treatment from Spiritual Healers & type of treatment provided.

Spirituality and religion are sometimes equated with each other. Spirituality is the essence of religion and many a times, principles of spirituality as a mind-set or in human interactions could exist in non-religious persons. The core and starting points of all religions have been the eternal principles of spirituality and value systems in all societies. Unfortunately, systematization of the core principles at times leads to dogmas, rituals, and dualities,

hardened stances, barbaric and zealous guarding of idiosyncratic belief systems which are reflected in many religious sects today. Mental Health; normal, away from normal and abnormal is an area where the societal trends get reflected the most.

Most Ayurvedic physicians in India will use herbal medicine but only a few will use religious healing in conjunction. From this point of view, this healer is different and his own training and explanations highlight his approach. Reduction in material necessity (worldliness and need) was seen as a cure for mental illness. In spite of the chains, he argued in the treatment process, love and affection are important factors. Another Ayurvedic physician working at an Ayurvedic hospital acknowledges that they would see some patients suffering from anxiety and depression, especially if it was related to sudden fear. Under these conditions treatment would include application of oils and prescribing herbal preparation according to Dosha (depending upon three basic humours described in Ayurveda). He went on to confirm that medicine needed to act on both mental and physical aspects as these were very closely related.

Table No. 5B. 21.

PWMI Access Treatment from Spiritual Healers & Type of Treatment provided.

Type of Treatment		**You went to Spiritual Healers**		Total
		Yes	No	
Herbal Powder	Count	57	0	57
	% of Total	38.0%	.0%	38.0%
Prayer to God, Herbal Powder & Tabij	Count	38	0	38
	% of Total	25.3%	.0%	25.3%
NA	Count	0	55	55
	% of Total	.0%	36.7%	36.7%
Total	Count	95	55	150
	% of Total	63.3%	36.7%	100.0%

Chi-square test: (Pearson chi-square =150.00, df=2, No. of valid cases = 150, Contingency Coefficient = .707, P<0.05)

The above table depicts that strong relationship between the two variables and the null hypothesis rejected as there is significant difference (Pearson chi-square =150.00, df=2, No. of valid cases = 150, Contingency Coefficient = .707, P<0.05)**.** 36.7% of the respondents did not visit a spiritual healer for treatment. 63.3% of those who preferred taking treatment form spiritual healers, 38% were administered with herbal powder and 25.3% with herbal powder, tabij and also offered prayer to god. **:** (Pearson chi-square =150.00, df=2, No. of valid cases =

150, Contingency Coefficient = .707, $P<0.05$). As there is no difference between the null hypothesis and

It is evident from this table that most (63.3%) of the people who are mentally ill believe that spiritual healers are the best source of treatment and prefer to go to them in the initial phase and most (38%) of the spiritual healer gives herbal powder in the treatment. Ignorance about these illness lead people to such beliefs. There is a great need to generate awareness amongst the masses, if people have to access proper treatment for mental illnesses. Also there is a need to assist people to demand for their rights to live a life of dignity so it is suggested that such efforts should be encourage and incentivised.

5B. 22. Usefulness of type of treatment provided by Spiritual Healers

Pooja (prayers) and other rituals are part of the social and cultural background of this nation. When the patient is brought up in such an environment, this way of healing will be more suitable for him than others. We do three poojas each day: we will also do pooja in emergency if the patient is referred by an astrologer complaining of fear or evil spirits. This physician asserted that because of the training he had received with his family he would combine a number of methods. However, if a patient were suicidal, he would not admit them unless relatives or friends were accompanying them. He emphasized that not all illnesses can be cured by religious treatment. The type of therapy given was dependent upon the nature (habits and personality) of the patient and the type of mental illness. He went on: 'If it is apt for a patient to go to church and pray at the same time as taking medicines that is fine. Otherwise, some kind of occupational therapy may be more suitable. Appropriateness of therapy is very important. If the patient is given unnecessary religious therapy, it may make him worse; if the illness has religious roots but the patient is not religious it is also not good'. He described using the chains to restrain patients, which allowed the patients to concentrate their thoughts on having the chains removed and consequently getting better.

Table No. 5B.22.

Usefulness of Type of Treatment provided by Spiritual Healers

Type of Treatment		**Usefulness**		Total
		Yes	No	
Herbal Powder	Count	0	57	57
	% of Total	.0%	38.0%	38.0%
Prayer to God + Herbal Powder + Tabij	Count	38	0	38
	% of Total	25.3%	.0%	25.3%
NA	Count	0	55	55
	% of Total	.0%	36.7%	36.7%
Total	Count	38	112	150
	% of Total	25.3%	74.7%	100.0%

Chi-square test: (Pearson chi-square =150.00, df=2, No. of valid cases = 150, Contingency Coefficient = .707, P<0.05)

The table show that 25.3% of the PWMIs went to spiritual healers for treatment. 74.7 not preferred treatments form the spiritual healer as they opined it was not useful. From the table we can infer that the relationship is highly significant with chi-square=150, df= 2, Contingency Coefficient = .707, No. of valid cases = 150 and P<0.05). Null hypothesis is rejected as there is no significant relationship

As 25.3% who still access treatment form spiritual healers is alarming people from tribal areas do not have access to treatment for mental disorders in and around their locality. Tribal communities who also have poor educational and economic status are ignorant about proper treatments to mental disorders. The tribal areas are still deprived of government health systems.

Finding from the above table that 74.7% PWMIs feel that spiritual healer's treatment is not useful for them therefore they haven't prefer the kind of treatment provided by spiritual healers. It is recommended for initiating promotion and prevention activities in these areas.

5B. 23. Place and accessed treatment from Spiritual Healers

Spiritual healing is a term known to many. However it means different things to different people. Spiritual healing is defined as overcoming the spiritual root causes of problems through spiritual means. Spiritual healing in the past twenty-five years has evolved from a model in which healers could heal with the instantaneous power of their touch, to a model in which healers facilitate the awakening of a person's inner healer.

Table No. 5B. 23.

Place and Accessed treatment from Spiritual Healers

Access treatment from Spiritual Healers		**Place**			Total
		Within Village	Other Village	NA	
Yes	Count	46	61	0	107
	% of Total	30.6%	40.7%	.0%	71.3%
No	Count	0	0	43	43
	% of Total	.0%	.0%	28.7%	28.7%
Total	Count	46	61	43	150
	% of Total	30.7%	40.7%	28.7%	100.0%

Chi-square test: (Pearson chi-square =106.0543, df=2, No. of valid cases = 150, Contingency Coefficient = 0.644, P>0.05)

From the above table we can observe that 30.6% of the people took treatment from spiritual healers who were available within the village, 40.7% took treatment from spiritual healer outside the village. Overall 71.3% persons with mental illness have been taken treatment from spiritual healer in the initial stage and 28.7% PWMIs were not approach spiritual healer at all. It also shows that majority of the people who have been taken treatment from spiritual healers that may be believe that the mental illness is not an illness it caused by evil spirit or black magic. (Pearson chi-square =106.0543, df=2, No. of valid cases = 150, Contingency Coefficient = 0.644, P>0.05) hypothesis nullified.

Findings draw from above table that 40.7% PWMIs took treatment from spiritual healer who is located outside the village. It shows that due to stigma attached with mental illness people prefer to take treatment from outside the village. It is thus suggested to sensitize masses the treatment for mental illness exists and many people who have taken treatment are living better lives.

5B. 24. Useful Treatment and Status of Daily Life

Effective treatments are available for a range of mental disorders; medication and psychological interventions. In most countries, especially those with low and middle income economies, there is an enormous gap between those who need mental health care, on one hand, and those who receive care, on the other hand. The causes of mental health disorders are widespread and understandable. Difficult socio-economic conditions are associated with significantly higher levels of mental health problems and mental illness. The World Health Organization (WHO) involved more than 30 collaborating centres in the development of its

Box 1: The World Health Organization Quality of Life (WHOQOL) domains
Physical health
Psychological health
Level of independence
Social relationships
Environment
Spirituality, religion and personal beliefs

instrument for measuring quality of life, the WHO Quality of Life (WHOQOL), which is structured by six domains (Box 1). A report on the proposed spirituality, religious and personal beliefs (SRPB) domain (WHO, 1998) quotes the WHO Constitution's definition of health as 'a state of complete physical, mental and social well-being, not merely the absence of disease'.

Table No. 5B.24.
Useful Treatment and Status of Daily Life

Status of Daily Life		**Useful Treatment**		Total
		Spiritual Healers	Psychiatrist	
Very good	Count	0	57	57
	% of Total	0%	38.0%	38.0%
Good	Count	0	55	55
	% of Total	.0%	36.7%	36.7%
To Sum extend good	Count	38	0	38
	% of Total	25.3%.	.0%	25.3%
Total	Count	38	112	150
	% of Total	25.3%	74.7%	100.0%

Chi-square test: (Pearson chi-square =52.268, df=2, No. of valid cases = 150, Contingency Coefficient = 0.508, P<0.05)

This table explicitly state that 38% PWMIs opined that psychiatric treatment was very good and useful for them to get relief from their symptoms. 36.7% opined that their life is good after taking treatment from a psychiatrist and 25.3% opined that their life is good to some extent after taking treatment from spiritual healers. Over all 74.7% PWMIs took treatment from psychiatrist and 25.3% from spiritual healers.

The findings from above table also depicts a significant relationship and with no effect or difference between the means and thus reject the null hypothesis (Pearson chi-square =52.268, df=2, No. of valid cases = 150, Contingency Coefficient = 0.508, P<0.05) the 74.7% of PWMIs opine that a psychiatrist treatment is bring better improvement in their life. It also shows that people with mental illnesses and the community where CMHD program implemented have become more literate about their mental illness. 25.3% of PWMIs stated that they have taken treatment from spiritual healer which they feel very less resulted in their daily life. In the tribal community spiritual healer has a key role in the all rituals therefore if anything happen they have to go to the spiritual healer first. Even the other side of the reality there were no psychiatric services available nearby and the health services are inadequate.

5B. 25. Action taken in the initial period of mental illness and advised sought

Good mental health is a cornerstone to build and maintain a good life. Most people with mental health problems or mental illness experience one-off or intermittent occurrences of poor mental health and are able to sustain family, work and community lives with support from primary health care services. Around two percent of the population, however, experience recurring mental illness which significantly affects their quality of life. Specialist mental health services are available to provide treatment through clinical support and to facilitate longer term support from primary health services and significant others including family, carers, friends, employers and communities. A small number of people experience lifelong mental illness that significantly impairs every facet of their lives, requiring periods of hospitalization and ongoing support from community mental health services. For some, mental illness is coupled with additional challenges including alcohol and drug problems, disability and physical health issues. The stigma associated with mental health problems or mental illness can result in shame and isolation for some individuals experiencing a mental health problem.

Table No. 5B.25.
Action taken in the initial period of Mental Illness and Advised Sought

Advised by		Action taken in the initial period of Mental Illness						Total
		Nothing	Faith Healer (FH)	GP	Psychia trist (Psy.)	FH, GP & Psy.	Home Remedies, GP	
Friends	Count	0	3	0	0	4	0	7
	% of Total	.0%	2.0%	.0%	.0%	2.7%	.0%	4.7%
Community Members	Count	19	0	0	0	0	0	19
	% of Total	12.7%	.0%	.0%	.0%	.0%	.0%	12.7%
Other Relatives	Count	0	7	0	0	24	0	31
	% of Total	.0%	4.7%	.0%	.0%	16.0%	.0%	20.7%
CHW	Count	0	9	18	18	11	19	75
	% of Total	.0%	6.0%	12.0%	12.0%	7.3%	12.7%	50.0%
Community Members & CHW	Count	0	0	0	0	18	0	18
	% of Total	.0%	.0%	.0%	.0%	12.0%	.0%	12.0%
Total	Count	19	19	18	18	57	19	150
	% of Total	12.7%	12.7%	12.0%	12.0%	38.0%	12.7%	100.0%

Chi-square test: (Pearson chi-square =247.681, df=20, No. of valid cases = 150, Contingency Coefficient = 0.789, P>0.05)

In the initial period of mental illness 2% friends advised the patient to go to Faith Healers and 2.7%to General practitioner or Psychiatrics. 12.7% of community member did not advice. 4.7% of other relative advised go to the Faith Healer and 16% to General practitioner or Psychiatrist. 6% of CHW advised to go to Faith Healers 12% to General practitioner 12% to Psychiatrist. 7.3% advised to go to various institutions with Psychiatrist. 12.7% advised to take home remedies or go to General practitioner. 12% of community member and CHW advised to go to various institutions for taking action against initial period of mental illness. Greater the initiatives taken by the CHW to the advice to take psychiatric treatment in the initial period of mental illness, lower the rate of people access faith healers treatment. (Pearson chi-square =247.681, df=20, No. of valid cases = 150, Contingency Coefficient = 0.789, $P>0.05$). The hypothesis is accepted as there is no significant difference to reject the null hypothesis.

Findings from the above table shows that mostly (12%) equal number of PWMIs took treatment from faith healers, general practitioners, psychiatrist, home remedies or both either of the treatment in the initial phase of the illness and 50% CHW advise them to take the treatment it shows that community health worker is the person how has community recognition and plays essential role in the life of PWMIs as well as in the community. From these findings we can also infer that different people suggested different ways and since the mentally ill area not aware of type of treatment to be accessed they may guides in a wrong way so it is suggested that to reduce ignorance mental health education should be provided to a very large extent especially in rural and tribal areas.

5B. 26. Reason for mental illness by sex

More than (Campion & Bhugra, 1997) one quarter of relatives had acknowledged evil eye and black magic as underlying causes of illness. Bearing in mind the large numbers (45%) who had been to see religious healers prior to going to see the psychiatrist, it would appear that broadly similar models of evil eye, life events producing stress and anxiety and disturbance in environment and personality and interaction between the two are being used. Interestingly, the highest consultation rates were in those with schizophrenia and delusional disorders. This may also explain the high number of drop-outs from traditional religious healing. As the family plays a very important role in help seeking the drop-outs may reflect ambivalence on the part of the patient or family. The siddha healer described the origins of his practice in the writings of 18 siddha men and the basic ideology of problems was related

to sexual desire. He acknowledged that 20-30% of his patients had psychological problems and these were related to separation from spouse, persecution for property, unfulfilled sexual desire, loneliness and black magic perpetrated by jealous individuals and his management of these conditions is related to the use of holy ash, and ash from the crematoria. His explanation of causation of distress of mind was linked with the bad spirits of cobras.

Table No. 5B.26.

Reason for Mental Illness by Sex

Sex		**Reason for Mental illness**				Total
		Evil spirit	Hereditary	Stressful life	Don't Know	
Male	Count	10	12	58	9	89
	% of Total	6.7%	8.0%	38.7%	6.0%	59.3%
Female	Count	9	6	35	11	61
	% of Total	6.0%	4.0%	23.3%	7.3%	40.7%
Total	Count	19	18	93	20	150
	% of Total	12.7%	12.0%	62.0%	13.3%	100.0%

Chi-square test: (Pearson chi-square =2.812, df=3, No. of valid cases = 150, Contingency Coefficient = 0.136, $P<0.05$)

From the above table we can observe that 6.7% of male and 6% female think that mental illness is caused by evil spirit. 8% of male and 4% female gives the hereditary reason for mental illness. 38.7% of male and 23.3% of female think that mental illness is caused by stressful life events. Overall 12.7% people feel that mental illness is caused by evil spirit, 12% PWMIs feel that caused by hereditary, 62% feel that caused by stressful life events and 13.3% people don't know the cause of mental illness. (Pearson chi-square =2.812, df=3, No. of valid cases = 150, Contingency Coefficient = 0.136, $P<0.05$). There is significant difference between the means of variables and thus the null hypothesis is rejected.

We can infer that most of the 62% people stated that stressful life events are the main caused for mental illness. Day to day stressful life events were play a major role in the life of human being and that stressful life events may lead towards mental illness. Also 13.3% people don't know the cause of mental illness and 12.7% people feel that mental illness caused by evil spirit.

5B. 27. Negative feeling about PWMI and reasons for the feeling

Mental illnesses can take many forms, just as physical illnesses do. Mental illnesses are still feared and misunderstood by many people, but the fear will disappear as people learn more about them. Social relationships are important for anyone in maintaining health, but for the mentally ill it is especially important. People with mental illness value contact with family. But families may be unwilling to interact with their mentally ill family member. Social isolation is also sometimes due to the unwillingness of others to befriend the mentally ill. The public may avoid them altogether. The stigma associated with mental illness creates huge barriers to socialization. People with severe mental illness are probably the most isolated social group of all. They are judged, disrespected and discriminated. They fear rejection from others, who may be afraid of the mentally ill. They may make a great effort to conceal their condition from others, which results in additional stress from worrying about their true condition being discovered. It is sometimes the case that the severely mentally ill person becomes homeless. This in itself is isolating, and they then must suffer the double stigmatization of being homeless as well as mentally ill. Another reason the person with mental illness may experience social isolation is because of there the nature of their mental illness.

Table No. 5B.27.
Negative Feeling about PWMI and reasons for the feeling

Feeling about PWMI		**Reasons for the feeling**			Total
		Don't say anything	Because he has MI	S/he is ill	
They don't understand anything	Count	0	71	4	75
	% of Total	.0%	47.3%	2.7%	50.0%
They never improve	Count	1	53	3	57
	% of Total	0.7%	35.3%	2.0%	38.0%
Very Violent & They don't understand any thing	Count	2	16	0	18
	% of Total	1.3%	10.7%	.0%	12.0%
Total	Count	3	140	7	150
	% of Total	2.0%	93.3%	4.7%	100.0%

Chi-square test: (Pearson chi-square = 9.96, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.250, P<0.05)

The above table reveals that 47.3% of people consider that the PWMI don't understand anything because they are mentally ill.2.3% considers that it's because s/he is ill.35.3% gives the reason for their non-improvement in their condition is that they are mentally ill and 2%

thinks that it's because s/he is ill.1.3% people do not give any reason for their violent behaviour and not understanding anything. 10.7% gives the reason that they are mentally ill and 2% people don't say anything about mentally ill people. (Pearson chi-square = 9.96, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.250, $P<0.05$). With the mentioned p-value there is significant difference to rejected the null hypothesis.

According to the PWMI most of the people feel that they don't understand anything (50%) due to their mental illness. 38% people feel that PWMI will never improve. It shows that most of the people still have miss understanding about mentally ill person as well as mental illnesses. Such misconceptions about the mentally ill person need to be eradicated completely. Only then will it be possible for the mentally ill to access proper treatments and live a rightful life just like others who are ill with physical illnesses.

5B. 28. Type of mental illness and stabilization

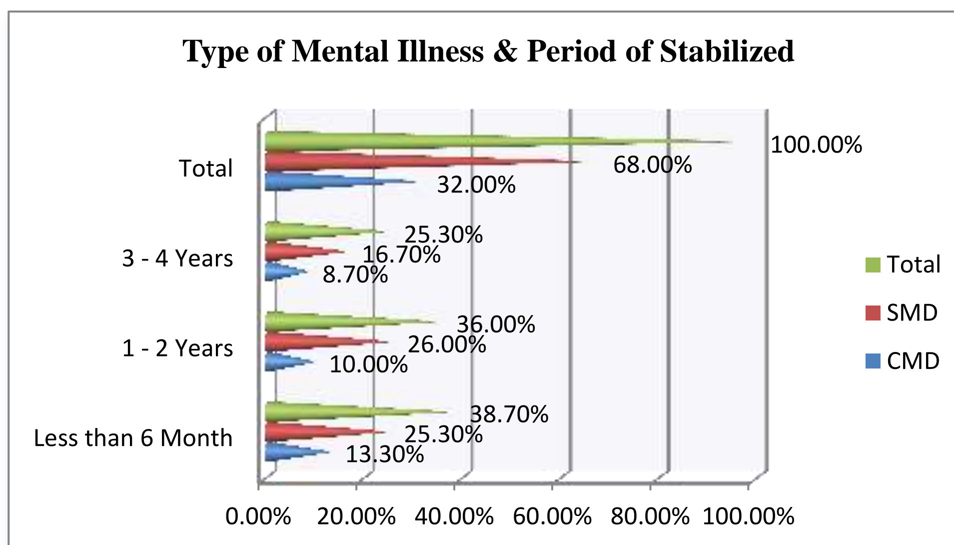
For people with severe mental illness, like bipolar disorder or schizophrenia, stability comes with having a routine and regular treatment. When the routine is broken, many times it can lead to a relapse of symptoms. In one of the study, it was found that persons with common mental illness were often irregular because the symptoms thin out with treatment and the individual feels that s/he is cured from the illness; common mental illness sometimes can also be treated with alternative treatment such as counselling and psychotherapy. The fear of stigma often inhibits the PWMI to continue treatment. Stabilized people with mental illness were included in to community groups such as self-help groups of people with disabilities, self-help groups of women and co-operative federations of women. People with severe mental illness were included more in to self-help groups of disabled and this indicate the level of awareness and acceptance that mental illness is one of the disability. This social inclusion is supportive in getting loans for livelihoods and to advocate for the rights of PWMI.

Table No.5B.28.
Type of Mental Illness and Stabilization

Type of Mental Illness		Period of Stabilized			Total
		Less than 6 Month	1 - 2 Years	3 - 4 Years	
CMD	Count	20	15	13	48
	% of Total	13.3%	10.0%	8.7%	32.0%
SMD	Count	38	39	25	102
	% of Total	25.3%	26.0%	16.7%	68.0%
Total	Count	58	54	38	150
	% of Total	38.7%	36.0%	25.3%	100.0%

Chi-square test: (Pearson chi-square =.692, df=2, No. of valid cases = 150, Contingency Coefficient = .068,P<0.05)

Figure No: 5B.28.8



The table shows that severe mentally ill people became stabilized (26%) within one and two years form the treatment in Basic Needs program. In the common mental disorder very few people (8.7%) takes almost 3 to 4 years to reduce symptoms because they haven't take regular treatment therefore it takes a longer time to become stable. Evidence shows that in the case of CMD symptoms reduce within 6 month or maximum period will take 2 years depend on the person and year of illness.

Over all inferences shows that 38.7% PWMI become stable within 6 month of regular treatment. 36% PWMI become stabled within 1-2 year of treatment and 25.3% PWMI became stable within 3-4 year of treatment. (Pearson chi-square =.692, df=2, No. of valid cases = 150, Contingency Coefficient = .068, P<0.05). There is significant difference and the null hypothesis can be rejected. Severe mentally ill patients take longer period of time to be stabilised. It's tough enough managing a serious mental illness. So it is recommended that

things to do to help maintain stability- good regular sleep patterns and eating healthy scheduled meals should go a long way. If you are on medications, take it at the times prescribed by your doctor and mental health professionals recommended staying away from alcohol and drugs, don't make hasty life changing decisions like suddenly quitting your job, moving away from family or friends, or buying something you always wanted but can't afford.

5B.29. Period of treatment and stabilization

A study (Edwards J, Maude D, McGorry PD, Harrigan SM, and Cocks JT 1998) found that 6.6% of sample of individuals experiencing their first episode of psychosis were treatment resistant, and that between 9 and 17% of individuals with their severe mental disorder were treatment resistant. These rates are much lower than the 30% reported in more chronic samples. In assessing differences between treatment resistant individuals and those who responded to treatment, it was found that the duration of psychotic symptoms before treatment approached significance, which suggests that untreated psychosis may lead to treatment resistance, and supports the argument for early intervention as soon as possible following the onset of positive symptoms.

Table No.5B.29.
Period of Treatment and Stabilization

Years of Treatment		Month/Year of Stabilized			Total
		Less than 6 Month	1 - 2 Years	3 - 4 Years	
2 to 4 years	Count	58	54	0	112
	% of Total	38.7%	36.0%	.0%	74.7%
More than 7 years	Count	0	0	38	38
	% of Total	.0%	.0%	25.3%	25.3%
Total	Count	58	54	38	150
	% of Total	38.7%	36.0%	25.3%	100.0%

Chi-square test: (Pearson chi-square =150.000, df=2, No. of valid cases = 150, Contingency Coefficient = 0.707, P>0.05)

From table it can be observed that stabilization period in mental illness depended on chronicity of the illness and regularity in the treatment these two factors play a major role. The table shows that 25.3% of PWMIs have taken treatment for more than 7 years of which were taken 3 to 4 year to reach in the stabilization stage. The figure 38.7% also shows that those PWMI taking treatment from 2 to 4 years to were reach the stage of stabilization within the 6 month period of treatment it also shows that regular treatment and effective support of family and the community helps PWMI in their recovery process. (Pearson chi-square

=150.000, df=2, No. of valid cases = 150, Contingency Coefficient = 0.707, P>0.05). There is significant relationship and the null hypothesis is rejected which shows that PWMIs with severe mental illnesses take a longer period of time to stabilize.

Overall 74.7% of PWMIs had taken treatment up to 2 to 4 year and the same percentage of PWMIs reached the stage of stabilization within 2 years of regular psychotropic treatment as well as psychosocial treatment from the community health worker and caregivers. Pharmacological, psychosocial treatment and support of CHW and caregivers which very necessary to bring changes in the lives of PWMIs should be promoted and encouraged.

5B. 30. Number of PWMI approach Spiritual Healers by their location

The concept of spirituality is inclusive and affects everybody. It overlaps with religion, but unlike spirituality, religion is potentially divisive and adopted only by some. By permitting consideration of 'secular' spiritual activities and short-circuiting destructive arguments about beliefs, a valuable perspective can be applied to the whole field of mental health care. Comprehensive research evidence shows that religious and spiritual beliefs and practices help prevent many physical and mental illnesses, reducing both symptom severity and relapse rate, speeding up and enhancing recovery, as well as rendering distress and disability easier to endure. Especially important is that religious and spiritual factors can significantly affect the presentation of mental disorder. Furthermore, psychiatric patients have consistently identified spiritual needs as an important issue, and spiritual care as contributing to symptom relief and general well-being. It follows that psychiatric care should routinely include a careful and sympathetic assessment or 'spiritual screening'.

Table No. 5B.30.
Number of PWMI Approach Spiritual Healers by Their Location

Approach Spiritual Healers		**Location**			Total
		Within Village	Other Village	NA	
Yes	Count	37	58	0	95
	% of Total	24.7%	38.7%	.0%	63.3%
No	Count	9	3	43	55
	% of Total	6.0%	2.0%	28.7%	36.7%
Total	Count	46	61	43	150
	% of Total	30.7%	40.7%	28.7%	100.0%

Chi-square test: (Pearson chi-square =106.0543, df=2, No. of valid cases = 150, Contingency Coefficient = 0.644, P>0.05)

From the above table it can be concluded that there is a significant relationship between the affirmation of people and taking treatment from spiritual healers. 63.3% people affirmed that they visit spiritual healers. Of these 24.7% take treatment from spiritual healers within the village and 38.7% treatment from outside the village. In reference to above table it seems that 38.7% of the people prefer taking treatment from outside the village because if they took treatment in the village that would be embarrass them due to stigma. 63% people first approached to spiritual healers it is suggested that mental illness still today people believe that mental illness is caused by evil spirit. It also reveals that there could be other reasons also for people to access treatment from spiritual healer. Mental illness is an 'illness' like other physical illness this massage has to be widely spread. : (Pearson chi-square =106.0543, df=2, No. of valid cases = 150, Contingency Coefficient = 0.644, P>0.05). There is significant relationship with the stated p-value. The increase in mentally ill persons result in increasing number of them visiting the spiritual healers for treatment.

5B. 31. Advice given by and type of mental illness

When mental illness strikes family members are overwhelmed by feelings of bewilderment and guilt. Most deny the seriousness of the situation, at least at first. Professionals may be exhausted after being on call 24 hours a day and this may be coupled with frustration and anger from family members when professionals are unable to accomplish what the family sees as basic: prompt diagnosis and treatment, and assistance to help their relative regain a productive life. It is not "unloving" to feel resentment in response to the behaviour of the relative with mental illness. Realizing the person is ill does not always overcome the hurt, dismay and anger felt by those trying to help. S/he may rebuff attempts to reach them and may be fearful or accusatory toward those trying to help. Understandably, families, friends, and co-workers have problems with these symptoms, yet a hostile reaction will almost certainly intensify or lengthen the episode. It is natural and necessary to grieve for the person who used to be. But strength and determination are needed to meet the coming challenges. Caring, supportive family members can play a vital role in helping their relative to regain the confidence and skills needed for rehabilitation.

Table No. 5B.31.
Who Advice and Type of Mental Illness

Who Advice		**Type of Mental Illness**		Total
		CMD	SMD	
Friends	Count	2	5	7
	% of Total	1.3%	3.3%	4.7%
Community members	Count	7	12	19
	% of Total	4.7%	8.0%	12.7%
Other Relatives	Count	10	21	31
	% of Total	6.7%	14.0%	20.7%
CHW	Count	22	53	75
	% of Total	14.7%	35.3%	50.0%
Community members & CHW	Count	7	11	18
	% of Total	4.7%	7.3%	12.0%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =.881, df=4, No. of valid cases = 150, Contingency Coefficient = 0.076, $P<0.05$)

The above table depicts that of the 32% people who are living with common mental disorders 1.3% received advice from friends to access treatment at public or private health systems. 4.7% from community members, 6.7% from other relatives, 14% from community health workers and 4.7% from community members and community health workers.

From these findings we can infer that community health workers have played a major role in motivating patients to access proper treatments for dealing with mental illnesses. Which shows that the highest number (50%) of CHW advice to take treatment for mental health problem. Informal community care comprises services provided in the community that are not part of the formal health care system. Examples include traditional healers, professionals in other sectors such as teachers, and police, services provided by nongovernmental organizations, user and family associations and lay people. This level of care can help prevent relapses among people who have been discharged from hospitals. Informal services are usually accessible and acceptable because they are an integral part of the community.

5B.32. Reason for hiding mental illness and type of mental illness

Stigma is a serious impediment to the well-being of those who experience it. It affects people while they are ill, while they are in treatment and healing, and even when a mental illness is a distant memory. Clearly, it seems difficult to get rid of the stigmatizing labels once the stigmatizing behaviour has occurred.

Stigma has been defined as an identifying mark of shame or discredits (Goffman, 1963). It also refers to negatively perceived defining characteristics used to set individuals and groups apart from the normalized social order (Khakha, 2003) and is also associated with discrimination (Sartorius, 2002). Discrimination is defined as the action or treatment based on stigma and directed towards the stigmatized (Bunting, 1996). Stigma and discrimination have been found to be associated with schizophrenia, as it is one of the most severe psychiatric disorders (SMD) characterized by deviation from reality and or by significant social or occupational dysfunction (Wing &Agrawal, 2003). Schizophrenia is reported to occur in 1% of the world's population and the stigma and discrimination that surrounds it has been confirmed by several researchers (Poulton, Caspi & Moffitt, 2000; Cannon et al., 2002; Loganathan & Murthy, 2008). In fact, the stigma associated with mental illness is viewed as a primary barrier to the accessibility of care today (Sartorius, 2002). Some investigators have found that the stigma surrounding severe mental disorder may result in delayed treatment, thereby increasing risks for health problems, abnormal behaviour and violence (Link, Andrews & Cullen, 1992; Farrington, 1994; Link & Stueve, 1995; Appelbaum, Robbins & Monahan, 2000). Stigma as described by the family members and caregivers is different than what is perceived by the patients (Schulze & Angermeyer, 2002); however, few studies have focused on the multifaceted stigma of SMD and its impact on the patient.

Stigma and discrimination associated with poor mental health exacerbate these impacts. Consistently evidence points towards strongly negative attitudes towards people with mental health problems: in particular there is an inaccurate view that they represent a danger to the community, a view strongly reinforced in the media. Negative attitudes are not only found among the general public, but even among mental health professionals. This and other elements of stigma increases social distance: it for instance reduces the likelihood of an individual becoming employed or accessing health care services. It is important that strategies to counter stigma are evidence-based.

Table No. 5B.32.

Reason for hiding mental illness and type of mental illness

Reason for Hidings MI		**Type of Mental Illness** CMD	SMD	Total
Due to stigma	Count	13	25	38
	% of Total	8.7%	16.7%	25.3%
Misconception about mental illness	Count	3	15	18
	% of Total	2.0%	10.0%	12.0%
Illiteracy about mental illness	Count	24	51	75
	% of Total	16.0%	34.0%	50.0%
Other	Count	8	11	19
	% of Total	5.3%	7.3%	12.7%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =2.922, df=3, No. of valid cases = 150, Contingency Coefficient = 0.138, $P<0.05$)

The table reveals that 8.7% of person with common mental disorder and 16.7% with severe mental disorder hid their illness status due to stigma. 2% With CMDs 10% with SMD hide their illness status they feel that many people have misconception about mental illness.

The above table shows that people living with mental illnesses do not want to disclose their mental health status because 25.3% have experienced discrimination due to stigma 12.0% are victims of misconception, 50% feel that the community is not aware about mental illness and they hid the status of their illness. 12.7% hid their status due to various other reasons.

From these findings it can be inferred that a large number (87.3%) of person diagnosed with mental illness faced discrimination in their lives due to stigma, misconceptions and illiteracy i.e. lack of awareness about treatment of mental illnesses. The available evidence suggests that persons with mental illness still struggle on a daily basis to access appropriate health care or be treated with respect or dignity when they do enter our health care systems.

5B. 33. Usefulness of treatments and type of mental illness

Yes, mental illness can be treated. This means that many people who have a mental illness, and are treated, recover well or even completely. However, because there are many different factors contributing to the development of each illness, it can sometimes be difficult to predict how, when, or to what degree someone is going to get better. Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing

on medicines and surgery, and gives less importance to beliefs and to faith in healing, in the physician and in the doctor–patient relationship. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realize the value of elements such as faith, hope and compassion in the healing process. The value of such 'spiritual' elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension (emphasizing the seamless connections between mind and body).

Spiritual authenticity involves maintaining a feeling of inspiration, thus continuing to derive a strong sense of meaning and purpose in daily life. It is an important contributor to contentment and happiness in the workplace, in recreation and in enlivening human relationships. Spirituality is the cornerstone of the hierarchy of dimensions of human experience, Body and mind are both influenced and united by its action, which informs and enriches the biological, psychological and inter-personal realms. The evidence supports the view, inherent in this model, that paying due attention to human spirituality will yield significant rewards in terms of healing and health at all levels.

Human beliefs are beyond scientific measurement. Their precise effects, including their benefits, are therefore unpredictable. Spiritual gains can result in partial or full transformation of the individual, serving to promote hope and the regeneration of faith in patients and carers alike. As Powell (2001) puts it, 'When we enquire into the beliefs our patients hold, such matters deserve to be discussed with a genuinely open mind … our patients may sometimes be closer to the truth than we know.' One way forward, taking the lead from the WHO and using Trent's (1999) two-continuum model, is to undertake research using both empirical and new paradigm methods along both the mental disorder axis and mental health axis. When we as psychiatrists, both individually and collectively, are much clearer about what genuinely constitutes mental health, we will be able to reach towards it more securely and with increasing skill, on behalf of our patients. There is much to be gained (and little to be lost) in discussing this further. It might, therefore, be to the singular advantage of mental health professionals everywhere to develop and make frequent, regular use of a non-denominational language or 'rhetoric' of spirituality (Nolan & Crawford, 1997) so as to foster energetically what Swinton (2001) calls 'the forgotten dimension'.

Table No. 5B.33.

Usefulness of Treatments and Type of Mental Illness

Usefulness of Treatment		**Type of Mental Illness**		Total
		CMD	SMD	
Spiritual Healers	Count	12	26	38
	% of Total	8.0%	17.3%	25.3%
Psychiatrist	Count	36	76	112
	% of Total	24.0%	50.7%	74.7%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =.004, df=1, No. of valid cases = 150, Contingency Coefficient = 0.005, P<0.05)

The above table depicts 8% CMD and 17.3% SMD of the respondents accessed treatment from spiritual healers and 74.7% from Psychiatrists, 25.3% are people with common mental disorders who went to spiritual healers and 24% took treatment from a psychiatrist. 17.3% of persons with severe mental illnesses took treatment from spiritual healers and 50.7% from psychiatrist.

From the above findings it can be inferred that a majority (74.7%) of mentally ill patients have taken treatment of psychiatrist, this is basically due to the community mental health program being implemented by BNI in these tribal areas where these psychiatric services made available on a monthly basis. These findings also suggest that community model of providing mental health services works in an effective manner.

5B. 34. Type of mental illness and advice given by to take mental health treatment

BNI has looked at the social model for mental health interventions. PWMI often have to brave considerable stigma that is attached with mental disorders. Furthermore, lack of information about mental illness and available help for and treatment make it difficult for PWMI to avail the services.

Table No. 5B.34.

Type of Mental Illness and Advice given by to take Mental Health Treatment

Type of Mental Illness		**Advice given by**		Total
		CHW	General Practitioner	
CMD	Count	41	7	48
	% of Total	27.3%	4.7%	32.0%
	Count	90	12	102
SMD	% of Total	60.0%	8.0%	68.0%
Total	Count	131	19	150
	% of Total	87.3%	12.7%	100.0%

Chi-square test: (Pearson chi-square =.234, df=1, No. of valid cases = 150, Contingency Coefficient = .049, $P<0.05$)

The table depicts the importance of advice provided by service providers to the mentally ill person. The important role of the CHW in the lives of the PWMIs is evident form the table. 27.3% of patients with common mental disorders were advised for treatment 4.7% were referred by a general physician. 60% for those with severe mental disorders were referred for treatment by the CHW and 8% by the general physician.

From the table we can infer that 87.3% of the PWMIs were referred for specialist (psychiatrist) treatment by the community health workers. Any community workers who are trained to spread awareness about mental health can easily provide information about proper treatments accessible by PWMI just like the community health worker mentioned in the above table.

5B. 35. Type of mental Illness and Villager Know about Your illness

Generally mental illness has two types one is call severe mental illness and another called is common mental illness. Severe mental illnesses are mostly easily too identify because of the wearied behaviour and symptoms. But in the common mental illness people doesn’t recognised that the trouble they faced it is due to the illness. In the general community awareness about mental illness is very less therefore mental illness is not treated as a illness in the community. There must be continuous mental health education for the general population so that they can have basic knowledge about both mental health and mental illness and appropriate (and available) treatment.

Table No. 5B.35.

Type of Mental Illness and Villager Know about Your illness

Type of Mental Illness		**Villager Know About Your Illness**		Total
		Yes	No	
CMD	Count	40	8	48
	% of Total	26.7%	5.3%	32.0%
SMD	Count	74	28	102
	% of Total	49.3%	18.7%	68.0%
Total	Count	114	36	150
	% of Total	76.0%	24.0%	100.0%

Chi-square test: (Pearson chi-square = 2.081, df=1, No. of valid cases = 150, Contingency Coefficient = .117, $P<0.05$)

The above table shows that 26.7% of the people with common mental disorders opine that their community members know about their illness. 49.3% with severe mental disorders say that their village community knows about their illness. 24% of all PWMI feel that their village communities are not aware about their mental illness. Findings drawn from the above table reveal that 76% people opined that they villagers know about their illness amongst that 26.7% from common mental disorder and 49.3% from severe mental disorder. This evidence clearly shows that severe mental disorders cannot be hidden from the community. (Pearson chi-square = 2.081, df=1, No. of valid cases = 150, Contingency Coefficient = .117, $P<0.05$)

From the above table we can infer that there is no significant relationship between these above two variables and as severe mental illness cannot be hidden, so the number of people aware about the illness would be more.

5B. 36. Reason for mental disorder and type of mental illness

Every organ in the human body has a function, and numerous problems can arise with each organ. The specific problem with the organ and the resultant disorder dictate the appropriate treatments. Mental illness is brain dysfunction, affecting:

a. **Perception** – People may experience the world with their senses (vision, smell, taste, touch, and hearing) in unusual and or strange ways (e.g., hearing voices, seeing things that others do not see).

b. **Thinking** – Thoughts may occur very quickly slowly, may be poorly organized, confusing, illogical, irrational, etc.

c. **Mood** – All human beings experience a variety of moods (e.g., depression, anxiety, and mania) and mood changes. Mental illness can emerge when symptoms cause significant distress over time and impair one's ability to function in daily life.

Most mental health professionals believe that there are a variety of contributing factors to the onset of a mental illness. Studies have found that there are physical, social, environmental and psychological causes for mental illness.

Physical Causes

(Biological factors) Each individual's own genetic make-up can contribute to being at risk of developing a mental illness and traumas to the brain (via a form of head-injury) can also sometimes lead to changes in personality and in some cases 'trigger' symptoms of an illness. Misuse of substances (such as alcohol or drugs) and deficiencies of certain vitamins and minerals in an individual's diet can also play a part.

Social and Environmental Causes

(Factors around us) Where someone lives and their living conditions along with family and community support networks can play a part along with employment status and work stresses. Living in poverty or social isolation, being unemployed or highly stressed in your work can all put pressure on an individual's mental health.

Psychological Factors

(Your Psychological state) Coping with past or current traumatic experiences such as abuse, bereavement or divorce will strongly influence an individual's mental and emotional state which can in turn have an influence on mental health.

Family History

There is evidence to suggest that heredity can play some part in the development of some forms of mental illness. However like with many physical health conditions (such as Heart Disease or Diabetes) that fact that a family member has experienced a mental illness does not mean that all other genetic family members will experience the same condition. As with physical health conditions the other factors shown above will play a significant part too.

Table No. 5B.36.

Reason for MD and Type of Mental Illness

Reason for MD		**Type of Mental Illness**		Total
		CMD	SMD	
Evil spirit	Count	7	11	18
	% of Total	4.7%	7.3%	12.0%
Hereditary	Count	5	14	19
	% of Total	3.3%	9.3%	12.7%
Stressful life	Count	31	62	93
	% of Total	20.7%	41.3%	62.0%
Don't Know	Count	5	15	20
	% of Total	3.3%	10.0%	13.3%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =1.201, df=3, No. of valid cases = 150, Contingency Coefficient = .089, P<0.05).

From the above table we can infer that there is a significant relationship and so the hypothesis could be nullified with these stated values/results (Pearson chi-square =1.201, df=3, No. of valid cases = 150, Contingency Coefficient = .089, P<0.05). The cross tabulation shows that 12% patents attribute their illness once to evil spirit and so either pray to god, take herbal powder or use a locket type called 'Tabij' as being treated. 12.7% feel it is a genetic problem i.e. hereditary and so consume herbal powder for treatment. 23.3% who opine their mental disorders due to stress filled lives take herbal powder for treatment and an additional 36.7% go to general practitioners for treatment. 13.3% of patients with mental disorders opine that the cause for their illness is due to evil spirit and stress filled lives and so take treatment either by praying to God, consuming herbal powder or using the Tabij.

From these findings we can infer that stress is the major factor that can lead to mental illness as 62% opined the cause of mental illness is due to stress in the life.

5B. 37. Duration of stability of PWMIs and efforts for livelihood

Livelihood is the one of the component of treatment; those PWMIs started working with small things on their own or with the help of others their stabilization period were seen as very small. 38.7% PWMIs have been stabilized less than 6 months. Many studies have confirmed the association between unemployment and poor mental health, including

depression. But the workplace itself is also an important determinant of mental health, furnishing an environment that may be either beneficial or harmful. Poor mental health may result from high levels of psychological demand at work, job insecurity, lack of reward or opportunity to use skills, or low decision making authority. Mental health problems are the second largest category of occupational ill health after musculoskeletal problems, and work related mental health problems are a leading cause of sickness leave and disability in OECD countries. There is growing concern that employment patterns or working conditions are evolving in ways that may cause or aggravate mental illness. A recent OECD study found a steep rise in disability benefit receipt for mental illness in some countries, and there is some evidence that work related mental health has worsened in several countries, most notably Greece, Luxembourg, Sweden and Belgium, and for a number of workforce groups, such as low-skilled workers. The self-reported incidence of certain potentially stressful working conditions has also increased (e.g. high-intensity work and long working hours), but it has decreased for others (e.g. experiencing discrimination on the job). In addition, working conditions were found to be important in maintaining mental health. Moving into a temporary job or one that involves long hours is associated with higher stress and anxiety than a standard employment arrangement. The mental health payoff to employment, therefore, varies depending on the type of employment contract and working conditions. In particular, the mental health benefits for inactive individuals who obtain a temporary job or a job with long hours appear to be smaller than for those moving into standard employment arrangements, particularly for persons with pre-existing mental health problems.

Table No. 5B.37.
Duration of Stability of PWMIs and Efforts for Livelihood

Month/Year of Stabilized		**Efforts for Livelihood**			Total
		Starting from small work	Started work With the Help of Others	Starting from Self Care	
Less than 6 Month	Count	19	19	20	58
	% of Total	12.7%	12.7%	13.3%	38.7%
1 - 2 Years	Count	0	18	36	54
	% of Total	.0%	12.0%	24.0%	36.0%
3 - 4 Years	Count	0	38	0	38
	% of Total	.0%	25.3%	.0%	25.3%
Total	Count	19	75	56	150
	% of Total	12.7%	50.0%	37.3%	100.0%

Chi-square test: (Pearson chi-square =82.345, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.138, P<0.05)

The above table reflects that 38.7% started working within 6 months of treatment of 25.4% started small work with the help of others. 6% started earning their livelihoods within 1-2year of treatment and 25.3% between 3-4 years of treatment. From these finding we can infer that there is a significant relationship between being stabilized and efforts made to earn a living. The lesser the time taken to stabilize the sooner the person can start earning. (Pearson chi-square =82.345, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.138, P<0.05).

5B.38.Time spent on caring by Sex

Caregiving in mental illness involves a significant expenditure of time and energy over extended periods of time, involves tasks that may be unpleasant and uncomfortable and is often a role that had not been anticipated by the caregiver. When these unanticipated roles are incongruent with stereotypical gender expectations (e.g., when a male caregiver must attend to a physical hygiene of female mentally ill or when a female caregiver is responsible for controlling a violent mentally ill relative's dangerous behaviour), the stress can be exacerbated (Tessler and Gamache 2000).

Burden can be defined as the time and effort required for one person to attend to the needs of another. Thus, it might include the amount of time spent in caregiving, the type of caregiving services provided, loss of income, and disruption of family relationships and household routines and drain in financial resources.

Table No. 5B.38.
Time spent on caring by Sex

Time spent on caring/day		**Sex**		Total
		Male	Female	
1 to 2 Years	Count	22	36	58
	% of Total	14.7%	24.0%	38.7%
2 to 3 Years	Count	16	12	28
	% of Total	10.7%	8.0%	18.7%
3 to 4 Years	Count	10	18	28
	% of Total	6.7%	12.0%	18.7%
More than 5	Count	19	17	36
	% of Total	12.7%	11.3%	24.0%
Total	Count	67	83	150
	% of Total	44.7%	55.3%	100.0%

Chi-square test: (Pearson chi-square = 4.694, df= 3, No. of valid cases = 150 Contingency Coefficient= .518, P<0.05)

In relation to table no. 5A.7 if you observe this table, it depicts that 24% of females have spent between 1-2 years. 8% of females between 2-3 year, 12% between 3-4 year and 11.3%

more than 5 year 55.3% are females who spend time on a daily basis in caregiver 44.7% are males. Findings draw from above table that 55.3% females are involved in the caring of PWMIs as a caregivers which is highest in number than the males. Most of the studies emphasis on that more number of women in the role of caregiver apart from their daily routing works and with a significant p-value of (Pearson chi-square = 4.694, df= 3, No. of valid cases = 150 Contingency Coefficient= .518, $P<0.05$) the hypothesis could be nullified.

5B.39. Type of care provided by caregivers:

A significant part of the caregiving burden falls on family members, especially for more serious mental disorders. This role is often undertaken by parents when a young person or child is affected, by spouses, siblings or ageing parents when an adult is affected, and by adult children of the elderly. Notable issues for carers of people with severe mental disorders include access to specialist services, availability of ancillary services such as respite care, eligibility for financial assistance and therapeutic support for themselves. However, it should be noted here that there is no clear-cut separation between caregiving (with a defined carer and receiver) and the more common circumstance of providing emotional and practical support for a relative with mental health problems.

Table No. 5B. 39.
Type of Care provided by Caregivers

Valid	Frequency	Percent	Valid Percent
Physical Care	34	22.6	22.6
Psychological Care	47	31.5	31.5
Medical Care	58	38.7	38.7
Social Care	10	6.0	6.0
None of above	1	0.6	0.6
Total	150	100	

Mean=2.57, Median=1.00, Std. Deviation=1.866

The above table shows that 38.7 percent caregivers provide medical care to the person with mental illness. 31.5 percent caregivers provide psychological care, 22.6 percent provides physical care, 6.0 percent provides social care and 0.6 percent not provided any care as mentioned.

Majority 92.8% of the caregivers said that medical, psychological and physical care is a larger part of their caregiving component. One could be the reason is number of PWMIs come under SMD and most of the persons with mentally ill firstly need medication rather than psychological care in the severe mental health condition.

Section C: Impact of Myths on the Lives of Person with Mental Illness and Caregivers.

Myths about mental illness still exist in the community at larger level and it has wider impact on the lives of person with mental illness as well as the caregivers and their family. The myths and negative stereotypes about mental illness, although strongly held by the community, can be overcome as communities recognize the importance of both good mental and physical health care; as advocacy renders people with mental disorders and their families more visible; as effective treatments are made available at the community level; and, as society acknowledges the prevalence and burden of mental disorders.

Introducing legislative reforms that protect the civil, political, social, economic, and cultural entitlements and rights of the mentally ill is also crucial. However, this step alone will not bear the fruits expected by legislators without a concerted effort to erase stigmatization as one of the major obstacles to successful treatment and social reintegration of the mentally ill in communities. The public needs to be engaged in a dialogue about the true nature of mental illnesses, their devastating individual, family and societal impacts, and the prospects of better treatment and rehabilitation alternatives. At the same time, stigmatizing attitudes need to be tackled frontally through campaigns and programs aimed at professionals and the public at large. Public information campaigns using mass media in its various forms; involvement of the community in the design and monitoring of mental health services; provision of support to nongovernmental organizations and for self-help and mutual-aid ventures, families and consumer groups; and education of personnel in the health and judicial systems and employers all are critical strategies to start dispelling the indelible mark, the stigma caused by mental illness. The most top ten common myths about mental illness are used below.

1. **Mental health problems are uncommon:-** In fact, nearly 1 out of every 5 people will have a diagnosable mental disorder within their lifetimes, according to the National Institute of Mental Health.

2. Mental health problems are caused by the person suffering from them:- While people do need to take responsibility for their own thoughts, feelings and behaviours associated with disorders, they are not to blame for them. There is an important difference between taking responsibility and accepting blame, but unfortunately, many people confuse these two things.

3. Mental health problems are purely biological or genetic in nature:- Some professionals and mental health advocacy organizations feel that mistruths like this one will better forward their professional biases or political agendas, yet this remains a myth. Mental health problems are not caused by solely bad genes or a biological chemical imbalance, according to the research we have to date. Any health care professional, doctor, or mental health advocate who claims otherwise is telling you a half-truth to forward their own, unspoken agendas.

4. Mental health disorders are often life-long and difficult to treat:- So many times, individuals with a newly diagnosed disorder such as depression or anxiety are told they have to take medication for it. Yet, when they question their physician about how long they must remain on the medication, they receive a mushy, non-answer, such as, "As long as you need to." Most medications (with a few notable exceptions, such as those prescribed for bipolar disorder and schizophrenia) prescribed for mental disorders should be taken for short-term (under a year) symptom relief. Some medications have withdrawal effects that are often worse than the original problem. Quiz your doctor about these issues (length of stay on medication, plan for titrating off the medication, etc.) before you are placed on any medication for a mental disorder.

5. Psychotherapy takes forever and gets into childhood issues:- This is a myth and holdover from the older days of psychotherapy. Modern psychotherapy, however, can be short-term, solution oriented. Most short-term psychotherapy approaches use a cognitive-behavioural model, which emphasizes irrational thoughts which lead to dysfunctional behaviours and feelings. This type of therapy emphasizes learning what those thoughts are and how to easily change many of them, often in a matter only a few weeks. Most common mental health disorders can now be treated in a matter of months instead of years. Insurance and managed care plans usually cover much of this sort of treatment.

6. I can handle my own mental health problems and if I can't, I'm weak:- The first part of this statement may not be so much a myth, as most people who have a mental health problem do not seek treatment for it. Rather, they rely on their traditional coping mechanisms (such as exercise, eating, hanging out with friends, working longer and harder, etc.) to take care of the problem. Many problems which may be diagnosable may also be mild enough for this type of care to be sufficient. Talking with friends, reading a self-help book on the subject, or visiting an online self-help support group may be enough to get you through it.

When those problems, however become overwhelming despite your efforts to cope that is a sure sign you need additional help. This does not you are weak-weak-minded, weak-willed or whatever. This means you realize and accept your human and natural limitations, and seek

appropriate care when your coping skills go beyond being able to help you deal with the problem. For example, imagine yourself in a volleyball game. You go to hit the ball back for that winning point, and in the process of doing so, you injure one of your fingers. It hurts like heck, but you figure you just sprained it. For a few days afterward, you monitor the injury and hope it gets better, perhaps putting ice on it, etc. But after a few days, if your finger is still twisted and badly bruised, you might begin to wonder whether indeed it only was a sprain. You maybe consult with a friend or family member for their opinion about what to do. Eventually, you're convinced it may be worse than you thought and go to see your doctor. He looks at it and takes a few X-rays. He tells you that you're lucky you came in when you did because indeed it was worse than a sprain. It was a hairline fracture which could have been made worse if not placed in a cast.

Are you a weak person because you sought help for your injury? Most people don't seem too much care for going to the doctor, yet we do when we have to rather than face the risk of permanent disability or something worse. Mental health problems are no different. They too can result in permanent disability or worse if left untreated.

7. If I admit I have problems, everyone will think I'm crazy and I'll need to go into the hospital for a very long time:- Crazy is a generic term which is meaningless in this context. Everybody is crazy a little bit, some of the time. Having a mental disorder really doesn't mean you're crazy though. It just means you have a problem, similar to a medical disease, which needs treatment. Would a family member or friend think any less of you for having leukemia? Cancer? The flu? Then why should they think any less of you for having depression or anxiety? If they do, they are the ones who need education and to be more open-minded. Most people who have a diagnosable mental disorder do not need hospitalization (also called inpatient treatment). Hospitalization is only used in extreme cases, when the problem puts you in imminent risk of dying (or causing the harm or death of another). Even if you are hospitalized for your problem, it doesn't mean you will be there for days, weeks, or longer. Just like in the ER, you will be assessed, treated, and released as soon as you are feeling better.

8. Being suicidal means I'm crazy:- Suicidal feelings are most often symptoms of depression or a related mood disorder. Feeling suicidal does not make you any more or less crazy than anybody else. Suicidal feelings go away once you begin to receive adequate care for your depression or other mood disorder. That's why it is so tragic when people actually succeed in taking their own lives... Had the person been receiving adequate treatment, they could be alive and feeling much less depressed and suicidal.

9. Mental health problems are best treated by my primary care physician or a general practitioner (GP):- No matter what their field, nearly every mental health professional agrees that diagnosable mental disorders are best treated by a trained specialist are mental health professional. Whether that professional is a psychiatrist, psychologist, or other clinician specially trained to diagnose and treatment mental health problems, you will always receive the highest quality care and treatment when seen by one of them over a general practitioner. Mental disorders should be taken as seriously as any potentially chronic and disabling medical condition. You'd go to an oncologist for cancer, a dermatologist for skin problems, etc., etc. You should not expect or demand any less in the quality of care you receive when dealing with mental health problems. GPs are good, but it is difficult for them to keep up with the latest research in the field and often they will prescribe only a psychopharmacological treatment approach first the least effective treatment approach available. This will usually add unnecessary weeks of suffering onto your treatment, and often draws out the length of treatment, as opposed to a combined approach (psychopharmacology with psychotherapy).

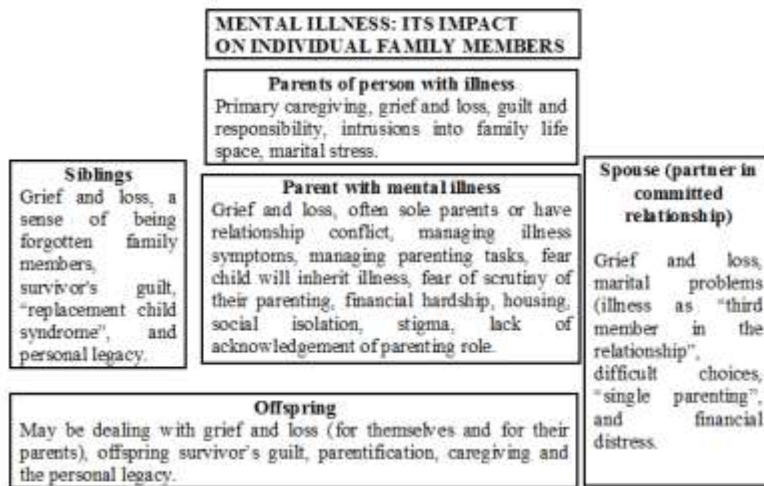
10. Mental health professionals:- (psychologists, psychiatrists, social workers, psychiatric nurses, marriage and family counsellors, etc.) make a ton of money off people suffering from these disorders.

At one time in the not-too-distant past, this was true. But no longer In fact, due to the vast expansion of managed care into the mental health field over the past 6 to 7 years, is mental health care often the lowest paying, longest work day healthcare profession. The majority of behavioural healthcare and related professionals work in this area because they want to, not because of the pay. It is well documented that psychiatrists are often the lowest-paid physician specialty field.

5C. 40. **Type of Mental Illness and Impact on Family**

When mental illness strikes family members are overwhelmed by feelings of bewilderment and guilt. Most deny the seriousness of the situation, at least at first. Professionals may be exhausted after being on call 24 hours a day and this may be coupled with frustration and anger from family members when professionals are unable to accomplish what the family sees as basic: prompt diagnosis and treatment, and assistance to help their relative regain a productive life. It is not "unloving" to feel resentment in response to the behaviour of the relative with mental illness. Realizing the person is ill does not always overcome the hurt,

dismay, and anger felt by those trying to help. S/he may rebuff attempts to reach them, and may be fearful or accusatory toward those trying to help.



Understandably, families, friends, and co-workers have problems with these symptoms, yet a hostile reaction will almost certainly intensify or lengthen the episode. It is natural and necessary to grieve for the person who used to be. But strength and determination are needed to meet the coming challenges. Caring, supportive family members can play a vital role in helping their relative to regain the confidence and skills needed for rehabilitation.

Table No. 5C.40.

Type of Mental Illness and Impact on Family

Type of Mental Illness		**Impact on Family**				Total
		Financially week	Increase stressor factors	Financially week & Increase Stressor factors	Increase stressor factors, Personal& Social relationship gets affected	
CMD	Count	13	15	12	8	48
	% of Total	8.7%	10.0%	8.0%	5.3%	32.0%
SMD	Count	25	40	26	11	102
	% of Total	16.7%	26.7%	17.3%	7.3%	68.0%
Total	Count	38	55	38	19	150
	% of Total	25.3%	36.7%	25.3%	12.7%	100.0%

Chi-square test: (Pearson chi-square =1.545, df=3, No. of valid cases = 150, Contingency Coefficient = .101,P<0.05)

The above table shows that 32.0% of people are having common mental disorders and 68% with severe mental disorders. The table with chi-square =1.545, df=3, No. of valid cases = 150, Contingency Coefficient = .101 shows that the two variables don not have a significant relationship of the 32.0% with common mental disorders. 8.7% live in families who are financially weak, 10.0% have increased stress factors in the families due to their illness, 8%

experience weak financial situations as well as increased stressor factors in the family, and 5.3% are overburdened with also deteriorated social relationships. The 68% who are affected with severe mental disorders, 16.7% are members of families with a weak financial situation, 26.7% have increased stressor factors in the family, and 17.3% have families who are financially weak and also increased stressor factors. Another 7.3% have expressed to increased stressor factors in the family and a badly affected social relationship. (Pearson chi-square = 4.694, df= 3, No. of valid cases = 150 Contingency Coefficient= .518, $P<0.05$). The p-value suggests that the family is definitely negatively impacted in various ways if there is a mentally ill person in the family. The findings suggest for increased psychosocial support to caregivers of mentally ill persons.

5C. 41.More Impact on by Type of Mental Illness

Individuals with psychological disorders are at greater risk for decreased quality of life, educational difficulties, lowered productivity and poverty, social problems, vulnerability to abuse, and additional health problems. Education is often compromised when early onset mental disorders prevent individuals from completing their education or successfully pursuing a career. Kessler et al. (1995) found that individuals with a psychological disorder were significantly less likely to complete high school, enter college, or receive a college degree, compared to their peers without mental illness. In addition, psychological disorders result in lowered individual productivity due to unemployment, missed work, and reduced productivity at work.

Table No. 5C.41.
More Impact on by Type of Mental Illness

More Impact on		**Type of Mental Illness**		Total
		CMD	SMD	
Family members	Count	13	25	38
	% of Total	8.7%	16.7%	25.3%
Self	Count	15	40	55
	% of Total	10.0%	26.7%	36.7%
Both	Count	20	37	57
	% of Total	13.3%	24.7%	38.0%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =.900, df = 2, No. of valid cases = 150, Contingency Coefficient = 0.077, $P<0.05$)

The above table shows that 8.7% of CMD and 16.7% of SMD experienced negative impact in their family life. 10% CMD and 26.7% of SMD had experienced negative impact on their self. 13.3% of CMD and 24.7% of SMD had experienced negative impact on their self and in family life as mental illness are chronic and long lasting and cause impact on both self and family life.

Findings draw from above table that 38% PWMIs said that the mental illness is impacted on them as well as on their family which is the highest in number. 36.7% PWMIs said that mental illness is more impacted on their self and 25.3% impacted on their family members. (Pearson chi-square =.900, df = 2, No. of valid cases = 150, Contingency Coefficient = 0.077, $P<0.05$). There is significance showing the years of disability (DALY=Disability Adjusted Life Years) of an individual increases if he is severely mentally ill.

5C. 42.More impact of mental illness on by Sex

Currently evidence shows regarding rates, risk factors, correlates and consequences of gender disparities in mental health. Gender is conceptualized as a structural determinant of mental health and mental illness that runs like a fault line, interconnecting with and deepening the disparities associated with other important socioeconomic determinants such as income, employment and social position. Gender is a term that refers to an individual's self-representation as male or female. More than biological sex, gender is a complex set of biological, psychological, and behavioural processes. These processes can influence the cause and development of mental disorders in a number of ways, including the following:

- the prevalence of mental illness
- how symptoms are expressed
- how well a patient is likely to respond to treatment

Women, for example, are twice as likely as men to be depressed, but they respond better than men overall to serotonin reuptake inhibitors, a form of medication commonly prescribed for depression. Environmental factors, such as social support, economic status, and cultural expectations, differ by gender and may impact on an individual's vulnerability to mental illness. Epidemiological studies suggest that women are more affected by marital discord than men, and that men are more likely to be affected by work-related stress. These trends may have as much to do with gender roles and experiences as with biological sex.

For the practicing clinician, a thorough understanding of the interplay between biological and sociocultural factors in the development of mental illness can lead to better identification of symptoms and improve treatment outcomes for both men and women

Table No. 5C.42.
More Impact of Mental illness on by Sex

More Impact on		**Sex**		Total
		Male	Female	
Family Members	Count	23	15	38
	% of Total	15.3%	10.0%	25.3%
Self	Count	36	19	55
	% of Total	24.0%	12.7%	36.7%
Both	Count	30	27	57
	% of Total	20.0%	18.0%	38.0%
Total	Count	89	61	150
	% of Total	59.3%	40.7%	100.0%

Chi-square test: (Pearson chi-square = 1.937, df= 2, No. of valid cases = 150, Contingency Coefficient = 0.113, $P<0.05$)

The above table reveals that 16.3% of males and 10% females because of their illness have experienced negative impacts in their family life. 24% males and 12.7% females have experienced negative impacts in their self and 20% of males and 18% females have experienced impacts on self and in family life. As mental illnesses are chronic long-term illness there is a large impact on self and family life.

Findings draw from above table (Pearson chi-square = 1.937, df= 2, No. of valid cases = 150, Contingency Coefficient = 0.113, $P<0.05$) that mental illness impacted more on male rather than female in terms of self-impact. In terms of impact of mental illness on both, self as well as family member there is not much difference (20% males and 18% females) found amongst males and females.

5C. 43. Impact of mental disorders on family by type of mental illness

The burden of caring for a mentally ill individual often falls on the patient's immediate family or relatives. Families and caregivers of individuals with psychological disorders are often unable to work at full capacity due to the demands of caring for a mentally ill individual, leading to decreased economic output and a reduction in household income. Loss of income and the financial costs of caring for a mentally ill person put these households at an increased risk of poverty. Family members may also experience significant and chronic stress due to the emotional and physical challenges of caring for a mentally ill family

member. Although the experience of caring for mentally ill relatives varies among families and cultures, a 1999 review article reported that family caregivers' largest challenges were providing assistance with daily activities (e.g. providing transportation, offering financial assistance, helping with housework, cleaning, and money management) and stress associated with care (e.g. concerns about possible violence, embarrassing behaviours, and intra-family conflict). For instance, a 2006 study in Botswana investigated the experiences of families caring for a mentally ill family member. The study was conducted using in-depth interviews, focus group discussions, and field observations in Gaborone, the capital city, and Molepolole, a rural village. Although the extended family structure common in Botswana allowed for distribution of caregiver responsibilities, most families reported that lack of financial and medical resources at the family and community levels made it difficult and stressful to provide adequate care. In South Africa, in-depth interviews with eight family caregivers in Limpopo revealed that many caregivers felt that their own physical and mental well-being was at risk, particularly when caring for a violent or destructive family member. Caregivers also reported social isolation due to their family member's mental illness, as caregiving duties prevented them from attending social events such as funerals and church services. Particularly in rural areas lacking community resources for the mentally ill, the degree of satisfaction with family functioning (perception of "family burden") and the size of a caregiver's support network may significantly influence patient functioning, with increased support improving patient outcomes even in cases with high reported family burden.

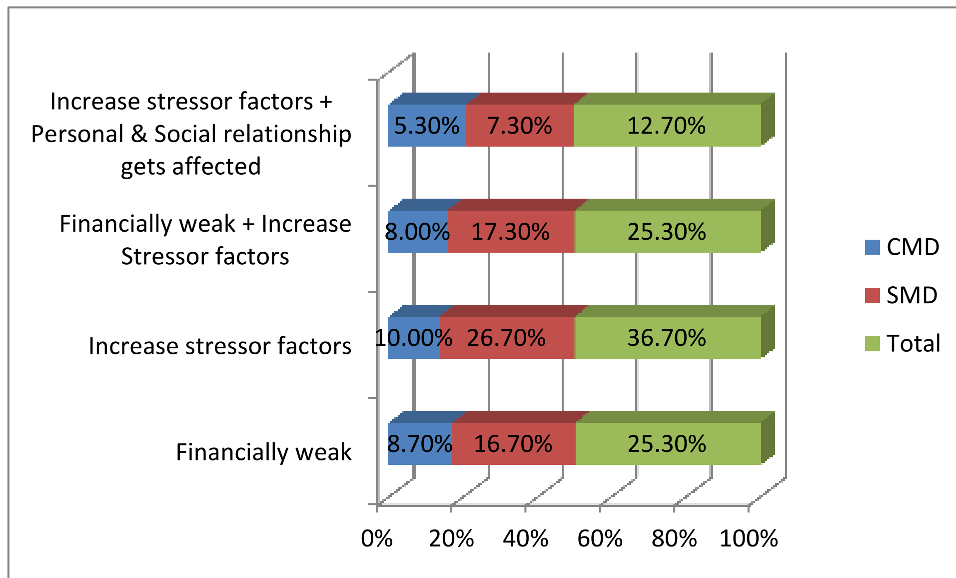
Table No. 5C. 43.
Impact of Mental Disorders on Family by Type of Mental Illness

Impact on Family		**Type of Mental Illness**		Total
		CMD	SMD	
Financially weak	Count	13	25	38
	% of Total	8.7%	16.7%	25.3%
Increase stressor factors	Count	15	40	55
	% of Total	10.0%	26.7%	36.7%
Financially weak + Increase Stressor factors	Count	12	26	38
	% of Total	8.0%	17.3%	25.3%
Increase stressor factors + Personal & Social relationship gets affected	Count	8	11	19
	% of Total	5.3%	7.3%	12.7%
Total	Count	48	102	150
	% of Total	32.0%	68.0%	100.0%

Chi-square test: (Pearson chi-square =1.545, df=3, No. of valid cases = 150, Contingency Coefficient = 0.101, $P<0.05$)

Figure No: 5C. 43.9.

Impact of Mental Disorders on Family by Type of Mental Illness



From the above table we can observe that any type of mental illness does have an impact on the family of the 32% affected with common mental disorders, 8.7% have grown financially weak because of their illness. 10% feel that their illness has increased stressor factors in their family. 8% have experienced financial decline and stressor factors in the family. 5.3% families were impacted with increase in stressor factors and negative impacts personal and social relationship.

From the findings we infer that mental illness whether common mental disorder or severe mental disorders severely (cumulatively 87.3%) impacted on the family in terms of family become financially weak, increased stressor factors. 12.7% felt that mental illness has negative impact on personal and social relationship. (Pearson chi-square =1.545, df =3, No. of valid cases = 150, Contingency Coefficient = 0.101, $P<0.05$). There is significant relationship to reject the null hypothesis.

5C. 44. Reason for Feeling Threatened from the Community

Although the specific societal impact of mental illness varies among cultures and nations, untreated mental illness has significant costs to society. In 2001, the WHO estimated that mental health problems cost developed nations between three and four % of their GNP (gross national product). When mental illness expenditures and loss of productivity are both taken into account, the WHO estimated that mental disorders cost national economies several billion dollars annually. In 1997, a Harvard Medical School study estimated that the United

States lost more than 4 million workdays and experienced 20 million "work cutback days" (days of impaired workplace performance) due to mental illness.

In addition, psychological disorders can exacerbate other public health issues, increasing the burden on national economies and impeding international public health efforts. In 2001, at least five to ten million people worldwide used intravenous drugs, and five to ten % of new HIV infections were due to transmission via intravenous drug use. Mental illnesses are also associated with increased risk of non-adherence to medical regimens for other health conditions. For infectious diseases, improper or incomplete use of medication can lead to drug resistance, which may have "profound public health implications" for the global community. Furthermore, maternal depression may put infants at increased risk of low birth weight, childhood health problems, and "incomplete immunization", all of which are risk factors for childhood mortality. Although the majority of individuals with mental illness do not exhibit dangerous behaviours, violence and incarceration among mentally ill individuals can place a significant financial and social burden on communities and nations. Worldwide, approximately 10 million people are incarcerated, and the WHO reports that the prevalence of mental health problems is "very high", especially among female inmates. In the U.S. in the late 2000s, nearly one million adults with serious psychological disorders were incarcerated annually. A study in the Pinellas Country, Florida jail found that not having outpatient mental health treatment was significantly associated with increased risk of misdemeanour arrests and days incarcerated, and having a substance abuse disorder was associated with more days in jail, which is consistent with national incarceration statistics. National data from the 2002 Survey of Inmates in Local Jails revealed that homelessness was significantly more prevalent among the inmate population as compared to the general U.S. adult population, and inmates who had been homeless were significantly more likely than were other inmates to have mental health and substance abuse problems. The authors posit that the relationship between homelessness and mental illness "may reflect limited access to mental health services, particularly inpatient services", due to deinstitutionalization in the United States, which has resulted in limited availability of psychiatric hospital beds, and strict criteria for hospitalization. The WHO recommends that developing and developed nations adopt more comprehensive preventative and interventional mental health programs to reduce the negative effects of mental illness on patients and their local and global communities.

Table No. 5C.44.
Reason for Feeling Threatened from the Community

Feeling Threatened from Community		Reason for Feeling Threatened			Total
		Discrimination	Other	NA	
Yes	Count	56	0	0	56
	% of Total	37.3%	.0%	.0%	37.3%
No	Count	0	76	18	94
	% of Total	.0%	50.7%	12.0%	62.7%
Total	Count	56	76	18	150
	% of Total	37.3%	50.7%	12.0%	100.0%

Chi-square test: (Pearson chi-square = 150.000, df= 2, No. of valid cases = 150, Contingency Coefficient = 0.707, $P<0.05$)

From the above table we can observe that 37.3% of the mentally ill persons who felt threatened by the community experienced discrimination. 50.7% did not feel threatened and so did not experience discrimination and 12% were non-responsive respondent.

Findings from the above table shows that 37.3% mentally ill persons felt threatened by the community because they faced discrimination from the community. (Pearson chi-square = 150.000, df= 2, No. of valid cases = 150, Contingency Coefficient = 0.707, $P<0.05$). There is significant relationship with the stated p-value which shows most of the mentally ill persons face discrimination in every aspect of their lives.

Stigmatization and violations of human rights represent a sizeable, albeit hidden, burden of mental illness. Around the world, many mental health patients still receive outmoded and inhumane care in large psychiatric hospitals or asylums, which are often in poor condition. Besides contributing to endemic stigmatization and discrimination of the mentally ill, these failings have led to a wide range of human rights violations. Mental illness has often been seen as untreatable, and mentally ill individuals are labelled as violent and dangerous. People with alcohol and substance dependence are considered morally and psychologically weak. The media perpetuate these negative characterizations. Stigmatization often leaves persons suffering from mental illness rejected by friends, relatives, neighbours and employers, leading to aggravated feelings of rejection, loneliness and demoralization. Stigmatization also leads to discrimination; thus it becomes socially acceptable to deprive stigmatized individuals of legally granted entitlements. Health insurance companies discriminate between mental and physical disorders and provide inadequate coverage for mental health care. Labour and housing policies are less open to people with a history of mental disorders than people with physical disabilities.

Surveys have shown that negative social attitudes toward the mentally ill constitute barriers to reintegration and acceptability, and adversely affect social and family relationships, employment, housing, community inclusion and self-esteem. Equally, they create barriers to parity of treatment opportunities, restrict the quality of treatment options and limit accessibility to best treatment practices and alternatives. Unfortunately, negative attitudes towards the mentally ill and stigmatizing stereo types may also be shared by medical and hospital personnel; patients frequently complain that they feel most stigmatized by doctors and nurses, ignorance breeds negativity. It is therefore suggested to generate more awareness in the community and empower the caregivers groups who would be able to fight discrimination broadly.

5C. 45. PWMI lived isolated from the society by Sex

Stigma in the form of social distancing has been observed when people are unwilling to associate with a person with mental illness. This might include not allowing the person to provide childcare, or declining the offer of a date (Corrigan et al, 2001).Self-stigma or internalized stigma is the process in which people with mental health problems turn the stereo types about mental illness adopted by the public, towards themselves. They assume they will be rejected socially and so believe they are not valued (Livingston and Boyd, 2010) Being discriminated against has a huge impact on self-esteem and confidence. This can increase isolation from society and reinforce feelings of exclusion and social withdrawal. Stigma can be a barrier to seeking early treatment; often people will not seek professional help until their symptoms have become serious. Others disengage from services or therapeutic interventions or stop taking medication, all of which can cause relapse and hinder recovery.

Table No. 5C. 45.
PWMI Lived Isolated from the Society by Sex

Sex		PWMI Lived Isolated from the Society			Total
		Some time	Very Rarely	Always	
Male	Count	50	12	5	67
	% of Total	29.1%	7.0%	2.9%	39.0%
Female	Count	64	13	6	83
	% of Total	37.2%	7.6%	3.5%	48.3%
Total	Count	114	25	11	150
	% of Total	66.3%	14.5%	6.4%	100.0%

Chi-square test: (Pearson chi-square = 150.166, df=6, No. of valid cases = 150 Contingency Coefficient= .707, P<0.05)

This table displays that 39% of males have been isolated from the community. 48.3% are females who have been living in isolation. Of the males 29.1% were sometimes isolated and 2.9% always isolated. From amongst the females 37.2% were sometimes isolated and 3.5% always.

From the above finding it can be clearly interpreted that 66.3% of the mentally ill person have faced isolation in the community due to various reasons, but mostly due to stigma they have been facing discrimination. (Pearson chi-square = 150.166, df=6, No. of valid cases = 150 Contingency Coefficient= .707, P>0.05). Through the stated p-value it could be decided there is significance to reject the null hypothesis. Greater the number of persons facing discrimination greater the number of persons being isolated from the community.

5C. 46. Impact of Fear

Fear is the primary affective cause of stigmatization. For a variety of reasons, human beings tend to fear differences, fear the future, and fear the unknown. Consequently, they stigmatize that which is different and unknown.

Table No. 5C.46.
Impact of Fear

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Work	42	28.0	28.0	28.0
Finding spouse	17	11.3	11.3	39.3
Social inclusion	25	16.7	16.7	56.0
Career & Study	20	13.3	13.3	69.3
Career & Finding spouse	25	16.7	16.7	86.0
All above	21	14.0	14.0	100.0
Total	150	100.0	100.0	

Mean=4.24, Median=4.00, Mode=1, Std. Deviation=2.548.

The above table shows that the impact of fear on the life of person with mental illness in everyday life. We can see 28.0% of impact of fear on his/her work 11.3% effect on finding spouse 16.7% affects his social inclusion 13.3% affects his career and study 16.7 find hard to manage career and finding spouse 14% think fear affect entire lifestyle. Findings draw from above table that person with mental illness felt 28% of impacts of fear on his/her work and 16.7 of impact on finding spouse for marriage as well as same percentage of person with mental illness felt that impact of fear on their social inclusion in the community.

5C. 47. Impact of the Fear by Sex

Fear and stigma relating to mental health, in both professionals outside the mental health service system and in the community, cannot be underestimated. Many studies have indicated that stigma is the most prominent issue related to seeking help for mental health problems (Corrigan, 2004; Kelly & Jorm, 2007). Family relationship services are in a good position to respond to mental health problems as they are not necessarily directly associated with mental health service delivery. To consider the specific role that non-mental health services can play in ameliorating the damaging effects of stigma related to mental illness.

Table No. 5C.47.
Impact of the Fear by Sex

Impact of The Fear		**Sex**		Total
		Male	Female	
Work	Count	27	15	42
	% of Total	18.0%	10.0%	28.0%
Finding spouse	Count	9	8	17
	% of Total	6.0%	5.3%	11.3%
Social inclusion	Count	12	13	25
	% of Total	8.0%	8.7%	16.7%
Career & Study	Count	10	10	20
	% of Total	6.7%	6.7%	13.3%
Career & Finding spouse	Count	18	7	25
	% of Total	12.0%	4.7%	16.7%
All above	Count	13	8	21
	% of Total	8.7%	5.3%	14.0%
Total	Count	89	61	150
	% of Total	59.3%	40.7%	100.0%

Chi-square test: (Pearson chi-square = 4.488, df= 5, No. of valid cases = 150, Contingency Coefficient = 0.170, $P<0.05$)

The above table revels that 18% male and 10% female found difficulty in finding work. 6% male and 5.3% female were unable to found spouse. 8% male and 8.7% female could not involve themselves in community activities. 6.7% male and females were unable to pursue their study and their career. 12% are male and 4.7% females found difficulty to make a career and found a spouse. 8.7% male and 5.3% females due to fear had negative impact on their work, finding spouse, were socially exclude, had problems in pursuing career and study.

Findings draw from above table that person with mental illness felt 28% of impacts of fear on their work amongst that 18% are male and 10% are females and 16.7 of impact on social inclusion in the community amongst that 8% are male and 8.7% are females it shows that social inclusion in the community for female is difficult than the man who has mental illness. (Pearson chi-square = 4.488, df= 5, No. of valid cases = 150, Contingency Coefficient = 0.170, P<0.05). The stated p-value suggests the significance of the null hypothesis which shows that fear impacts both male and females differently on various aspects of their lives.

5C. 48. Type of Mental Illness and PWMIs Presently involved in the Activity

PWMI Involved in productive work based shows that out of the identified 54.95% of PWMI who were productive, 30.06% were females and 24.89% were males. Some of the common productive activities people involved were agricultural activities like sheep and goat raring, dairy farming, working in the agricultural land and taking care of household activities. It is evident that PWMI from rural background have more opportunities to involve themselves in productive activities because of rural culture and environment. During the study, many caregivers expressed that they were relieved from stress and were able to go out and earn their livelihood.

Table No. 5C.48.
Type of mental illness and PWMIs presently involved in the activity

Type of Mental Illness		**Involved in the Activity**					Total
		House work	Farming	Agricultural Labour	Labour	Not Working	
CMD	Count	4	19	4	12	9	48
	% of Total	2.7%	12.7%	2.7%	8.0%	6.0%	32.0%
SMD	Count	14	30	17	23	18	102
	% of Total	9.3%	20.0%	11.3%	15.3%	12.0%	68.0%
Total	Count	18	49	21	35	27	150
	% of Total	12.0%	32.7%	14.0%	23.3%	18.0%	100.0%

Chi-square test: (Pearson chi-square = 3.550, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.152, P<0.05)

From this above table we can observe that 2.7% of persons living with common mental disorder are engaged in house work, 12.7% are engaged in farming, and 2.7% in agricultural labour, 8% in labour and 6% are not working. From amongst the person living with severe

mental disorders 9.3% are engaged in house work, 20% in farming, 11.3% in agricultural labour and 15.3% in labour activities and 12% is not working.

Findings draw from above table that the highest number (32.7%) of person with mental illness are engaged in agricultural work amongst that 20% SMD and 12.7% CMD. 23.3% PWMIs engaged in labour work amongst that 15.3% SMD and 8% CMD. **:** (Pearson chi-square = 3.550, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.152, $P<0.05$). There is significant relationship with p-value less than the significance level of 0.05. Research has shown that, even when good programs offer good services, they may be slow to adopt emerging and evidence based practices related to employment and often focuses on more immediate clinical goals at the expense of recovery and rehabilitation related outcomes.

Section D: Impact of Community Mental Health and Development Model in Community Setting.

Community mental health has become equated in the minds of many with primary health care. Against the backdrop of long-term institutionalization, which has been the mainstay of mental health services in some countries for decades, primary care treatment seems the remedy. In many developed countries, community care came to the forefront in the 1970s in tandem with a push towards deinstitutionalization, spearheaded in Italy by Franco Basaglia. In much of the developing world, however, the move towards community care is a recent development, which is to be celebrated. There is more, however, to community mental health than the primary clinic.

The World Health Organisation (WHO) has been a driver of the community mental health agenda, forming the Global Forum for Community Mental Health in 2007 and publishing a number of reports promoting community care. Basic Needs India has more than ten years of practical experience delivering mental health in the community. The organisation uses an intervention, called the Model for Mental Health and Development, which can be easily, replicated so as to reach large volumes of people in need. The Basic Needs India model adopts a participatory rights-based approach to mental health, which it delivers in five interwoven modules: capacity building; community mental health; sustainable livelihoods; research; and management. Through the community mental health module, rather than provide services directly, Basic Needs India mobilizes psychiatric clinicians from the public sector and health volunteers from the community to coordinate monthly mental health clinics in outpatient primary health centres and follow-up care in doorstep. The successful community care for mental health is the community health worker. Community based workers fulfil a crucial role in delivering community mental health services. Despite the growing global popularity of community-based models for mental health, the community plays important roles in a person's recovery from mental illness and mental health advocacy. Other key players from the community include village leaders, religious leaders, traditional healers, teachers, and community workers.

Community mental health development:

BNI is a mental health agency with emphasis on rights and development approaches. The consultation with affected people and family members resulted in a comprehensive strategy in addressing mental health within their own communities, economic empowerment, social inclusion and human rights violation and research in relevant areas to advocate for their own entitlements and rights.

Community Mental Health: The purpose of this model is to assist individuals with mental illnesses in experiencing and acting upon their full potential as human beings in their own communities. With the assistance of professionals and BNI staff, partner organizations receive training to design and implement care programmes in the community. People living with mental illnesses attend camps to receive treatment. Community-based follow up processes are set up. These include individual home visits and group meetings. Local doctors are trained in basic psychiatry so that nearby services are available. Self Help Groups comprising people living with mental illnesses and carers are formed.

Capacity Building: BNI builds capabilities among a range of people-people living with mental illnesses, family members, carers, BNI staff members, staff members of CBOs and NGOs and psychiatric professionals, to adequately address mental health issues in various spheres. BNI works continuously with CBOs and NGOs as a partner. Staff members of organizations are trained in animation techniques, process reporting, participatory evaluation, and basic research which involves information gathering. The training equips them with skills to bring affected people together and to address issues both within and outside communities. The focus is on community development by working with people living with mental illnesses and their carers, recognizing that such people are discriminated against and marginalized.

Training to community volunteers on community mental health: Community volunteers were trained on mental health and how to identify people with mental illnesses in the community and convince them to attend clinics. In addition, community volunteers were trained on making follow up visits to the mentally ill people at their homes and also on how to gather information, how to fill individual files, report writing and participatory data analysis.

Training of generalist health workers on mental illness and treatment: Mental health care has been integrated into primary health care system through training, support of health management teams at national, regional, and districts levels, and the use of existing resources

within the area. Due to the shortage of psychiatrists, the implementation followed by the training of generalist health care so that they can be able to provide mental health services in primary health care. The training started with mental health coordinators as trainers of trainees (TOT). Thereafter, the mental health coordinators conducted training to generalist health workers including clinical officers and nurses. During the trainings, few traditional healers were invited so as to share experiences on how to treat mental illness and also to identify the mentally ill people and advise them to attend clinics. Currently, traditional healers refer mentally ill people to near dispensaries or health centres. "Although there was a detailed training to generalist health care, refresher and on-job training are still needed. This is because some of the generalists who trained on mental health services in the pilot areas are transferred to the other regions replace other staffs that do not have enough skills on mental health and treatment. Also for those who are transferred to other areas, the government should develop a mechanism to ensure that, they will implement what they learnt from mental health services so that they can provide health services to the mentally ill people in that area"

Consultation meeting with mentally ill people and their carers: The aim of the consultation meeting were to understand general lives of mentally ill people and their carers, also to understand their needs and to discuss what to be done (the way forward) on findings observed. Process documenter gathers all information coming out from the mentally ill people and carers. These process documents are used in quarterly and annual report through participatory analysis with stakeholders. The information documented are number of mentally ill people and carers who participates in the consultation meeting (sex and their age), their voices, about their lives and the way of improving their lives. Mentally ill people and carers are able to express their views. Consultation meetings were the initial stage of identifying mentally ill people at village level. Basic Needs India in collaboration with local partner organization and all leaders at village level organized the meetings. A the end of each meetings, all participants including mentally ill people agreed the role of each other on the needs of mentally people including access to treatment.

Sustainable Livelihoods: BNI believes that poverty is both an outcome and root of mental illnesses. Thus, involving people living with mental illnesses and family members in economically viable activities is a crucial step. The programme addresses the central issues of sustainable livelihoods and poverty alleviation. BNI has developed an approach that builds the confidence of people living with mental illnesses and addresses their treatment needs so

as to permit them to engage fully in economic activities. Ensuring gainful occupation is an essential part of a process that enhances confidence and facilitates integration into the family, community and society. Economic development programmes suitable for the individual and family members are designed. CBOs and NGOs are trained in identifying local resources and economic opportunities. People living with mental illnesses form their own savings and credit groups or join other such existing groups in the community. Necessary links are made with micro finance organizations and with locally based employment schemes run by the Government.

Research and Advocacy: Life stories and other relevant empirical data are documented. These provide the basis for significant insights that influence the programme and are shared with other organizations. Partner organizations track changes in individuals. Factors influencing changes are recorded and made use of for people's benefit. Advocacy work involves ensuring the implementation of existing government policies, influencing formation of new policies and enabling people to directly access government facilities.

Non-Government Organizations: - (NGOs) play a vital and important role in building local communities. They are platforms for community participation enabling more socially inclusive societies. They promote the involvement of users and carers in the delivery and management of their services. NGOs are interactive and consultative, making links and partnerships with other community organizations, businesses and public services to better meet the needs of people accessing their service or program.

More broadly, NGOs raise community awareness around mental health through community education, enabling attitude change and reduction of the stigma associated with mental illness. NGOs also undertake mental health awareness campaigns promoting good mental health within communities.

Administration and Management: A Board of Trustees comprising individuals who offer their services voluntarily as custodians of the ethos of the organization governs Basic Needs India. Partner organizations are assisted in the areas of project management that includes finance, monitoring, evaluation and reporting. It is in this context that the Basic Needs India's (BNI) decade long interventions on community mental health and development (CMHD) assume importance. In an effort to understand and intervene in mental illness and mental health from a social development and rights paradigm, BNI developed the CMHD approach. The program has sustained in its core areas.

5D. 49.Encouraged by to Start Work

The support systems those are imperative for a PWMI, the caregivers and family. In this study important changes were seen when attempts were made to promote the need for inclusive development for people with disabilities in terms of education, access to employment and information. A sharing of cultural spaces and belongingness go a long way in healing and rehabilitation. Community and social participation emphasizes the need to promote the empowerment of people with mental illness.

Table No. 5D.49.
Encouraged by to Start Work

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Family	57	38.0	38.0	38.0
CHW	93	62.0	62.0	100.0
Total	150	100.0	100.0	

Mean=2.62, Median=3.00, Mode=3, Std. Deviation=0.487

In this table we can observe that 38% mentally ill were encouraged by family members to start work. 62% were encouraged by community health workers.

From these findings we can infer that capacity building activities at the community level enhance skills of a trained community person can do great wonders and deliver non-specialist treatment which are very helpful in treating mentally ill. 38% mentally ill persons were encouraged by family members to start work. 62% were encouraged by community health workers. Many studies have proved that training of lay worker is of much important is poorly resourced setting where specialists treatments cannot be continuously provided. The role of CHW and its effectiveness can also be observed in this below table which reflects that information about mental health in the program was impacted by a community health worker.

5D. 50. Information Providers about CMHD Program

Information about community mental health and development program in the village basically provided through various awareness programs including mass awareness, small group meetings with various stakeholders from the community, self-help groups using different kinds of method like stress play, wall painting etc. Basic Needs has been work with key people in the implementation of community mental health since they work very close with community. Therefore the first stage was introductory meetings to ward and community

leaders about community mental health. Introduction to ward and community leaders was fundamental for them to have a clear understanding of what is community mental health. During these introduction meetings it was noted that community volunteers are key people in the identification of the mentally ill people as well as influencing them to attend treatment in primary health centres dispensaries.

Table No. 5D.50.
Information Providers about CMHD Program

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Friends	25	16.7	16.7	16.7
Family members	18	12.0	12.0	28.7
Relatives	14	9.3	9.3	38.0
Community People	21	14.0	14.0	52.0
CHW	72	48.0	48.0	100.0
Total	150	100.0	100.0	

Mean=3.65, Median=4.00, Mode=5, Std. Deviation=1.564

The table reveals that 16.7% mentally ill received information about that positivity of a mental health program from friends, 12% from family members, 9.3% from relatives, 14% from community people and 48% from community health workers.

From these findings we can add to the above that a community health worker is an important link between specialist and the PWMIs and the caregivers. 48% CHW, 14% community people, 12% family members and 16.7% friends provide information about the CMHD program it shows that all the people in the community aware about the community mental health and development program implemented in their area. Community health workers played role as “life line” in the life of PWMIs and their families.

5D. 51.Usefulness of CMHD Program

There is a need for communities to mobilize and work together to prevent mental health problems, promote positive mental health, and improve the health of the community. Individuals can come together to make their communities ones in which healthy choices are easier to make and are supported by the environment around them. Communities can help create supportive environments by giving attention to community policies and processes that support health and reduce poor mental health. Specific activities may include: community

youth programs, volunteer and civic engagement opportunities, alcohol and drug free community events and activities and youth mentoring and leadership programs.

Table No. 5D.51.
Usefulness of CMHD Program

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Free treatment	48	32.0	32.0	32.0
Counselling	7	4.7	4.7	36.7
Free Medicines	7	4.7	4.7	41.3
Free Treatment, Counselling, Regular Follow-up & Livelihood Support	80	53.3	53.3	94.7
Livelihood Support	8	5.3	5.3	100.0
Total	150	100.0	100.0	

Mean=2.95, Median=4.00, Mode=4, Std. Deviation=1.44

The above table shows that how community mental health and development program gives many benefits to the PWMIs32% get free treatment 4.7% get counselling facility 4.7% patient get free medicine. Among them 53.3% patient get free treatment, concealing, regular follow up and also livelihood support. 5.3% patient gets only livelihood support.

The major finding from the above table shows that all the people said that the community mental health and development program is very useful for the life of person with mental illness and caregivers and also the family and community from different dimensions which including treatment, medication, counselling and livelihood support for the better rehabilitation in the community. Among them 53.3% person with mental illness got free treatment, concealing, and regular follow up and also livelihood support under the CMHD program.

5D. 52. Type of Helps Offered

In the community mental health and development program offered various help support to the person with mental illness, caregivers and the community. This program is focused on community rehabilitation therefore all the key stakeholders each and every person from the community participates directly or indirectly in the program and community started taking lead in the program. Through this program specific helps offered to the PWMI which include

free treatment and medication, psychosocial support including counselling and livelihood support for their rehabilitation in the community.

Table No. 5D.52.
Type of Help Offered

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Home visit	9	6.0	6.0	6.0
Emotional Support	7	4.7	4.7	10.7
Treatment in Outreach Camp	7	4.7	4.7	15.3
Livelihood Support	15	10.0	10.0	25.3
Home visit & Emotional Support	13	8.7	8.7	34.0
Home visit & treatment in Outreach Camp	22	14.7	14.7	48.7
Emotional Support & Treatment in Outreach camp	42	28.0	28.0	76.7
Change Attitude of family & Community through Creating Awareness	35	23.3	23.3	100.0
Total	150	100.0	100.0	

Mean=5.83, Median=7.00, Mode=7, Std. Deviation=2.090

The above table shows that out of the total respondent PWMI 6% person with mental illness said that they received help as 'home visit' in the CMHD program. 4.7% PWMIs received help as emotional support, 4.7% treatment in outreach camp, 10% livelihood support, 8.7% home visit and emotional support, 14.7% home visit and treatment in outreach camp, 28% emotional support and treatment in outreach camp and 23.3% PWMIs said that they received grater help through the CMHD program as 'change in the attitude of family member and the community through different kind of awareness program, one to one interaction.

5D. 53. Number of Meeting Participated by Sex

The participation of PWMIs and their families in social and development activities is very rare in Maharashtra in the initial period because of the stigma experienced by the PWMIs and their families who fear to join the community activities for fear of being discriminated and isolated. When PWMIs attempt to attend, for instance, a party, they are made to do certain works (fetching firewood and water) yet they are the last to eat or even eat leftover food (MHU Advocacy Report, 2004). More often than not such people or families are never called to participate in such activities. Because of the negative attitudes surrounding mental illness, it is hard to find people marrying or getting married to PWMIs or even socializing with them.

But after sometime their participation were increased tremendously in social activities and community meetings.

Table No. 5D.53.
Number of Meeting Participated by Sex

Number of Meetings		**Sex**		Total
		Male	Female	
Two-Three	Count	69	44	113
	% of Total	46.0%	29.3%	75.3%
More than Three	Count	20	17	37
	% of Total	13.3%	11.3%	24.7%
Total	Count	89	61	150
	% of Total	59.3%	40.7%	100.0%

Chi-square test: (Pearson chi-square = .567, df= 1, No. of valid cases = 150, Contingency Coefficient = 0.061, P<0.05)

Above table infer that 40.7% females were participated in the community meetings under the CMHD program. 59.3% males participated in the community meeting. 75.3% male and female both are participated two- three times in the community meetings and 24.7% male and female participated more than three times in the community meetings. (Pearson chi-square =.567, df= 1, No. of valid cases = 150, Contingency Coefficient = 0.061, P<0.05). It is evident from the stated p-value that women are more participatory.

Its shows that most of the people from the community well accommodate in the various activities of the program and they were voluntarily participated in the awareness meetings more number of times.

5D. 54. Number of meeting participated and it's use.

In the Basic Need India's community mental health and development program focused on community participations. Community Mental Health and Development Program in Maharashtra delves closely into the lives of people with mental health problems, delving into a key strategy that community based rehabilitation are an important way to respond to the needs of PWMI. PWMI have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty.

Table No. 5D.54.
Number of Meeting Participated and it's Use.

Use of Participation		**No. Meeting Participated**		Total
		Two-Three	More than 3	
Get Information On Mental Illness	Count	19	3	22
	% of Total	12.7%	2.0%	14.7%
Generate hope regarding mentally ill can be treated	Count	44	13	57
	% of Total	29.3%	8.7%	38.0%
Increase Community expectance	Count	23	10	33
	% of Total	15.3%	6.7%	22.0%
Reduce Stigma	Count	27	11	38
	% of Total	18.0%	7.3%	25.3%
Total	Count	113	37	150
	% of Total	75.3%	24.7%	100.0%

Chi-square test: (Pearson chi-square = 2.485, df= 3, No. of valid cases = 150, Contingency Coefficient = 0.128, P<0.05)

Figure No. 5D. 54.10

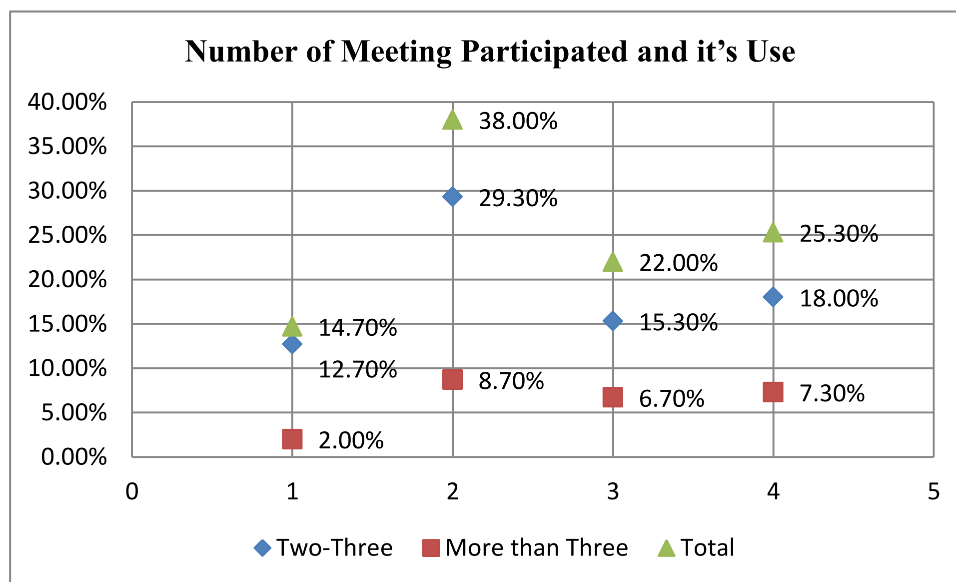


Figure 5D.54.10 shows that out of the total identified 75.3% PWMIs were participated two-three times in the community meetings and 24.7% PWMIs participated more than three times in the community meetings. Through the various meetings PWMIs feel that these meetings were useful for them.14.7% PWMIs said that these community meetings were useful for them to getting information on Mental Illness and mental health. 38.0% PWMIs said that through these meeting they hope were generate amongst them and their family members that mental illness can be treated. 22.0% PWMIs said that through the small groups meeting

community expectance is increase and 25.3% PWMIs feel that these meetings helpful for reduce stigma about the mental illness from the community.

The findings from the study with significance in the p-value shows that out of the total identified 75.3% PWMIs were participated two- three times in the community meetings and 24.7% PWMIs participated more than three times in the community meetings. (Pearson chi-square = 2.485, df= 3, No. of valid cases = 150, Contingency Coefficient = 0.128, P<0.05)

The participation of people with mental illness in community and social activities was comparably more therefore they feel the CMHD program is useful for them in many aspects and specifically increasing community support.

5D. 55. Impact of CMHD Program and Improvement among PWMI.

Mental health: central to human development, positive mental health is linked to a range of development outcomes, including better health status, higher educational achievement, enhanced productivity and earnings, improved interpersonal relationships, better parenting, closer social connections and improved quality of life. Positive mental health is also fundamental to coping with adversity. On the other hand, poor mental health impedes an individual's capacity to realize their potential, work productively and make a contribution to their community. The social and economic impact of mental and psychosocial disabilities is diverse and far-reaching, leading to homelessness, poor educational and health outcomes and high unemployment rates culminating in high rates of poverty. All these issues are directly linked to the Millennium Development Goals (MDGs).

Table No. 5D.55.
Impact of CMHD Program and Improvement Among PWMI.

Impact of CMHD program		**Improvement among PWMI though this program.** 25%	50%	75%	100%	Total
Large Extent	Count	1	12	22	58	93
	% of Total	.7%	8.0%	14.7%	38.7%	62.0%
Some Extent	Count	0	3	20	34	57
	% of Total	.0%	2.0%	13.3%	22.7%	38.0%
No Impact	Count	0	0	0	0	0
	% of Total	.0%	.0%	.0%	.0%	.0%
Total	Count	1	15	42	92	150
	% of Total	.7%	10.0%	28.0%	61.3%	100.0%

Chi-square test: (Pearson chi-square = 4.368, df= 3, No. of valid cases = 150, Contingency Coefficient = 0.128,P<0.05)

The above table shows that 61.3 percent caregivers feel that the 100% impact they have seen through CMHD program in the life of PWMIs. They have improved their life and started living productive life. 28 percent caregivers said that 75% improvement amongst the PWMI, 10 percent caregivers feel 50% PWMIs were improved from the program.

Overall majority which is 61.3 percent caregivers feel that the 100% impact they have seen through CMHD program in the life of PWMIs. 62 percent person with mental illness has been improved up to large extent and 38% of them improved up to some extent. (Pearson chi-square = 4.368, df= 3, No. of valid cases = 150, Contingency Coefficient = 0.128,P<0.05). The community mental health and development program is highly impacted in the lives of mentally ill person as well as in their families and also in the community.

5D. 56. Impact of mental health program in the community

Although the specific community impact of mental illness varies among cultures and nations, untreated mental illness has significant costs to society. Impact on community level more inclusive and supportive it's include community environment, increased civic engagement, community cohesion, awareness of the value of diversity and the harmful mental health effects of isolation and discrimination. Local leaders also have the responsibility of raising awareness in the community. Basic Needs India organized meetings with all local leaders in the program area and shared experience with them about community mental health intervention at community level. Then they were contributed a lot in awareness rising in the community during their general meeting with the community.

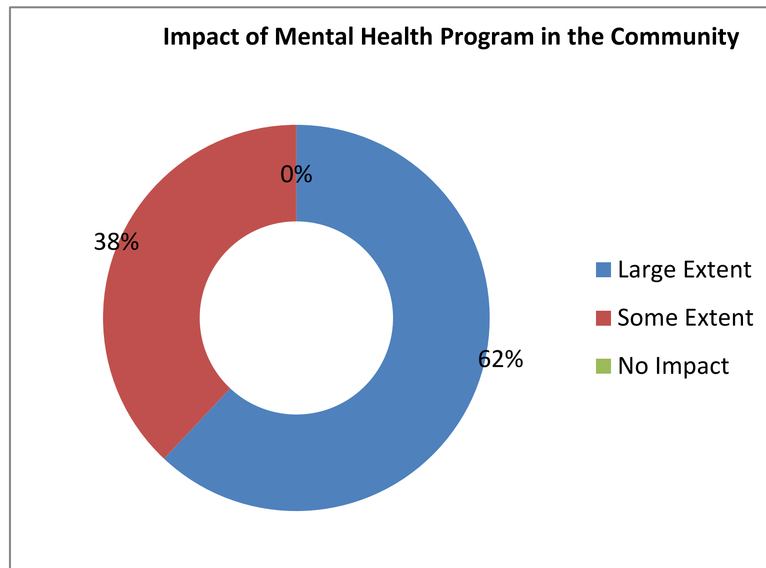
Table No. 5D.56.

Impact of Mental Health Program in the Community

Valid	Frequency	Percent	Valid Percent
Large Extent	93	62.0	62.0
Some Extent	57	38.0	38.0
No Impact	0	.0	.0
Total	150	100.0	100.0

Mean=1.50, Standard Deviation= 0.502

Figure No. 5D. 56.11



The figure No.5D.56.11 illustrates that BNI's community development module in treating mental illness has had great impact as 62% state the same. 38% opine that the program was impacted well to some extent.

From the above findings we can interpret that the model was well received in terms of its programs and people who have benefitted are highly satisfied to a great extent. Great impact as 62% state the same. 38% opine that the program was impacted well to some extent. The community mental health program most of the components are fulfil the needs and basic rights of mentally ill person therefore community participation and ownership is much more than any other program it reflects into impact of the program in the community.

5D. 57.PWMIs Opinion on CMHD program

Basic Needs India also is working with partnership with community based organizations and non-governmental organizations in the program area in awareness creation and identification of the mentally ill people in the community. The program provides those skills on how to identify the mentally ill people and influence them to attend clinics. In general, partner organization contributes much in identifying the mentally ill people since they work very close with people in the society.

Table No. 5D.57.

PWMIs Opinion on CMHD Program

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
We received better treatment and recovered from the MI and started working	70	46.7	46.7	46.7
Future Continuity of the program depend on funding	7	4.7	4.7	51.3
Useful program in Tribal Area where general health services not function well	47	31.3	31.3	82.7
This Program Creates Hope in our life.	26	17.3	17.3	100.0
Total	150	100.0	100.0	

Mean=2.19, Median=2.00, Mode=1, Std. Deviation=1.202

The above table shows that out of the total respondents 46.7% PWMIs were said that 'We received better treatment and recovered from mental illnesses' and started working and started working because of the community mental health and development program. 4.7% PWMIs opined that 'future continuity of the program depends on funding'.31.3% PWMIs said that 'useful program in Tribal area where general health services are not function well'. 17.3% PWMIs said that 'this program creates hope in our life.

Findings from above table infer that out of the total respondents 46.7% PWMIs were said that 'We received better treatment and recovered from mental illnesses' and started working because of the community mental health and development program. 31.3% PWMIs said that the program is useful in the tribal area where general health care services are not functional well. Overall the major findings from the above table infer that mental health services should be community driven rather than institutionalizing it. Community mental health program helps not only PWMIs in terms of treatment but also helpful for creating awareness in the community and reduce stigma and discrimination which mentally ill person and their families faced in the community.

5D. 58. Suggestions about the Program

In the CMHD program community services and programs are provided by NGOs across all aspects of care and include: children's services, youth services, women's services, education, employment, and assistance to acquire government schemes and benefits such as housing, disability pension. NGOs provides people with a mental illness or disorder with a range of psychosocial rehabilitation and support services, including social and emotional support, practical support to live at home, support in employment, social activities, helping link people with services and advocating on their behalf.

Table No.5D.58.
Suggestions about the Program

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
The Program is very Useful please continue to give life of PWMI	39	26.0	26.0	26.0
This is first time I have seen the Psychiatrist services provide in the tribal area so don't stop	30	20.0	20.0	46.0
Without this program we were rooming in the village like animals, because of this program we get human life	43	28.7	28.7	74.7
We are living Normal life	38	25.3	25.3	100.0
Total	150	100.0	100.0	

Mean=2.53, Median=3.00, Mode=3, Std. Deviation=1.133

The above table suggests that persona with mental ill have provided their suggestions regarding the program 26% feel that the program is very advantageous which bring light in the life of mentally ill person and it should be continue. 28.7% opined that without this program we were rooming in the villages like animals but after CMHD program and their treatment is exceptionally useful in terms in providing a sense of dignity of human lives but still we faced some kind of discrimination from the community.

Overall, the entire respondent expressed the effectiveness of community mental health program. This program established psychiatrist services in the tribal area and that services were made available free of cost which reflects in the life of mentally ill person. 25.3% mentally ill person said that they have started living normal life, 28.7% opined that without this program we were rooming in the villages like animals but after CMHD program and their treatment is exceptionally useful in terms in providing a sense of dignity of human lives.

Chapter-6.

Findings, Conclusions and Recommendations

This chapter presents the major inferences drawn from the data analysis. It also depicts some work able suggestions which have been derived based on the study inferences. The researcher would like to initially present the socio-demographic factors of the respondents while and analysing the age factor

The program implementation is a collective effort of BNI, implementing partner organizations, the field personnel, the PWMI; the caregivers, the families of PWMI, the village community and village level community organizations. Tracking of PWMI over the years is dependent on every one of these players. This is just to bring home the complexity of the process of keeping track of every individual PWMI.

Findings:-

- Findings from the study show that majority of the mentally ill person fall under young age group. 32% PWMIs a young group between 18-27 years of age that were mentally ill. In overall 80% of the mentally ill person from the 18 to 47 year age group has higher prevalence of mental illness during the most productive years of life. This young adult age group is a productive age group and they faced lot of stress in most of the roles and responsibilities. Both the variables do not significantly affect each other's degrees of change. At any age people are likely to having mental illnesses. Chi-square tests: Pearson's Chi-square = 1.95, df=4, no of valid cases = 150. P>0.05. The test reveals that since the p-value is more than 0.05. Thus from these findings it can be inferred that age and mental illnesses do not have a significant relationship and so the null hypothesis is accepted.
- A very large number that is 52% of the mentally ill respondents are illiterate. Their illness could possibly be one of the causes for them not being able to perceive education. This also suggests that one of their basic fundamental rights has been infringed due to their illness. Their illness could possibly one of the causes for them not being able to perceive education. It also states since the p-value is more than

0.05% , the null hypothesis is accepted because there is no enough evidence to prove against the null hypothesis (Pearson chi-square =106.0543, df=3, No. of valid cases = 150, Contingency Coefficient = 0.644, P>0.05). Here again the focus is on the vulnerable section of the people with little or no education. Education has strongly correlated with poverty. Education is an important determinant of present and future life opportunities which promote mental health in later life. In any case it is important to realize that the socioeconomic variables beloved by epidemiologists might have different meanings and significance in different societies.

- In this study it evidently shows that there is no significant relation between the two variables (Sex and type of mental illness) and so null hypothesis is rejected and the alternate hypothesis is accepted which states that women do have greater rates of prevalence of mental disorders. With this p-value (Pearson chi-square = 0.649, df=1, No. of valid cases = 150, Contingency Coefficient = 0.518, P>0.05). In this study overall in both the mental health conditions were men percentage is higher than women due to unavailability of equal number of male and female respondent. But most of the studies show that the common mental disorders were higher number in women than in men. Here this difference came due to cultural context and gender difference ruling out in the society were usually women hide their illness in the family but more caring for men. Therefore the basic difference we can see in the identification also (89 male & 61 female). There is a gender gap for mental illness with females being up to 40.7 percent more likely to develop some type of mental health condition than their male counterparts. A new study to be published by Oxford University Press finds that women are nearly 75 percent more likely than men to have suffered from depression.
- Findings from the study show that all 44.7% were males and 55.3% females were in caregiver's role. Women outnumber men in providing care to mentally ill person irrespective of their gender; women have always played a major role in the family as a care provider in general also. (Pearson chi-square = 1.327, df=4, No. of valid cases = 150 Contingency Coefficient= .094, P>0.05). The null hypothesis is rejected as there is a difference between caregiving by a male and female family members.
- Findings from the study infer that women are 74% (mother, sister and wife) who are caregivers. Thus women play an important role in caring of the person with mental illness. But most is shown un-productive services where as they contribute productively indirectly. 51% are mothers who are caregivers, 19.3% are fathers, 2%

are brothers, 4.7% are sisters, 18% are wives and 4.7% are husbands. Tests show (Pearson chi-square = 17.275, df= 20, No. of valid cases = 150 Contingency Coefficient= .321, P>0.05) There is no significant evidence to accept the null hypothesis and hence it is rejected.

- In the study found that the higher percentage of unmarried men suffers from common mental illness (14.6% and 16.7%) severe mental illness in comparison with unmarried women (6.3% and 11.8%). The data on PWMI according to sex and marital status show that a higher percentage of married men were with mental illness, it is not merely the stresses of family responsibilities that marriage brings to men.
- Daily wage earners work in agricultural fields, construction work, carpentry, weaving and NREGA. The study shows that 13.3% persons (women and men) are not involved in any productive work. It was observed that the PWMI who were in the symptomatic state, had poor family support, little or no enthusiasm of the community to integrate the individual, stigma and hence were unemployed.
- Finding from the study shows that 9.3% unemployed (not working) and 8% household work among the PWMI is higher in the category of SMD than CMD. It has relationship with their employment and illness category. In the severe mental illness people need lot of time to stabilize and back to the work.
- Finding from the study shows that 66.7% families have only one earning members in the family because even if there is another adult in the family s/he would have to stay back at home to look after the mentally ill person. (Pearson chi-square = 6.770, df= 6, No. of valid cases = 150 Contingency Coefficient= .518, P>0.05). There is no enough evidence to accept the null hypothesis and so null hypothesis is rejected with no significance between the variables.
- Finding from the study shows that 30% of the PWMIs which is the higher number among the total number of PWMIs full under the income group 20001 to 30000 annually. Findings with (Pearson chi-square =2.575, df=4, No. of valid cases = 150, Contingency Coefficient = 0.130, P>0.05), we can infer that there is no significant relationship between both the variables and the null hypothesis is rejected.
- There is a significant relationship between income and type of occupation of caregivers. Most of (30.7%) the respondents' are in the category of 10,001-20,000 and are agricultural labour who earns a meagre income 39.3%. Mental illness which is chronic deteriorates the economic condition of caregivers. From the findings we can infer that there is a significant relationship between income and type of occupation

with these test results (Pearson chi-square = 54.984, df=15, No. of valid cases = 150 Contingency Coefficient= .518, P<0.05). Null hypothesis is accepted.

- Findings draw from the study that severe need long term treatment than the common mental disorder. 16.7% PWMIs who has severe mental disorder had taken more than 7 years of treatment for their illness.
- Findings draw from the study that 20% male and female both received more than 7 years of treatment for their illness but within this more number of male (12.7%) were received long treatment than the (7.3%) female.
- In this study overall 38% PWMIs were taken treatment from faith healer, general practitioner and psychiatrist. It shows that people firstly access faith healer than general practitioner and finally to the mental health specialist (psychiatrist). Psychiatrist treatment comes very late in to the picture, in the initial period of mental illness people try to take treatment from local faith healer. In the severe condition people preferred to take treatment from psychiatrist.
- Finding draw from the study that 12.7% male and female both does not received any kind of treatment in the initial phase of illness. 8.7% male and only 3.3% females PWMIs who were received psychiatric treatment in the initial phase of their illness it shows that more number males got psychiatric treatment than the female PWMIs.
- The highest number of (37.7%) PWMIs who have received treatment from a psychiatrist in the CMHD program after which they feel quite better improvement in their condition. (Pearson chi-square =227.027, df=9, No. of valid cases = 150, Contingency Coefficient = 0.776, P>0.05).There is no significant relationship. The alternate hypothesis is accepted.
- Finding from the study shows that 22.7% get better due to medicines, 7% due to proper guidance and counselling for effective treatments. 57.6% PWMI feel that both medicine and counselling have been effective in treatments of the mentally ill person.
- Out of the total respondent 22.7% PWMI get better due to medicines, 7% due to proper guidance and counselling for effective treatments. 57.6% PWMI feel that both medicine and counselling have been effective in treatments of the mentally ill person.
- Counselling and pharmacotherapy both are important methods for treatment of severe and common mental ill. Even though 22.7% PWMIs feel that the medication is the best methods for recovery from mental illness, this is true in case of severe mental disorder they first need medication and then the counselling or psychosocial

intervention. In case of CMD they can be treated with counselling and psychosocial interventions.

- Almost 78.7% people with mental illness with SMD and CMD access treatment from faith healer, spiritual healer, darga and temple, religious or holy person. It also shows that cultural beliefs are stronger and still exist in the society especially in the tribal communities. (Pearson chi-square=3.842, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.158, P<0.05). There is significant difference to nullify the hypothesis.
- There is a significant relationship between religious treatment and its impact. The more the people access religious treatment the lesser the impact. 67% person with mental illness said that they don't see any positive impact on the treatment from religious treatment which includes faith healers, spiritual healer's darga/temple and religious or holy person.
- It is evident from the study shows that most (63.3%) of the people who are mentally ill believe that spiritual healers are the best source of treatment and prefer to go to them in the initial phase and most (38%) of the spiritual healer gives herbal powder in the treatment. Ignorance about these illness lead people to such beliefs. There is a great need to generate awareness amongst the masses, if people have to access proper treatment for mental illnesses.
- Finding from the study state that 74.7% PWMIs feel that spiritual healer's treatment is not useful for them therefore they haven't prefer the kind of treatment provided by spiritual healers. Depicts a significant relationship and with no effect or difference between the means and thus reject the null hypothesis (Pearson chi-square =52.268, df=2, No. of valid cases = 150, Contingency Coefficient = 0.508, P<0.05) the 74.7% of PWMIs opine that a psychiatrist treatment is bring better improvement in their life.
- Finding from the study shows that 40.7% PWMIs took treatment from spiritual healer who is located outside the village. It shows that due to stigma attached with mental illness people prefer to take treatment from outside the village.
- The findings from draw from the study that the 74.7% of PWMIs opine that a psychiatrist treatment is bring better improvement in their life. It also shows that people with mental illnesses and the community where CMHD program implemented have become more literate about their mental illness. 25.3% of PWMIs stated that they have taken treatment from spiritual healer which they feel very less resulted in their daily life. In the tribal community spiritual healer has a key role in the all rituals therefore if anything happen they have to go to the spiritual healer first. Even the other

side of the reality there were no psychiatric services available nearby and the health services are inadequate.

- Findings from the study shows that mostly (12%) equal number of PWMIs took treatment from faith healers, general practitioners, psychiatrist, home remedies or both either of the treatment in the initial phase of the illness and 50% CHW advise them to take the treatment it shows that community health worker is the person how has community recognition and plays essential role in the life of PWMIs as well as in the community. (Pearson chi-square =247.681, df=20, No. of valid cases = 150, Contingency Coefficient = 0.789, P>0.05). The hypothesis is accepted as there is no significant difference to reject the null hypothesis.
- Most of the 62% people stated that stressful life events are the main caused for mental illness. Day to day stressful life events were play a major role in the life of human being and that stressful life events may lead towards mental illness. Also 13.3% people don't know the cause of mental illness and 12.7% people feel that mental illness caused by evil spirit. (Pearson chi-square =2.812, df=3, No. of valid cases = 150, Contingency Coefficient = 0.136, P<0.05). There is significant difference between the means of variables and thus the null hypothesis is rejected.
- According to the PWMI most of the people feel that they don't understand anything (50%) due to their mental illness. 38% people feel that PWMI will never improve. It shows that most of the people still have miss understanding about mentally ill person as well as mental illnesses.
- The severe mentally ill people become stabilized (26%) within one and two years from the treatment in CMHD program. In the common mental disorder very few people (8.7%) takes almost 3 to 4 years to reduce symptoms because they haven't take regular treatment therefore it takes a longer time to become stable. Evidence shows that in the case of CMD symptoms reduce within 6 month or maximum period will take 2 years depend on the person and year of illness. Over all 38.7% PWMI become stabled within 6 month of regular treatment. 36% PWMI become stabled within 1-2 year of treatment and 25.3% PWMI become stable within 3-4 year of treatment. (Pearson chi-square =.692, df=2, No. of valid cases = 150, Contingency Coefficient = .068, P<0.05). There is significant difference and the null hypothesis can be rejected.
- Overall 74.7% of PWMIs were taken treatment up to 2 to 4 year and the same percentage of PWMIs reach in the stage of stabilization within 2 years of regular psychotropic treatment as well as psychosocial treatment from the community health

worker and caregivers. Pharmacological, psychosocial treatment and support of CHW and caregivers is very necessary to bring changes in the lives of PWMIs. (Pearson chi-square =150.000, df=2, No. of valid cases = 150, Contingency Coefficient = 0.707, P>0.05). There is significant relationship and the null hypothesis is rejected which shows that PWMIs with severe mental illnesses take a longer period of time to stabilize.

- Most of the people prefer taking treatment from outside the village because of they take treatment in the village that will embarrassing them due to stigma. 63% people first approach to the spiritual healers it shows that mental illness still today people believe that mental illness is caused by evil spirit. People not seen mental illness is illness like other physical illness.
- From these findings of the study we can infer that community health workers have played a major role in motivating patients to access proper treatments for dealing with mental illnesses. Which shows that the highest number (50%) of CHW advice to take treatment for mental health problem.
- From study findings it can be inferred that a large number (87.3%) of person diagnosed with mental illness faced discrimination in their lives due to stigma, misconceptions and illiteracy i.e. lack of awareness about treatment of mental illnesses. The available evidence suggests that persons with mental illness still struggle on a daily basis to access appropriate health care or be treated with respect or dignity when they do enter our health care systems.
- A majority (74.7%) of mentally ill patients has taken treatment of psychiatrist, this is basically due to the community mental health program being implemented by BNI in these tribal areas where these psychiatric services made available on a monthly basis.
- A finding from the study shows that 87.3% of the PWMIs were referred for specialist (psychiatrist) treatment by the community health workers. Any community workers who are trained to spread awareness about mental health can easily provide information about proper treatments accessible by PWMI just like the community health worker.
- Overall 76% people opined that they villagers know about their illness amongst that 26.7% from common mental disorder and 49.3% from severe mental disorder. This evidence clearly shows that severe mental disorders cannot be hiding from the community. This evidence clearly shows that severe mental disorders cannot be hidden from the community. (Pearson chi-square = 2.081, df=1, No. of valid cases = 150,

Contingency Coefficient = .117, P<0.05) From the above table we can infer that there is no significant relationship between these above two variables and as severe mental illness cannot be hidden, so the number of people aware about the illness would be more.

- Findings from the study infer that stress is the major factor that can lead to mental illness as 62% opined the cause of mental illness is due to stress in the life. There is a significant relationship and so the hypothesis could be nullified with these stated values/results (Pearson chi-square =1.201, df=3, No. of valid cases = 150, Contingency Coefficient = .089, P<0.05). The cross tabulation shows that 12% patents attribute their illness once to evil spirit and so either pray to god, take herbal powder or use a locket type called 'Tabij' as being treated.
- Finding from the study shows that 38.7% started working within 6 months of treatment of 25.4% started small work with the help of others. 6% started earning their livelihoods within 1-2year of treatment and 25.3% between 3-4 years of treatment. From these finding we can infer that there is a significant relationship between being stabilized and efforts made to earn a living. The lesser the time taken to stabilize the sooner the person can start earning.
- Findings of the study shows that 55.3% females caregivers are involved in the caring of PWMIs as a caregivers which is highest in number than the males. Most of the studies emphasis on that more number of women in the role of caregiver apart from their daily routing works.
- Majority 92.8% of the caregivers said that medical, psychological and physical care is a larger part of their caregiving component. One could be the reason is number of PWMIs come under SMD and most of the persons with mentally ill firstly need medication rather than psychological care in the severe mental health condition.
- The 68% people who are affected with severe mental disorders, 16.7% are members of families with a weak financial situation, 26.7% have increased stressor factors in the family, and 17.3% have families who are financially weak and also increased stressor factors. Another 7.3% are expressed to increased stressor factors in the family and a badly affected social relationship. (Pearson chi-square = 4.694, df= 3, No. of valid cases = 150 Contingency Coefficient= .518, P<0.05). The p-value suggests that the family is definitely negatively impacted in various ways if there is a mentally ill person in the family. The findings suggest for increased psychosocial support to caregivers of mentally ill persons.

- Findings draw from the study that 38% PWMIs said that the mental illness is impacted on them as well as on their family which is the highest in number. 36.7% PWMIs said that mental illness is more impacted on their self and 25.3% impacted on their family members. (Pearson chi-square =.900, df = 2, No. of valid cases = 150, Contingency Coefficient = 0.077, P<0.05). There is significance showing the years of disability (DALY=Disability Adjusted Life Years) of an individual increases if he is severely mentally ill.
- Mental illness impacted more on male rather than female in terms of self-impact. In terms of impact of mental illness on both, self as well as family member there is not much difference (20% males and 18% females) found amongst males and females.
- Mental illness whether common mental disorder or severe mental disorders severely (cumulatively 87.3%) impacted on the family in terms of family become financially weak, increased stressor factors. 12.7% felt that mental illness has negative impact on personal and social relationship.
- Finding from the study shows that 37.3% mentally ill persons felt threatened by the community because they faced discrimination from the community. (Pearson chi-square = 150.000, df= 2, No. of valid cases = 150, Contingency Coefficient = 0.707, P<0.05). There is significant relationship with the stated p-value which shows most of the mentally ill persons face discrimination in every aspect of their lives.
- Findings from the study shows that overall 66.3% of the mentally ill person has faced isolation in the community due to various reasons, but mostly due to stigma they have been facing discrimination. (Pearson chi-square = 150.166, df=6, No. of valid cases = 150 Contingency Coefficient= .707, P>0.05). Through the stated p-value it could be decided there is significance to reject the null hypothesis. Greater the number of persons facing discrimination greater the number of persons being isolated from the community.
- Person with mental illness felt 28% of impacts of fear on his/her work and 16.7 of impact on finding spouse for marriage as well as same percentage of person with mental illness felt that impact of fear on their social inclusion in the community. (Pearson chi-square = 4.488, df= 5, No. of valid cases = 150, Contingency Coefficient = 0.170, P<0.05). The stated p-value suggests the significance of the null hypothesis which shows that fear impacts both male and females differently on various aspects of their lives.

- Findings from the study shows that the highest number (32.7%) of person with mental illness are engaged in agricultural work amongst that 20% SMD and 12.7% CMD. 23.3% PWMIs engaged in labour work amongst that 15.3% SMD and 8% CMD. (Pearson chi-square = 3.550, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.152, $P<0.05$). There is significant relationship with p-value less than the significance level of 0.05.
- The capacity building activities at the community level enhance skills of a trained community person can do great wonders and deliver non-specialist treatment which are very helpful in treating mentally ill. 38% mentally ill persons were encouraged by family members to start work. 62% were encouraged by community health workers. Many studies have proved that training of lay worker is of much important is poorly resourced setting where specialists treatments cannot be continuously provided. The role of CHW and its effectiveness can also be observed that information about mental health in the program was impacted by a community health worker.
- The community health worker is an important link between specialist and the PWMIs and the caregivers. 48% CHW, 14% community people, 12% family members and 16.7% friends provide information about the CMHD program it shows that all the people in the community aware about the community mental health and development program implemented in their area. Community health workers played role as “life line” in the life of PWMIs and their families.
- The major finding from the study shows that all the people said that the community mental health and development program is very useful for life of the person with mental illness and caregivers and also the family and community from different dimensions which including treatment, medication, counselling and livelihood support for the better rehabilitation in the community. Among them 53.3% person with mental illness got free treatment, concealing, and regular follow up and also livelihood support under the CMHD program.
- Finding from the study shows that 40.7% females were participated in the community meetings under the CMHD program. 59.3% males participated in the community meeting. 75.3% male and female both are participated two-three times in the community meetings and 24.7% male and female participated more than three times in the community meetings. (Pearson chi-square =.567, df= 1, No. of valid cases = 150, Contingency Coefficient = 0.061, $P<0.05$). It is evident from the stated p-value that women are more participatory. Its shows that most of the people from the community

well accommodate in the various activities of the program and they were voluntarily participated in the awareness meetings more number of times.

- The findings from the study shows that out of the total identified 75.3% PWMIs were participated two-three times in the community meetings and 24.7% PWMIs participated more than three times in the community meetings. The participation of people with mental illness in community and social activities was comparably more therefore they feel the CMHD program is useful for them in many aspects and specifically increasing community support. The findings from the study with significance in the p-value shows that out of the total identified 75.3% PWMIs were participated two-three times in the community meetings and 24.7% PWMIs participated more than three times in the community meetings. (Pearson chi-square = 2.485, df= 3, No. of valid cases = 150, Contingency Coefficient = 0.128, $P<0.05$) The participation of people with mental illness in community and social activities was comparably more therefore they feel the CMHD program is useful for them in many aspects and specifically increasing community support.
- Overall majority which is 61.3% caregivers feel that the 100 percent impact they have seen through CMHD program in the life of PWMIs. 62 % person with mental illness has been improved up to large extent and 38 percent of them improved up to some extent. The community mental health and development program is highly impacted in the lives of mentally ill person as well as in their families and also in the community. (Pearson chi-square = 4.368, df= 3, No. of valid cases = 150, Contingency Coefficient = 0.128,$P<0.05$). The community mental health and development program is highly impacted in the lives of mentally ill person as well as in their families and also in the community.
- The model was well received in terms of its programs and people who have benefitted are highly satisfied to a great extent. Great impact as 62% state the same. 38% opine that the program was impacted well to some extent. The community mental health program most of the components are fulfil the needs and basic rights of mentally ill person therefore community participation and ownership is much more than any other program it reflects into impact of the program in the community.
- Finding from the study shows that 46.7% PWMIs were said that 'We received better treatment and recovered from mental illnesses' and started working because of the community mental health and development program. 31.3% PWMIs said that the program is useful in the tribal area where general health care services are not

functional well. Overall the major findings from the study that mental health services should be community driven rather than institutionalizing it. Community mental health program helps not only PWMIs in terms of treatment but also helpful for creating awareness in the community and reduce stigma and discrimination which mentally ill person and their families faced in the community.

- Findings from the study shows that overall, the entire respondent expressed the effectiveness of community mental health program. This program established psychiatrist services in the tribal area and that services were made available free of cost which reflects in the life of mentally ill person. 25.3% mentally ill person said that they have started living normal life, 28.7% opined that without this program we were rooming in the villages like animals but after CMHD program and their treatment is exceptionally useful in terms in providing a sense of dignity of human lives.

Recommendations:-

The above findings of the CMH&D of Maharashtra program clearly brings out that this model is functional and hence valuable in reaching the tribal, rural and urban socio-economic groups of PWMI with considerable success. This is a pointer to take this tested functional model to areas other than those already covered.

In the process of implementation and from the findings of the study consolidating the data it was found that certain program areas are strong and certain other areas need further strengthening. Based on these strengths and needs the following recommendations are made:

- The young adult age group is a productive age group who has higher prevalence of mental illness; therefore it is highly recommended that all the mental health program should be address the psychological needs of these age groups.
- The CMH&D program study findings show that the approach is developmental and that the program is also gender-sensitive. These are fundamental strengths of the program and it should be ensured that these strengths are kept alive in future programs as well.
- It is highly recommended that CMHD program should focused on vulnerable population in the community like…unemployment, illiterate, dalits, tribal, marginalized communities, farmers who have debt ...etc.

- Women played a major role in the family as a care provider but their productive contribution not accounted as like domestic work therefore it suggest that identify the needs of women care providers and appropriate support system should be develop to address their needs with gender sensitive manner.
- Strengthen the concern for the mental health of women and girls who bear a disproportionate responsibility for care-giving despite being disadvantaged by gender bias and access to educational and income producing opportunities. Keeping mothers of young children mentally healthy and physically safe is perhaps one of the single most powerful interventions to reduce mental illness and to increase resilience. Simultaneously, it is important to address the psychosocial and health needs of older persons who are also often in care-giving roles.
- It is also recommended that caregivers group should be treat one of the main pillar in the treatment of mentally ill person therefore their involvement in the treatment process helps PWMI to recover fast from the illness.
- It is important to promote case management services for the continuity of care for PWMI in reducing chronicity of illness and caregivers who experience tremendous levels of burden.
- It is recommended the component of 'livelihood' activities especially through developing occupational skills and becoming active members of SHGs be strengthened through analysis of already existing information from the program experience, gaining insights and putting these insights into the program planning. The livelihood component needs to look as a treatment part rather than economical part.
- Finding from the study shows that SMDs need long term treatment than the CMDs therefore it is suggested that continue and long term treatment facility should be made available to the people suffering from severe mental illness.
- In the initial stage of mental illness most of the people taken treatment from faith healers, general practitioners therefore it suggest that faith healers and general practitioners should be involved in the mental health program as a main community stakeholder at the community level and build their capacity to deliver psychosocial intervention in the patient friendly manner. First level of treatment they can provide like mental health first aid or psychosocial treatment. In the server mental illness they will refer the patient to psychiatrist.
- It was found that program included both persons with severe mental illnesses (such as schizophrenia, psychosis and bipolar affective disorder) and also persons with minor

mental disorders (such as anxiety and depression). Formation of a program environment that brings in all those who need the services within their own familiar area of living is crucial for the success of the program. This is again a basic principle of the program that was in focus and this needs attention in all the future programs as well.

- It is also suggested that the mobile psychiatrist services will be helpful in the remote rural and tribal areas.
- 'Mental illness is treatable' this massage needs to spread widely in the community through mental health education in both the stream of education that is informal and formal education.
- It is highly recommended that Counselling and medicines are the most effective treatment in the mental illness. Only psychotropic drug not solved the purpose. Therefore both should be promoted and more emphasized on counselling treatment.
- It is highly recommended that government mental health units should recruit community health workers that provide an environment equivalent to that provided by the "traditional healers".
- It is highly recommended that mental health should be integrated with other aspects in the health field at the level of planning to avoid its neglect in planning.
- It is highly recommended that drugs for mentally ill patients should be made available free of charge or at subsidized prices by government as it is done for drugs of TB or HIV/AIDS.
- Psycho social issues and needs of caregiver and their PWMI have vast scope for research. The results of which would help researchers in sensitizing policy planners, media and the public for legislating and advocacy of services.
- Recovered people with mental illness and their caregivers should be consulted by at least few members of the Annual Planning Committee of the Health Directorate to plan related services.
- All people with mental disorders have the right to receive high quality treatment and care delivered through responsive health care services. They should be protected against any form of inhuman treatment and discrimination.
- Psychiatric services should be made available and decentralized in the Rural and Tribal Public Health System-sub taluka, divisional hospitals, District hospitals, Sub-health centers and secondary and tertiary hospitals.

- Working intensely with partner organizations has been a valuable experience. In this specific experience so far, it was mainly working with Community Based Organizations (CBO) with CBR focus for cross-disability. It is recommended that organizations in the fields of disability, health and development interested in including mental health component in their existing programs.
- Free psychiatric medicines should be provided in the above centers as per WHO norms. (According to the Health Directorate there are supposedly 17 types of medicines available, but only 6 to 7 types of medicines are actually supplied.)
- It's tough enough managing a severe mental illness. So things to do to help maintain stability- good regular sleep patterns and eating healthy scheduled meals will go a long way. If you take medication, take it at the times prescribed by your doctor and mental health professionals recommended staying away from alcohol and drugs, don't make hasty life changing decisions like suddenly quitting your job, moving away from family or friends, or buying something you always wanted but can't afford.
- Caregiver burden and burnout are important, prevalent and preventable. Social workers aware of the symptoms and signs can better assess, identify, prevent and intervene in these situations. Such efforts result in improved quality of life for both patients and Caregivers.
- Early intervention could result in reduction in morbidity and better quality of life for the patients and their families.
- Treatment is focused primarily on the management of symptoms with drugs. Rehabilitation and psychosocial intervention are frequently neglected and rarely available in the rural and tribal area therefore government should fully adopt community mental health and development model and ensure the effective implementation of it.
- Caregivers with PWMIs are encouraged not to isolate them because this act encourages the community to do likewise. Instead, they should handle them as other members of the family.
- Community members should be encouraged to handle PWMIs as fully human beings because this gesture contributes to the gradual healing process of these people. PWMIs, then, attend and participate in community events. This role could be served by civil society organizations operating at the community level in the mental health field.

- In rural and tribal settings stigmatization comes from differences in tribe and culture and therefore there is a need to use forums that unite people to bring messages of PWMIs, for example, worshipping communities and local councils.
- The effort of training volunteers at the local level in mental health education needs strengthening so that they help people at this level to understand issues related with PWMIs.
- Government needs to put in place a law to protect PWMIs so that those families or community members who mishandle them are dealt with consequently. This law should criminalize those acts which dehumanize PWMIs. The law should also recognize the roles and responsibilities of different stakeholders in the management of mental health.
- PWMIs are fully respected as human beings. They are involved in the decisions that affect their health and life; consultations with attendants are made about the treatment of their patients and are involved in productive activities. These best practices need to be scaled up and taken on by whoever is involved in the mental health field.
- There is a need to always organize meetings that bring together members of the community and PWMIs to share experiences. Such meetings can be organized by the users associations or volunteers trained for that purpose.
- All medical officers should be trained on mental health / illness and inpatient services should be made available at all district hospitals.
- Patient-friendly environment needed at the hospitals where psychiatric services provided.
- The long-term mentally ill should be made the highest priority in public mental health and a comprehensive system of care that recognizes their heterogeneity needs to be established.
- Regularity in undergoing treatment on the part of the PWMI with severe mental illness leading to stabilization, monitoring side-effects of medicines, relapse of symptoms, following-up with necessary action to keep these adverse effects minimal were considered the effects of a strong capacity building input in CMH&D program especially for care-givers, field personnel and the community groups. It is recommended that a resource team in training stake holders and partner organizations should form the core of BNI as training at different levels visualized and implemented in the current program have contributed to the success of the program.

- It is also recommended that training materials should be developed on the basis of the rich program experiences, in the form of Handbooks or Manuals for use with Senior Development Practitioners, field staff or grass root level workers.
- It is recommended that necessary steps be taken to include tools for collection of basic data and information and also strengthen the skills of the staff in this regards.
- It is also recommended that for enabling development of the required skill in documentation incorporating in training programs of the field-staff.
- One of the most effective ways to positively affect attitudes is to deliver appropriate messages that will vibrate with target audiences, encourage the public to recognize, acknowledge and release their own problems or those of family members, and provide information that will help the audience to access help. These kinds of initiatives create greater acceptance for conditions and their treatments. One-on-one communication approaches will be effective in creating greater public understanding and reducing stigmatization.
- Training programs are needed to raise awareness of the experience of mental illness, sensitize to stigmatizing behaviors, and provide direction to creating more accommodating environments.
- The stigmatization of people with mental health problems are policies which are not supportive of recovery and which contribute to the resulting stigmatization. We need a supportive policy framework which ensures the provision of income support, housing, employment, court diversion programs and an accessible and comprehensive treatment system.
- The community based services should emphasize on community acceptance, family involvement, and social integration and livelihood opportunities as a key component of interventions while rehabilitating people with mental disorders. Similar approach is required for PWMI for integrating them in to the community. An approach, where in medical inputs are seen as a part of a larger whole including income generation and mainstreaming individuals with mental health problems into the community.
- There is a need to robust partnership between government, communities and civil society organizations in order to put in place a psycho-social support and conflict resolution systems that would address the causes of mental illness in rural and tribal area of Maharashtra.

- The role played by some civil society organizations in Maharashtra in the mental health field needs to be further strengthened because they have been able to show that mental illness is a curable disease contrary to earlier beliefs.
- Government needs further encouragement in its efforts to recruit mental health specialists at the local level so that they can handle mental health related issues.
- Disability certificates should be provided for all eligible mentally ill and s/he should get an acknowledgement whenever an application is made.
- Community mental health workers should be appointed based on the population of the area.
- Police and judicial officials should be given orientation on mental health issues, services and related Acts.
- Provide job opportunities for the recovered or stabilized mentally ill persons.
- Policies and programs are needed which strengthen the ability of caregivers to effectively provide services and empower PWMIs, families and the communities.
- More prominence on Social Action which is one of the least used Social Work methodologies, in practicum and field work training, is necessary in addressing social issues and problems like human rights violation, stigma, lack of appropriate service, high costs of treatment modalities etc.
- Promoting and establishing Self-Help Groups (SHGs) and self-advocacy building measures, which in turn reduce dependency of Caregivers on the limited human resources resulting in greater empowerment of Caregivers.
- Emphasis and importance on Social Policy and Social Legislations at the course curriculum level, to address medico-legal issues, advocacy rights, benefits accruing from legislations, coordinating with judiciaries, participating in the policy making bodies, creating awareness in the lacunae in the existing laws and creating awareness for amendments for the same. Effective implementation of all legislative measures through caregiver forums.
- WHO (2008) in collaboration with the World Association of Family Doctors brought out a detailed document on how to integrate mental health into the PHC system. Governments make necessary changes in order to integrate mental health into the PHC system.
- The government, public sector, private sector, voluntary sector, families, committed individuals and affected persons need to come together as a broad federation on a common platform.

- Include mental health issues within social services development. Establish strong linkages between social services such as housing, health and mental health services.
- Mainstream mental health issues into education. Ensure that educational opportunities are both available and accessible, and that social barriers that might prevent children with mental and psychosocial disabilities from attending school are removed.
- Include people with mental health conditions in income generating programs. Employment programmes and other poverty alleviation initiatives such as small business grants and social security must reach out to people with mental health conditions.
- Strengthen human rights protections. Using the UN Convention on the Rights of Persons with Disabilities, highlights the need to develop and implement policies and laws that promote the rights of persons with mental and psychosocial disabilities, including the rights to autonomy, liberty, to exercise legal capacity and to live independently and be included in the community.
- Build the capacity to participate in public affairs. Promote and support the development of civil society groups for people with mental and psychosocial disabilities and facilitate their participation in decision-making processes including policy, planning, legislation and service development.

- It is recommended that the 'advocacy' component should be further strengthened through building in strategies for advocacy with up-dated relevant information such as relevant legislations (Acts), UNCRPD and allocation of Government resources and orienting the partner organizations and primary stakeholders.
- It is also recommended to orient and network with departments like NRHM, DMHP, disability, revenue and judiciary etc...
- It is recommended that concerted efforts should be made in building and strengthening primary stake holders, namely, PWMI, care-givers and cross-disability federations especially in terms of providing follow-up care, accessing social entitlements, advocate for their rights and linking them to relevant mass movements such as mass disability groups, health movements, tribal, dalit and women's movements and concerned district and state level government departments and officials.
- It is recommended that BNI and other civil society organizations to take measures to inform funding agencies about CMH&D program experiences and underline the urgent need to include 'mental health' as one of the priority areas.

Chapter-7.

Appendixes

I. **Bibliography**:

1. A Report on Health Inequities in Maharashtra, by SATHI January (2008).
2. Achieving the Millennium Development MDGs: Does Mental Health Play a Role? PLoS Medicine.
3. Alan Brymanmm, Social Research Methods, Oxford University Press (2004).
4. Amin,G., Shah,S., and Vankar, G.K. The prevalence and recognition of depression in primary care, Indian Journal of Psychiatry, (1998); 40:364-369.
5. Anant Kumar. District Mental Health Programme in India: A Case Study, Journal Health & Development, (2005); 1:24-35.
6. Basic Needs, Impact Report (2008).
7. Bhargavi V Davar Deepara Dandekar, Women and Mental Health a beginning, Pune (2002).
8. Bhore, J.Health Survey and Development Committee.(1946); Government of India. New Delhi.
9. Bradshaw D, Norman R, Schneider M. A clarion call for action based on refined DALY estimates for South Africa. Editorial, South African Medical Journal (2007); 97:438-40.
10. Byrne, P, (1997), "Psychiatric Stigma: Past, Passing and to Come", Journal of the Royal Society of Medicine, P. 90.
11. Byrne, P, (2000), Stigma of Mental Illness and Ways of Diminishing it: Advances in Psychiatry Treatment, P. 65-72.
12. Carastairs G.M.(1974) In community action for mental health care. WHO/SEARO MENT/22: (1974).
13. Chandrasekhar, C.R., Issac, M.K., Kapur, R.L., Parthasarathy, R. Management of priority mental disorders in the community. Indian Journal of Psychiatry, (1981); 23,

14. Chang, H. Y., Chiou, C. J. & Chen, N.S. (2009). Impact of mental health and caregiver burden on family caregivers' physical health. Arch Gerontology Geriatric. May 12.
15. Chappell, N. and L. Funk (2004) ‘Lay perceptions of neighborhood health.’ Health and Social Care in the Community.
16. Chisholm, D., Sekar, K., Kishore Kumar, K., Saeed, K., James, S., Mubbashar, M., and Srinivasan Murthy, R. Integration of mental health care into primary health care: Demonstration cost-outcome study in India and Pakistan, British Journal of Psychiatry, (2000).
17. Community Mental health News, District Mental health Programme, (1988), Issue No.11 and 12, 1-16.
18. Corrigan PW, Markowitz FE, Watson AC. Structural levels of mental illness stigma and discrimination. Schizophrenia Bull (2004).
19. Crisp, A. H, (1999), "The Stigmatization of Sufferers with Mental Disorders" British Journal of General Practice.
20. Deborah, W Reidy, (1993), "Stigma is a Social Death", Mental Health Consumers
21. Director General of Health Services (DGHS). (1990). National Mental Health Programme: A Progress Report (1982–1990), New Delhi: DGHS.
22. Features of Mental Disorders - A Folder ICMR Centre for advanced research on Community Mental Health. Department of Psychiatry, National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore (India). (1987).
23. Gautam,S., Kapur, R.L., and Shamasundar, C. Psychiatric morbidity and referral in General Practice. Indian J. of Psychiatry, (1980).
24. Gender and women's mental health factsheet. Geneva, World Health Organization. Accessed 15 August (2010).
25. Government of India. Implementation of National Mental Health Programme during the Eleventh Five Year Plan-approval of the manpower development component, Ministry of Health and Family Welfare, New Delhi.Dtd.24 April (2009).
26. Government of India. In Annual report, National Mental Health Programme for India. 2000 Ministry of Health and Family Welfare, New Delhi.
27. Government of India. National Mental Health Programme for India. Ministry of Health and Family Welfare, New Delhi.(1982).
28. Indian Council of Marketing Research, Evaluation of District Mental health Programme-final report, (2009), New Delhi.

29. Indian Council of Medical Research. Department of Science and Technology (ICMR-DST). A collaborative study of severe mental morbidity. Indian Council of Medical Research, New Delhi, (2005).
30. Indian Journal of Community Medicine Vol. XXVII, No.4, Oct.-Dec., 2002 Moving away from Mental Institutions-towards Community Mental Health Care.
31. Integrating mental health into primary care: A global perspective. Geneva, World Health Organization, 2008. Miranda JJ, Patel V. (2005)
32. Isaac, M.K. (1988). 'Bellary District Mental Health Programme', Community Mental Health News, 11 & 12, ICMR-CAR on Community Mental Health, NIMHANS, Bangalore.
33. Janardhan & Bitopi, Introduction to India and Mental Health in India, 5th edition of E-Journal, Mental Health and Development (2006).
34. Janardhan and Naidu (2007) Mental Health in India: an over view, CHC publication, circulated during national assembly on health of Janaarogya Andolona.
35. Janardhan and Naidu (2006), Community Mental Health and Development model evolved through consulting PWMI in Mental health by the people Edited by Murthy (2006).
36. Janardhana, N. & Shravya Raghunandan, Caregivers in Community Mental Health – A Research Study, Basic Needs India, Bangalore (2008).
37. Kay, A. (2006) 'Social capital, the social economy and community development.' Community Development Journal.
38. Kumar N. Development in Mental Health Scenario: Need to Stop exclusion - Dare to Care. ICMR Bulletin Vol 31, No. 4 April 2001 Division of Publication and Information, ICMR, New Delhi.
39. Kumar, Anant. (2002). 'Mental Health in India: Issues and Concerns', Journal of Mental Health and Ageing.
40. Luktuke Ulhas, Divided Mind- A Handbook of Schizophrenia, Schizophrenia Awareness Association Pune (2004)
41. Maya Thomas and M.J. Thomas (2003) Manual for CBR planners, Asia pacific Disability Rehabilitation Journal.
42. Mental health and development: Targeting people with mental health conditions as a vulnerable group. Geneva, World Health Organization, (2010).
43. Mental health aspects of women's reproductive health: A global review of the literature. Geneva, World Health Organization, (2009).

44. Mental Health Atlas 2005, World Health Organization, Geneva (2005).
45. Mental Health Manual for Health Workers ICMR Centre for advanced research. NIMHANS Bangalore – (1990).
46. Mental health research in India, Technical Monograph on ICMR Mental Health Studies. New Delhi: Indian Council of Medical Research; (2005).
47. Mental health, poverty and development. Discussion paper presented on 8 July 2009 at the 2009 ECOSOC High-level Segment Ministerial Roundtable Breakfast Meeting on Addressing non-communicable diseases and mental health: Major challenges to sustainable development in the 21st century. Geneva, World Health Organization.
48. Mental Health: Facilitator's Manual for Training Community Health Workers in India. Basic Needs India (2008).
49. Miranda JJ, Patel V. Achieving the Millennium Development Goals: Does mental health play a role? PLoS Med. (2006); 2: e 291. doi: 10.1371/journal.pmed.0020291
50. Mudaliar, A.L. Health Survey and Planning Committee, Government of India, New Delhi. (1962).
51. Nagaraja, D. Mental Health Care and Human Rights, National Human Right Commission & National Institute of Mental Health and Neuro Sciences, Bangalore (2008).
52. Naidu, D.M. Putting People First, Basic Needs India, Bangalore (2006).
53. Naik, Naik,A.N., Parthasarathy,R. and Issac, M.K. Families of rural mentally ill and treatment adherence in district mental health programme, International Journal of Social Psychiatry, (1996).
54. National Health Policy (2002). MOH&FW, GOI, New Delhi.
55. National Mental Health Programme for India. Recommendations of the Central Council of Health and Family Welfare (1982).
56. Pai. S, Kapur RL. The burden on the family of a psychiatric patient; development of an interview schedule. British Journal of psychiatry (1981).
57. Patel V, Kleinman A. Poverty and common mental disorders in developing countries. Bull World Health Organ (2003); 81: 609-15.
58. Patel V, Thara R, editors. Meeting mental health needs in developing countries: NGO Innovations in India, Sage (India), New Delhi, (2003).
59. Patel, V. Explanatory models of mental illness in sub-Saharan Africa. Soc. Sci. Med (1995) May; 40(9):1291-8.

60. Patel, V. The need for treatment evidence for common mental disorders in developing countries, Psychological Medicine, (2000).
61. Patel, V., Pereira, J., Fernandes, J. and Mann, A. Poverty, psychological disorder and disability in primary care attenders in Goa, India. British Journal of Psychiatry, (1998).
62. Persons with Disabilities Act, 1995.
63. Phadke Kamlini, A Beautiful Mind (Marathi translated), Schizophrenia Awareness Association Pune (2005).
64. Pinfold V et al. Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. British Journal of Psychiatry, (2003).
65. Poster, R, (1998), "Can the Stigma of Mental Illnesses be Changed?", pp.1049-I050.
66. Prathima Murthy (1998) Manual of mental health care for women in custody, Department of psychiatry, National Institute of mental health and Neuro sciences
67. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. (2007) No health without mental health. The Lancet. 370:859-877.
68. Published by Basic Needs and the Nossal Institute for Global Health (2009).
69. Raja S, Gibson K, Sunder U, Kermode M, Mannarath S, and Devine A: An Introduction to redistribution of tasks among health workforce teams (2008)
70. Raja S: Practice of Community Mental Health: Seven Essential Features for Scaling Up in Low and Middle Income Countries (2009), Basic Needs.
71. Ramesh Godbole, Mental Health (Marathi) Pune (2006).
72. Ramesh S. Manual on Living Skills Training For the Chronic Mentally Ill, National Institute of Mental Health And Neuro Sciences. Bangalore (1997).
73. Realizing the Millennium Development Goals for persons with disabilities through the implementation of the World Programme of Action concerning Disabled Persons and the Convention on the Rights of Persons with Disabilities, 2008. Report of the Secretary-General. Sixty-third session of the General Assembly, United Nations, (2009).
74. Report of National Workshop on undergraduate Medical Education in Mental Health (sponsored by WHO) December 22-24, 1985. Edited by Dr. Mrs. S. Trivedi and Co-edited by Dr. D.K. Srinivasa - JIPMER Pondicherry India.
75. Review of Mental Health Uganda Field Reports, (2003-2005).

76. S.Pruthvish (2006) Community Based Rehabilitation of persons with Disabilities, Jaypee publishers
77. Sartorius N. Stigma and mental health. Lancet 2007 Sep 8; 370(9590):810-1.
78. Saxena FD, and Andrew G: Barefoot Counselling: A Manual for Community Workers. published
79. Shantna Kumari,. Mishra, S. N., Chaudhury, S., Singh, A. R., Verma, A. N., and Sangeeta Kumari (2009). An experience of community mental health program in rural areas of Jharkhand. IInd Psychiatry J. Jan-Jun; 18(1): 47-50.
80. Shobha Raja. The Way I Have Recovered, Basic Needs India, Bangalore.
81. Shrinivas, R. Murti. Mental Health for Health workers, National Institute of Mental Health And Neuro Sciences. Bangalore (1990).
82. Srinivasa Murthy, R Status Paper on delivery of mental health services in India (1947-1987) Indian Council of Medical Research, New Delhi.1987.
83. Srinivasa Murthy, R. (1986). A decade of rural mental health care. Bangalore: NIMHANS.
84. Srinivasa Murthy, R. (1987). Status paper on delivery of mental health services in India (1947-1987). New Delhi: Indian Council of Medical Research.
85. Srinivasa Murthy, R., Kaur, R., and Wig. N.N. Mentally ill in a rural community: Some initial experiences in case identification and management, Indian Journal of Psychiatry, (1978).
86. Thara, R., Padmavati, R., Aynkran, R.A., John, S. Community mental health in India: A rethink, International Journal of Mental Health Systems, (2008).
87. The Convention on the protection and Promotion of the Rights and Dignity of Persons with Disabilities Simplified text May (2007).
88. The global burden of disease: 2004 update. Geneva, World Health Organization, (2009).
89. The Rights of Persons with Disabilities Bill, 2011
90. The world health report: 2001: Mental health: New understanding, new hope. Geneva, World Health Organization, (2001).
91. Thorneycroft G, Tansella M, eds. The mental health matrix: a manual to improve services. Cambridge, Cambridge University Press, (1999).
92. UNFPA emerging issues: Mental, sexual and reproductive health. New York, UNFPA, (2008).

93. Vaddadi KS. Burden of care in the home: issues for community management. Advances in Psychiatric Treatment (1997).
94. WHO and World Organization of Family Doctors, Integrating Mental
95. WHO. Integrating mental health into primary health care- a global perspective, WHO-WONCA, Geneva, (2009).
96. WHO. Setting the Agenda for Mental Health, WHO/MNH/99.1, (1999).
97. WHO. The World Health Report 2001 - Mental Health: New understanding New Hope.
98. WHO. World Health report 2001-Mental health-New understanding, new hope, Geneva. (2001).
99. WHO.ICD-10: Diagnostic and management guidelines for mental disorders in Primary Care-ICD-10 Chapter V. Primary care Version. Hogrefe and Huber, Bern. (1996).
100. World development report 2002: building institutions for markets. Washington, DC, World Bank, (2002).
101. World Federation of Mental Health (WFMH) World Health Day (2009).
102. World Health Organisation, Mental Health Gap Action Programme (2008)
103. World Health Organisation, UNAIDS and PEPFAR: Treat, Train, Retain: Task Shifting Rational.
104. World Health Organisation, World Health Report: Changing History (2004)
105. World Health Organisation, World Health Report: Mental Health, New Understanding New Hope (2001).
106. World Health Report (2006), working together for health Geneva, WHO

II. Weblography:

1. http://www.righttofoodindia.org/orders/ 2006dec135corder.doc.
2. http://apps.who.int/gb/ebwha/pdf files/WHA66/A66 R8-en.pdf
3. http://whqlibdoc.who.int/publications/2009/9789241563567_eng.pdf
4. http://www.dinf.ne.jp/doc/english/asia/resource/apdrj/213jo0300/z13jo0310.html
5. http://www.nesf.ie.
6. http://www.un.org/disabilities/documents/who.desa.
7. http://www.unfpa.org/public/global/pid/910
8. http://www.who.int/entity/nmh/publications/discussion_paper_en.pdf
9. http://www.who.int/healthinfo/global_burden_disease/estimates_regional/en
10. http://www.who.int/healthinfo/global_burden_disease/estimates_regional/en/index.html
11. http://www.who.int/mental_health/media/ investing_mnh.pdf.
12. http://www.who.int/mental_health/policy/
13. http://www.who.int/mental_health/policy/development/en/index.html
14. http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf
15. http://www.who.int/mental_health/prevention/genderwomen/en/
16. http://www.who.int/whr2001/2001/main/en.
17. www.basicneeds.org/download/mental%20health%20manual%20for%20training%20CHWs.pdf
18. www.mentalhealthngo.org
19. www.mentalhealthngo.org
20. www.stigma.org
21. www.sangath.com/publications/pub%20pddf/BFCMain-web.pdf

III. Interview Schedules

A. Interview Schedule for PWMI

PWMI: Personal details:

Q.1.Name……………………………………………………………………………………..

Q.2. Age: 1. 18 to 27 years 2. 28 to 37 years 3. 38 to 47 years

4. 48 to 57 years 5. 58 and above

Q.3. Sex: 1. Male 2. Female

Q. 4. Case Category: 1. ST 2. SC 3.OBC 4. Open

Q. 5. Religion: 1. Hindu 2. Muslim 3.Buddhist 4. Other

Q.6. Qualification: 1. Primary 2. Secondary 3. Higher Education 4. I.T.I

Q.7. Occupation: 1. Agricultural 2. Daily wage Labour 3.Household work
4. Not working 5. Private Job 6. Government job

Q.8. Income: 1. Less than Rs. 6000 2. Rs.6000-12000
3.Rs. 12000-18000 4.Rs. 18000-24000
5. More than Rs.24, 000

Q.9. Number of earning members in the family: 1. 2 2. 3 to 5
3. More than 5

Q.10. Marital status: 1. Unmarried 2. Married 3. Widowed
4. Deserted 5. Divorces

Q.11. Type of family: 1. Nuclear 2. Joint 3. Separated

Q.12. Number of member in the family: 1. 2 2. 3to 5 3. More than 5

Q.13. Number of years of illness: 1. Less than 1 year 2. 1 to 3 years
3. 4 to 7 year 4. More than 7 years.

Q.14 Type of illness diagnosed: 1. CMD 2. SMD

Q.15. Duration of treatment: 1. Less than 1 year 2. 2 to 4 years
3. 5 to 7 years 4. More than 7 years

Q.16. How long was it highly symptomatic:
1. Less than 2 months 2. 2 to 6 months
3. 7 months to 1year 4. More than 1 year

Q.17. Since how many years/months has stabilized?
1. Less than 2 months 2. 2 to 6 months
3. 7 months to 1year 4. More than 1 year

a) Treatment needs:-

Q.18. what do you think causes your mental illness?
1. Evil spirit 2. Black Magic
3. Hereditary 4.Stressful life 5. Don't know

Q.19. How long has you been sick?
1. Less than 1 year 2. 1 year to 3year
3. 3year to 5 year 4. More than 5 year

Q.20. When you started to fall ill, what action did you take at that time?

1. Nothing 2. Home Remedies 3. Faith Healer
4. General Doctor 5. Psychiatrist

Q.21. Who did you seek help/advice from?

1. Friends 2. Family members' 3.Community members
4. Other Relatives 5. CHW

Q.22. Where did you seek for treatment at the time?

1. Faith Healer 2. Spiritual Healer
3. General Doctor 4. Psychiatrist

Q.23. While and after that treatment, how was your illness condition?

1. Better 2. Quite better
3. Not improved 4. Become worst then previous

Q.24. For those that did not get better after the treatment, what further action did you take?

1. Find out other option 2. Change the doctor & Medicines
3. Local medicines 4. Nothing

Q.25. Who has given you suggestion of where to seek mental health treatment?

1. Friends 2. Family members 3. Community member
2. Other Relatives 5 . CHW 6. General Doctor

b) Spiritual Healers

Q.26. Have you ever seen spiritual healers for treatment?

1. Yes 2. No

Q.27. Which spiritual healer did you see?

1. In the Community 2. Outside the Community

Q.28. What kind of treatment did the spiritual healers practice toward your illness?

1. Pray to God 2. Herbal Powder 3. Tabij

Q.29. Comparing between spiritual healer and medical doctor in the hospital, who do you feel most comfortable to see when it comes to consultation about your mentally illness?

1. Spiritual Healers 2. Psychiatrist

c) The impact of illness to you and your family

Q.30. How is your daily life now when you have to live with mental illness?

1. Good 2. Better 3. Worst

Q.31. How the illnesses affect you as well as your family?

1. Financially week 2. Increase stressor factors
3. Personal & Social relationship gets affected.

Q.32. Who is most affected? 1. Family members 2. Self

Q.33. Any impact on following areas?

1. Family income 2. Social life
3. Health condition of family members 4. Livelihoods

d) Coping with Illnesses

Q.34. How have you been coping with your illness?

1. By regularly taking Medicines 2. Working in the farm
2. Do things which you like

Q.35. Who has given hands or advices to you?

1. CHW 2. Family 3. Friends

Q.36. What type of advice/or help did you receive?

1. Take regular medicines 2. Do things which you like

Q.37. Does the community knows about your illness?

1. Yes 2. No 3. Don't Know

Q.37.1 If yes, how did they know?

1. Friends 2. Neighbor

Q.38. Do you wish that the community would not know about your illness or do you prefers them to know?

1. Community would not know 2. Community would know 3. Don't Know

Q.39. Through our experience, some family tied or hid the mentally sick persons, what do you think why did not they take her/him to hospital?

1. Due to stigma 2. Misconception about mental illness
2. Illiteracy about mental illness

Q.40. What do you think about mentally sick persons?

1. Disgraceful 2. Harmful 3. Violent

Q.40.1 could you please tell us why? ---

Q.41. Because of mental illness which impact did you and your family feel?

1. Discriminated 2. Not Discriminated

Q.42. what type of fear do you have from the community?

1. Discrimination 2. Boycott

Q.43. How this fear has impact on social life or meeting new people?

1. Feeling 2. Career 3. Study (if you are studying)
4. Finding spouse 5.Social inclusion

Q.44. which discrimination had your family been concerned?

1. Social 2. Economical 3. Behavioral

e) Religious Roles

Q.45. Any other treatment has been ever taken by you?

1. From Temple 2. Religious or Holy person 3. Spiritual Hiller

Q.46. Who talked or gave you an advice at the temple?

1. Friends 2. Family members 3. Community members

Q.47.Which temple did you seek help?

1. God 2. Goddess 3. Darga

Q.47.1 what did s/he gave you?

1. Medicines 2. Herb 3. Any other(specify)_______________

f) Livelihoods

Q.48. Generally how is your livelihood condition now?

1. Mild 2. Moderate 3. Sever

Q.49. What do you do for a living?

1. Labour 2. Farmer 3. Agricultural Labour
2. Any other_______________

Q.50. What causes you not to be fully productive, or could not find a job or cannot work actively?

1. Low concentration 2. Poor physical condition

Q.51. How have you tried to cope with livelihood difficulty?

1. Started with small things 2. Handholding with other

Q.52. Who have helped you finding job or doing productive work for living?

1. Family member 2. Friend 3. CHW

Impact Assessment:-

Q.53. How do you get information about the Basic Needs programme?

1. Village health worker   2. Relatives

3. Friends   4. Doctors

Q.53.1 Was it of any benefit?   1. Yes   2. No   3. Not Applicable

Q.53.2 Which kind of benefit?   1. Free treatment   2. Counselling

3. Other_______________

Q.54. What kind of help did the program staff offered?

1. Home visit   2. Take to Psychiatrist

3. Emotional support

Q.55. How frequently did you attend Mental Health Camp?

1. Regularly on Monthly basis   2. Once in two months

3. Once in a three Months

Q.56. Where you referred for the treatment?

1. Mental Hospital   2. District Hospital   3. Private Psychiatrist

Q.56.1 Explain the benefit____

Q.57. Who was visited from the organisation at your home?

1. CHW   2. Field Supervisor   3. Program coordinator

Q.55. How many group meetings you have attended organised by the organisation?

1. One   2. Two- Three   3. More than three

Q.55.1 How it was benefited?---

Q.56. Did you get any Vocational training organised from the organisation?

1. Yes   2. No

Q.57. What kind of Vocational training?--

Q.58. Are you a member of any groups of the organisation?

1. SHG 2. Farmers group 3. Women group 4. Other.

Q.59. Did you get any loan/credit? 1. Yes 2. No

Q.59.1 From where you get the loan/credit?

1. Organisation 2. From village groups (SHG)

3. Other__________________________

Q.59.2 How it was benefited? --

Q.60. Have you received any benefits from government?

1. Disability Certificate 2. Disability schemes (Specify)

3. Other govt. schemes (Specify)

Annexure: III- B

Interview Schedule for Caregivers

Carer(s): Personal Details

Q.1. Name

Q.2. Age: 1. 18 to 27 years 2. 28 to 37 years 3. 38 to 47 years

4. 48 to 57 years 5. 58 and above

Q.3. Sex: 1. Male 2. Female

Q.4. Marital status:

1. Single 2. Married 3.Divorced

4. Deserted 5. Widowed

Q.5. Educational Qualification:

1. Primary 2. Secondary

3. Higher Education 4. I.T.I

Q.6. Occupation: 1. Labour 2. Agriculture Labour 3. Farming

4. Private Job 5.Government job 6.Domestic work 7.N.A.

Q.7. Relationship with the person with mental illness:

1. Mother 2. Sister 3. Brother 4. Father

5. Uncle 6.Wife 7.Husband 8. Other________

Q.8 No. of years they have been caring: 1. Less than 1 year 2. 1 to 3 years
3.4 to 7 year 4. More than 7 years.

Q.9. Time spent on caring/day: 1. 1 to 2 2. 3 to 4 hours 3. Whole day

Physical care

Q.10. Brushing:

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q.11. Bathing

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q.12. Combing the hair

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q.13. Helping with nature's call and cleaning afterwards

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q.14. Cutting the person with mental illness's hair.

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q.15. Ensuring s/he wears clean clothes

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q.16. Feeding the person with mental illness

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Psychological care:

Q. 17. Treating the person with love and affection whenever the person is restless.

1. Sometime 2. Always 3. Not applicable

Q.18. Listening to the person when s/he speaks.

1. Sometime 2. Always 3. Not applicable

Q.19. Speaking to the person as and when physical care is given (as one would speak to the child)

1. Sometime 2. Always 3. Not applicable

Q.20. Comforting the person when upset

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q.21. With whatever the person does, being patient, not getting irritated or angry

1. Sometime 2. Always 3. Not applicable

Q.22. Allowing the relatives or others who are nice to the person to come, be with the person and speak to the person.

1. Sometime 2. Always 3. Not applicable

Q. 23. Listening to the person with mental illness what work he wants to do and if feasible, encouraging him/her to do it.

1. Sometime 2. Always 3. Not applicable

Q. 24. Engaging the person with mental illness in household work, decision-making and communication.

1. Sometime 2. Always 3. Not applicable

Medical care:

Q.25. Taking the person to faith healers, temples, churches, black magicians, etc

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q. 26. Motivating the person with mental illness to undergo treatment and spending money on the same.

1. Yes 2. Sometime 3. Always 4. No

Q.27. Bringing the person to the camps regularly.

1. Yes 2. Sometime 3. Always 4. No

Q.28. If hospitalization is required, then being with the person with mental illness in the hospital and meeting his needs.

1. Yes 2. Sometime 3. Always 4. No

Q.29. Reminding the person to take medication.

1. Yes 2. Sometime 3. Always 4. No

Q.30. Motivating the person with mental illness to take medicines.

1. Yes 2. Sometime 3. Always 4. No

Q.31. Observing and understanding the side effects of medicines.

1. Yes 2. Sometime 3. Always 4. No

Q.32. Once the medicines are over, making sure that they bring it to the notice of the field staff and procure more medicines.

1. Yes in Highly symptomatic case 2. No 3. Not applicable

Q.33. Being supportive by letting the person oversleep and take rest.

1. Yes in Highly symptomatic case 2. No

3. Yes in Stabilized condition 4. Not applicable

Q.34. Helping the person with mental illness to overcome side effects by providing adequate food intake, liquid consumption etc.

1. Yes 2. Sometime 3. Always 4. No

Q.35. Observing keenly all the side effects and bring it to the notice of the field staff.

1. Yes 2. Sometime 3. Always 4. No

Social care (Family and community):

Q.36. Making the community understand that his/her behaviour is only due to illness and nothing else.

1. Yes in Highly symptomatic case 2. No 3. Not applicable

Q.37. Preventing the community from abusing the person with mental illness, physically, mentally and sexually.

1. Yes 2. Sometime 3. Always 4. No

Q.38. Telling the prospective spouse and their family about the illness.

1. Yes 2. Sometime 3. Always

Q.39.Taking the person to religious and social functions of only close relatives

1. No 2. Not in Highly symptomatic case 3. Yes Sometime

Q.40. Taking the person to all religious and social functions the family attends.

1. No 2. Not in Highly symptomatic case 3. Yes Sometime

Q.41. Encouraging the person with mental illness to mingle and interact with friends.

1. No 2. Not in Highly symptomatic case 3. Yes Sometime

Q.42. Helping the person with mental illness to get married and lead a normal life.

1. Yes 2. Sometime 3. Always 4. No

Q. 61. Problems faced by the carers?

Q.62. How have they overcome those problems?

Annexure IV:

Interview Guide for NGO Director

Organisation Name:
Name of the Director:
Designation:
Email:

Q.1. In which sectors does your organisation currently work? (You can choose more than one)

1. Public Health 2. Agriculture 3.Tribal Development
4. Resource Gathering 5.Rural development 6.Community Development
7. Livelihood development 8. Other (please specify)__________

Q.2. In which provinces and district does your organisation currently work?

1. Yavatmal 2. Chandrapur
3. Nagpur 4. Other_______________

Q.3. What are your main project activities? (you can choose more than one)

1. Training (please specify)_________________________________
2. Prevention 3. Income generating
4. Primary health care 5. Other (please specify)

Q.4. Does your organisation provide vocational training?

1. Yes 2. No

Q.4.1 . If yes, what type of vocational training? (you can choose more than one)

1. Handicraft 2. Harvesting NTFP 3. Agriculture 4.Other____________

Q.4.2 . For people in your programme receiving vocational training, how do you monitor the use/skill of trained person?

1. Monthly 2. Quarterly
3. Midterm review 4.Others____________

Q.5. How many times do you visit your project site in one quarter?

1. 5 times 2. 4 times 3. 3 times
4. More than 5 times 5. None

Q.6. Does your organisation provide micro-credit in your project area for your beneficiaries?

1. Yes 2. No

Q.6.1. If yes, what are the types of micro-credit (income generating activities) do you provide in your project?

Q.6.2. And to whom do you work with for these IGA (Income Generation Activities)?(you can choose more than one)

1. Women 2. Men 3. Children 4. Disabled people
5. Mentally ill people 6. Others (please specify)___________________

Q.7 How many income generating projects do you have?

1. One 2. Two- Three 3. More than three 4. None

Q.8. How long for each project?

1. 24 months 2. 18 months 3. 12 months 4. Other (please specify)

Q.9. How often do you evaluate these activities?

1. Every month 2. Every 3 months 3. Every 6 months
4. 12 months 5. No evaluation 5. Other (please specify)

Q.10. Who are your key partners in the community level? (*you can choose more than one*)

1. Village volunteers 2. Local authorities 3.Villagers 4. Other

Q.11. Have you ever heard about mental disorders in your project areas?

1. Yes 2. No

Q.11.1. If yes, what types of mental disorders, have you heard in your project area?

1. Psychosis 2. Neurosis 3. Depression 4. Epilepsy
5. Mental retardation 6. Others, (please specify)

Q.12. What do you think about mentally ill people?

1. Special patient 2. Ordinary patient 3.Mad person 4.Useless person
5. Considered as a social problem maker 6.Other (please specify)

Q.13. Have you ever worked with mentally ill people or disabled people?

1. Yes 2. No

Q.13.1 What types of mental diseases, do these people experience?

Q.14. Do you think that mentally ill people or disabled people can get involved in income generating activities? (Yes or No please explain)

Q.15. Do you think that mentally ill people or disabled people can get involved in social activities? (Yes or No please explain)

Q.16. How can your organisation and BNI CMHD work together?

1. Capacity Building (CB) 2. Community Mental Health (CMH)
3. Primary Health Care (PHC) 4. Research and Policy (RP)
5. Sustainable Livelihood (SL) 6. Others (please specify)

Annexure IV:

Guide for FGD

Script and Questions for Focus Group Discussion with Community Health Worker and community stake holders.

Introduction:

- The moderator introduces self and the team
- Explain to participants that the discussion will last about 1,5 to 2 hours
- Ask participants to kindly turn down or if possible switch off their mobile phone in order to avoid disturbance

Focus group discussion Objectives:-

• Give explanation on the objectives of this activity, information is to feed into baseline study:

The objective of this activity is to get your suggestions, attitudes and experiences on mental health in your community/district. All ideas and comments are valuable to the planning of the work of Community Mental Health and Development Project and we want to learn more about your mental health situation and challenge of mental health service in your district. Our specific objectives are:

- To understand mental health situation.
- Treatment needs;
- Available services about mental health.
- Impact of CMHD program among the PWMIs, caregivers, family members and the community.
- Rehabilitation of PWMIs in the community.

Permission request

• Ask participants' permission to use tape recorder to record the session, test the sounds and let them listen to the recorded sound

• Ask their permission to take photos of the session

Participants Consent

• All participants have the right to answer to the questions and please do not be afraid or shy

• All answers will be valued

• Please respect the others, while other talking please do not interrupt, wait until he/she finishes her/his dialogue then you can express yours

• We encourage all to talk in brief as to give opportunity for other to talk too

• Do not be afraid that your answer would be right or wrong, please answer to questions naturally as how you feel about the issues. If you have different perspective from the other please do express

• Your name would be kept as confidential and we will not display your name or give to other party

• We encourage you to speak aloud so that the tape recorder can record your sentence

Participant's introduction

• Participants introduce oneself names as she/he wishes the other to call her/him

• Use paper scotch tape to write down the name of each participant and gently seal it to their shirt

• Invite participants to have a coffee/tea break before the session begins