DRAFT

Community based mental health services for people with mental illness

Manual- community mental health and development for the field staff

BNI Team
Basic Needs India

Basic Needs India
...promoting mental health
and development

Contents

CHAPTER I

Manual for the field staff to implement community mental health and Development programme

Approach to manual

The manual on community mental health for the implementers would help the field staff to include community mental health programme in their community based rehabilitation programme. This also helps the field staff in identifying people with mental illness in their communities and to design community based interventions in meeting the needs of people with mental illness. The manual would give an out line of each module, each session, teaching methodology, information/ supporting documents for further reading will be provided in the manual.

The field staffs undergoing the training should have an experience of working with the marginalized in the community and have an experience of working with people in the community. The field staff should have inculcation/ openness to include mental health issues in their development work. The field staff should also have an experience of working with the self help groups, formation of federations and experience of advocating with the authorities.

It is important that we read through the whole manual and understand as much possible the development approach for meeting the needs of people with mental illness, which is holistic. The basic emphasis is given to developing right attitude and right approach, so that people with mental illness are treated rightly and respected in the communities. Opportunities to reflect on how the 'development and community based approach' would help in creating favorable environment for people with mental illness to lead life with dignity, their rights are respected, and provide opportunities for their recovery and raising voices so that they can advocate for their rights and entitlements. The process of reflections is facilitated through raising relevant and significant questions through out the manual and attempting to brainstorm on the questions, to change our own attitudes towards people with mental illness.

We believe that following the outline and proposed methodology and sincerely participating in the group discussions and reflections would help us to acquire knowledge, skills, attitudes and ability to include people with mental illness in the development activities of the organizations. The manual also facilitates in improving the quality of our reflections through emphasizing the 'perspectives' we need to gain, where in the good practices been theorized, so that many can benefit and work towards changing the world.

Another important aspect of this manual is to develop human force in community mental health, imbibe skills (consultation, participation, voices guiding the advocacy) in involving people with mental illness and their families in their own rehabilitation. The methods that are introduced in the manual such as role plays, small group discussion, brainstorming, case studies, demonstrations, problem analysis- drawing tree, group activities are useful in promoting the learning process. This process helps in the

involvement of the trainees in the programmes, meant for their own development. In short, these methods are participatory in nature.

Yet another important feature of our manual is continued support even after the class room training at the field level. The class room training are followed by two days of exposure visits for the community mental health and development programme (already implemented programme). The class room training been divided in two phases of 3 days each. During the interim period, the trainees will be supported with field training to initiate community mental health and development activities. The field support is designed to provide once in 4 months of 2 days duration at the organizations. Once the right attitude been formed, trainees (field staff) would tend to seek the information required work towards improving the quality of life of people with mental illness.

Why this manual?

The lives of people with mental illness is governed with many problems they encounter from the society like stigma, discrimination, isolation, marginalization, no respect, no concept of dignity for people with mental illness on one hand and on the other hand there is limited resources in terms of human resources, lack of understanding from the available resources and financial resources from the government to meet the needs of people with mental illness. The issue is compounded for person with mental illness if he or she is poor with the family and the person getting into the cycle of poverty exacerbating mental illness and vice versa. The human resources scarcity is governing the mental health sector, we do need human resources of various levels of categories. The national organizations continuously been training mental health professionals (psychiatrist, psychiatrist social worker, clinical psychologist, psychiatric nurse) in the country. There are various some manuals been developed for different categories of people like rehab workers, health workers, NGOs etc. This manual is unique as it meet the training needs of the field workers, draft methodology for the training is also given in this manual along with the reading materials, simplified for the field staff. After the field testing for one year same will be translated in the local languages so that it can have wider coverage. These efforts would go in the way of reaching the most marginalised sections of the society.

Who should use the manual?

This manual is to be used by the trainer's team consisting of the field staff/coordinators having experience of implementing community mental health and development model in the community. The trainer's team should have

1. Preferably have some experience in interviewing and working with the families of and persons with mental illness.
2. Preferably have attended training workshops to learn the required techniques and skill of community mental health and development model.
3. Known the contents of this manual thoroughly before beginning any intervention.

Who is the target group for the manual?

This training manual has been designed as a tool for training, keeping in mind field staff of the organizations. The manual should be able to meet the training needs of the field staff/coordinators of CBOS and NGOS (field staff would have some experience of working in the community with the educational background of plus or minus 10^{th} standard). The definition of the field staff include, any person involved in community development activities from the organizations/people's group who is passionate to work with the marginalized people in the community.

Where it has to be used?

Basic Needs India believes that mental health is a development issue, hence can be included in all the development activities of the development organizations working in the community.

What are the objectives of the manual?

The overall objectives of the manual for the field staff is:

1. *To build capacity of the community based organization/NGOS for implementing community mental health and development programme.*
2. *To build skills of the field staff in identifying people with mental illness and their needs in their community.*
3. *To develop skills in organizing community based interventions involving community in meeting the needs of people with mental illness in their community.*
4. *To build/capacitate the existing people's organizations to advocate with the government for meeting the needs of people with mental illness.*
5. *To understand mental health is a development issue, in can be included in any development activities.*

What are our basic beliefs?

Basic Needs India believes that:

1. Mental health is a development issue, can be included in all the development activities of the organizations.
2. How ever poor or ill the person is, has the capacity to manage his or her life if provided with support.
3. People with mental illness should be encouraged to voices their needs and work towards fulfillment.
4. Consulting people with mental illness, their own life experiences are valuable and meaningful to be understood.
5. Development approach is people gaining increased control over their lives and making optimum utilization of their potentials
6. Individual and group reflections would help to internalize learning's and changing the attitudes.

What extent the manual be?

The trainers (trainers group identified) should be able to train the field staff of the CBOs/NGos using the proposed manual. The manual should aim at support the trainees in designing the community mental health programme, same to be included in their development activity of the organization.

How many days the training be organized?

I am proposing 6 days of training (as said in the training proposal) with two intervals, followed by 2 days of field exposure to community mental health and development activities and 6 days of field support, field support is towards supporting the field staff in the community mental health activities (like supporting field staff in meeting the needs of the difficult families, in developing script for street theaters, in designing awareness programmes to community groups like women's group, youth groups, ICDS teachers etc).

What is the structure of the manual?

The structure of the manual should be; providing session plan for six days along with the trainers notes for summary for each session; reference materials for reading should be part of the manual; guidelines for the trainers to use the manual; designing field support (as proposed in the CBR proposal) etc. The community mental health and development manual would have 5 modules (as proposed in later pages).

The Manual will :

- Give an outline of each session with proposed topics, teaching methodology and the time devoted.
- Provide the relevant support materials to supplement and complement the training efforts.
- Lend itself to be used in parts or whole, depending on the needs of the trainer or the participants.

What is their in community mental health and development manual?

The Basic Needs India Model of Community Mental Health and Development is one such intervention been evolved through consultation and been tested and proven effective in meeting the needs of people with mental illness and their families and in involving them in their own rehabilitation and development. The model of CMHD incorporates five modules of

1) Community Mental Health,
2) Sustainable livelihood
3) Capacity Building
4) Action Research
5) Management

These modules work together in the field and have resulted in a holistic development of the program. This training manual is an effort to consolidate the 8 years experiences of the implementing community mental health and development programme. BNI has captured their experiences of working with partners in capacitating the partner organizations and the field staff for including people with mental illness in their development work, same been captured in the manual so that .

What are the chapters included in this manual and topics under each module?

1. Mental health and care services
2. Capacity building
3. Livelihoods and Income enhancement
4. Documentation and advocacy
5. Community based mental health services Project design

The proposed topics/contents to be included in the manual are given below under the modules (proposed) for the training programme:

Mental health and care services

The trainees should be able to:

1. Differentiate stress, mental illness and mental retardation
2. Identify people with mental illness among disabled and in the community.
3. Differentiate people with severe and common mental disorders
4. Able to identify and organize care/treatment services locally

Topics to be covered

a. Mental health and mental illness
b. Understanding human behaviour
c. Types of mental illness
d. Organizing treatment services
e. Multi dimensional approach
f. Mental Health in India an over view
g. Stresses in the day to day practice
h. Why community metal health
i. CBR ad community mental health and development prorgamme

Livelihoods and Income enhancement

The trainees should be able to:

1. *Understand relationship between mental illness and poverty*
2. *Understand family as a unit*
3. *Understand about the trade analysis*
4. *Understand various livelihood options*

Topics to be covered

a. Dignity, recovery, prosperity, and self worth
b. Poverty and mental health

c. Sustainable Livelihoods
d. Trade analysis
e. Livelihood options

Capacity Building

The trainees should be able to:

1. *Understand what is capacity building*
2. *Understand barriers in the familyP and community for the recovery of person with mental illness.*
3. *Understanding of consultation would consult people with mental illness and their caregivers in understanding their needs.*
4. *Understand needs of the families with mental illness and to design appropriate awareness programme to deal with the barriers in the family and community.*
5. *Understand the need for inclusion of people with mental illness in the group.*
6. *Understand various awareness strategies for various community groups.*

Topics to be covered

a. Capacity building
b. Animation
c. Consultation
d. Understanding barriers – Family and community
e. Organizing people with mental illness and caregivers in to self help groups/associations
f. Awareness generation
g. Gender
h. Mental health and development

Documentation and advocacy

Trainees should be able to:

1. *Develop format (individual file) for documenting*
2. *Develop an understanding on the various legislations related to mentally ill people in India*
3. *Have an understanding on the various provisions available for people with mental illness*
4. *Have an understanding on the national mental health and district mental health programmes*

Topics to be covered

a. Need for documentation
b. Individual file format
c. Provisions available for people with mental illness
d. District mental health programme and National mental health programme
e. Mental health act
f. People's with Disability Act
g. UNCRPD and other UN conventions
h. Human rights

Project Design

Trainees would have an understanding on:

1. *Mental health as a development issue*
2. *Mental Health in India an over view*
3. *Need for community based intervention versus institution based intervention*
4. *Similarities and differences of CBR and CMHD*
5. *Mental health and development model(BN Model)*
6. *and ability to design a community based mental health programme*

Topics to be covered

a. Strengths of development approach
b. Documentation in the community mental health and development programme
c. Consultation
d. Individual rehabilitation plan
e. Alliance building
f. Review and evaluation

Proposed topics for refresher training:

- Vibrant economy
- Meeting the needs of the Care givers
- People's organizations
- People's participation
- Community mobilizing
- Gender analysis
- Prevention and promotion strategies
- Recovery
- Advocacy
- Child mental health issues
- Problem solving approach
- Helping skills
- Communication training

Notes for the trainer

Basic Needs India believes that mental health is a development issue, believes in people developing abilities to have control over their life situations. This is achieved through a process which is people centered, people's participation, process of consultation and participation oriented, ultimately aiming at people exercising their own rights and their needs are respected in the community. It is necessary that the trainer should transfer the true spirit and philosophy behind the Community Mental Health and Development Model. To facilitate this process it is essential for the trainer to reflect on the following attitudes and beliefs which drive the CMHD model and our efforts to mainstream it.

- Change is the 'central' for any training. Change is continuous, people exposed with information and knowledge would lead to attitude change. Change is essential in the individual and for the community.

- Every human being is a thinking creative person with capacity for action. Every individual (how ever poor or ill) has the ability to manage his or her life. Trust in people's potential and confidence in people's ability to think, to solve, to express etc. This is crucial for the success of any development initiative.

- Critical and creative thinking is the main ingredient for social change. This need to be nurtured and fostered by the trainer. The trainer needs to question the prejudices and beliefs of the participants. Help them to acquire new understanding on the issues.

- Reflection is crucial for change. Reflection leads to action, and action would change the situation. By facilitating reflection in the group, this provokes thinking, leading to change in attitude and in their action. It is essential for the participants of the training program to imbibe skill of reflection on every day's inputs and plan an action based on their learning's.

- The group constantly changes; it becomes more and more capable of observing the content and transforms their learning in their daily life.

- Learning means change in the thinking, attitude and behavior and not just acquisition of knowledge. It is of importance that the participants to learn wider perspective about issues.

- Every individual or group if given opportunities and exposed to new learning's would change for the better.

- Development is people gaining increasing control over their lives; development is people making maximum use of their potentials.

- Reflections would build the capacity of the individuals leading change in ones thinking

BNI hope that the trainer shall uphold these values and beliefs and reflect them in the training.

Manual and Session Plans: The manual consists of eight chapters (encompassing how the community mental health and development model can be implemented), with the detailed session plans for each module. The session plans include:

  - What the trainer would learn under each module
  - The number of sessions per module, with the time frame given for each session.
  - The methodology planned for each session along with the necessary handouts/reading materials.

It is to be noted that the time indicated in the out line need not be binding on the trainer. Also the user is free to structure the session differently, including variance in methodology.

Role of trainer:
The manual envisages a training process that focuses on learning rather than teaching/delivering. The effective trainer is one who is:

1. Developing self awareness- discovery of self
2. Understanding the learner
3. Knowing more and more about people's learning styles
4. Understanding the learning process
5. Selects options for training from existing educational norms
6. A leader and democratic decision maker
7. Flexible in designing the training, plan to implement what been designed, decides not to implement what been planed.
8. Not a strainer rather shapes the learner.
9. Willingness to learn from others.
10. Readiness to respond to the learner's needs.
11. Trainer grows during the process of facilitating groups.
12. Training is for mutual resource enhancement.

Time Management:

The trainer should have good time management skills. This calls for a good preparation for the training session. The trainer avoids extending the session timings in general. Being alert, creative and making spot decisions helps the learning process.

Need to be good facilitator:

Small group work, role play, demonstration, paper readings etc., have been used extensively in the manual as teaching methodologies. Effectiveness of such strategies depends largely on trainers' competence in facilitating the given tasks, and monitoring and summarizing the sessions. The trainer should encourage the learner to summaries the sessions rather than he himself consolidating.

Need to use icebreakers/energizers to break the monotony:

There is a list of icebreakers/energizers given at the end of the manual for strengthening the training process. It depends on the skill of the trainer to use these effectively and competently to sustain the interest and the energy levels of the participants.

Need for home work/assignment:

Trainer assigns home work to the groups so that they would reflect, discuss in the group, make presentation on the next day. This increases the motivation for the participants and also would be able to consolidate their learning's.

Reflection dairy:

Trainer introduces the concept of reflection dairy. A 100 pages book will be kept at the training programme hall. Five trainees would volunteer each day to write the reflection dairy. The five trainees would discuss among themselves after the end of the training session. training document the reflection for the day

Exposure visit:

As part of the training, two days of exposure visit will be organized for the trainees to observe community mental health and development activities in the already implemented programme (Basic Needs India Partner). The trainees will be exposed to various dimensions of community mental health and development programme during these two days. A link between the class room teaching and observing the activities will be shown to participants. (Detail of exposure visit given in chapter 6)

Field support:

The training continues even after the class room training, the training team would visit the field to support and mentor field workers in the field. They would demonstrate the community mental health and development activities to the field workers, support field staff to deal with the problems at the field level. (Detail of field support given in chapter 7)

Chapter 2

Introduction to the training programme

Session I

Welcome & Introduction: 20 minutes

- Trainer after a welcome expression, invites participants to introduce themselves along with the food they like most.
- On completion, the trainer asks participants to reflect on when asked them to introduce they said about the organization, place, and the name. does it describes who the person is?.
- Trainer invites participants to express their thoughts on the same.

Expectations sharing : 20 minutes

- The trainer begins the session by asking the participants to express their expectations
- Trainer writes down the expectations on the board.
- Trainer presents the objectives of the training program and asks for responses from the participants.
- Trainer shares the training design along with the modules of training (given in chapter 1, modules of community mental health and development).

Norm Setting : 10 min

- Trainer suggests to the participants set the norms/ground rules for effective functioning as a group. Norms can be on the lines of:
  - Mobile phones not to be entertained, to be kept in silent mode.
  - Listening to each other.
  - Everyone's contribution is important.
  - Participants speak one at a time and no cross talk.

Familiarizing with the program : 25 minutes

a.) Reflection Daily Dairy:

- The trainer introduces the idea of participants maintaining a reflection Diary, following certain guidelines.

  - Purpose of reflection diary :
    - To think further about some aspects of each day's experiences and learning.
    - To provide an opportunity for issues and concerns within the groups to be raised.

- To provide a continuing commentary by participants on the life of the group.
- To bring the group members to a shared starting point each morning.

➢ Guidelines for the diary :
- Write as an informal diary, not as a report or minutes.
- Keep the emphasis on the life of the group, on the members of the group and on the process of learning.
- Avoid recording and repeating the factual content or subject matter of sessions.
- Choose only a few points, events or moments to mention something which strike you, which seem important or you feel strongly about.
- Write from your own personal observations and experience of the group and the day.
- Remember that the purpose is reflection and not evaluating.
- Use your own style of writing and ways of expression.
- Write three or four sides only.

b.) Hand Outs:

- The trainer informs the participants that the sessions will be supported by handouts wherever required.
- Trainer asks the participants to read the handouts during the night and get back to the trainer for more clarification and understanding

c.) Overnight Assignments:

- The trainer tells the participants that there will be over night assignments relating to topics including discussions of paper readings (individually or in groups), and also other activities, (like Me and My work, Personal Profile sheet detailed in the last chapter on Strengthening the Trainer).

d) Field support:

The training inputs continue even after the class room input, the trainers' visits field mentor and support the field staff at their work place. They would demonstrate community mental health and development activities and support the field staff in dealing with difficult families.

e) Exposure visit:

Two days of exposure visit will be organized as part of the training. The trainees are exposed to community mental health and development activities and the dimensions from the already implemented organizations.

Chapter 3

Community mental health

The trainees should be able to:
1. Differentiate stress, mental illness and mental retardation
2. Identify people with mental illness among disabled and in the community.
3. Differentiate people with severe and common mental disorders
4. Able to identify and organize care/treatment services locally

Number of session 11

Session 1: Stresses in the day to day practices
Session 2: Mental health and mental illness
Session 3: Understanding human behaviour
Session 4: Types o mental illness
Session 5: Mental illness and mental retardation
Session 6: Mental health interventions, NMHP and DMHP and multidimensional approach
Session 7: Prevention and promotional strategies
Session 8: Child and Adolescent mental health
Session 9: Mental health and development model
Session 10: CBR and people with mental illness
Session 11: Why community mental health

Session 1:

Stresses in the day to day practice : 45 minutes

a. Trainer divides the participants in to three groups
b. Trainer ask each groups to discuss on the painful event/ losses/ difficulties in their life over last six months
c. After listing down the events, Trainer ask them to describe about their behaviour/ emotions/ reactions to the event
d. Trainer invites the participants to present on the discussion
e. Trainer writes in the black board the reactions of people facing difficult situation, group them in to physical and psychological reactions
f. Trainer summarizes the session, describing stress and its reactions

How They managed.

→ Stressing coping with feelings. and de stressing

Session 1

Stress and mental health

Some observations

- Stress is reaction to an external situation that results in deviation from normal standards, it is bi product of pressure (physical, psychological and behavioural pressures).

- A stressful circumstances is one with which a person can not cope successfully, or believe he/she can not cope successfully, and which results in unwanted physical, mental and emotional reactions.

- 75% of the bodily disease is said to be stress related – heart disease, diabetes and hypertension.

- Stress can be both positive and negative stress. It is good to have some level of stress during exams (positive stress), as it helps us to prepare better for the exams, but if we are extremely stressful (negative stress), it may lead to decreased performance because of extreme anxiety.

- Handling stress will increases self image, confidence of the people and gives innovative ideas/alternatives and creative solutions.

- Our ability to cope, adapt and accept challenges/changes will help us come to terms with problems, and boast our confidence level and self image.

Stress is expressed through following expression (voices):

- Where will it end
- Nothing seems to work
- Who is responsible for this situation
- How much more can I take
- Can/will any one help me
- I feel helpless to stop this
- No one seems to care
- What have I done to deserve this

Definitions of stress:

- Stress is the internal state which can be caused by physical demand on the body (disease condition, exercise, extremes of temperature) or by environmental and social situations which are evaluated as potentially harmful, uncontrollable or exceeding our resource for coping.

- Stress is uncomfortable gap between how we would like our life to be and how it actually is. If this gap is persistent – despite our efforts to reduce it, than we are distress

- Stress is state of physiological imbalance in the body which has unpleasant emotional and cognitive components. Stressor is something that threatens your safety or well being.

Some common stressful situations:

• Change of residence/migration • Change of teacher • Change of schools • Changing views of people about you • Child rearing • Death of a parent or sibling and near one • Disability of some kind • Failure in exams	• Ill Health • Injury • Loss of a possession • Marriage • New boss in the work place/leadership • Occupational stress • Onset of menarche • Rapid changes in physical characteristics/ adolescence etc.

The stress is manifested in various forms like

In the Mind	**In the Body**	**In the Behaviour**
• Anxiety – getting fearful or angry easily • Mood changes • Poor concentration and attention • Memory loss • Difficulty in abstracting	• Tiredness • Headache • Tense muscle • Poor appetite • Feeling of pain • Disturbed menstruation	• Reduced sleep • Restlessness • Increase in substance use • Difficult to complete the task • Lack of self control • Over reacting to the situation • Mistrust

Categories of stress:

- Anticipatory stress: always anticipating that any change in their life situation would lead to stress eg change in the school, new boss in the office etc.

- Situational stress: worried about facing the situation as they do not feel comfortable eg marriage,

- Chronic stress: exposed to difficult situation for longer duration of time, eg unhappy married life.

Some ways to manage stress

• Adequate sleep and food intake • Become aware of stress inducing occurrences by writing/understanding down events that are stressful • Become aware of emotional, physical and behavioural reactions to stress • Being positive – I can face challenges, say to your self that I would try my best. • Creative visualization: visualizing positive things/achievements • Develop cooperation with others, not competition, develop some mutual supportive relationship • Distance/away from problem/stressful event for a short time • Divert your mind with some pleasurable events • Do some things just for yourself and to enjoy like listen to music & watch TV • Elicit family and community support • Physical exercise- Hand gripper, tennis ball • Follow good and healthy diet • Have a good laugh every day • Learn to delegate responsibilities	• Listen to what others are telling you: people give their feed back saying you are appearing tensed, restless, take it serious • Notice what your medical check ups reveal • On a daily basis keep track of how often you are irritable, fatigued, restless, have a pain, sweaty palms, raising heart beats, eating out of control, have headaches • Plan recreation time and maintain routines • Pursue realistic goals rather than being in fantasy and pursuing unrealistic goals • Relaxation and sit still for few minutes • Share how you are feeling with some one you can trust • Stop smoking and taking substances. • Take at least few sips of water slowly – divert mind • Time management. • Try not to be perfectionist in every thing. • Try not to be very critical to others and yourself • Try not to self medicate • Use anger with physical activity

Mind and Body: relationship between emotions and the physical illness and disabilities:

Mental functioning and bodily functioning are intimately related. Each influences the other in health and illness. When we are mentally upset, we experience a number of uncomfortable bodily sensations. When our body systems do not function properly, we are not mentally relaxed. For eg. When we are witnessing a child who is coming under

the wheels of an lorry (unable to save), for a moment, we experience, dryness of mouth, unable to shout, palpitation, tremors, sweating etc. Similarly when the person with disability or the family member finds difficult to accept the medical illness resulting disability, in such situation if we teach them how to use aids and appliance, how for the interventions will be successful?. Let us examine the various types of associations between emotional processes and bodily illnesses.

Emotional factors can play a causal role in bodily illness: there are several disorders, especially those termed psychosomatic disorders, where psychological factors like mental tensions and worries play an important role in the development of bodily illnesses. Some of these conditions include peptic ulcer, hypertension, diabetes mellitus, rheumatoid arthritis. Studies have shown that individuals suffering from depression are prone to develop many types of physical illnesses.

Emotional problems can present with bodily complaints: several mental disorders, especially the common mental illnesses, manifest with a variety of bodily complaints. A person with anxiety experiences several uncomfortable bodily symptoms which include palpitation, sweating, tremors, dryness of mouth etc. Similarly, depressed patients often report aches and pains in various body parts, tiredness, weight loss, constipation and sexual dysfunction. Many people with common mental disorders have an excessive preoccupation with the functioning of their body parts.

Emotional symptoms can be part of a bodily illness: physical illnesses may present with mental symptoms as well. For example, a person with anaemia frequently complains of anxiety, tiredness, lack of energy and disturbed sleep. Hypothyroidism often manifests with memory disturbances, depression, lack of concentration and tiredness. Symptoms of anxiety and depression are reported by people with heart disease and kidney dysfunction.

Emotional problems can occur as a reaction to bodily illness: Physical illnesses frequently result in emotional disturbances. There are several undesirable emotional consequences that result from life threatening or chronic physical illnesses. These include, the physical disability produced by the illness, financial difficulties, occupational difficulties, difficulties in family life and sexual difficulties. As a result, people experience varying degrees of anxiety and depression. Fear of death may accompany illnesses like renal problems, heart problems, cancer etc. leading to emotional disturbances.

Session 2

Mental health and mental illness: 15 Minutes

1. The trainer will write in the black board mental illness
2. Trainer will ask the participants to share the words/thoughts that come to them on mental illness
3. Trainer will list down all the words in the black board
4. Trainer will ask one participants to summarize the words

30 minutes

1. Trainer describes the situation (one early morning, person need to travel a long distance, he will be in bus stand 1 hour before the schedule time, to get a seat in un reserved bus. He succeed in getting a seat, while he was sitting, he finds a person with physical impairment, finding difficult to stand as he do not have seat) and ask the participants to share their views.
2. Trainer ask the participants to share what they would do in that situation and why they do
3. Trainer describes another situation, (in the same bus, they find a person, un hygienic, smelling as he has not taken bath, nor brushed his teeth, found muttering him self) and ask participants to share their view
4. Trainer ask the participants to share what they would do in that situation and why they do
5. Trainer asks participants to share why they react differently in two situation
6. Trainer summaries on the attitude of general community on mental illness.
7. Trainer links the earlier presentation.
8. Trainer helps the participants to understand stress and mental illness.

45 minutes

a. Trainer invites three volunteers to be a drivers of the three buses, (1st bus is agree bus, 2nd bus is disagree bus, 3rd bus is not decided)
b. Trainer gives instructions to the participants that when the trainer finishes reading the statement, participants should occupy the three buses based on their views on the statement (agree/disagree/ not decided buses).
c. Trainer reads out the list of some of the prevailing attitudes/misconceptions in the community.
d. Participants will be occupying the buses,
e. After each statement, trainer asks them to state reason why they got in to the bus.
f. Trainer shares his views on each misconception and discuss on how to deal with such situations in the community.

Session 2

Health and Mental Health

Health is wealth; all of us want to be healthy. However mere absence of illness is not health. A healthy person has a sound body; are-happy and contented and ability to face difficulties, losses and frustrations. They are capable of living in harmony with others, and also to keep others happy. They see that others are not put into trouble because of them and obtain certain moral and spiritual values. Such persons who are physically, mentally, socially and spiritually well can be considered to be healthy.

People become physically ill due to many reasons. Under nourishment, diseases, fluctuations in the environment, wear and tear of bodily organs, injury to the body, defective blood supply to specific organs of the body etc., can lead to illness. When an individual is ill, it is usual to consult the doctor and take treatment.

Like the body, the "mind' too can become ill, and the mentally ill person's sense of well being and emotional equilibrium are disturbed. The various mental functions like thinking, emotions, memory, intelligence, decision-making etc., can become disturbed as a result, the ability to work satisfactorily is also impaired.

It is easy to imagine and share the experiences and difficulties caused by damage or dysfunction to any part of the body. For eg., all of us know what it is to have high fever, blindness or a broken leg. So we usually react and sympathize with a person who is physically ill or disabled. However, most of us do not understand what it is to be mentally ill. We often fail to sympathize with a mentally ill person. When a person becomes mentally ill, not taken to a hospital immediately for proper treatment, rather go to faith healer, temples and black magician for cure. To add to the problem, currently most of the mental health care' facilities are available only in cities and towns and not reaching the masses, who are in the villages.

A mentally healthy person as capacity/skills to:

- Respond positively to the crisis situations/problems
- Coping skills and mechanism to handle problems
- Positive attitudes
- Balancing the life situations
- Good stress management
- Assertive behavior
- Identification of ones own strengths and weaknesses
- Clear perception of reality
- Mastery over the environment

Session 2 b

Myths about Mental Illness

- Children do not get Mental Illness
- People do not recover from Mental Illness
- All Mentally ill people are violent and dangerous
- Marriage "cures "Mental Illness
- Evil spirits cause Mental Illness
- Past misdeeds cause Mental Illness
- Mental Illness spreads through constant contact
- Rituals can cure the mentally ill
- There is no cure for the mentally ill
- The mentally ill have to be kept isolated.

Session 3

Understanding human behaviour: 30 minutes

1. Trainer divides the three groups
2. Trainer distribute the flip chart to each group
3. Trainer shows the flip chart and ask the participants to create story and to record their observation on the flip charts
4. Trainer invites group to make presentation of the group discussion
5. Trainer gives his observation on the flip chart
6. Trainer summarizes the discussion saying that behaviors of the people with mental illness have reason.
7. Trainer asks the group to brainstorm on the reasons for violent/odd behaviours of people with mental illness
8. Trainer list down the responses in the black board
9. Trainer asks group to reflect in difference in perception of families/communities on mental illness and other illnesses.
10. Trainer asks group to reflect on when self worth get affected, how the people with mental illness would feel.
11. Trainer summarizes with the presentation on why do mentally ill people become aggressive and be aware of signs of violent/aggressive state of mind.

30 minutes

a. Trainer each invites participants to say about one symptom/observation of mentally ill person whom they have come across.
b. Trainer writes down all the words/responses of the participants in the black board.
c. Trainer asks the participants, do we all experience above listed symptoms in our day to day life.
d. Trainer also ask participants, that often in our day to day conversation we say that " I am getting mad" "my mind is stuck", "if you irritate me I will become mad", I need to smoke/ drink coffee to make my mind work" are we certifying that we all are mentally ill.
e. Trainer summarizes the discussion with presentation on characteristics and features of mental illness

60 minutes

1. Trainer makes brief presentation on the Structural Model of mental health, causes of mental illness
2. Trainer divides participants in to five groups
3. Trainer gives the case vignettes to group for smaller group discussion
4. Trainer asks the participants to identify mental illness in the given case vignettes, identify possible causes for mental illness and to substantiate their answer
5. Trainer invites the participants to share the discussion
6. Trainer shares his views and re assure on the characteristics, causes and on the structural model of mental health.

अजीबसा व्यवहार करना

BEHAVING IN A STRANGE MANNER

Session 3

Mental disorders and its manifestations

Mental illness is a group of disorders characterized by significant disturbance in thinking, emotions and perception resulting in psychological and/ or behavioral symptoms lasting for significant period of time. Mental illness is a general term, referring to a group of illnesses in the same way that heart disease refers to group of illnesses affecting the heart. It could be a severe disabling condition like schizophrenia or less severe condition like adjustment disorder. It includes conditions attributed to organic causes or to those caused by stress. It includes brief episodic illnesses to long-term persistent illnesses. It varies in its presentation, course and outcome. For some people it will come and persist throughout their lives. Some people experience their illness only once and fully recover and for some it recurs throughout lives.

Certain symptoms are specific to a particular mental illness (delusions, hallucinations, obsessions); however many illnesses herald their onset with non-specific symptoms (social withdrawal, anxiety). Sometimes, the typical symptoms appear late in the course of the illness after a prolonged period of non-specific symptoms. Waiting for occurrence of typical symptoms would delay early intervention and therefore affect the prognosis. However definite diagnosis of a particular illness is considered only when a certain numbers of symptoms are found for a certain period of time.

Three characteristics of mental disorders are:

- Changes in ones thinking, feeling, memory, perceptions and judgment resulting in changes in talk and behavior which appear to be deviant from precious personality or from the norms of community, last for long period
- Changes in behavior cause distress and suffering to the individual or others or both
- Changes and the consequent distress cause disturbance in day to day activities, work and relationship with important others (social and vocational dysfunction)

Features of mental illness:

Common features in all mental illnesses are its basic abnormalities in thinking, emotion and perception, however the degree and extent of the abnormalities may vary. For example a person with Schizophrenia may have predominant disturbance in thinking process and a person with mood disorder may have significant disturbance in emotions. The manifestation of these abnormalities can be easily recognized from the appearance and behavior. Any behavior out of the ordinary or the limits of 'normal' acceptable cultural and social norms may provide the first clue. Changes in behavior if persists for longer than expected, often make one to suspect mental illness. Disturbances in the occupational and / or social functioning might also point to mental illness.

Identifying mental illness as early as possible would help in early recovery and in the overall treatment and prognosis of illness. Family members, neighbors and friends of a person often are best source of information and it is always good to respect their opinion and also to talk to affected person before initiating appropriate intervention strategies. Most mental illnesses can be effectively treated, advances in drug management, psychosocial interventions and rehabilitation services have made outcome of mental illnesses as good/better than those of physical illnesses.

Features (symptoms) of mental illnesses are broadly grouped as:

- Disturbances in bodily functions
- Changes in mental functions
- Changes in personal and social activities

Disturbances in bodily function:

a) Sleep: Person finds it difficult to fall asleep. He stays awake and worries about his inability to sleep. At times he may wake up in the middle of the night, and finds it difficult to fall asleep again. He may have disturbed sleep through out the night or may not sleep at all. He does not feel fresh in the morning. Any of these types of sleep disturbance can be a manifestation of mental illness.

b) Appetite and food intake: Person does not have proper appetite and eats less. At times although appetite is normal, the individual does not enjoy what he eats. Patient may have increase in appetite and eats more. He may lose weight or gain weight.

c) Bowel and bladder functions: Person may pass urine more frequently than usual. He/she may have loose motions or become constipated. Some patients may soil their clothes and remain unaware of it.

d) Sexual desire and activity: Patients may lose interest in sex. Men may also complain of difficulty in sexual performance or inability to enjoy sex.

e) Bodily complaints continuous physical disorders/pains, without having evidence of physical illness. For e.g. person complaining of headache or body aches, same cannot be explained on the basis of known physical illness or though investigations.

2. Changes in mental functions:

a) Behavior: person may behave peculiarly and in a strange manner. His behavior may irritate family members and other people or place them in awkward and embarrassing situations. Person's behavior can be dangerous to self and others. He/She may become overactive, restless and wandering aimlessly. He/She may abuse and beat others for trivial or no reason. On the other hand, the individual can become very dull, inactive and lose interest in the day-to-day activities. He/she may sit or lie down for hours or at times, days together, refusing to move even to attend to their bodily needs

b) Talk (thought process): Person may talk excessively and unnecessarily or may utter only a few words and remain silent. At times talk becomes irrelevant and incoherent. The individual may express certain peculiar and wrong beliefs which are not shared by others. For example, the he/she may say that somebody is spraying poisonous gas into eyes, that thousands of worms are crawling under his/her skin or that his/her food article is mixed with poison.

c) Emotions (feelings): The person may exhibit excessive emotions of sadness or happiness. Emotions inappropriate to the situations may be shown. In contrast, some may be unable to express any emotions at all and just sit like a statue. Others may laugh or weep.

d) Perception (sensations): Person's ability to understand various stimuli reaching through different senses can be disturbed. Individuals may often misinterpret them. They may hear sounds that others do not hear and say that they can see enemies coming to kill them. They may see figures of devil on the wall. Persons with Mental Illness can see things which are not present or which are not seen by others. They can hear voices from empty spaces; often-spurious sensations are also reported. Thus, even without any external stimuli they perceive

things, and react to them. This is known as "Hallucination". When a person hears some voices, he/she may in turn start abusing or threatening the imaginary persons. On seeing someone with a weapon the person may run away to hide himself or attack others. A person, who is hallucinating, can be seen talking to self, laughing or weeping and wandering on the streets.

e) Memory: A person's memory may be disturbed and as a result family can report forgetting. Individuals may forget whatever they see, hear or experience within a few minutes. They may be unable to remember where they have kept common articles of daily use such as money, clothes, keys, umbrella etc. They may not remember transactions carried out a few days earlier or people whom they have met a week back. They may lose capacity to remember their past and may even find it impossible to recall names of their children, where their brothers and sisters live etc. In severe cases, individual may lose self even in a familiar place

f) Intelligence and judgment: In some mental illness, intelligence and the ability to take decisions deteriorate. Person can lose the capacity to think clearly and hence may commit mistakes in his routine work. He/she may not be able to do even simple arithmetic and appear dull. In many ill persons, the ability to take appropriate decisions in a variety of situations is impaired or lost. They may take wrong decisions, which can result in difficulties for themselves and others. For example, they may keep quiet even after seeing a child fall and get hurt.

g) Level of consciousness: In some mental illnesses, due to brain damage there can be changes in the level of consciousness. The person with mental illness can also become disoriented about time place and persons.

3 .Changes in personal and social activities:

a) Personal: A person with mental illness can neglect bodily needs and personal hygiene like washing combing hair, bath or change clothes. He/she s can remain unclean for many days and not bother even when such neglect causes discomfort. At times they may even soil their clothes and bed.

b) Social: A person with mental illness behaves strangely with family members, friends, colleagues and others by insulting abusing or assaulting them. The individual may behave inappropriately in social situations and embarrass others. He/she may be rude to others annoying them or resulting in others making fun of him/her.

Mental illness effect the functioning and thinking of the individual, greatly diminishing his/her social role in the community. In addition because mental illnesses are disabling and last for many years, they take a tremendous toll on the emotional and socio-economic capabilities of the people who care for the person with mental illness, especially when the health system is unable to offer treatment and support at an early stage. Some of the specific economic and social costs include:

- Lost production from premature deaths caused by suicide.
- Lost production from persons with mental illness who are unable to work for short, medium and long run.
- Lost productivity from family members caring for the persons with mental illness.
- Reduced productivity from people being ill at work.
- Cost of accidents by people who are psychologically disturbed.
- Supporting dependants of the person with mental illness.
- Direct and indirect expenses of families caring for the person with mental illness.
- Unemployment, alienation and crime in young people whose childhood problems, e.g., depression, behaviour disorder, were not addressed sufficiently enough for them to benefit fully from the education available.
- Poor cognitive development in the children of mentally ill parents
- Emotional burden and diminished quality of life of family members.

Causes of mental illnesses

Mental illnesses can be caused by a variety of factors as follows:

Changes in the brain. Any change either in structure or functions of the brain can cause mental illness. Damage to the brain due to any of the following reasons can also cause mental illness: infections, injury, poor blood supply, bleeding, tumors, substance abuse for long periods, vitamin deficiencies and untreated epilepsy. Biochemical changes at level of nerve cells are the causes in a majority of the severe type of mental illnesses (Schizophrenia, Mood disorders)

Hereditary factors: In a few cases of mental illness, there may be someone else in the family affected with a similar illness. In most cases however, there would not be anybody in the family with a similar mental illness. The tendency to develop a mental illness can be transmitted to an individual but whether the person actually manifests the illness depends on many other factors.

Childhood experiences: Adequate love and affection, suitable guidance, encouragement and discipline are all necessary for the healthy growth of a person. If they are not adequate and there are repeated unhappy experiences in childhood, they can contribute to development of mental illness later in adult life.

Home atmosphere: Frequent quarrels, misunderstanding and strained relationships among the family members, lack of warmth and trust among them can have undesirable effects on the persons. Such an individual when faced with stress and strain, in later life, can become ill as he lacks the necessary skills to deal with the situation or to control his emotions.

Other factors: If an individual does not get equal opportunities and facilities to live as an accepted and respected member-of the society, he/she can develop mental illness. Poverty, unemployment, injustice, insecurity, severe competition and social discrimination contribute to development of mental illness.

The causes of mental illness described above can also be groups as predisposing factors, precipitating factors and perpetuating factors

- **Predisposing factors**

Genetic
Trauma at birth
Psycho-social factors in development

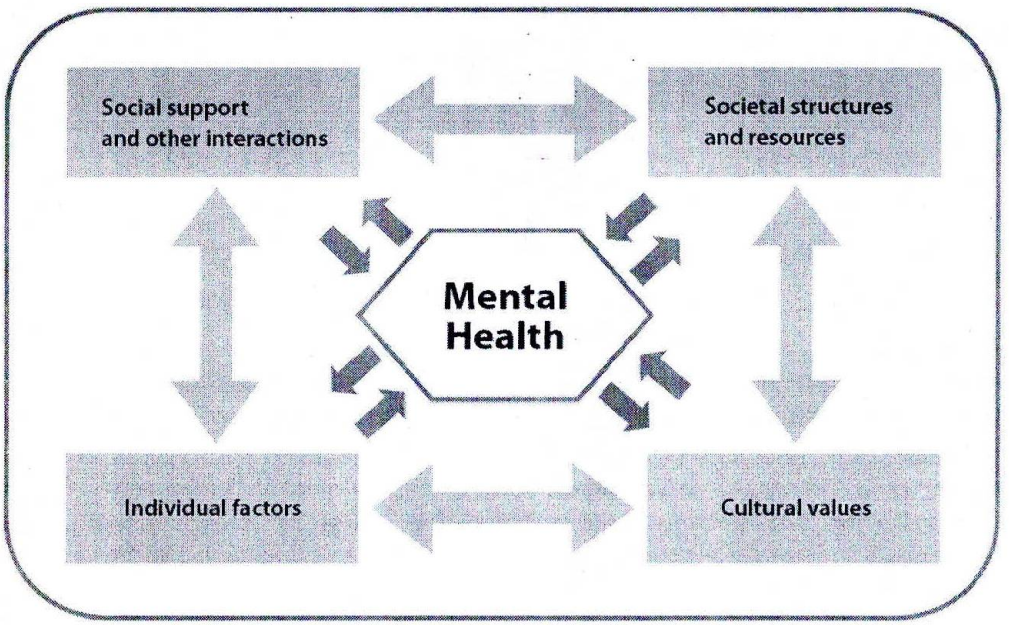
- **Precipitating factors**

Physical disease
Drugs
Psychological stress
Social changes
Accidents

- **Perpetuating factors**

Intrinsic to the disorder
Social circumstances

Figure 4.1
The structural model of mental health



Session 3 – case studies

Case study – 1

Ramalakshmama is a 30-year-old married woman who has studied upto grade XII, and was working in a garment factory as a helper. She has complained of dizziness and headaches for the past one year, but medical investigations revealed no physical illness. In course of sustained conversations with her, it has come to light that she is constantly thinking about various things, sleeping badly and occasionally having suicidal thoughts. She feels tired and not upto house hold chores. Her relationship with her husband worsened over time. A big cause for his displeasure has been that she has not borne a child and it has been two years since their marriage. He has been threatening to marry for the second time. To worsen matters, she also lost her job 3 months back as she was not able to concentrate on her work. She has no hope of securing another one given the way she is feeling. Currently she is feeling very lonely and helpless with no support system and has little hope of improving her situation.

Case Study-2

A 24-year-old married woman witnessed a horrific accident involving a man falling off a running train. By nature she was an anxious and fearful person. Post witnessing this accident, her anxiety and fear have increased manifold. She now complains of extreme fearfulness while traveling in bus or train. She felt a wave of fear every morning when she traveled to go to her work place. Within a week she started avoiding the train and started going by bus. Within few days, she developed anxiety while traveling by buses too. The very thought of traveling would trigger episodes of severe anxiety, accompanied by trembling, sweating of the palms, feelings of suffocation, and get a feeling that she would die. Due to these problems she stopped going to work, and even the thought of going out of the house brought on the same episodes of intense anxiety. Finally, over a period of two weeks, she started feeling sad, feeling fearful most of the time, felt a sense of loss of control over her life and began having suicidal thoughts. Her husband persuaded her to seek help from the counseling center.

Case Study-3

Mrs Geetha, 35 year old housewife, has been complaining of repeated episodes of heart attacks. She recalls that her problems began 10 years back when she delivered her only child. The first attack occurred while she was working in the kitchen. She suddenly felt that there was a dramatic increase in her heart beat. She also felt an intense stabbing pain in her chest and had difficulty in breathing. She started sweating and trembling, felt dizzy and was rushed to a physician. An ECG was performed immediately and was reported to be normal. Since then, Mrs Geetha has complained periodically of such episodes of heart attacks with each episode lasting about 15-30 minutes. There have been nearly four episodes every month. During these episodes, she seeks medical help. Over the past 10 years she has undergone many medical investigations, each of them reconfirming and reassuring her that she has no cardiac disorder.

After her first few attacks, she has developed a fear of having an attack and not being able to access medical aid. Since then she avoids crowded places such as banks, marriage parties and cinema houses, where quick escape might be blocked and medical aid not easily available. The episodes still occur and are observed more frequently in those situations which she fears most. Mrs. Geetha recognizes that both her symptoms and her avoidance behavior are unreasonable and excessive, but nevertheless they dominate her life. She feels mildly depressed and restless and has difficulty falling asleep. Her confidence is low, and she is unable to focus on any activity.

Case Study - 4

Mrs K is 45 years old, married for last 25 years. Her relationship with her spouse is strained and there is a severe marital conflict. For the past five years, Mrs. K has been having episodes of physical discomfort where she has difficulty in breathing, complaints of chest pain, sweating, and tremors. She has burning sensation in the chest and abdomen and feels that she is having heart attack. During this phase of discomfort, she has intense fear and cannot sit in a place and wants somebody to be with her. Each of such episodes lasts 5 to 10 minutes. Mrs. K has consulted a heart specialist, who after series of tests and examinations has reassured her that her heart is healthy. In spite of this she continues to have instances of discomfort and often visits her family physician and also approaches different doctors to find a solution. The frequency of such episodes has increased, affecting her daily routine and has also aggravated the marital discord.

Case Study-5

Mr. Suresh, 36-year-old and married, working as a mechanic in a private factory, was of an energetic and pleasant disposition. His family comprised of his wife and two daughters. One day while returning from his factory, Suresh met with an accident in which he sustained an injury to his right leg. He was taken to a private hospital where the orthopedician tried to do restorative surgery. Unfortunately gangrene set-in after the surgery. Hence the specialist suggested to go for a below knee amputation. Suresh consented to the surgery after initial refusal. The surgery was done without any complications and postoperative-period was uneventful. Suresh was discharged within a week. A fortnight later, when Suresh was brought in for a follow up, he complained of uneasiness, decreased sleep and body aches. His family reported him to be withdrawn and irritable with frequent anger outbursts. His wife said that he was often fearful, had very little interest in pleasurable activities and even indulged in tears at times. She mentioned that for two days before the consultation, he had spoken of suicidal thoughts. She revealed that all this had increased since listening to his colleague who mentioned that Suresh might lose his job on account of his condition. The wife also shared that all aspects of marital relationship had been affected post the accident. During the consultation Mr. Suresh started crying and asked the orthopedician for an injection which would put an end to his life without any pain. He shared a feeling of worthlessness and being a burden on the family as he couldn't return to his job. He expressed helplessness and hopelessness and a deep sense of life being unfair to him.

Case Study-6

Lawrence, a 20-year-old boy discontinued his studies as he was not able to pass his 7th standard since the age of 15. He started working as a helper under a contractor at the construction sites. He was honest in all his dealings and gave his earnings to his parents. He had lot of friends where he was living. His evenings were spent in the company of his friends, playing cricket, football etc. One of his friends was in love with a girl residing in the neighborhood. His friends used to tease that girl often. One day a group of 5 youth attacked Lawrence and his friends unexpectedly. Lawrence was also badly assaulted as he was part of the group. He had a head injury and was hospitalized. Few weeks later he developed excessive fear and was not ready to go out of the house. He would scream constantly and sound very abnormal.

Lawrence's sister speaks of the incident and what followed. "He was an ok boy. Did not do well in the school and discontinued his studies. He started learning carpentry and the trainer was also a contractor. Hence, he had no problem in getting work. One day he did not feel normal. He was disoriented, speaking unnecessary things and behaving abnormally. We took him to various healers and offered prayers in the church but there was no improvement. One day he ran away from home. We searched all over but did not find him. I think after more than two months his brother found him in another part of the town. When he was brought home, my heart sank and I wept. Every one was in tears. He was in his underwear and had an old coat on him. Even now if I think of that scene, some thing happens in my stomach."

Case Study-7

Mrs Nagarathna, a 55 year old Telugu speaking retired employee from Hyderabad, was reported to have died in a railway accident. She was run over by a moving train and her body was found on the railway tracks. As she was often crossing the railway tracks, the neighbors surmised that she went wrong in her judgment while crossing the tracks on that day and met with an accident.

A doctor who was a friend of Mrs. Nagarathna, however, spoke to her daughter and elicited some information regarding her behavior during the past six months. Mrs. Nagarathna had opted for voluntary retirement the previous year and was not interested in taking up another job. She would spend her time reading, watching TV and helping her daughter in law in managing the house. She seemed to enjoy this new lifestyle for the first six months. However, subsequently her family began to notice considerable change in her behavior. She seemed worried and tense most of the time for no apparent reason. She would wake up at 3 in the morning and would find difficulty in going back to sleep. She tried taking sleeping pills on her own but it did not help her much. She would feel excessively tired throughout the day. She lost her appetite and ate nearly half her usual intake. As a result, she lost 10 kilos over a period of three months. She also complained of constipation very often. She stopped her morning walks, watching TV and reading books. She would often remark that she had wasted all her life for the sake of family. She would share her guilt for not saving enough money for her children. Gradually she started feeling more and more helpless about the lack of control over her life. She often expressed that life was not worthy to continue, and expressed death wishes. Finally she decided to end her life by going under the moving train.

Session 4

Types of mental illness: 120 minutes

1. Trainer refers back on the previous presentation of the group and ask them to identify difference between case vignettes
2. Trainer list down all the responses in the black board
3. Trainer summarizes the discussion through differentiating severe mental disorders and common mental disorders
4. Trainer gives four case vignettes on depression, anxiety, bipolar affective disorder, schizophrenia
5. Trainer ask the participants to do a role play based after reading the case vignettes
6. Trainer invites the group for the role play
7. After each role play trainer summarize with the presentation on the type of mental illness.
8. Trainer summarizes the discussion with a triangle describing types of mental illness and with its prevalence.

Session 4

Types of mental illness

I. Severe mental illness: 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.

II. Common Mental Disorders: Patients show either excessive or prolonged emotional reaction to a stress situation. They have symptoms like anxiety, fear, sadness, vague aches and pains and other bodily symptoms. They are aware of their problems and seek help. They do not have psychotic symptoms.

III. Alcohol and substance dependence: this are generally divided up partly according to the substance involved (alcohol, opioids, cocaine and etc), partly by clinical syndrome. The clinical syndromes are of three main kinds, addiction states, complications of use/abuse, and withdrawal syndromes.

IV. Childhood behavior problems: These are mostly disturbances of behavior and conduct occurring in stressful family situations or as part of development, manifestation as abnormal behavior not appropriate to the age of the child.

V. Personality disorders: personality disorder can be thought of as maladaptive exaggeration of a personal trait. Symptomatically, a personality disorder may appear very similar to one or other type of the mental disorder. However, where a disease represents a change from what is normal for the patient concerned, a personality disorder is normally established by late adolescence and continues more or less unchanged in to old age.

VI Psychosexual disorders: Psychosexual disorders are of two types: sexual dysfunction and sexual deviation. Sexual dysfunction includes any persistent impairment of the normal patterns of sexual interest or response. Sexual deviation is a term to any sexual interest or activity that is preferred to, or displaces, adult hetrosexual interest or behavior, that are unusual and bizarre that violates prevailing social norms of the society.

VII Organic Mental disorder:
These disorders are caused directly by damage to the structures of brain. The underlying disease may be in the brain itself or may be in the other parts of the body. The important symptoms and signs of the disorders are; disorientation to time, place and person, poor Comprehension, poor calculation, memory deficits, changes in personality, emotional lability, self neglect and absence of awareness of the same

Session 4 b

Severe mental illnesses

Each of us is very individual in our own way. Every individual has different interests and methods of dealing with different situations in life. Similarly behavior of individuals to life situations is also not uniform. However, most of the people in one community have fairly similar ways of thinking (mentally reacting), feeling and behaving. In all communities there are agreed norms as to what should be considered normal and what should be considered 'ABNORMAL'. For example, nobody will consider the wearing of colorful dress to a village get together or a fair as abnormal, but anyone coming with similar dress to sad occasion will be immediately considered as being abnormal, by almost all persons.

In the medical sense, any persistent and severe disturbance of thinking, feeling and behavior is considered abnormal. In the past such conditions were called 'insanity or melancholia'. Modern science classifies them as PSYCHOSES/severe mental illness. In popular language they are often wrongly referred to as 'mad' or 'insane'.

Till recent times, persons with severe mental illnesses were feared and managed harshly by tying up, chaining or locking them in a room. Some also considered mentally ill persons as holy men and cared for them with respect. In the last 40 years of medical treatment has become available which can make these ill persons normal so that they lead a normal life. The following section deals with persons having major mental illness, their recognition and care. It is estimated that 1% persons in 1000 population suffer from one or other form of psychoses at any point of time.

It is a common belief among general population that psychoses are not illnesses. They are thought to be due to religious and supernatural causes. Illness is attributed to phenomenon like 'ill will of Gods' and 'visitation of evil spirits and souls of dead persons'. As a result of these beliefs persons with severe mental illness are usually taken initially to religious healers, magicians, temples instead of medical facilities. It is also thought that there are no care services to treat people with severe mental illness. It is very important to recognize and remember that severe mental illness are similar to other physical problems in that persons, which can recover from them as much from other physical illnesses. As in the case of all disorders the outcome with treatment varies with the severity and type of the problems and the time of starting treatment.

The important features are:
1) Loss of touch with reality
2) Symptoms like hallucinations, delusions
3) Neglect of body needs and personal hygiene
4) Socially disruptive behavior like aggression and violence
5) Neglect of work and responsibilities
6) Social isolation
7) Thought disturbances

Acute psychosis – in India, a number of studies have shown that about 10% of all persons with psychosis belong to the category of acute psychosis. This condition is characterized by:
1. An acute onset (within 2 weeks), presence of associated stress,
2. A typical syndrome characterized by rapidly changing and variable clinical picture.

Complete recovery usually occurs within 2 to 3 months and most often within few weeks or even days. In view of these features, the treatment of these disorders is very effective and the duration of treatment is not as long as in schizophrenia.

Schizophrenia – schizophrenia is the commonest of the severe mental illness and the symptoms of this illness closely correspond to the layman's concept of madness. It is an illness, which interferes with individual's personal and social functioning and if untreated, can run a chronic stage and disability. Schizophrenia usually starts in the age group 15-25 years. The onset can be acute or insidious. Some times the onset may be precipitated by a stressful event. The illness affects both sexes equally and occurs in all social groups.

The illness is characterized by abnormalities of thinking, perceptions and emotions resulting in abnormal behavior, action and talk. An individual with schizophrenia has abnormal ideas and thoughts of various kinds, which the individual believes and are unshakable (delusions). Ill persons perceive things which really do not exist (i.e. hears voices and sees visions which are non existent – (hallucinations).

Bipolar affective disorder – This type of mental illness is also called "Affective psychosis" because the primary abnormality in this illness is one of affect (emotion-mood). The disturbances in mood occur both in quality and quantity and ranges from extreme sadness to extreme happiness. The mood disturbances occur in episodes of either happiness (mania) or sadness (depression). These episodes can also occur alternatively, this is called Bipolar Affective Disorder.

Some observations on severe mental illness :

- Major mental disorders begins in young adulthood
- It has potential to be chronic and or disabling
- 1% of the population are having diagnosable severe mental illness
- High usage of mental health services
- Risk for home less ness
- Heavy emotional and financial burden for the caregivers
- Largely un treated
- The illness results in social and occupational dysfunction

Session 4 c
Common mental illnesses

Common mental illness/Neuroses are a group of minor mental disorders, which are not easily defined. Unlike in severe mental illness/psychoses, persons suffering from common mental disorders do not lose touch with reality and they are able to meet the ordinary demands of every day living. They generally have a good understanding of their problems while they do not cause much of distress to others in the family, but more distress to the person himself/herself. They themselves experience varying degrees of personal responsibilities, work and other usual social situation though disturbed to varying extent, usually does not disable the person completely. The disability caused is generally related to the degree of personal suffering the patient experience.

The basic and predominant features of common mental illness are mental tension and worry. All people get tense or worried from time to time especially when faced with difficult problems. However, they are able to cope with the situations and overcome their tensions or worry with passage of time. If the tension, worry is too much in intensity or prolonged in duration, they tend to interfere with the person's sense of well being and disturb the normal functioning. Many persons with common mental illness, basically have feelings of inadequacy and inferiority (lack of confidence) which lead them to perceive common every day problems as difficult and threatening. This constantly produces tension and worry and these individuals prefer to avoid facing these problems, ultimately resulting in a multiplicity of physical or psychological complaints.

Majority of individuals with minor mental illnesses, there can be stressful factor either precipitating or perpetuating the symptoms. The stress can be in the form of a disturbance in relationship with a person, a family quarrel, an unhappy marriage, difficulty at work place, persistent financial problems, serious/chronic physical illnesses in family or a death in the family or a social set back.

It would be easy to recognize that all individuals cannot escape from suffering, from some degree of mental tension, unhappiness. They experience symptoms in the presence of problems of every day life, at one time or the other. However in the case of person with common mental illness, these tensions, worries, unhappiness and the consequent symptomatology become part of their life style, leading to constant feelings of insecurity and a need for support from others. The exact clinical presentation of common mental illness can markedly vary from one person to another.

Types of common mental illness:

Depression:
We all might have experienced feeling of unhappiness sometimes or the other and also intense grief following death of a close relative or a family member. But these feelings go off with time and usually do not require any treatment and also would not cause significant disturbances in the day-to-day affairs. But persons with depressions would require appropriate care services for improving their functioning ability. Depression is one such disorder that hampers the quality of life of an individual remarkably and can lead to life-threatening complications such as suicide. It is therefore important for a clinician to recognize the presence of this condition in people during their consultations and provide adequate care services for the recovery. Generally, the outcome of care

services is good if the condition is detected early and referred for appropriate care including counseling and psychotherapy. There have been various studies among different populations measuring the risk of major depression; generally, the results all over the world are more or less similar. The lifetime prevalence of depression is 15.3%. Most of them reported to have recurrent episodes. In general depression is higher in women than men. About 18 to 23% of all women and 8 to 11% of all men have depressive episodes at some time. 6% of those women and 3 % of those men require hospitalization at some time.

Anxiety –
In our day to day work in the communities we would have seen substantial number of people having symptoms of anxiety and depression. Generalized anxiety disorder is a condition that is commonly seen in people. According to a rough estimate more than 30% of patients attending medical or surgical problems have one or more symptoms of anxiety or depression. However, it is often unrecognized and under diagnosed because of many physical symptoms leading in search of a physician to attend to their physical illnesses. The characteristic features is excessive anxiety and worry (apprehensive expectation of negative outcomes) about various events and activities such as concerns about family and interpersonal relationships, work, school, finances and health. The person suffering from generalized anxiety disorder finds it difficult to control the worry and present for most part of the day.

Phobic Disorders:
Phobia is defined as 'an irrational fear that produces conscious avoidance of the feared object, activity or situation'. Either the presence or the anticipation of the phobic entity elicits severe distress in an affected person who usually recognizes that the reaction is excessive. Phobic reactions usually disrupt the ability to function in life. The sufferer would know that his fear is absolutely silly and there is no reason for fear but still he cannot help avoiding the object or situation. The common feared situations or objects include leaving home, crowds, public places, pet animals, speaking in public, entering small places like lift.

Panic disorder:
Panic disorder draws its name from the Greek god pan, god of flocks. Pan was known for suddenly frightening animals and humans out of the blue. The spontaneous 'out of the blue' character of panic attacks is the principal identifying characteristics of panic disorder and central to its recognition. Often people present with the complaints of heart attack, when investigated, reveals no abnormalities. Panic disorder is a chronic but treatable problem, associated with a high degree of social and work impairment, poor quality of life, and frequent relapses. Often unrecognized, it is associated with excessive use of medical services.

Post Traumatic Stress Disorder:
After exposure to a traumatic life threatening accident or natural disaster such as tsunami, earth quakes, floods and manmade disaster like bomb blasts and riots and etc. Some people involved in or witnessing it develop a group of symptoms termed as acute stress reaction. These symptoms usually resolve gradually over a period of one month. In some susceptible individuals these symptoms persist beyond one month and cause severe distress and functional impairment.

Adjustment disorders:
The development of psychiatric symptoms in the context of stress is virtually a universal experience. An adjustment disorder is defined as development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within a month of the onset of the stressor(s) and the duration of symptoms usually does not exceed 6 months. These symptoms or behaviors are clinically significant as evidenced by either of the following:
1) Marked distress that is in excess of what would be expected from exposure to the stressor.
2) Significant impairment in social, occupational or educational functioning.

Obsessive-compulsive disorder (OCD):
Many of us have habits and routines, which help to organize daily lives. but if a person develops a pattern of behavior which takes too much time and interferes with daily lives, then he/she is said to have OCD. OCD is an intriguing and often disabling syndrome characterized by two distinct phenomenon's obsessions and compulsions. Obsessions are unwanted and intrusive ideas, images and impulses that run through the person's mind over and over again. Sometimes these thoughts come only once in a while and are only mildly annoying, but at other times the thoughts comes constantly and cause significant distress. A compulsion is a behavior that is performed in response to the obsessions. Individual put this thoughts in to actions as per the rules he has made for himself/herself in an attempt to control the distress causing by the obsession. People with OCD hide their problem to avoid embarrassment. Often this people are labeled as perfectionist/hygienic person. The studies established it has being a fairly common syndrome with a prevalence of over 2%.

Session 5

Mental illness and mental retardation: 30 minutes

1. Trainer invites participants to share their experience of working with children with mental retardation
2. Trainer invites participants to share their view on "is mental retardation a mental illness"
3. Trainer invites participants to share their view on differences between mental illness and mental retardation
4. Trainer summarizes the discussion with presentation on the difference between mental illness and mental retardation.

Session 5
Mental Retardation and Mental Illness: **What's the Difference?**

Mental Retardation	Mental Illness
1. Mental retardation* refers to subaverage intellectual functioning. Mental retardation can be classified as profound, severe, moderate, mild and borderline mental retardation.	1. Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life. Mental illness has nothing to do with intelligence. Mental illness are mainly classified as severe mental illness and common mental illness
2. Mental retardation is a condition, hence no treatment for recovery, they can be trained for daily living skills	2. Mental illness is an illness, if identified and provide appropriate care services would recover from illness and manage his/her life.
3. Mental retardation refers to impairment in social adaptation.	3. A person with a mental illness may be very competent socially, but may have a character disorder or other aberration.
4. National incidence: 3% of the general population.	4. Mental disorders fall along a continuum of severity. Even though mental illness disorders are widespread in the population. 1 % of the population have severe mental illness, 5- 15% of them have common mental illness
5. Mental retardation is present at birth or occurs during the period of development.	5. Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weakness, lack of character, or poor upbringing. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms and manage symptoms by actively participating in an individual treatment plan.
6. In mental retardation, some degree of intellectual impairment can be expected to be permanent.	6. Individuals with mental illness and their families if provided support and services can recover from illness and would be able to manage his/her life
7. A person with mental retardation can be expected to behave rationally at his/her functional level and not to his/her age.	7. A person with mental illness may vacillate between normal and irrational behavior.
8. People with mental retardation can also experience different types of mental illness with symptoms such as hallucinations or severe depression, secondary to the condition of mental retardation.	8. The term mental illness covers a wide variety of symptoms that may indicate that someone is in emotional trouble, including: excessive moodiness, suspicion and mistrust, or poor emotional control.

Session 6

Organizing care services

a. Mental health Interventions
90 minutes

1. Trainer divided participants to go back to same groups (role plays and case vignettes)
2. Trainer refer back to the role plays and the case vignets and ask the participants to make a problem tree
3. Trainer invites participants to make presentation on the problem tree
4. Trainer ask larger group to share their thoughts on the possible interventions to improve the quality of life of people with mental illness and their families after each presentation
5. Trainer invites participants to share their thoughts on how to change the attitude of the community members
6. Trainer invites participants to summarize the list of the interventions
7. Trainer summarized with their experience of working with people with mental illness in the community
8. Trainer categorizes the list of the interventions in to what can community worker do and what support structures are needed for the care services from external sources.

b. District mental health programme and National mental health programme:
30 minutes

1. Trainer shares about the objectives of National Mental health programme of 1982
2. Trainer makes presentation of the objectives of District mental health programme
3. Trainer makes a presentation of DMHP- Bellary model to 10^{th} five year plan
4. Trainer distributes paper on the 11^{th} five year plan and mental health programme
5. Trainer invites participants to brainstorm How NGOs can take up complementary role in DMHP programme.

c. Multi dimensional approach:
60 minutes

1. Trainer divides participants in to three groups
2. Trainer distributes the article on Multi Dimensional Approach
3. Trainer invites participants to read the article on multidimensional approach
4. Trainer invites the group to share the summary of the presentation
5. Trainer sums up the discussion sharing his/her experience of implementing community mental health and development programme.

Session 6

Mental health care services

It has been seen that mental illnesses are of different types. Each of them affects the individual in varying degrees. Their duration also varies. So the available treatments also vary. It was often thought that no specific treatments are available for mental illnesses. This is not correct. This wrong notion occurs because people commonly believe that admission to a mental hospital, for lifetime, is the only means available to care for persons with mental illness. This belief is also the result of seeing only the chronically ill patients. In the last 50 years specific treatments for selected mental illnesses are available which are as effective as the treatments for physical illnesses like tuberculosis, leprosy, malaria and typhoid fever

The different types of treatment and healing practices are:

1. Medicines: If treatment is started early and is continued regularly complete recovery is possible. These medicines are available in the form of tablets, capsules, syrups, and injections. Medicines are available for all severe and common mental disorders.

2. Electroconvulsive treatment (ECT): It is commonly believed to be "the final treatment" for all types of mental disorders when no other treatment helps in recovery. However, it is one of the effective and safe methods of treatment for some specific mental disorders when given appropriately by a team of specialist. In few patients it can bring about dramatic recovery, e.g., as in severe depression. The person/ family need to give consent for taking ECT. It is given friction of second under the influence of anaesthesia.

3. Psychological help (psychotherapy): Individuals faced with stressful situations experience psychological distress. Such persons can be helped by simple methods like listening to their difficulties, talking to the family as a group, bringing about change in their life situations. These efforts can result in greater harmony in their lives and thus improvement in their symptoms.

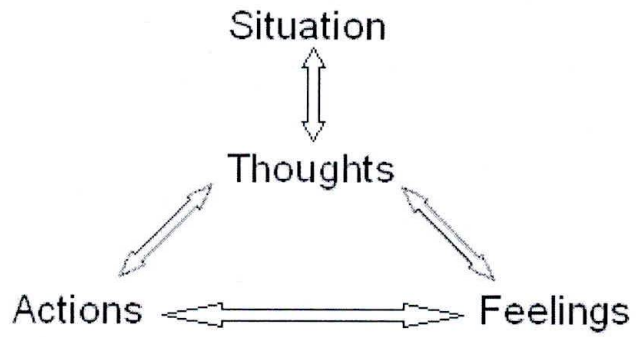
a. Family Therapy: Family therapy is a branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development. It tends to view these in terms of the systems of interaction between family members. It emphasizes family relationships as an important factor in psychological health. As such, family problems have been seen to arise out of systemic interactions, rather than to be blamed on individual members. Family therapists may focus more on how patterns of interaction maintain the problem rather than trying to identify the cause, as this can be experienced as blaming by some families. It assumes that the family as a whole is larger than the sum of its parts. Family therapy may also be used to draw upon the strengths of a social network to help address a problem that may be completely externally caused rather than created or maintained by the family.

Family therapy has been used effectively where families and or individuals in those families experience or suffer serious psychological disorders (eg schizophrenia anxiety depression, personality disorders, Attention deficit hyperkinetic disorders, additions and eating disorders.

b. Cognitive behaviour therapy: CBT can help you to change how you think ("Cognitive") and what you do ("Behaviour)". These changes can help you to feel better. Unlike some of the other talking treatments, it focuses on the "here and now" problems and difficulties. Instead of focusing on the causes of your distress or symptoms in the past, it looks for ways to improve your state of mind now. CBT can help you to make sense of overwhelming problems by breaking them down into smaller parts. This makes it easier to see how they are connected and how they affect you. These parts are:

- A Situation- a problem, event or difficult situation
  from this can follow:
- Thoughts
- Emotions
- Physical feelings
- Actions.

Each of these areas can affect the others. How you think about a problem can affect how you feel physically and emotionally. It can also alter what you do about it.
This is a simplified way of looking at what happens. The whole sequence, and parts of it, can also feedback like this:



This "vicious circle" can make you feel worse. You can start to believe quite unrealistic (and unpleasant) things about yourself. This happens because, when we are distressed, we are more likely to jump to conclusions and to interpret things in extreme and unhelpful ways.
CBT can help you to break this vicious circle of altered thinking, feelings and behaviour. When you see the parts of the sequence clearly, you can change them - and so change the way you feel. CBT aims to get you to a point where you can "do it yourself", and work out your own ways of tackling these problems.

c. Group therapy: In group therapy approximately 6-10 individuals meet face-to-face with a group therapist. Members are encouraged to give feedback to others. Feedback includes expressing your own feelings about what someone says or does. Interaction between group members are highly encouraged and provides each person with an opportunity to try out new ways of behaving; it also provides members with an opportunity for learning more about the way they interact with others. It is a safe environment in which members work to establish a level of trust that allows them to talk personally and honestly. Group members make a commitment to the group and are instructed that the content of the group sessions are confidential. It is not appropriate for group members to disclose events of the group to an outside person.

As the group members begin to feel more comfortable, the group member will be able to speak freely. The psychological safety of the group will allow the expression of those feelings which are often difficult to express outside of group. The group member will begin to ask for the support needed. The group member will be encouraged to tell people what is expect of them. In a group, the member probably will be most helped and satisfied if given opportunity to express and talk about their feelings.

d. Couple/Marital therapy: Couples therapy is a form of psychological therapy used to treat relationship distress for both individuals and couples. The purpose of couple therapy is to restore a better level of functioning in couples who experience relationship distress. The reasons for distress can include poor communication skills, incompatibility, or a broad spectrum of psychological disorders that include domestic violence, alcoholism, depression, anxiety, and schizophrenia. The focus of couple therapy is to identify the presence of dissatisfaction and distress in the relationship, and to devise and implement a treatment plan with objectives designed to improve or alleviate the presenting symptoms and restore the relationship to a better and healthier level of functioning. Couples therapy can assist persons who are having complaints of intimacy, sexual, and communication difficulties.

Rehabilitation: Certain proportion of persons with mental illness may not recover completely and left with longstanding impairments and disabilities. Such persons would benefit from rehabilitation programs, which include simple measures like involving them in recreational activities, teaching them simple things repetitive type of jobs, (eg. basket making, agarbathi making etc), social skill training, communication training, and including them in the daily household routines.

Session 6 b

Family interventions in community mental health programme:

What are Family Interventions?

During family visits, a development worker provides support and understanding of the illness for the affected individual and family members. Person with mental illness and their caregivers are consulted and involve them for the planning for assessment, diagnose and care services. This support helps the family in understanding of the illness. Intervention helps the person in gaining insight into the problems. Family interventions also help the family to cope with a chronically mentally ill member as well as reduce the burden faced by the families.

Why involve the families in the care of their mentally ill members?

There are a number of reasons for this:
1. Family members and relatives are the main care givers of people with mental illness.

2. Family supervises the care services like medication intake, follow up of psycho social intervention and provide emotional, social and financial support for the affected member.

3. To deal with the fears and anxieties about the causes of mental illness and the affected member's future.

4. The family's lack of understanding of the resource available for treating their affected family member, lead them to helpless situation and force them to get involved in human rights violation.

5. Families may feel they are contributing to the affected member's problems, feel guilt and would be more supportive. They can become defensive in the treatment process.

6. The presence of an affected member changes the routine of the family life. The family members have extra household chores, as the affected member is unable to contribute. Trying to keep the family life as normal as possible while simultaneously trying to help the affected member is going to be frustrating more tedious/strainful. Due to caring their mentally ill family member would loose his or her livelihood opportunities.

7. The family may find the affected member's behaviour embarrassing and painful. They may avoid their normal socialization with others due to the stigma of having a mentally ill member, leading to self isolation of the family.

8. Families may feel angry with the affected member especially when they feel that the affected member is 'lazy' or not trying to control their behaviours due to the negative symptoms.

9. Families may experience severe stress, or marital discord or depression associated with living with this illness, requiring attention from the mental health professionals for their improving mental health.

10. The probability of the affected member relapsing is greater when the family's behaviour with them tends to be over-involved, hostile, critical and dissatisfied

11. The environment in which person lives would contribute towards the prognosis of the illness.

12. Due to the mental illness in one of the family member, families would experience burden, it is seen at two levels, subjective and objective burden:

a) What mental illness means to the family constitutes the subjective burden. It includes a *sense of defeat, feelings of guilt, inadequacy, helplessness, confusion, hopelessness anger, disappointment and depression* following the realization that the affected member is not like a normal individual like his or her fellow beings in the community. All their dreams set on the individual been unfulfilled because of the mental illness.

b). Objective burden such as decline in the economic status, as poverty is the cause and consequence of mental illness, *(expenses on* medication, hospitalizations, travel etc, and loss of livelihood opportunities for the affected person as well as the family member*), sleep disruption, interference's with daily routines in the family, disruption of family's leisure time, difficulties in communicating with the affected member, strained family relationships and reduced social supports etc.*

Why families need social support ?

Families with mentally ill member have fewer people to support because of social stigma and families isolating themselves. Families need to turn for emotional or practical support from their networks which includes Immediate family members, neighborhoods, extended families, peer group, self help groups, federations, caregivers groups, care givers associations, community based organizations, NGOs, volunteers, staff of the NGOs, panchyaths, PHCs, health workers and etc.

The advantages of having social contacts are:

a) Can be useful as temporary distractions from experiencing the pain of having a severe mentally ill member.
b) They provide general support and recreation to help the family members relieve their tensions.

c) Prevents the family member from focusing and spending too much energy on the affected member, and

d) Provide support in times of crisis.

e) Care givers groups and self help group helps them to ventilate their feelings, accepted as they are homogeneous groups

f) Caregivers forum gives platform for them to raise their collective voices would help them for advocating for their rights

How effective are Family Interventions?

Family interventions designed to reduce the risk of relapse developed as a result of the burden experienced by the family members after hospitalization and in the treatment process. Many research studies, and the experience of Basic Needs India has revealed that a substantial reduction in relapse rates are due to family interventions and home based support given by the field staff. Because of the clear relationship between expressed emotion and relapse, the interventions concentrate on diminishing the level of expressed emotion through education on the illness and care process, creating a platform for expressing their problems in a homogeneous groups, dealing with the side effects and negative symptoms during the home visits, helping families to have realistic expectations from their mentally ill family member, encouraging, consulting and engaging the mentally ill in the care process, supporting caregivers to deal with their problems would be the focus of family interventions in community mental health and development programme.

What does Family Intervention involve?

We will be seeing the families and the affected person during:

a) When the affected member is acutely symptomatic or relapsed.
b) When the affected member is in the recovering phase.
c) During follow-ups when the affected member is maintaining well on treatment.

As the families that you meet may be in different phases of the illness, they may have different needs and expectations. The needs of the family per se will differ from that of the affected member's.

1. Treatment for PWMI – support for the travel and medicines.
2. Dealing with negative symptoms.
3. Referral services.
4. Psycho education.
5. Need for skill training for taking up profession.
6. Economic empowerment needs (Housing, BPL card, Voters ID, Construction workers ID, Bus pass, Train pass, Disability ID card, Pension for persons with mental illness, Old age pension, Widow pension
7. Day care/work therapy centers for PWMI.
8. Institutional care for PWMI – especially families of single parent and aged parents.
9. Support for general health.
10. Legal support related to property rights/separation.
11. Financial assistance from banks.

Once the person with mental illness had been identified in the community, the field worker starts working with the family, understanding the problems, assessing the situation, differentiating with mental retardation and stress. Field workers would provide

information about the available services for treating people with mental illness. The field staff also would encourage the families to attend the caregivers meeting, or meeting other families having similar experiences so that they can get convinced about the need for regularizing treatment.

The field staff would build rapport with the affected persons; consult him to understand his or her needs. Educate the family about the illness and guide them or escort them for consulting mental health professional for assessment diagnosis and treatment services. The field staff would educate them about the illness, and would inform them about the medicine intake. Field staff would visit the families, educate them about side effects, share his experiences of dealing with side effects, if necessary would refer back to the mental health professional for managing side effects. The affected person would be encouraged to take up responsibilities at home, motivate the families for involving in productive work along with the medicines.

Once the affected person and the family feels confidence of involving in productive work (household activities). Encourage them for going back to the previous work what he or she was doing (prior to illness). Incase if it becoming difficult, than encourage them for involving in income generation activities like agricultural work, goat/cow/ramlamb gracing, skilled work.

Session 6 c

National Mental Health Programme (NMHP) 1982

The huge country like us lack mental health policy, instead we have National Mental Health Programme. The National Mental Health Program is the outcome of the developments in providing mental health care through different methods as well as the overall goals of the health care in general. The Government of India has launched the National Mental Health Programme (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it. The formulation of NMHP in 1982 was a milestone in the history of mental health care.

The **objectives** of the NMHP program are:

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

The specific **approaches** suggested for the implementation of the NMHP are:

- Diffusion of mental health skills to the periphery of the health service system
- Appropriate appointment of tasks in mental health care
- Equitable and balanced territorial distribution of resources
- Integration of basic mental health care with general health services
- Linkage to community

Progress of the NMHP

From the time of the formulation of the NMHP in August 1982, in the last two decades the following initiatives and activities have been taken up in districts where the district mental health programme has been implemented:

- Sensitization and involvement of state level programme officers
- Workshops for voluntary agencies
- Workshops for mental health professionals namely psychologists, psychiatric social workers and psychiatric nurses
- Training programmes in public mental health for programme managers
- State level workshops for the health directorate personnel, development of models of integration of mental health into primary health up to the district level
- Preparation of support materials in the form of manuals, health records for different types of health personnel and health education materials
- Training program for teachers of undergraduate psychiatry
- Initiation of district mental health programme in 28 districts of 22 states
- Expansion of district mental health programme for 100 districts with the budgetary allocation of rupees 190 crores in the 10th five-year plan (2002-03 to

2006-07) and 1200 crores been sanctioned in 11th five year plan to implement DMHP prorgamme.

- Expansion of district mental health programme to all the districts in the 11th five year plan.

The District Mental Health Programme (DMHP)

The 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 10th five year plan period the government has announced the programmes extension to 100 districts across the states, with a total budget outlay of 200 crore rupees, in 11th five year plan has allotted nearly 1300 crores for mental health services, agreed to implement district mental health programme in 500 districts through out India over a period of 5 years. The child mental health issues been given importance, and money for NGO's for initiating mental health services been made available in the current five year plan.

There have been many barriers to reach the goals set out in the 1982 document. The goals were too ambitious to begin with and sufficient attention was not paid to all aspects of implementation of NMHP. The other important barrier has been the lack of funding. Though NMHP came up in 1982 the subsequent three five years plans did not make adequate funding allocation. Further even the funds allotted were not fully utilized. It was only in the 9th Five-year plan that a substantial amount of Rs 28 cores was made available and it was projected to be Rs 190 cores in the 10th Five-year plan and in huge jump in 11th five year plan.

The critical review of District Mental health programme reveals that:

a. There was lack of administrative clarity to utilize the allocated funds. The programme looked good on paper, but was extremely unrealistic in its targets, especially considering the available resources of manpower and funds for its implementation.
b. The approach was top down and did not take into consideration the ground realities. The poor functioning of the primary health care in India in general as well as the poor morale of the health workers not taken into account. A structure that was attending to given tasks so inadequately would certainly be unable to absorb new targets of integration.
c. The DMHP continues to be the extension of professionals rather than integration of mental health with primary care

Even though, the Government of India has sanctioned DMHP to all the districts in the 11th five year plan. The districts are yet to implement the programme and to appoint required mental health professionals for the programmes. It has to be noted that a few districts do not have psychiatrists and the facilities in the district hospital to support the mobile team of the district mental health programme.

National Health Policy- 2002

The 2002 National Health Policy (NHP 2002) refers twice to mental health. In its assessment of the current scenario, Section 2.13 states that: '*Mental health disorders are actually much more prevalent than is apparent on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families. Sometimes, based on religious faith, mental disorders are treated as spiritual affliction. This has led to the establishment of unlicensed mental institutions as an adjunct to religious institutions where reliance is placed on faith cure. Serious conditions of mental disorder require hospitalisation and treatment under trained supervision. Mental health institutions are woefully deficient in physical infrastructure and trained manpower. NHP 2002 will address itself to these deficiencies in the public health sector*'.

Section 4.13 states the policy prescription towards mental health: '*NHP 2002 envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff.*

The proposed National Health Policy outlines the prioritized agenda for extending within a pragmatic time frame basic mental health care facilities to all sections of the populations across the country by the year 2020.

Session 6 d
Eleventh Five Year Plan
National Mental Health Programme

3.1.171. A multipronged strategy to raise awareness about issues of mental health and persons with mental illness with the objective of providing accessible and affordable treatment, removing ignorance, stigma and shame attached to it and to facilitate inclusion and acceptance for the mentally ill in our society will be the basis of the National Mental Health Programme (NMHP). Its main objective will be to provide basic mental health services to the community and to integrate these with the National Rural Health Mission. The programme envisages a community and more specifically family based approach to the problem.

3.1.172. The Plan will strengthen District Mental Health Programme (DMHP) and enhance its visibility at grass root level by promoting greater family and community participation and creating para professionals equipped to address the mental health needs of the community from within. It will fill up human resource gap in the field of psychiatry, psychology, psychiatric social work and DMHP. The plan will strive to incorporate mental health modules into the existing training of health personnel. It will also harness NGOs' and CSOs' help in this endeavour, especially family care of persons with mental illness, and focus on preventive and restorative components of Mental Health. The Eleventh Five Year Plan, recognizing the importance of mental health care, will provide counseling, medical services and establish helplines for people affected by calamities, riots, violence (including domestic) and other traumas. To achieve these, a greater outlay will be allocated to mental health.

3.1.173. During the Eleventh Five Year Plan, the Re-strategised National Mental Health Programme will be implemented all over the country with the following objectives:

• To recognize mental illnesses at par with other illnesses and extending the scope of medical insurance and other benefits to individuals suffering with them

• To have a user friendly drug policy such that the psychotropic drugs are declared as Essential drugs.

• To give greater emphasis to psychotherapeutic and a rights based model of dealing with mental health related issues

• To include psychiatry and psychology, and psychiatric social work modules in the training of all health care giving professionals

• To empower the primary care doctor and support staff to be able to offer psychiatric and psychological care to patients at PHCs besides educating family carers on core aspects of the illness.

• To improve public awareness and facilitate family-carer participation by empowering members of the family and community in psychological interventions.

• To provide greater emphasis on public private participation in the delivery of mental health services.

• To upgrade Psychiatry departments of all Medical colleges to enhance better training Opportunities

• To improve and integrate mental hospitals with the whole of health delivery infrastructure that offer mental health services thus lifting the stigma attached

• To provide after care and lifelong support to chronic cases.

• **6.153**. Mental Health of Children is an issue that the Eleventh Plan will fund and take up on priority basis. Counsellors will be appointed in all schools and helplines will be set up especially during exams. (pg 224, Vol. 2)

•**1.19** Address urgent mental health needs of women and increase and upgrade state support services for women and girls (Vol. 1)

• **6.61**The Eleventh plan is committed to mitigating the negative impact on women of displacement due to natural or man-made calamities, incidents of communal violence or social upheaval and development projects. It will formulate gender sensitive relief and rehabilitation policies; (pg 203, Vol. 3)

• **3.1.203** Providing humane Mental Health services (Pg 107, Vol. 2)

The following aspects of the NMHP require attention during the 11th Five Year Plan:

- The overall effort should be to create structures that will meet the long-term mental health programme development in the country, as against the focus on only rapid expansion of the current models of care.
- A system of support and supervision, along with evaluation should be the foundation of the programme.
- There is a need for a national level initiative for human resource development for mental health care.
- Consolidating the different models of care by systematic evaluation, specifically the DMHP, the school-based interventions, the suicide prevention programme, substance abuse programmes, family support initiatives, and engage the private stakeholders within the context of a national mental health programme.
- There is a greater need to use the mass media and information technology to spread the mental health information to the total population.
- Attention to the mental health impact of rapid social change, urbanization and changes in the family life and to develop corrective and humane interventions to address these effects.

Programme Component	10th Five Year Plan *(INR in millions)*	11th Five Year Plan *(INR in millions)*
D.M.H.Ps	**775**	**6800**
Modernisation of Mental Hospitals	**600**	**Nil**
Strengthening of Medical Colleges	**375**	**3210***
IEC & Training	**100**	**750**
Research	**50**	**Nil**
School Mental Health Programme	**Nil**	**2230**
Monitoring	**Nil**	**150**
NGOs	**Nil**	**100**
Total	**1900**	**11430**

National Mental Health Programme- Budget Allocation

* "Manpower Development"

Session 6 e
A Multi Dimensional Approach to Mental Health Promotion

Statistically serious mental illness affects one percent of the population (and a much larger percentage affected by minor mental illness). However at the community level their visibility is low as only1 or 2 affected persons present in a village. Being marginalized by the pervasive stigma against mental illness and by their own diffidence, mentally ill persons and their care givers have not been very articulate about their 'needs and rights' in India at a larger level. In recent times there is increasing interest in this issue to some extent stoked by public interest litigation (by the NGO SAARTHAK following the Erawadi tragedy in 2001), egging the reluctant public health structure to begin responding to the needs. However, the present situation is quite unsatisfactory in the different areas of policies, programs, models of care adopted, community attitudes and supports and family level awareness and capacities in relation to the issue of mental illness.

Multidimensional factors affecting quality of life of the mentally ill persons, in India.

Policy and Program level.

The Mental Health Act of 1987 though signifying a positive policy mindset (where mentally ill people were viewed as requiring treatment and care and not as criminals), however its base in institutional care makes it ineffectual in meeting mentally ill peoples needs. The inclusion of mentally ill people in the 'Persons with Disability Act 1995' is to all purpose peripheral and more like an after thought

There is no access to "medical care' for the large majority of persons affected. The allopathic and institutional approach to mental health in the national program has resulted in medical care and support resources being concentrated in the major cities. The plight of the public and private run institutions have come up for critical scrutiny by the NHRC and the judicial system. However even these rudimentary facilities are unavailable at the periphery. Many of the headquarters towns of the 500 odd districts in India do not have qualified mental health teams, or availability of medications. The recently launched District Mental Health Program-DMHP (extended to 22 districts in 2000 in the first phase and to spread to 100 districts in the 10th plan ,2003-2007, and to all districts in 11th five year plan) with a budget outlay of 1300 crore rupees, is yet to show results at the ground level. Data on the 3rd phase districts chosen are not yet available. It would appear in keeping with the problems affecting the public health system at large, the benefit to the clients; even in DMHP districts are likely to be low. Resources being likely to be cornered by the medical establishment themselves, rather than over all development of the individuals.

Beyond medical care the important needs (of the mentally ill persons and their caregivers) for 'welfare support measures' and 'livelihood generation' is not addressed at all. Similarly there is no nationwide 'awareness and education effort' directed against the pervading stigma and for generating community and family level solidarity.

Community Level:
The stigma against mental illness results in marginalization, excluding them from income earning opportunities, social recognition acceptance and making them vulnerable to physical harassment and exploitation. This is compounded by the gender discrimination existing, resulting in mentally ill wives being rejected by their husbands, affected women's inheritance being usurped and the local level opinion groups promoting suppressive dynamics against women.

Family Level:

Hostile family dynamics play an important role in the generation and maintenance of mental illness, (this is an area requiring further researching in India). Often the key caregivers are overburdened or themselves require physical and emotional supports. Another feature is that of mentally ill people becoming destitute, with family not able or willing to look after them. A not uncommon (though not understood) factor is the contribution to mental illness of sexual exploitation within the family.

Individual level:
Lack of access to quality health care and follow-up services for the side effects, leads to the high dropout rates from the treatment. Large numbers of individuals who could have been stabilized with drugs are remaining unmanageable for this reason. Beyond the bio-medical inputs, individuals have a variety of psychological needs, which are not getting addressed. Beyond both these aspects there is a lack of recognition of individuals ability to help themselves, given some critical supports.

Multi Dimensional Approach to Mental Health Promotion.

In the 'developmental model' of mental health professed and promoted by Basic Needs India, we see the need for changes at all of the above mentioned levels.

Policy and Program :
Mental illness and health is a developmental issue and not just a medical problem. Hence it needs to be addressed wholistically, in policies and programs. Within the health sectoral interventions, the potential for contribution of the various systems of medicine/health, needs to be evaluated scientifically. Where found appropriate they should be encouraged, so that people can choose the system they have faith in, assured of its quality.

Mental health care and medications need to be accessible to needed individuals through the PHCs, GPs and Voluntary Sector agencies. This would require appropriate professional training interventions and procurement and distribution of essential drugs. There is importantly a need for training and making available at the village level, skilled 'barefoot counsellors' who can be supportive in generating solidarity at family and community level. This is an important gap presently.

The welfare provisions of the 'People with Disability Act' need to be operationalized to benefit the mentally ill persons and where needed additional welfare measures instituted. Mentally ill persons cannot be well without the self-respect derived from being earning and contributing members of the family and community. Livelihood generation supports are important, with schemes addressing their special needs, where the ill person and the family are included.

There is need of educational campaigns to promote emotional wellness, at different walks of life. One of the positive features of the HIV/AIDS prevention campaign is the belated recognition of the importance of 'Life Skills Education' for adolescents. Other vulnerable segments also need to be addressed through promotive programs, which also should include stigma reduction.

Community Level:
Mentally ill persons and their caregivers need to be consulted and included in the community level developmental plans. Self help groups of only mentally ill persons are unlikely to be practical (too few in a village). Self-Help Groups of disabled persons (including mentally ill persons and caregivers) and which subsequently includes other marginalized group could be the mechanism for inclusiveness. Such SHGs could play important role in fostering solidarity and acceptance. At the same time awareness promotion through multiple means to address community level stigma is needed. There is need of a mechanism to address speedily exploitation and rights abuses, in the context of their vulnerability.

Family Support Structure:
Mentally ill persons in our experience get well within their family, as opposed to an institutional care approach. However the family needs new insights, skills and emotional support themselves. This is to be made available through visits and counseling by volunteers and SHG members who are trained themselves. Where family caregivers are not available, other local support systems may be developed. Part of the getting well process, is recognition and acceptance of their change by the family and community.

Individual level:
In the initial phase stabilization of the person's functioning and emotional state with appropriate medications seem to be a cost-effective step. Several psychological needs of the individual (such as need for structure, stimulation, belongingness etc.) require to get addressed. Beyond that the affected individual makes the choice to get well and become a contributing member of society.

Outcomes from Basic Needs India's Partnership Experiences.

In the most recent review of Basic Needs India's work held with our primary partner organizations, the major overall impact of our work was seen as the inclusion of mentally ill people in family and community activities; their involvement in making decisions about treatment and work opportunities; their increasing ability to access government poverty alleviation's schemes; and their improved participation and visibility in social events.

The total number of mentally ill people identified by Basic Needs India in our projects in around 16000. About eighty percent of them have attended consultation, sixty percent of them are under treatment and fifty three percent are engaged in productive work. Basic Needs India has facilitated local policy initiatives of its partners, supporting them to root their advocacy actions in research based evidence.

This has resulted in district official releasing free food quota to a family, the district mental health teams extending clinics into the community, or the state mental hospital extending their services to several district.

Key problems experienced in the work.

- District hospitals not equipped to provide treatment to mentally ill
- Non availability of psychiatric medicines through government centers (Taluk hospitals, CHCs, PHCs etc.
- Mechanism for professional monitoring and follow up for side effects of drugs is inadequate, and would require an enhanced team of paramedicals with simple training.
- Lack of awareness on mental health issues in the community, as well as resistance of the community and the spouses of individuals in recognizing growth and change in individuals.
- People with minor mental illness not addressed at the community level.
- Gender related discrimination and oppression
- Harmful practices and human rights abuse existing in the community.
- Problem of destitution (no care giver available)
- Need for sensitive skills training (respecting the individual's dignity and gender sensitive) to field staff of facilitating NGO and SHG group leaders.

Mani Kalliath- Basic Needs India

(Paper *presented at International Health Forum for the Defense of People's Health on 15th Jan 2004, Mumbai*)

Session 7

Prevention and promotional strategies: 60 minutes

1. Trainer invites participants to list out the causes of mental illness.
2. Trainer asks participants to reflect on the causes that can be prevented
3. Trainer asks participants to brainstorm on the promotional strategies for mental health.
4. Trainer summarizes the discussion through power point presentation on the promotional strategies, and share about preventions strategies for relapses.
5. Trainers shares with the participants on child mental health programme, and life skill trainings, suicide prevention etc.

Session 7
Prevention of Mental Disorders

About 450 million people suffer from mental and behavioural disorders worldwide. One person in four will develop one or more of these disorders during their lifetime. Neuropsychiatric conditions account for 13% of the total Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries in the world and are estimated to increase to 15% by the year 2020. Five of the ten leading causes of disability and premature death worldwide are psychiatric conditions. Mental disorders represent not only an immense psychological, social and economic burden to society, but also increase the risk of physical illnesses. Given the current limitations in effectiveness of treatment modalities for decreasing disability due to mental and behavioural disorders, the only sustainable method for reducing the burden caused by these disorders is prevention.

Overall, the economic costs of mental ill-health are enormous and not readily measurable. In addition to health and social service costs, lost employment, reduced productivity, the impact on families and caregivers, the levels of crime and public safety and the negative impact of premature mortality, there are other hard-to-measure costs, such as the negative impact of stigma and discrimination or lost opportunity costs to individuals and families that have not been taken into account.

To reduce the health, social and economic burdens of mental disorders it is essential that countries and regions pay greater attention to prevention and promotion in mental health at the level of policy formulation, legislation, decision-making and resource allocation within the overall health care system.

Mental disorder prevention

Mental ill-health refers to mental health problems, symptoms and disorders, including mental health strain and symptoms related to temporary or persistent distress. Preventive interventions work by focusing on reducing risk factors and enhancing protective factors associated with mental ill-health.

Although there are definitional nuances in the field, mental disorder prevention is broadly understood Mental disorder prevention aims at "reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society".

Mental disorders have multiple determinants; prevention needs to be a multipronged effort Social, biological and neurological sciences have provided substantial insight into the role of risk and protective factors in the developmental pathways to mental disorders and poor mental health. Biological, psychological, social and societal risk and protective factors and their interactions have been identified across the lifespan from as early as fetal life. Many of these factors are malleable and therefore potential targets for prevention and promotion measures. High co-morbidity among mental disorders and their interrelatedness with physical illnesses and social problems stress the need for integrated public health policies, targeting clusters of related problems, common determinants, early stages of multi problem trajectories and populations at multiple risks.

Effective prevention can reduce the risk of mental disorders

There is a wide range of evidence-based preventive programmes and policies available for implementation. These have been found to reduce risk factors, strengthen protective factors and decrease psychiatric symptoms and disability and the onset of some mental disorders. They also improve positive mental health, contribute to better physical health and generate social and economic benefits. These multi-outcome interventions illustrate that prevention can be cost-effective. Research is beginning to show significant long-term outcomes.

Prevention needs to be sensitive to culture and to resources available across countries

Current opportunities for prevention of mental disorders and mental health promotion are unevenly distributed around the world. International initiatives are needed to reduce this gap and to support low income countries in developing prevention knowledge, expertise, policies and interventions that are responsive to their needs, culture, conditions and opportunities.

Effective prevention requires intersectoral linkages

Prevention of mental disorders and mental health promotion need to be an integral part of public health and health promotion policies at local and national levels. Prevention and promotion in mental health should be integrated within a public policy approach that encompasses horizontal action through different public sectors, such as the environment, housing, social welfare, employment, education, criminal justice and human rights. This will generate "win-win" situations across sectors, including a wide range of health, social and economic benefits.

Protecting human rights is a major strategy to prevent mental disorders

Adverse conditions such as child abuse, violence, war, discrimination, poverty and lack of access to education have a significant impact on the development of mental ill-health and the onset of mental disorders. Actions and policies that improve the protection of basic human rights represent a powerful preventive strategy for mental disorders.

Risk factors

• Academic failure and scholastic demoralization • Access to drugs and alcohol • Caring for chronically ill or dementia patients • Child abuse and neglect • Chronic insomnia and chronic pain • Communication deviance • Displacement • Early pregnancies • Emotional immaturity and dyscontrol • Excessive substance use • Exposure to aggression, violence and trauma • Family conflict or family disorganization • Isolation and alienation • Lack of education, transport, housing	• Medical illness • Neuro chemical imbalance • Parental mental illness • Peer rejection • Personal loss – bereavement • Poor nutrition • Poor social circumstances • Poor work skills and habits • Poverty • Racial injustice and discrimination • Reading disabilities • Sensory disabilities or organic handicaps • Social incompetence • Stressful life events • Unemployment • Urbanisation • War • Work stress

Protective factors which has to be strengthened

• Ability to cope with stress • Ability to face adversity • Adaptability • Autonomy • Early cognitive stimulation • Empowerment • Ethnic minorities integration • Exercise • Feelings of mastery and control • Feelings of security • Good parenting • Literacy • Positive attachment and early bonding • Positive interpersonal interactions	• Positive parent–child interaction • Problem-solving skills • Pro-social behaviour • Self-esteem • Skills for life • Social and conflict management skills • Social participation • Social responsibility and tolerance • Social services • Social support and community networks • Social support of family and friends • Socio-emotional growth • Stress management

Session 7 b

What is Mental Health Promotion?

Mental health promotion often refers to positive mental health, considering mental health as a resource, as a value on its own and as a basic human right essential to social and economic development. Mental health promotion aims to impact on determinants of mental health so as to increase positive mental health, to reduce inequalities, to build social capital, to create health gain and to narrow the gap in health expectancy between countries and groups (Jakarta Declaration for Health Promotion, WHO, 1997). Mental health promotion interventions vary in scope and include strategies to promote the mental well-being of those who are not at risk, those who are at increased risk, and those who are suffering or recovering from mental health problems.

Defining mental health promotion
"Mental health promotion activities imply the creation of individual, social and environmental conditions that enable optimal psychological and psycho-physiological development. Such initiatives involve individuals in the process of achieving positive mental health, enhancing quality of life and narrowing the gap in health expectancy between countries and groups. It is an enabling process, done by, with and for the people. Prevention of mental disorders can be considered one of the aims and outcomes of a broader mental health promotion strategy."

Research shows that mental health promotion is a concept that has significant potential for contributing to the well-being of individuals and communities.

Good mental health is a goal that most of us share, and mental health promotion is a means of reaching that goal. Mental health is promoted through processes which give people the ability to function well, or which remove barriers that may prevent people from having control over their mental health.

For example, strengthening people's ability to bounce back from adversity and manage the inevitable obstacles that life tends to throw in our path is a fundamental way of promoting mental health. In general, though, any actions which are taken for the purpose of fostering, protecting and improving mental health can be seen as mental health promotion. These can range from community-level interventions such as equitable social policy development, to individual-level interventions which cultivate skills, attitudes and behaviors conducive to mental health.

Mental health promotion applies to the whole population in the context of everyday life; it is not only for those who experience mental health illness, nor for those who are considered to be at risk. There is a role, however, for interventions designed specifically for certain groups, such as people who care for a family member with mental illness.

There a few key factors to keep in mind in relation to mental health promotion. One is the importance of informal relationships -- with friends, family, co-workers, and others - which play a vital role in supporting and maintaining positive mental health. Mental health promotion initiatives build on the networks of social support that are already present in communities, and create new relationships that enhance our sense of belonging.

Secondly, it is important to consider that mental health promotion can take many forms. Because positive mental health is the result of many interacting factors, there is no single way to promote it. Communities are made up of a diverse range of people, so efforts to promote mental health need to consider a variety of strategies and approaches that are relevant to the full range.

Finally, it is essential that efforts to promote mental health recognize and reflect the diversity of cultures within our communities; these efforts will contribute to building a society that ensures fair and equitable treatment -- one that accommodates and respects the dignity of people of all origins. To be successful, mental health promotion efforts require active citizen involvement in identifying mental health needs, setting priorities, controlling and implementing solutions, and evaluating progress towards goals - essentially a community development model.

Although the principles and processes may be similar, the outcomes of mental health promotion and generic health promotion can be quite different whereas health promotion projects might be working toward improved cardiovascular health or decreased rates of smoking, mental health promotion focuses explicitly on mental health outcomes such as increased sense of personal control, empowerment, self-determination, and resilience.

Much of the work of mental health promotion has to do with shifting attitudes -- emphasizing the importance of maintaining positive mental health instead of dealing with individual distress, and dealing with mental illness in a balanced and humane way that will dismantle stigma and encourage recovery.

We all need mental health promotion. By identifying and activating the personal and social strengths that support positive mental health, people can work together to develop healthier communities.

There is no health without mental health: The essential dimension of mental health is clear from the definition of health in the WHO constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Mental health is an integral part of this definition. The goals and traditions of public health and health promotion can be applied just as usefully in the field of mental health as they have been in the prevention of infectious or of cardio-vascular diseases, for example.

Mental health is more than the absence of mental disorders: Mental health can be conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. This core concept of mental health is consistent with its wide and varied interpretation across cultures.

Mental health promotion covers a variety of strategies, all aimed at having a positive impact on mental health. Like all health promotion, mental health promotion involves actions that create living conditions and environments to support mental health and allow people to adopt and maintain healthy lifestyles. This includes a range of actions that increase the chances of more people experiencing better mental health.

Mental health is determined by socio-economic and environmental factors: Mental health and mental health disorders are determined by multiple and interacting social, psychological, and biological factors, just as health and illness in general. The clearest evidence is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and poor income. Increasing and persisting socio-economic disadvantages for individuals and for communities are recognized risks to mental health.

The greater vulnerability of disadvantaged people in each community to mental health disorders may be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health. A climate that respects and

protects basic civil, political, socio-economic and cultural rights is also fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.

Mental health is linked to behaviour: Mental, social, and behavioural health problems may interact to intensify their effects on behaviour and well-being. Substance abuse, violence, and abuse of women and children on the one hand, and health problems such as HIV/AIDS, depression, and anxiety on the other, are more prevalent and more difficult to cope with in conditions of high unemployment, low income, limited education, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, and human rights violations.

Enhancing the value and visibility of mental health promotion: National mental health policies should not be solely concerned with mental health disorders, but also recognize and address the broader issues which promote mental health. These would include the socio-economic and environmental factors, described above, as well as behaviour. This requires mainstreaming mental health promotion into policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector. Particularly important are the decision-makers in governments at local and national levels, whose actions affect mental health in ways that they may not realize.

- Cost-effective interventions exist to promote mental health, even in poor populations
- Low cost, high impact evidence-based interventions to promote mental health include:
- Early childhood interventions (e.g. home visiting for pregnant women, pre-school psycho-social interventions, combined nutritional and psycho-social interventions in disadvantaged populations).
- Support to children (e.g. skills building programmes, child and youth development programmes)
- Socio-economic empowerment of women (e.g. improving access to education, microcredit schemes)
- Social support to old age populations (e.g. befriending initiatives, community and day centres for the aged);
- Programmes targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters (e.g. psycho-social interventions after disasters);
- Mental health promotion activities in schools (e.g. programems supporting ecological changes in schools, child-friendly schools)
- Mental health interventions at work (e.g. stress prevention programmes)
- Housing policies (e.g. housing improvement)
- Violence prevention programmes (e.g. community policing initiatives); and
- Community development programmes (e.g. 'Communities That Care' initiatives, integrated rural development)

Session 8

Child and adolescent mental health: 60 minutes:

1. Trainer introduces child and adolescent mental health problems through power point/ chart presentation
2. Trainer divides participants in to three groups asks them to share their experiences of seeing a child/ adolescent with emotional problems
3. Trainer invites groups to share their discussion in the larger group
4. Trainer summarizes the discussion sharing the various interventions.

Session 8
Mental health problems in children:

It's easy to know when your child has a fever. A child's mental health problem may be harder to identify, but you can learn to recognize the symptoms. Like adults, children and adolescents can have mental health disorders that interfere with the way they think, feel, and act. Untreated emotional problems in children can lead to school failure, family conflicts, drug abuse, violence, and even suicide. Untreated emotional problems in children can be very costly to families, communities, and the health care system. Pay attention to excessive anger, fear, sadness or anxiety. Sudden changes in your child's behavior can tip you off to a problem. So can behaviors like exercising too much, or hurting or destroying things. The emotional disturbances in children are differently presented when compared to that of adults. The communication of discomfort will always be different in case of children when compared to that of adults.

Indeed, most parents are not abusive, but many are also unsupported and ill equipped for the never ending demands of child care. Most parents wanted their children to secure good percentage in exams in this competitive world. Their influences become stresses for the children affecting their mental health. Others are poor, struggle with their own illness or substance abuse problems or live in violent relationships. These are facts that are hard to reconcile.

Studies show that at least one in five children and adolescents have a mental health disorder. At least one in 10, or about 6 million people, have a serious emotional disturbance

Be aware of adolescent experiences do not understand it has emotional problems:

- Showing declining performance in school.
- Losing interest in things once enjoyed.
- Experiencing unexplained changes in sleeping or eating patterns.
- Avoiding friends or family and wanting to be alone all the time.
- Daydreaming too much and not completing tasks.
- Feeling life is too hard to handle.
- Hearing voices that cannot be explained.
- Experiencing suicidal thoughts.
- Poor concentration and is unable to think straight or make up his or her mind.
- An inability to sit still or focus attention.
- Worry about being harmed, hurting others, or doing something "bad".
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger.
- Racing thoughts that are almost too fast to follow.

Signs of Mental Health Disorders Can Signal a Need for Help:

Children and adolescents with mental health issues need to get help as soon as possible. A variety of signs may point to mental health disorders or serious emotional disturbances in children or adolescents. Pay attention if a child or adolescent you know has any of these warning signs:

A child or adolescent is troubled by feeling:

- Sad and hopeless for no reason, and these feelings do not go away.
- Very angry most of the time and crying a lot or overreacting to things.
- Worthless or guilty often.
- Anxious or worried often.
- Unable to get over a loss or death of someone important.
- Extremely fearful or having unexplained fears.
- Constantly concerned about physical problems or physical appearance.
- Frightened that his or her mind either is controlled or is out of control.

The emotional disorders in children

Externalizing Disorders (ED): The term ED includes disorders with behavior that are disruptive and aggressive, often harmful to others. some of the emotional disorders falling under this category are:

Hyperactive attention deficit disorder (ADHD) :

This disorder is identified by inattention, hyperactivity and impulsivity. The other disorders likely to occur along with ADHD are depression, learning disorders, conduct disorders and anxiety disorders.

ADHD produces two important consequences in children – deficiencies in both academic and social skills. In a school setting this problem is compounded by distraction and lack of organization in school assignments. These difficulties result in lack of practice of basic skills such as those gained by completing sets of arithmetic problems or spelling exercises.

Dyslexia:
Specific signs of dyslexia can be of three types – academic, motor and language

a. Academic – ask the child to write a few lines on any subject, check for spelling errors such as reversal of letters or words that look like a mirror image of each other such as 'no' and 'on'. The child may make spelling mistakes by omitting letters or putting the wrong letters in a word. The hand writing is often untidy. Difficulties in calculation can be tested by asking the child to repeat multiplication tables. Dyslexia children have difficulty in putting the order of multiplication correctly and get the results wrong.

b. Motor signs – the child may be restless or overactive. They may appear distracted and forgetful. They may be clumsy. You can ask for right or left arm for right – left orientation. They may be unable to do the shoe lace or button the shirt/ dress.

c. Language signs - There may be difficulty understanding instructions, reading a watch or telling a story.

Conduct disorders (CD):
Children misbehave much more than are normal the important societal norms are violated and the basic rights of others are often severely violated as well. The persistent behavior typical of CD include aggressive actions that cause or threaten harm to people, or animals, non aggressive conduct that causes property damage, major deceitfulness or theft and serious rule violations. Several of these characteristic behaviors must have occurred in the past year and at least one in the last six months.

The Internalizing Disorders (ID)

The ID refers to condition whose most important features is disordered mood or emotion. The ID are often overlooked or at least not brought to clinical attention for long periods of time – because they are less to detect and their potential seriousness is often discounted by parents and teachers.

Separation anxiety disorder –
This is unique to children, they show excessive anxiety or even panic when they are not with major attachment figures, usually parents or in familiar surroundings, although this is normally common to childhood and decrease by the age of 10. These normally developmentally related fears are different from the excessive reaction to separation that occurs in children who develop a separation anxiety disorder.

Other Anxiety disorders:
These are not specific but occur also in adults. They are social phobia, generalized anxiety disorder and obsessive – compulsive – disorder

Social phobia: Children show excessive shrinking from contact with unfamiliar people that makes it hard for them to function normally in daily social contacts. However their relationships with familiar people like family members are generally warm and satisfying.

Generalized anxiety disorder: Children must have been affected by anxiety symptoms for at least six months to diagnose. This problem is related to situations that involve pressure for performance or that carry the risk of loss of self esteem or feelings of lack of competence.

Obsessive – Compulsive Disorder: Obsession involves the persistent intrusion of intense, unwanted, senseless thoughts while compulsions are marked by repetitive, ritualistic behaviors. The younger the child is when severe symptoms develop, the more likely the disorder is to continue into adulthood.

Depression: Although childhood is often pictured as a happy time of little responsibilities, endless play and infinite enjoyments on the contrary depressive children/ adolescents show withdrawal, volatile moods, problems with over eating and over sleeping and suicidal thoughts. Failure to experience pleasure, apathy, low self esteem, fatigue, delinquent behavior, substance abuse and poor school performance are some of the manifestations.

Bed wetting: Where children wet the bed at an age when they should not. The commonest cause is a delay in this area of development of the child. Some children may start bed wetting after having learned how to control their urine. This is often due to the child becoming upset about something, such as fights in the family or arrival of a baby. Other less common reasons include urinary infections, child abuse, diabetes, physical problems in the urinary tract and some neurological problems.

Session 9

Mental health and development model: 60 minutes

1. Trainer divides participant in to three groups and ask them to list out the needs of people with mental illness from their past experiences of knowing the person with mental illness
2. Trainer invites the group to make presentation on the discussion
3. Trainer shares with them the needs expressed by people with mental illness in past consultations through power point presentation/ chart papers
4. Trainer summarizes the discussion through presenting Mental Health and Development Model of Basic Needs
5. Trainer shares about BNI partnership and its activities

Session 9

Mental health and development model

Mental health and development is an innovative model. Basic Needs India believes that how ever poor or ill the person is has the capacity to manage his or her life. Basic Needs India believes that people with mental illnesses have rights and are entitled to dignity and respect.

The vision and mission of Basic Needs India is:

- Basic Needs India seeks to satisfy the essential needs of all people with mental illness in India and to ensure that their basic rights are respected and fulfilled

- Initiate programmes in India which actively involve people with mental illness and their carers and enable them to participate in their own development of larger society. In so doing, stimulates supporting activities by other organizations and influence public opinion.

Basic Needs India underlying conviction: "**Mental Health is a Development Issue".** Hence it aims at active participation of community in creating/designing a caring accommodative and understanding environment to ensure fair treatment to PWMI in the community. A holistic approach would include implementing existing policies and advocating for the new ones.

Objectives of Basic Needs India is to:

- To restore mental health and human dignity, and ensure their rights
- To alleviate poverty through economically viable income generation activities,
- To carry out action research and disseminate the information and influencing public opinion
- To work with government organizations / NGOs

Basic Needs India's Approach

- "Inclusion of mentally ill in the development process"
- Work as collaborators with CBOs,NGOs and Government
- Consultations with PWMI to plan any programme
- Matching resources with needs

Basic Needs in participation with persons with mental illness, their carers\ families and CBO's evolved a model comprising of five modules. The mental health and development model comprises five modules that are designed to make desirable changes that facilitate social integration of people with mental illnesses adapting development practices.

Community Mental Health

The purpose of Community Mental Health Care is to assist the individual with mental illness to obtain an adequate level of functioning, to enable them participate in a sustainable self-reliant programme leading them to exert the human potentials within their own communities. The staff of the NGO's will be trained in identifying persons with mental health problems and designing a need based care programme and follow up. Training will be provided by the staff of BNI and external resource persons and organisations.

Capacity Building and Animation

As Basic Needs India works as a catalyst through NGO's, it is important to build the capacities of the local organisations so that they would be able to independently manage the community mental health and development programme. The project holders and the staff will be trained on an ongoing basis, the training will equip them with the skills to manage all the capacity building elements of the programme. In particular the focus of this community development work will be mentally ill people themselves and their carers affording them opportunities to come together at regular intervals to talk about relevant issues and to assist them in developing appropriate strategies in sustainable livelihoods. Capacity building will equip them with the knowledge about the illness and the coping mechanism. Ultimately the stigma attached to people with mental illness fades and they have a rightful place in their community.

Sustainable Livelihoods

Poverty is a consequence and cause of mental illness, therefore one of the touch stone's of the philosophy is to involve people with mental illness and family members in economically viable activities. Using a group animation approach, mentally ill people will be encouraged to find practical solutions to the problems that they themselves have identified. Economic development programmes appropriate to the individual or his family members will be designed. The CBO's will also be trained in identifying local resources and trades and in identifying the capabilities and making appropriate referrals. Savings and credit groups comprising of mentally ill people and their carers will be formed and appropriate links will be made to micro finance organisations and to locally based schemes run by the Government for disadvantaged people.

Research

Action research will be developed along with people who have experience of mental illness to understand their lives in the community. The NGO's will document their learning's , experiences and impact and disseminate this information to other interested organisations and individuals . The end product of research is attaining knowledge leading to change in the life styles of people with mental illness as well as improving the efficacy of mental health programs- of the partnership as well as of the government .

Administration

The programmes will be reviewed through meetings and field visits. Individual case records and activities will be documented for monitoring and evaluation. Programme and financial reports will also be submitted periodically.

Session 10

CBR and people with mental illness: 45 minutes

1. Trainer invites participants to share on the activities of the community based rehabilitation
2. Trainer shares the community mental health and development activities
3. Trainer invites participant to identify similarities and differences in CBR and community mental health and development work.
4. Trainer summarizes the discussion sharing their experiences of including community mental health activities in their CBR programme.

Session 10

Community mental health services through CBR

Community based mental health services:

People and the community are the biggest resources available for the community mental health services. Many of the mental health problems can be effectively dealt by the people and within resources available close to them. Large-scale dissemination of knowledge and skills to people would help in reducing stigma attached to illness. Building knowledge and awareness of families can make the real difference. Should create a platform to discuss about "sound mind in sound body" and importance of positive mental health and well being.

There is international focus of human resources for health care. The theme of the World Health Report 2006(WHR 2006) is **Working Together for Health**.

The world health report 2006 emphasis that "the ultimate goal of health workforce strategies is a delivery system that can guarantee universal access to health care and social protection to all citizens in every country. There is no global blueprint that describes how to get there- each nation must devise its own plan. Effective workforce strategies must be matched to a country's unique situation and based on social consensus"(emphasis added)(p.119)

The 2001 WHO document, titled "Mental Health: New Understanding, New Hope" provide importance to community based mental health services. emphasizing community acceptance, family involvement, social integration and livelihood opportunities as a key components of the interventions. This path- breaking WHO document proposed a new course of action for implementing mental health programmes in developing countries. This course of action promoted an approach where medical inputs were seen as a part of a larger whole, that included income generation and mainstreaming individuals with mental health problems into the full community.

Why mental health to be integrated in CBR programmes:

CBR programmes can and do successfully include people with mental illness and people with psychosocial disabilities. This process has been beneficial to people with psychosocial disabilities and their families, the CBR programmes themselves and the mental health services for a number of reasons including:

- Community processes, full participation, equal opportunities, social inclusion, gender, diversity and a focus on rights are some of the key common elements of CBR work. Community mental health work is no different so the programmes integrate well together.

- The high prevalence of psychosocial disabilities emerging through mental illness and its impact on communities, societies and economies means that CBR workers are confronted with the issues in their work. CBR programmes can have a positive impact on the lives of people with mental illness, their families and on the situations in which people live by including people with psychosocial disabilities in their programmes.

- There are a limited number of mental health professionals and mental health services in low income countries, making a CBR strategy which empowers community level stakeholders to take action an important strategy.

- The emerging trend away from vertical health programmes to integrated, multipurpose health programme models favors primary level services and community-based strategies.

- There is an increasing recognition of the importance of early detection and treatment of mental illness in order to prevent chronic conditions.

- The goal of continuity of care and inclusion of people who are mentally ill into the community is more readily achieved when there is an existing community-based strategy.

- The prevalence of mental health problems among people with other disabilities means that a mental health component in the CBR programmes brings added value.

CBR approach and the role of the development workers

Development and changes in the concept of CBR over last two decades has influenced the thought of inclusion of mental health in the CBR programmes. The CBR approach aims at shifting rehabilitation interventions to homes and communities of people with disabilities, to be carried out by the rehabilitation workers who are minimally qualified non professionals. The main goal of rehabilitation has become broader than earlier, and focus beyond the individual, to his community where he/she need to be integrated.

Thus the universal mission of CBR is:

1. To enhance activities of daily life of disabled persons (people with mental illness also need help in this regard)
2. To create awareness in disabled person's environment to achieve barrier free situations around him and help him in meeting all human rights. (need conducive environment, where in people with mental illness are respected and their rights are protected, leading to lead life in dignity)
3. To create a situation in which the community of the disabled persons, participates fully and assimilated ownership of their integration in to the society. The relation ship here is affected people ownership.

Advantages of integration of people with mental illness in the existing CBR programme would be:

- Meeting the needs of most disadvantaged group, been considered as disabled as per the PWD act. Inclusion would ensure coverage of all people with disabilities.
- This promotes faster integration of PWMI in to the mainstream societal activities.
- Promotes good mental health in the community and leads to early identification.
- Inclusion of PWMI in CBR programme would be cost effective.
- CBR strategies and approaches very much fit in meeting the needs of PWMI.
- Encourages innovative use of the resources like street theatre troops, advocacy groups already existing.
- Mental health problems of people with disabilities also get addressed and add value to the existing CBR programme.
- A conducive environment would be built where in all disadvantaged groups including PWMI fully participate in their own development and the community in which they live in.

Local community organizations staff like community rehabilitation workers/field staffs, coordinators of self-help/user groups and other programmes, lay volunteers/ animators, nurses,

and health workers; who are not professionals in mental health or health care can provide variety of services. Many of these informal community-care providers have little or no formal mental health care training, but in many developing countries they are the main source of community mental health provision. They are usually accessible and generally well accepted in local communities. Mental health issues can be well integrated in to the community activities and the other developmental activities of the development organizations.

Some of the important roles of the CBR /development work force are:

- Awareness raising and dissemination of information.
- Identification of people with mental health problems and referral to health services.
- Crisis support.
- Home based support - supportive care, including basic information and counselling.
- Helping in the activities of daily living skills and community reintegration.
- *Integrating people with mental illness in to the self help groups (already existing)*
- *Formation of caregiver's groups/associations.*
- Supporting people with mental illness in accessing livelihood programmes and government schemes
- Advocating the rights of PWMIs.
- Preventive and promotive services.
- Organising affected people to advocate for meeting their needs.
- Conducting consultation to understand the individual needs of person with mental illness and to draw individual rehabilitation plan (IPR)

The interventions should be tailored to individuals' needs and aimed to make the person independent in community. Some may not have adequate skills to live independently in the community. They might not have acquired the necessary skills or lost the skills due to the illness. Then they need to learn/relearn the skills required to live in the community. Interventions should be aimed at teaching these skills. Some may have frequent anger outbursts, which might result in poor interpersonal relationships. Here focus should be on teaching the person on how to control anger. Some may have multiple problems. It is necessary to prioritize which problem should be tackled first.

The care for People with mental illness can be provided by :

- Family members providing care to PWMI starts from baring all the violent behaviour, to accompanying them for treatment, than administering medicines, helping to engage in gainful productive work.
- Community providing support for the well-being of PWMI. This is seen in the form of not calling them as mad people, giving opportunities and advocating for the ensuring measures to meet the needs of PWMI.
- Community based rehabilitation workers providing care for the PWMI and their families. This starts with identification, assessment, follow up, home based support and linking them to existing groups and mainstreaming.
- Organization providing support to deal with other associated problems of PWMI and their caregivers. This is seen in the form of conducting camps, integrating them in to their existing programmes.
- Provided with the above support, the role of mental health professionals would be more meaningful.

A different and better world for PWMI can be created through community based mental health services, where in the communities would understand issues related to mental health, resulting in positive response to the issues. In this scenario the families of the mentally ill are vitally involved in bringing change in the attitude of the community. Through these an environment of mutual understanding can be built, where in PWMI enjoy their rights.

Session 11 :

Why community mental health: 60 minutes

1. Trainer invites participants to share their views on the prevalence of mental illness (what is the percentage of people with severe mental illness, common mental illness, epilepsy, mental retardation)
2. Trainer provides information on prevalence of mental illness, project numbers for Indian population
3. Trainer asks the participants to share about the available mental health resources in the country (number of mental hospitals, number of psychiatrist, psychologist, psychiatric social workers, psychiatric nurses, budgetary allocations etc)
4. Trainer provides information on the available mental health infrastructure against the projected numbers of prevalence of mental illness for the country
5. Trainer invites the participants to share about the attitudes of the community on people with mental illness
6. Trainer shares their experience of working with people with mental illness and how the quality of life has changed after the intervention
7. Trainer makes presentation on the district mental health programme (Bellary model to 11^{th} five year plan)
8. Trainer invites participants to conclude the discussion by summarizing why community mental health from the previous discussion

Session 11 a

Why community mental health – some observations

Community Mental Health is concerned with the early recognition and treatment of the mentally ill as close to their homes as possible, on an out -patient or day patient basis in a centre situated in the middle of the community, with a short term in - patient treatment facility leading to an early discharge and community -based rehabilitation.

- One in four people suffer from a mental or neurological disorder at some point during their life time. Prevalence of mental illness. 450 million people are currently affected.
- Major public health burden (30-40%,PHC) Association between physical and p psychological problems
- Able to transfer some of the mental health care skills to people so that care can begin locally in their own locality (doctors, nurses, health workers, CBR workers)
- Mental illness are very disabling
- Depression is the number two public health problem in the world (121 million)
- Inadequate mental health infrastructure in the country
- Mental illness leads to stigma and isolation leading to marginalization becoming vicious circle
- Mental illness can be treated with simple, relatively in expensive
- Small percentage require institutional care
- Early diagnosis prevents unnecessary investigation and promotes recovery
- Most disorders can be treated in the community and promotes early recovery
- Most people with mental illness with adequate and appropriate care services will be able to lead normal life and take care of their own life.
- Un treated mental illness in the person leads to disability and increases the burden of care for the family and for the state
- When services are located locally it has more reach to meet the needs of vast majority located in the community
- People lock or chain their kith and kin (mentally ill) under pressure from others, due to helplessness and ignorance of how to manage the person.

Session 11 b

Community Mental Health: Need of the day

Mental health is as important as physical well-being of individuals, societies and countries. Yet only a small minority of the 450 millions people suffering from a mental or behavioral disorder are receiving treatment. Unfortunately, in most parts of the world, mental health and mental disorders are not regarded with any thing like the same importance as physical health. Instead they have been largely ignored or neglected. Mental and behavioral 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 behavioral 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. World health report provided following recommendation for all the developing countries in order to improve mental health services in all developing and underdeveloped countries.

The ten recommendations for action are as follows.

1. PROVIDE TREATMENT IN PRIMARY CARE

The management and treatment of mental disorders in primary health care is a fundamental step, which enables poor mentally ill to get easier, and faster access to services. There is also need to recognize that many people with common mental disorders are already seeking help at this level. This not only gives better care; it is economical as it cuts expenditure on creating a new system to treat people with mental illness. It is also economical as it prevents unnecessary investigations and inappropriate and non-specific treatments. For this to happen, however, general health personnel/ NGOs/community groups need to be trained in the essential skills of mental health care. Such training ensures the best use of available knowledge for the largest number of people and makes possible the immediate application of interventions. Mental health should therefore be included in training curricula, with refresher courses to improve the effectiveness of the management of mental disorders in general health services.

2. MAKE PSYCHOTROPIC DRUGS AVAILABLE

Essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in the essential drugs list, and the drugs to treat conditions should be made available whenever possible. In some countries, this may require enabling legislation changes. These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent

relapse. They often provide the first-line treatment especially in situations where psychosocial interventions and highly skilled professionals are unavailable.

3. GIVE CARE IN THE COMMUNITY

Community care has a better effect than institutional treatment on the outcome and of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing, and sheltered employment.

4. EDUCATE THE PUBLIC

Public education and awareness campaigns on mental health should be launched in all Countries. The main goal is to reduce barriers to treatment and care by increasing awareness on prevalence of mental disorders, their prognosis, treatment, the recovery process and the human rights of people with mental disorders. The care choices available and their benefits should be widely disseminated so that responses from the general population, professionals, media, policy-makers and politicians reflect the best available knowledge. This is already a priority for a number of countries, and national and international organizations. Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other.

5. INVOLVE COMMUNITIES, FAMILIES AND CONSUMERS

Communities, families and consumers should be included in the development and decision-making of policies, programmes and services. This should lead to services being better tailored to people's needs and better used. In addition, interventions should take account of age, sex, culture and social conditions, so as to meet the needs of people with mental disorders and their families.

6. ESTABLISH NATIONAL POLICIES, PROGRAMMES AND LEGISLATION

Mental health policy, programmes and legislation are necessary steps for significant and sustained action. These should be based on current knowledge and human rights. The health department needs to increase their budgets for mental health programmes from existing low levels. Some states have recently developed or revised their policy and legislation has made progress in implementing their mental health care programmes. Mental health reforms should be part of the larger health system reforms. Health insurance schemes should not discriminate against persons with mental disorders, in order to give wider access to treatment and to reduce burdens of care.

7. DEVELOP HUMAN RESOURCES

Most states need to increase and improve training of mental health professionals, who will provide specialized care as well as support the primary health care programmes. Most developing countries lack an adequate number of such specialists to staff mental

health services. Once trained, these professionals should be encouraged to remain in their native states and in positions that make the best use of their skills. This human resource development is especially necessary for countries with few resources at present. Though primary care provides the most useful setting for initial care, specialists are needed to provide a wider range of services. Specialist mental health care teams ideally should include medical and non-medical professionals, such as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers and occupational therapists, who can work together towards the total care and integration of patients in the community.

8. LINK WITH OTHER SECTORS

Sectors other than health, such as education, labor, welfare, and law, and nongovernmental organizations should be involved in improving the mental health of communities. Nongovernmental organizations should be much more proactive, with better-defined roles, and should be encouraged to give greater support to local initiatives.

9. MONITOR COMMUNITY MENTAL HEALTH

The mental health of communities should be monitored by including mental health indicators in health information and reporting systems. The indices should include both the numbers of individuals with mental disorders and the quality of their care, as well as some more general measures of the mental health of communities. Such monitoring helps to determine trends and to detect mental health changes resulting from external events, such as disasters. Monitoring is necessary to assess the effectiveness of mental health prevention and treatment programmes, and it also strengthens arguments for the provision of more resources. New indicators for the mental health of communities are necessary.

10. SUPPORT MORE RESEARCH

More research into biological and psychosocial aspects of mental health is needed in order to increase the understanding of mental disorders and to develop more effective interventions. Such research should be carried out on a wide international basis to understand variations across communities and to learn more about factors that influence the cause, course and outcome of mental disorders. Building research capacity in developing countries is an urgent need.

Mental and physical healths are the two vital strands of life that are closely interwoven and deeply interdependent. Advances in behavioral medicines have shown that like many physical illnesses, mental and behavioral disorders are the result of a complex interaction between biological, psychological and social factors. Community care is about providing good care and the empowerment of people with mental and behavioral disorders. In practice community care implies the development of wide range of services with in local settings.

Session 11 c

Mental Health in India – An Overview

1. Introduction

Mental, behavioral and social health problems are an increasing part of health problems in the world and in India too. Though the burden of illness resulting from psychiatric and behavioral disorders is enormous; it is grossly under represented by conventional public health statistics, which lead to focus on mortality rather than morbidity and on being dysfunctional. The number of people with mental illness will increase substantially in the coming decades. It is seen that there is an increase in the number of young adults with mental disorders, and 50-75% of mental disorders begin during youth. Secondly, there has been substantial increase in the geriatric population having mental health problems, as the life expectancy is increasing. Thirdly, social factors which are established risk factors are also causing a change in the rate of depression seen in all age groups.

Mental and behavioral disorders account for 12% of the global burden of disease. It is estimated that nearly 450 million people suffer from a mental or behavioral disorders in the world. Nearly 10 % of disability adjusted life years (DALYs) across all age groups are due to depressive disorders, suicides and alcohol related problems. Depression ranks third among men and second among women, yet mental health budgets of most of the countries are less than 1% of the total health expenditure. Mental disorders also kill in many indirect ways such as suicides, worsening the outcome of physical illness, medical complications and injuries related to alcohol abuse (i.e mental disorders as a risk factor for other health problems),unhealthy lifestyles and so on.

2. Ground realities

2.1 Demographic Characteristics

India is a country with an approximate area of 3287 thousand square kilometres (UNO, 2001). Its population is over one billion and the sex ratio (men per hundred women) is 106 (UNO 2004). The literacy rate is 68.4 % for men and 45.4% for women. The proportion of population under the age of 15 years is 32 % and the proportion of population above the age of 60 years is 8%. The life expectancy at birth is 60.1 years for males and 62 years for females. The healthy life expectancy at birth is 53 years for males and 54 years for females.

2.1 Prevalence

A majority of the classical psychiatric epidemiological studies in the last four decades have been population based, focusing on general psychiatric morbidity in a small to medium population. From these house-to-house surveys, it is found that:

- An estimated 1 percent of the population, including children suffering from severe mental disorders.
- Five to ten percent of the population is reported to have common mental disorders.

- 15 – 20 % (in some studies it is 40 %) of the people approaching primary health care centers, general hospitals or private clinics for general health problems requires psychiatric assessment and evaluation. Some of them are not aware of it. They think and believe that they have some physical illness, and take various methods of treatment for relief, often in vain. Some of them are not aware they suffer from a biomedical mental illness, but they are aware that their symptoms are related to stress. In most other cases, the morbidity is unrecognized by doctors who treat the condition with symptomatic drugs .

If this figure is projected in India, there would be more than ten million people suffering from severe mental illness, and the figures for common mental disorders would be five to ten times that of severe mental illness. In addition there are issues related to suicide, substance abuse and mental disorders in children. There is also a close association of mental illness with the larger social development agenda, such as the Millenium Development Goals (MDGs).

2.3 Mental Health Care

Mental health care has always been influenced and determined by contemporary beliefs, and India is no different. Traditionally, mentally ill people 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 makes subjects people with mental illness to various harmful treatments. Often, certain treatment practices by black-magicians, village quacks, witches and physical abuse in the name of treatment can have harmful effects on the people with mental illness. They are kept outside the margin of the community by being chained, locked in rooms, found wandering on the streets, or staying for ever in closed wards of asylums, hospitals, etc. While the situation described above is mostly applicable only for the rarer, severe forms of mental disorder (e.g. psychotic disorders) the vast majority of mental disorders are either managed at home or through primary care

2.4 Stigma and Discrimination

A large section of people with mental illness are still locked inside their houses without any treatment, because their family members don't recognize the illness or they find it embarrassing to be recognized as family member of a mentally ill person, who are commonly called as 'mad'. There is also a fear that they would be victims of disgrace and indignity and thereby lose the status or acceptance they enjoy in the community. The stigma is so tremendous that people feel ashamed and deny the illness. Therefore, the first and foremost element that shrouds the realm of mental illness is stigma attached to it. The very thought of some one in the family getting mental illness is a big shock and they do not want to believe it.

Due to stigma attached to the families, people with mental illness become the victims of discrimination and human rights abuse. The discrimination is seen from the family members and goes right up to the policy makers and state authorities. The attitude of the public is often, "*who cares about what is done for people with mental illness*".

People with mental illness have been treated as second-class citizens with no adequate facilities given, either at the state or the central government. As a result they face chronic ill health, and are seen as an economic and social burden to the community, leading to social destitution. Soon families lose hope and are left to the mercy of others.

2.5 Human Rights Violations

People lock or chain their kith and kin under pressure from others, due to helplessness and ignorance. It happens due to the ignorance of family members and community in which they live. It happens in hospitals, asylums and special homes. It is grossly inhuman. Violence against women is a public health concern in all countries and especially women with mental illness are often subjected to physical and sexual abuse.

2.6 Existing Laws

As per the law, a person with mental illness cannot sign any documents of sale, purchase, lease or any contract. The act is silent on these issues during the lucid moments or stabilized stage. Family members, mostly brothers, take undue advantage of this clause to deny property rights to the person with mental illness and enjoy all the property.

Marriage and Divorce Act also permits legal separation of life partners if one of them is found to be mentally ill (certified by a psychiatrist). Generally in rural communities men are permitted to marry for the second time if his first wife is suffering from any disease like mental illness, epilepsy and so on. On the other hand if a married man becomes mentally ill, the community insists that the wife continues to be the caregiver. If a family has a person with mental illness, getting life partner for a boy or girl from that family is almost next to impossible because of the stigma, as it is seen as a family illness. There are occasions where they hide the information and problems erupt after the marriage. It is also common that a close relative gets pressurized to marry such a person. Stigma also affects health care insurance - many companies exclude mental illness from their cover.

2.7 Social Determinants

Poor people with mental illness are not only vulnerable due to their condition, but also the vulnerability brought about by poverty, which is related to their condition. One of the main reasons that people find it hard to accept people with mental illness as equal members of their communities is that they do not see them as capable of contributing to the household or the community. The effects of social determinants such as poverty, conflict, gender disadvantage, social exclusion, etc. on mental illnesses are well known. It is also found that, people are not able to access care due to their social conditions. And due to inadequate treatment, people with mental disorders remain disabled for longer and incur greater health care costs and lesser ability to work, thus worsening poverty.

3. Infrastructure and Present Status

The major changes in mental health scenario began with the tragedy at Erwadi, the asylum fire in the Ramanathapuram district of Tamil Nadu. It was a disaster that opened the eyes of policy makers and the general public to attend to the needs and voices of people with mental illness. During the last 50 years, the place of mental health as part of the general health has changed to some extent. From a situation of no organized mental health care at the time of independence, currently mental health issues are seen as part of the public agenda in a few places at least and part of the credit goes to the intervention of the judiciary.

While mental health has been stated as part of primary health care system on paper, primary health centers (PHCs) are not equipped to treat people with mental illnesses in their centers. Only few primary health centers (where programmes such as the District Mental Health Programme or DMHP are implemented) provide mental health care and treatment in the community. In addition, PHCs are not geared towards the provision of chronic disease care (which is a characteristic of most mental disorders), and psychosocial interventions are rarely available in any sector.

3.1 Treatment Facilities

Most of the district hospitals are not fully equipped and supplied with psychiatric medicines to treat people with mental illness; most often they are referred to multi specialty centers in the capital cities or big towns. Many medical professionals view mental health as an alien subject and do not give importance to either learn or practice it in their day-to-day practice.

There are 42 mental hospitals in the country with the bed availability of 20,893 in the government sector and another 5096 in the private sector hospital settings to take care of an estimated 1,02,70,165 people with severe mental illness and 5,12,51,625 people with common mental disorders needing immediate attention.

Psychiatric medicines have been supplied only in a few primary health centers, community centers and district hospitals. Amitriptyline, lithium, chlorpromazine (CPZ), phenobarbital, phenytoin sodium, haloperidol, carbamazepine, imipramine and risperidone are made available in a few district hospital. The rates of risperidone (better drug than CPZ in terms of side effects) are cheaper then CPZ. Unfortunately, drugs like CPZ which have lesser utility have been purchased in surplus, (for example in Karnataka). Adequate laboratories facilities are also lacking in the district hospitals to find out the serum level for lithium administration. None of these drugs are routinely distributed by government to the primary health centers except in some districts, where DMHP is operational. Services like child guidance and rehabilitative services are also available only in mental hospitals and in big cities.

One third of the mental health beds are in the state of Maharastra and several states do not have mental hospitals. Some mental hospitals have more than 1000 beds and several still have a large proportion of long stay patients. During the past two decades,

many hospitals have been reformed through the intervention of the voluntary organizations, media, National Human Rights Commission (NHRC) and the judiciary.

Availability of psychiatric beds in India

Total psychiatric beds per 10,000 population	0.25
Psychiatric beds in mental hospitals per 10,000 population	0.2
Psychiatric beds in general hospitals per 10,000 population	0.05
Psychiatric beds in other settings per 10,000 population	0.01

The survey of 37 mental hospitals conducted between November 2001 and January 2002 revealed a dismal picture. Apart from poor infrastructure, the greatest deficiencies were in the area of qualified staff. Some mental hospitals do not have even a single psychiatrist on their permanent roster.

Survey results of mental health facilities in India

Sl. No.	Facilities	Adequate		Inadequate	
		Number	%	Number	%
1	Infrastructure	12	32.4	25	67.6
2	Staff	10	27	27	73
3	Clinical services including investigations	16	43.2	21	56.8
4	Availability of medicines and treatment modalities	28	75.7	9	24.3
5	Quality of food	23	62.2	14	37.8
6	Availability of clothing and linen	15	40.5	22	59.5
7	Recreational facilities	18	48.6	19	51.4
8	Vocational rehabilitation facilities	14	37.8	23	62.2

3.2 Mental Health professionals

We have limited facilities to train human resource in mental health. The irony is that inspite of this, all centers have become centers to export trained mental health professionals abroad. Many mental health professionals are immigrating to other developed countries, where jobs are more lucrative. For instance in 2003 itself, more than 82 psychiatrist sought short term and long term employment in the United Kingdom in response to the latter's international recruitment drive.

Undergraduate training in psychiatry is not changing in spite of many efforts and this continues to be a major barrier to create medical doctors adequately trained in psychiatry after their basic training. Some of the government and private medical colleges do not have the departments of psychiatry in its full strengths to train young medical graduates in psychiatry,

The inadequacy of mental health human resource is a major barrier in caring for people with mental illness in the community. Even most of districts don't have public sector psychiatrists. Comparatively mental health professionals are more in the states of Kerala and Tamil Nadu. Very few mental health professionals are based in rural areas. Many states allow public sector psychiatrist to have private clinics.

Availability of mental health professionals in India

Number of psychiatrist per 100, 000 population	0.2
Number of psychiatric nurses per 100,000 population	0.05
Number of psychologist per 100,000 population	0.03

3.3 General Hospital Psychiatry

It is speculated that the birth of general hospital psychiatry in India was due to lack of sufficient funds to open more mental hospitals. These new units needed mobilization of very few resources like a little space in an already functioning hospital and few mental health professionals to manage the people with mental illnesses. What probably started as an economic necessity, has now become a major force in the delivery of health care. A provision for establishment of inpatients wards for people with mental illnesses requiring admission has been provided in the Mental Health Act. It has to be noted that the psychiatric units in the general hospitals are not well established, and are not able able to take care of psychiatric problems associated with other illnesses.

3.4 Private Psychiatry

It is interesting to note that very large numbers of private psychiatrist have located themselves in cities that are district headquarters but are not the state capitals. The reason could be that most state capitals have medical college departments of psychiatry or some other governmental psychiatric facility and a private psychiatric facility would be more welcomed in other cities of the state where no such facility exists. It seems that distribution of private psychiatrists in India is in a way related to the position of the states in socioeconomic hierarchy. Thus relatively prosperous states with higher number of literate people (like Kerala and Tamil Nadu) have the highest number of psychiatrists. North zone has proportionately lesser number with the exception of Punjab and Delhi. States of the Central and East zone have the least number of psychiatrists in private practice.

3.5 Mental Health Financing

The country spends 2.05% of the total health budget on mental health. The primary sources of mental health financing in descending order are tax based, out of pocket expenditure by the patient or family, private insurance and social insurance. Government fund for health services are provided both by the states and the center. In the tenth five-year plan estimates, mental health constituted 2.05% of the total plan outlay for health. The country has a Disability Act, which has included mental illness as the seventh disability. However in reality, people with mental illness rarely avail any benefits available under disability schemes.

3.6 Regional Disparity

The state run health care system in India is striving hard to overcome the regional disparity between rural and urban. The adequate health services and the normal health

standards in rural areas seem to be much below the average. Cities and big towns are growing with private health care facilities catering to the needs of middle class and rich communities. The costs for diagnosis and treatment are so exorbitant that some get into debt traps. In rural areas hardly any facilities exist and the attitude of the government health professionals are often not patient friendly. The budgetary allocation for mental health is very meager, as most of it goes to maintenance of hospitals and a very little portion for treatment.

3.7 Non-Governmental Organisations (NGOs)

NGOs are involved with mental health in the country mainly in the areas of advocacy, promotion, prevention, treatment and rehabilitation. They are also involved in counseling, suicide prevention, training of lay counselors, and provision of rehabilitation programmes through day care, sheltered workshops, halfway homes, hostels for recovering patients and long term facilities. There are also self-help groups of parents and people with mental illness that have been recently established. It has to be noted that most of the NGOs have their setups and outlets in the urban areas catering to the needs of middleclass and higher economic groups.

It is evident from the above reading that mental health care in India is characterized by:

(i) Very limited mental health care facilities;
(ii) Grossly inadequate professionals to provide mental health care;
(iii) Less than 10% of those needing urgent care are getting any modern medical care;
(iv) Families are the current care providers but with limited support and skills for care
(v) No support schemes for voluntary organization;
(vi) Lack of a regular mechanism for public mental health education;
(vii) Limited administrative structure for monitoring the mental health programme and
(viii) Limited budget for mental health care as part of the total budget

4. Policy and legislation

4.1 National Mental Health Programme (NMHP) 1982

The National Mental Health Program is the outcome of the developments in providing mental health care through different methods as well as the overall goals of the health care in general. The first concerted efforts to formulate a national program were held in July 1981. Later, on August 2 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 and the committee 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 underprivileged of the population
- To encourage application of mental health knowledge in general health care and social development.
- To promote community participation in mental health services development and to stimulate effort towards self –help in the community.

The specific **approaches** suggested for the implementation of the NMHP are:

- Diffusion of mental health skills to the periphery of the health service system
- Appropriate appointment of tasks in mental health care
- Equitable and balanced territorial distribution of resources
- Integration of basic mental health care with general health services
- Linkage to community

4.1.1 Progress of the NMHP

From the time of the formulation of the NMHP in August 1982, in the last two decades the following initiatives and activities have been taken up in districts where the district mental health programme has been implemented:

- Sensitization and involvement of state level programme officers
- Workshops for voluntary agencies
- Workshops for mental health professionals namely psychologists, psychiatric social workers and psychiatric nurses
- Training programmes in public mental health for programme managers
- State level workshops for the health directorate personnel, development of models of integration of mental health into primary health up to the district level
- Preparation of support materials in the form of manuals, health records for different types of health personnel and health education materials
- Training program for teachers of undergraduate psychiatry
- Initiation of district mental health programme in 28 districts of 22 states
- Expansion of the district mental health programme for 100 districts with the budgetary allocation of rupees 190 crores in the 10^{th} five-year plan (2002-03 to 2006-07).

4.2 The District Mental Health Programme (DMHP)

The 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 10^{th} plan period the government has announced the programmes extension to 100 districts across the states, with a total budget outlay of 200 crore rupees

There have been many barriers to reach the goals set out in the 1982 document. The goals were too ambitious to begin with and sufficient attention was not paid to all

aspects of implementation of NMHP. The other important barrier has been the lack of funding. Though NMHP came up in 1982 the subsequent three five years plans did not make adequate funding allocation. Further even the funds allotted were not fully utilized. It was only in the 9th Five-year plan that a substantial amount of Rs 28 cores was made available and it was projected to be Rs 190 cores in the 10th Five-year plan.

The critical review of District Mental health programme reveals that:

- There was lack of administrative clarity to utilize the allocated funds. The programme looked good on paper, but was extremely unrealistic in its targets, especially considering the available resources of manpower and funds for its implementation.
- The approach was top down and did not take into consideration the ground realities. The poor functioning of the primary health care in India in general as well as the poor morale of the health workers not taken into account. A structure that was attending to given tasks so inadequately would certainly be unable to absorb new targets of integration.
- The DMHP continues to be the extension of professionals rather than integration of mental health with primary care

Central Government has sanctioned DMHP in 100 districts in the year 2004. The districts are yet to implement the programme and to appoint required mental health professionals for the programmes. It has to be noted that a few districts do not have psychiatrists and the facilities in the district hospital to support the mobile team of the district mental health programme.

4.3 National Health Policy- 2002

The 2002 National Health Policy (NHP 2002) refers twice to mental health. In its assessment of the current scenario, Section 2.13 states that: '*Mental health disorders are actually much more prevalent than is apparent on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families. Sometimes, based on religious faith, mental disorders are treated as spiritual affliction. This has led to the establishment of unlicensed mental institutions as an adjunct to religious institutions where reliance is placed on faith cure. Serious conditions of mental disorder require hospitalisation and treatment under trained supervision. Mental health institutions are woefully deficient in physical infrastructure and trained manpower. NHP 2002 will address itself to these deficiencies in the public health sector*'.

Section 4.13 states the policy prescription towards mental health: *'NHP 2002 envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff.*

The proposed National Mental Health Policy outlines the prioritized agenda for extending within a pragmatic time frame basic mental health care facilities to all sections of the populations across the country by the year 2020.

4.4 Legislations Related to Mental Health:

The Mental Health Act of 1987 and the Persons with Disabilities Act 1995 are the two legislations that are directly applicable to people with mental illness. While these are legislations, the World Mental Health Atlas 2005, reports that there is no Mental Health Policy in India.

4.4.1 The Mental Health Act (MHA), 1987

Mental Health Act is "*an act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their properly and affairs and for matters connected therewith or incidental thereto*". In the Mental Health Act, 1987, a modest attempt has also been made to bring mental illnesses on par with physical illnesses, thus reducing the stigma attached to mental illnesses

The Mental Health Act is not just a cosmetic improvement over the out dated Indian Lunacy Act 1912, but represents the conclusion of lengthy presentation by the Indian Psychiatric Society to the Government of India. This Act came into force in April 1993, as per the Government of India order, even though it is still in hibernation in some states. The establishment of mental health authorities, both at the center and state is a welcome step. These authorities are expected to act as a friend, philosopher and guide to the mental health services. Provisions have been made for establishing separate hospitals for children under the age of 16 years; for people abusing alcohol and other drugs and for other special groups. Emphasis on outpatient care has been made to safeguard the human rights of the mentally ill person. Stringent punishment has also been prescribed for those who subject the mentally ill to physical and mental indignity within hospitals.

The notion of care in the community has not been addressed in the current legislation. No effort has been made to provide after care services for the discharged patients. There is no thinking over the alternative to hospital care. Authorities are using the clauses of the act leading to many medico-legal problems, and difficulties for the private nursing homes.

The Ground Realities of its Implementation: The Mental Health Act has not been implemented in Arunchal Pradesh, Chhattisgarh, Uttaranchal, Bihar, and Orrisa. State Mental health Authority has not been constituted in Arunchal Pradesh, Chhattisgarh, Uttaranchal, Bihar and Orrisa. Mental health rules have been framed only in Goa, Manipur, Sikkim, Assam, Chandigarh, Delhi, Gujarat, Madya Pradesh, Mizoram, and Tamil Nadu.

4.4.2 The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995, commonly called the PWD act came into force on February 7, 1996. This law is an important landmark and is a significant step in the direction of

ensuring equal opportunities for people with disabilities and their full participation in the nation building. The Act provides for both preventive and promotional aspects of rehabilitation like education, employment and vocational training, job reservation, research and manpower development, creation of barrier-free environment, rehabilitation of persons with disability, unemployment allowance for the disabled, special insurance scheme for the disabled employees and establishment of homes for persons with severe disability etc. There are also statutory bodies for implementing the Act at central and state levels.

Even though it is encouraging that mental illness has been considered in the act, the later chapters of the act do not talk about any provisions to be given or set aside for people with mental illness. The act also does not assure the right to treatment. While there is much talk about the implementation or lack of implementation of the Act, there is little understanding about the indicators to measure the level of implementation. At present, conducting a session on the Act or putting up posters on the Act, are referred to as 'advocacy'. A clearly defined set of indicators for the implementation needs to be worked out. There is also a great need to come up with strategies to decentralize the implementation of the Act at the district/ taluk and village level.

5. Conclusion

The rate of mental illness is being increasingly recognised across different divides like the rich and the poor, urban and rural and so on. With some help from the judiciary, it seems like the states are taking notice of the gravity of the issue and attempting to address the needs of people with mental illness.

Health including mental health is a fundamental right. Millions in India perhaps, don't know that it is their right to avail treatment. People with mental illness are crying ***''My name is today''*** Do we hear their voice?

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Chapter 4

The trainees should be able to:

1. *Understand what is capacity building in the context of determinant*)
2. *Understand barriers in the family and community for the recovery of person with mental illness.*
3. Understand role of Gender in illness presentation and recovery
4. *Design appropriate awareness programme to deal with the barriers in the family and community.*
5. *Understand the strategies for inclusion of people with mental illness in the community groups and in accessing community resources).*

Number of sessions : 8

Session 1: Capacity Building

Session 2: Animation

Session 3: Understanding barriers – Family and community

Session 4: Organizing people with mental illness and caregivers in to self help groups/associations

Session 5: Care givers needs

Session 6: Awareness generation

Session 7: Awareness materials

Session 8: Gender and mental health

Session 1:

Capacity building : 30 minutes

1. Trainer asks the participants to share their views on what is capacity building in the context of determinants
2. Trainer writes the responses in the black board
3. Trainer defines capacity building
4. Trainer invites comments from the participants to share on different levels of capacity building for different groups
5. Trainer invites list of people whom the capacity to be build on mental health issues in the community.
6. Trainer invites participant to summarize on the need for community groups trainings/ awareness for various groups in the community.

Session 1

CAPACITY BUILDING

Capacity Building is:

- Engaging minds and hearts with whom we work
- It means being sensitive, actively listening and dialoguing
- Understanding from stakeholders, and their perspectives
- Preserving human dignity even in the context of struggle
- Dealing with diversity
- Active engagement as a means to an end
- Thirst for search
- Promoting critical thinking
- Using materials which touch our emotions that propels us to action
- Dropping baggage or our own biased beliefs about self and people

Nothing happens until we reduce strategy to work

Peter Drucker

Session 2:

Animation: 60 minutes

1. Trainer plays a DVD on the Tom and Jerry for 10 minutes
2. Trainer invites participants to share their view on the cartoon seen
3. Trainer divides participants in to 3 groups and ask them t discuss on what is animation
4. Trainer invites group to make presentation on their discussion
5. Trainer sums up the discussion by sharing principles of animation
6. Trainer invites comments on difference between facilitation and animation
7. Trainer writes down the responses on the black board.
8. Trainer makes a presentation on difference between facilitation and animation.

Session 2

Animation

In Greek, the word *anima* means life, soul, and auto-movement. In the context of community development, animation means the group getting life and the group/community getting stimulated so that it moves, lives and develops. Once stimulated the people would undertake initiatives based on their awareness and knowledge. They assess the reality in which they live and gain confidence to mobilize them selves and the larger community to seek the change they want. Therefore, animation is process oriented. The process starts from where people are and certainly not where you want them to be. The time and space available is best utilized by the group to undertake self-analysis of their situation, causes, facts, etc., that form the basis for initiating change. From there follows the plans, strategies, mobilizing required resources, demanding their rights, executing their plans, reviewing the outcomes, etc. Thus they become the primary stakeholders in their own development.

Animation is that stimulus to the mental, physical, and emotional life of people in a given area which moves them to undertake a wider range of experiences through which they find a higher degree of self-realization, self-express, and awareness of belonging o a community which they can influence (Simpson 1989:54)

Therefore, the dynamic process of animation:

- Promotes critical thinking & self-enquiry
- Promotes social change
- Promotes self-help
- Increases capacities of the group/community
- Ensures community taking control of its own development

As Paulo Freire has said, the issues facing people are often complex and no expert has all the answers. On the other hand, nobody is totally ignorant. Each person has different perceptions based on their own experience. To discover valid solutions, everyone needs to be both a learner and a teacher. It is a mutual learning process. This understanding is a must for good animator. Animator should have genuine belief that people, however poor or ill are they; have the capacity to contribute to the transformation of their community. Animation is not a mere technique; it is a belief animator lives through. S/he genuinely takes guard not to control the group but to enable the group grow in awareness, maturity and self-reliance. It calls for intense faith in human beings; their power to make and remake, to create and recreate; faith that the vocation to be fully human is the birthright of all people, not the privilege of an elite. The animator should be fully conversant with the needs of the group. They include:

- Acceptance
- Sharing information and concerns
- Setting goals
- Organising for Action

Acceptance

The uniqueness of each person, with her/his own experience and insights, needs to be recognized. The acceptance of each member should be such that s/he feels safe to say

in the group what s/he really thinks and feels. Hence building such atmosphere is of vital importance for any group to move forward.

Sharing information and concerns
People working in groups need information about each other; their experience, their ideas, their values and opinions and about the issues which they consider to be important in their lives. They need to workout for them selves.

Very often the concern of the animator and those who arranged the meeting will be to help deepen their awareness, to move from the symptoms to the causes of the problem. The best way is to pose the problem.

Setting goals
Unless the goals are set clearly by the group, people will not be interested or committed to carrying them out. Unless the goals are clear to all, people become frustrated. The way decisions are made is directly related to how committed people feel to carrying them out.

Organizing for action:
To achieve the goals set, definite people need to take specific responsibility and should be accountable to the group. Actions get started and the group feels the ownership.

Ten Principles for an Animator

1. Approach each situation with humility and respect
2. Understand the potential of local knowledge
3. Adhere to democratic practice
4. Acknowledge diverse ways of knowing
5. Maintain a sustainability vision
6. Put reality before theory
7. Embrace uncertainty
8. Recognize the relativity of time and efficiency
9. Take a holistic approach
10. Exercise an option for community

Things to remember:
An animator is an applied sociologist. S/he should/must:

- Know some important features of the subject.
- Always be able to separate what is happening to the overall community itself, in contrast to what is happening to **particular individuals.**
- Encourages the community to choose what it wants so as to be more consistent with prevailing values and attitudes – does not impose her/his notion.
- Be able to identify the leadership within the group.
- Know the local structures and functions
- Be aware of what the prevailing beliefs are in the community.
- Learn more and more about their culture, and the dynamics of the culture dimensions.
- Be aware that each person brings unique skills and knowledge to a process.
- Put reality before theory – real issues and complexity of community, which must be the starting point for learning and transformation.

Session 3:

Understanding barriers – Family and community: 120 minutes

1. Trainer invites participants to share their experiences of home visit of person with mental illness in their families.
2. Trainer notes down the supportive environment and barriers from their sharing.
3. Trainer divides participants in to three groups, assigns topics for discussion
4. Group one discusses the attitude of families towards family members with mental illness
5. Group two discusses the attitude of communities towards people with mental illness
6. Group three discusses the attitude of local government/local leaders towards meeting the needs of people with mental illness.
7. Trainer invites group to make presentation on their discussion.
8. Trainer invites participant to summarize the presentation.

Session 3

Understanding barriers in the family

Session 4:

Organizing people with mental illness and caregivers in to self help groups/associations: 60 minutes

1. Trainer invites participants to share their views on inclusion of people with mental illness in the community activities
2. Trainer notes down the responses on the black board
3. Trainer shares the experiences of including people with mental illness in the disability groups
4. Trainer invites participants to share their views on difference between impairment and disability, by asking them to respond on the statement "all visually impaired people are not disabled".
5. Trainer invites participant to summarize the discussion on impairment and disability
6. Trainer invites participants to share their views on mental illness and disability.
7. Trainer summarizes the discussion on mental illness and disabilities

Session 4

Caregiver's forum

Caregiver's forum consists of old and new members (caregivers and stabilized individuals) in a given locality, who meet regularly to share experiences. The sharing of experiences and convictions from old members benefits the new. It is a forum where people (caregivers) gain new insights and make attitudinal changes and gain courage to take action to solve their problems. For women carers, it is often an opportunity to come out of the (isolating) home atmosphere and gain confidence in-group situations. Often they gain confidence in speaking in a group, which can be an achievement in itself. Information's about medicines, side effects, effective ways of administering (in non-cooperative clients), and other related information's are learned from experienced carers. Over a period of time attitudinal changes takes place in individual cares in areas such as:

- about trying out hospital medicines and sticking through the early difficulties with medicines
- about seeking government benefits
- about volunteering to help other affected families in simple ways
- about taking responsibility for the affected ward (there are examples of 'shifting responsibility' towards affected individual by giving in marriage a PWMI, resulting in compounding of the problem).

The members learn to take responsibility for self help actions (an early one being holding the caregivers meetings regularly). Leadership and initiatives are fostered. Some groups decide to act on local community issues thereby contributing to the larger community leadership (eg getting municipality/ panchayat authorities to attend to civic amenities)

The active members in the forum get identified over a period of time and get selected to be representatives in the larger apex body (federation).

They would be enabled through building capacity to function as effective representatives of PWMI.

Session 5: Caregivers needs: 30 minutes

1. Trainer invites participants to list out the needs of caregivers of people with mental illness.
2. Trainer invites some caregivers members to the session and share their experience of being caregiver (video clipping)
3. Trainer shares with the group of the caregivers meetings held and its benefits.
4. Trainer summarizes the discussion sharing about care givers associations, how federations have included mental health issues in their activities, and alliance building.

Session 6

CARERS, THEIR ROLE IN HEALING

Severe mental disorder is the most common and disabling mental disorder, affecting nearly 1% of the population world wide. The illness is characterized by delusional and confused thinking, hallucinations and social isolation. In fact, more than 40 percent 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.

Family members can play an important role in helping the person with severe mental illness. Before they can be properly supportive, however, they must first understand and accept that mental illness is a disorder of the brain just like diabetes is a disorder of the body; not anyone's fault; and not an indication of moral or spiritual failure. Family members need to know this so that they do not blame their mentally ill relatives, or think of them as lazy. People with mental illness are often incapacitated, and a drain on family energy and resources, but this is not intentional on the part of them, who are in many ways victims more than anything else

The most important thing family members can do to support their ill relatives is to help them remain oriented and on task with their routines; helping them stay on medications, and attend scheduled and doctor visits, for instance. Family members can help their mentally ill relative by helping them with personal care, eating a well-balanced diet, and getting regular exercise. Caring for mentally ill relatives is frequently painful and heartbreaking. Family members some times need support and platform for ventilation for themselves. Participating in a self-help group for families of psychiatric patients is known to reduce family member's sense of burden, aloneness and stress, provides support and encouragement to continue their caring.

Especially for poor persons with mental illness, it leads to extreme marginalization of the individual and the family, as both these hampers the 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. Poverty and Gender compound 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 individuals sometimes leading to extreme crisis, poor coping abilities of the family, lost productivity and stress in the community.

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 the 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. 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.

A Good caregiver is one who has

1. Time for the mentally ill family member
2. Person who lives close by to mentally ill person
3. The person should have patience.
4. Has good emotional relationship
5. Has positive attitude towards the person,
6. Believes that all problems can be solved, be positive
7. The person is motivated to care and also has capacity to motivate the person with illness.
8. Creates favorable atmosphere for the person to be rehabilitated at home.

The basic level of care required for person with mental illness is

1. Follow up care/ need to give medication/ supervise whether the person is taking medicines
2. Need to provide adequate amount of nutritious food
3. Need to encourage the person for socialization
4. Need to motivate and monitor person for maintaining personal hygiene
5. Need to motivate the person for taking small responsibilities
6. Create awareness among the community so that the person with mental illness is accepted and integrated in all community activities
7. Engage in income generation/ productive activities.

In taking care of the people with mental illness, the carers play an important and difficult role, especially when their wards have severe mental illness. Their role is not as much recognized as the medicines and the doctor. This was evident in the findings of the annual reviews of Basic Needs, India. The carer(s) has/have a responsibility which is quite heavy and may weigh against their health and mental health as well.

Session 6:

Awareness generation: 60 minutes

1. Trainer divides the participants in to 4 groups.
2. Trainer assigns each group a role play to be performed on awareness generation on mental health issues for based on their understanding of determinants
    a. ICDS/Anganwadi teachers
    b. Volunteers/ panchyath members
    c. Community members
    d. Women's group
3. Trainer invites groups to perform role plays
4. Trainer invites comments from the participants after the completion of role play from each group
5. Trainer discusses with the group on areas that need to be improved while they create awareness on mental health issues

Session 6

Awareness generation

During the community meeting the field staff would share with the group

1. Misconceptions/attitudes of people related to people with mental illness.
2. What is mental health
3. Features of mental illness
4. Causes of mental illness
5. Need for inclusion in the community activities and in the self help groups.
6. Importance of continuing treatment.
7. Treatment facilities available in their locality.

Session 7:

Awareness materials: 60 minutes

1. Trainer asks the participants to go back to same groups and design a poster/ awareness material depicting the messages for the awareness programme.
2. Trainer distributes, sketch pens, old magazines, and chart paper
3. Trainer allows group to discuss on the posters to be developed
4. Trainer invites group to share their posters, followed by discussion on the posters.
5. Trainer summarizes the discussion.

Session 7

Awareness materials

A list of the awareness materials developed and maintained by our partners

1. Posters
2. Wall writings
3. Street theater scripts
4. Pluck cards
5. Banners
6. Handbook
7. Booklet on the legislations and the provisions
8. Pamphlets/hand bills
9. Videos
10. Audio cassettes
11. Presentations
12. Flip charts
13. Life stories and case studies
14. Resource directories
15. Calendars

Sample Posters on Mental health

POSTER –1

A person with good mental health

- Has clarity in his/her mid, is able to cope with his/her emotions and feelings and is able to carry out daily work and lead a normal life.
- Has strength to face his regular problems, pin and disappointment.
- Is able to live in harmony with and to relate to people around him.
- Is able to keep his balance through the normal ups and downs in his life.

A mentally ill person

- Might speak and behave differently from the normal way.
- Might have strange and dangerous thoughts.
- Might continuously find it difficult to do his/ her work and / or relate to others.

Causes of mental illness: Primary cause is unknown. But the following could cause mental imbalance and illness.

- Chemical change in the brain, caused by virus infection, tumor or blood clotting.
- Severe injury to the head to the nervous system.
- If there is a history of mental illness in the family.
- Excessive consumption of alcohol or drugs for a long period of time.
- A sudden shock due to an unexpected or massive loss or tragedy.
- Very bitter experience in childhood and deeply disturbed family atmosphere.
- Social problems such as unemployment, extreme poverty and deprivation.
- Being subjected to serious and constant cruelty, violence and abuse.

Who can be affected by mental illness?

Men, women, Children, Literate, illiterate, poor or rich, those living in villages or cities- anyone can be affected by mental illness

POSTER – 2

Symptoms of mental illness

- Abnormal speech, behaviour or expression of feelings
- Disorder in sleep, hunger and sexual desire.
- Disinterest in self-care (looking after oneself)
- Baseless fears, anxiety and anger.
- Sleeplessness, lack of appetite or interest in self-care.
- Desire to be left alone and or/ wandering aimlessly
- Dependency and disinterest in normal social life.
- Confused mind and sometimes, loss of memory.
- Reduced ability to take appropriate and timely decisions.

Symptoms of common mental disorder

- Long term depression, feeling excessively nervous, anxious or scared.
- Lock of clarity in thinking or dealing with ordinary, everyday situations
- Unusual behaviours, which may be embarrassing but is harmless.

The person is aware of the reality and that he has a disorder

Symptoms of severe mental disorder

- Dangerous behaviour, being extremely quarrelsome or withdrawn
- Abnormal behaviour (Example. Laughing without reason, talking irrelevantly or talking to oneself)
- Being excessively suspicious, having very wrong beliefs and wild imagination.
- These persons may hear or see things that others cannot and may, therefore, be confused due to that
- Two contradictory kinds of behaviours in the same person such as depression at times and highly excited at other times.
- Serious depression and thoughts of suicide.
- Lack of memory, lack of concentration, irregular in activities.
- Usually, these persons are not aware that they are ill.

POSTER- 3

Can mental illness be cured?

Yes, it can be...

- If it is identified at an early stage and treated
- By taking treatment and medicines regularly.

Following are not correct or proper methods to cure a person with mental illness.

- Witchcraft
- Marriage
- Scaring, branding or chaining up the person

POSTER –4

Person with mental illness needs persons who love and understand them.

They too have human rights like us.

What can you do?

- Increase their self-confidence by giving them affection, encouragement and support.
- Include them in the festivals you celebrate.
- Guide and encourage mentally ill persons to go to primary health centers or a hospital to get treatment.
- Help them to get some vocational training
- Create an opportunity for them to work and give them job according to their capacity.
- Recognise and respect their rights. Help them get the benefits from government schemes.
- Ensure that the mentally ill participants in the discussions concerning them and meat for their benefits.

Session 8:

Gender and Mental health : 90 minutes

2. Trainer introduces the gender concept inviting participants to share their experiences of the games they played while they were in their childhoods and adolescence.
3. Trainer ask group to reflect on the changes occurred from their childhoods to adolescence regarding gender relationship
4. Trainer divides participants in to four groups and ask group to discuss: (condensed case study of Gullappa, lakshmana, sugunamma, sasarasamma)
    i. The causes of the illness if any
    ii. The impact of illness on the person
    iii. Support network
5. Trainer invites groups to share their discussion in the larger group
6. Trainer ask group to identify the differences in the case studies
7. Trainer summarizes the discussion

Session 8

Gender and mental health

Chapter 5

Livelihoods and income enhancement

The trainees should be able to:

1. *Understand relationship between mental illness and poverty*
2. *Understand family as a unit*
3. *Understand about the trade analysis*
4. *Understand various livelihood options*

Why do you think we all need livelihood and income enhancement?

Trainer notes: independent living, self worth, how ever the world operates on interdependence.

Do you think in your opinion people with mental illness are different from this?.

Number of sessions: 5

Session 1: Poverty and mental health

Session 2: Poverty: Cause and consequences of mental illness

Session 3: Sustainable Livelihoods

Session 4: Livelihood intervention

Session 5: Trade analysis

Session 1

Poverty and mental health

Prosperity: 20 minutes

1. Trainer invites participants to share their thoughts on poverty.
2. Trainer list out the responses in the black board.
3. Trainer asks participants look in to their own responses and reflect on is it problem based or intervention based.
4. Trainer introduces the concept of prosperity!.
5. Trainer shares his views on poverty eradication and prosperity.

Trainer notes:

a. *Deprivation of capabilities (access to assets, access to knowledge and skills is real poverty)*

Self worth: 20 minutes

1. Trainer invites participants to form 3 groups, and share their thoughts on one's self worth.
2. Trainer notes down the responses from the presentations
3. The trainer introduces a paper on Looking at Self-Worth(SLB, Handout-2) to the participants. He suggests the participants to take a few minutes to look at the same and fill the appropriate columns with a minimum choice of five under each.
4. On completion, the trainer invites the participants to share their view on the picture that emerges about them selves.

Trainer notes: from the time we have come to this world, we wanted to be loved/accepted/appreciated/respected/understanding by all, and we work towards being loved similarly people with mental illness would have self worth and they need to be loved/understood/ respected/opportunities to be listened to, participation to the extent .

Leading to recovery: 20 minutes

1. Trainer invites the participants to share their views on recovery.
2. Trainer writes the responses in the black board.
3. Trainer summarizes the indicators of stabilization.
4. Trainer makes presentation on the definition of recovery.
5. Trainer discuss with the participants on need for reasonable accommodation.

Trainer notes: opportunities in socialization and any livelihood activities would faster the recovery process. Being aware of the nature of illness providing reasonable accommodation in organized and unorganized sectors is essential.

Session 1

Human Dignity

Dignity is a term used in moral, ethical, and political discussions to signify that as a living being has an innate right to respect and ethical treatment. Individuals have inherent, inviolable rights, and this is closely related to concepts like virtue, respect, self respect, autonomy, human rights, and enlightened reason. Dignity is generally proscriptive and cautionary: it is usually synonymous to 'human dignity', and is used to critique the treatment of oppressed and vulnerable groups and peoples, though in some case has been extended to apply to cultures and sub-cultures, religious beliefs and ideals, animals used for food or research, and even plants.

In more colloquial settings it is used to suggest that someone is not receiving a proper degree of respect, or even that they are failing to treat themselves with proper self-respect.

The Universal Declaration of Human Rights, adopted by the United Nations General Assembly on December 10, 1948, states:

Article 1. All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2. Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty

Human dignity is a type of worth that every human being has. It is used as a right of respect during political, moral, or ethical conversations. When someone is humiliated, it is damaging their human dignity.

Human dignity is an expression that can be used as a moral concept or as a legal term. Sometimes it means no more than that human beings should not be treated as objects. Beyond this, it is meant to convey an idea of absolute and inherent worth that does not need to be acquired and cannot be lost or sold. Human dignity is inviolable, it should be respected and protected.

The dignity of the human person is not only a fundamental right in itself but constitutes the real basis of fundamental rights. The 1948 Universal Declaration of Human Rights enshrined this principle in its preamble: 'Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world'.

Session 1 b

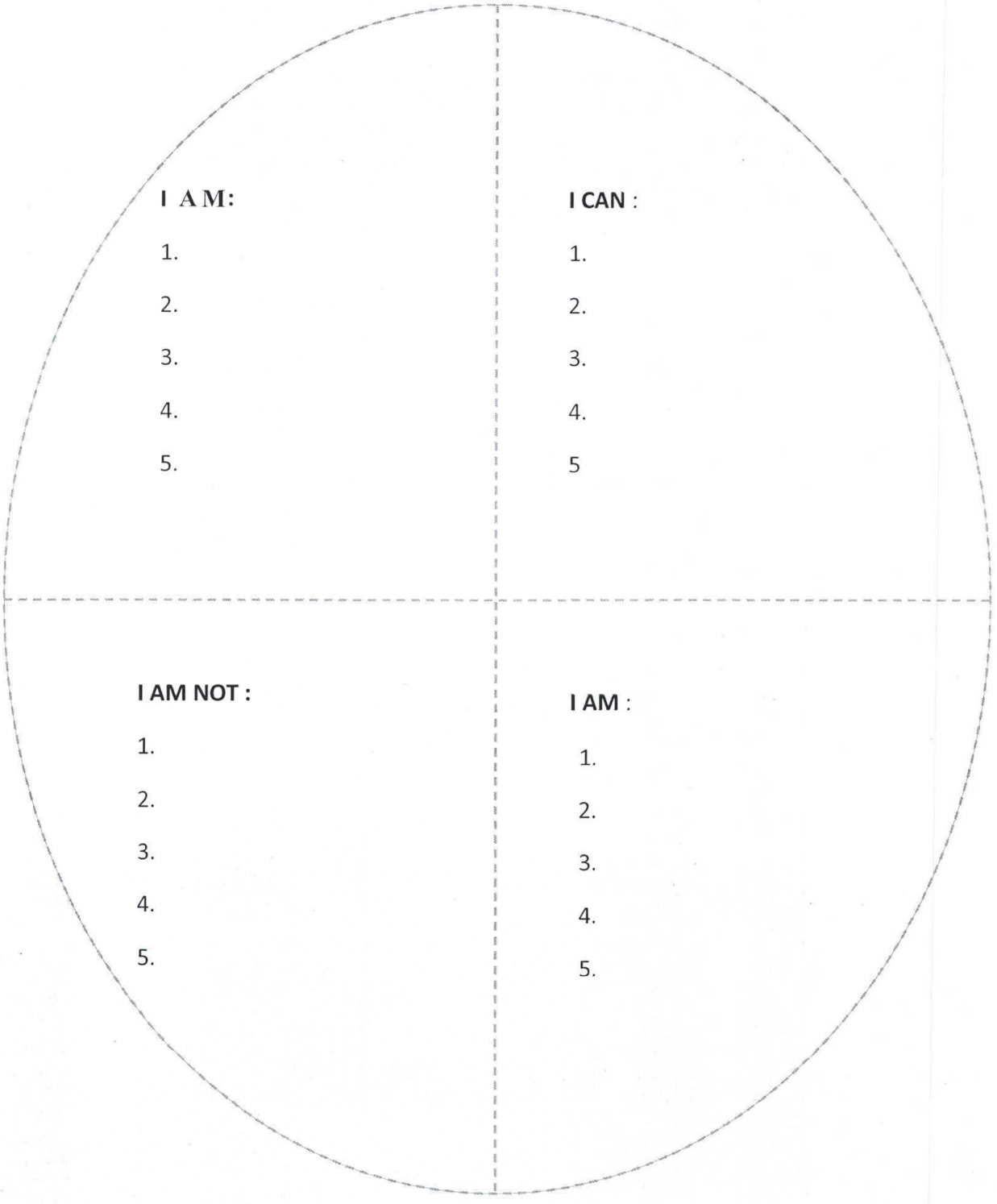
Self-Worth

Identity is a person's sense of placement in the world -- that which tethers us to our self-worth. Our identity can easily be over-inflated when our self-worth is miscalculated. Real self-worth is entirely internal. It's realizing the true strengths of the individual. How you feel about yourself is self-esteem. It is your perception of how you are doing in the world. Self-esteem may go up or down depending upon what is happening to you. Get an "A" on a test and you feel great, but if you fail you feel terrible. Self-esteem is changeable. Self-worth differs from self-esteem. Self-worth is what you are born with. As one of the creations of the universe you are worthwhile and have value, which cannot be taken from you.

Self-worth is frequently based on our feelings of worth in terms of our skills, achievements, status, financial resources, and physical attributes. This kind of self-worth often cultivates an independent attitude. When we find ourselves not measuring up to society's criteria for worth, we suffer serious consequences and our self-worth depreciates dramatically. Self-worth decreases faster with the feeling of regret, anger, and fear.

Every individual experiences basic needs -- hunger, thirst, fatigue, etc. We are conditioned to satisfy these needs by *getting* something -- food, drink, or rest. Mistakenly we conclude that by getting, we will achieve an acceptable self-worth/esteem. Self worth is related to self-esteem is an attitude of respect for and contentment with oneself based on the recognition of one's abilities and acceptance of one's limitations.

SELF WORTH



Session 1 c

Prosperity

Prosperity is the state of flourishing, thriving, success, or good fortune. Prosperity often encompasses wealth but also includes others factors which are independent of wealth to varying degrees, such as happiness and health.

Economic notions of prosperity often compete or interact negatively with health, happiness, or spiritual notions of prosperity. For example, longer hours of work might result in an increase in certain measures of economic prosperity, but at the expense of driving people away from their preferences like family life, and health. In Buddhism, prosperity is viewed with an emphasis on collectivism and spirituality. This perspective can be at odds with capitalistic notions of prosperity, due to their association with greed.

Data from social surveys show that an increase in income does not result in a lasting increase in happiness; one proposed explanation to this is due to hedonic adaptation and social comparison and a failure to anticipate these factors, resulting in people not allocating enough energy to non-financial goals such as family life and health.

Economic growth is often seen as essential for economic prosperity, and indeed is one of the factors that is used as a measure of prosperity. Many distinct notions of prosperity, such as economic prosperity, health, and happiness, are correlated or even have causal effects on each other. Economic prosperity and health are well-established to have a positive correlation, but the extent to which health has a causal effect on economic prosperity is unclear. There is evidence that happiness is a cause of good health, both directly through influencing behavior and the immune system, and indirectly through social relationships, work, and other factors.

The assumption that economic prosperity requires growth seems so reasonable that most of us don't think much about it. The trouble is, the word "growth" has two fundamentally different meanings: "expansion" and "development." Expansion means getting bigger; development means getting better, which may or may not involve expansion.

Session 1 d

Recovery

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. The need is to meet the challenge of the illness/disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the illness/disability; the aspiration is to live, work and love in a community in which one makes a significant contribution.

Person in the recovering phase will be:

a. Free from the symptoms/problems because of the illness.
b. Ability to understand the importance of care services and value same (follow the instructions).
c. Able to take care of his personal hygiene.
d. Able to involve in productive work in the family.
e. Contributing towards family income through involving in livelihood activities.
f. Participating in the self help group meetings and the activities.
g. The person has taken control of making the decision in his or her life
h. The person has come to an understanding and acceptance of his or her life experiences
i. The person is taking proactive steps in promoting his or her own wellness

What recovery does not mean

1. Recovery does not mean a person will no longer experience symptoms
2. Recovery does not mean a person will no longer have struggles
3. Recovery does not mean a person will not use medication
4. Recovery does not mean a person will no longer utilize mental health services
5. Recovery does not necessarily mean a person will be completely independent in meeting all of his/her needs.

Session 2

Poverty: Cause and consequences of mental illness: 60 minutes

1. Trainer divides participants in two three groups.
2. Trainer distributes news print on farmer's suicide, women poisoning children and committing suicide, and suicides because of family problems.
3. Trainer asks the group to identify issues in the news prints.
4. Trainer invites groups to make presentation on their discussion.
5. Trainer invites one of the participants to summarize all the three presentation, ask them to link poverty and mental health.
6. Trainer invites participants to share case histories/stories of few families having mentally ill members, describing access to care services since the onset.
7. Trainer list out the (black board) cost involved in caring a mentally ill person from the narrative of the case histories of the participants.
8. Trainer summarizes on consequences of mental illness.

Trainer notes:
Some of the hidden cost are cost for travel, meeting the expenses like black magician, temple etc. The burden of care givers are social burden, economic burden, psychological and emotional burden. Mental illness is a family diseases, family to be seen as a unit rather than individual mentally ill person.

Session 2a

Sustainable Livelihoods

A sustainable livelihood approach should operate at two fundamental levels.

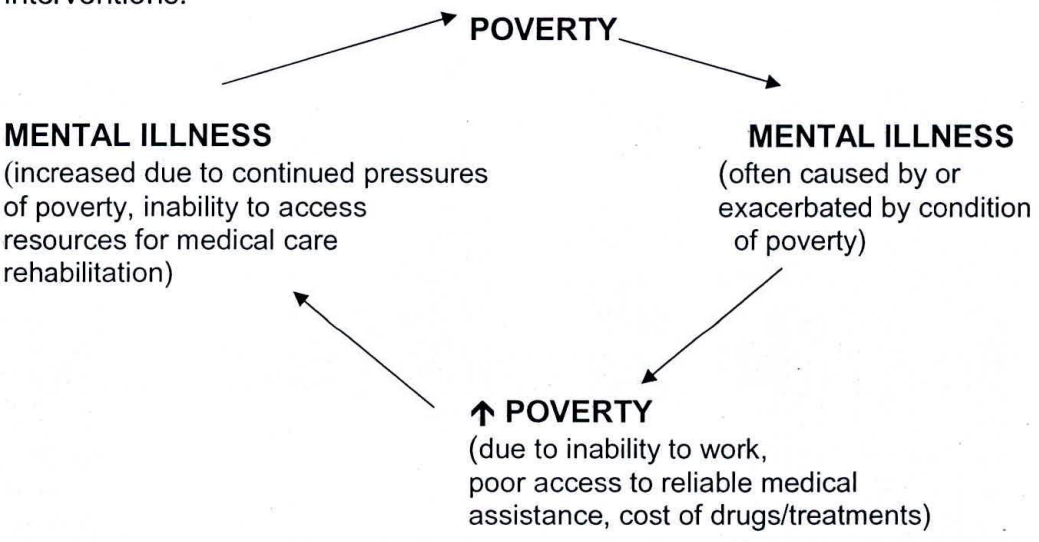
One level works directly to provide poor people with better access to assets or ways of improving existing assets. The second level works at a macro level, influencing policies in the private and public sector and promoting more effective functioning of structures and processes, thereby ensuring that livelihood strategies are open to poor people in a sustainable and equitable manner.

Basic Needs seeks to work at both levels in its work with people with mental illness.

The Sustainable Livelihoods Programme

Sustainable Livelihoods and the mentally ill

The issues of choice, access and opportunity are key issues that concern us when working with people with mental illness. For people with mental illness, who also find themselves in a position of long term poverty, the need for access and opportunity to sustainable livelihoods, as defined by Chambers and Conway "capabilities, assets including both material and social resources, and activities required for a means of living" is critical not only to tackling poverty but also providing a means of rehabilitation and regaining confidence and a place in the community. "A livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets..." (Chambers and Conway 1999). When dealing with poor people with mental illness, we have to consider not only their vulnerability due to their condition, but also the vulnerability brought about by poverty, which is a consequence and to some extent cause of their condition. It is this cycle, which mental health and development programme aims to address through its sustainable livelihoods interventions.

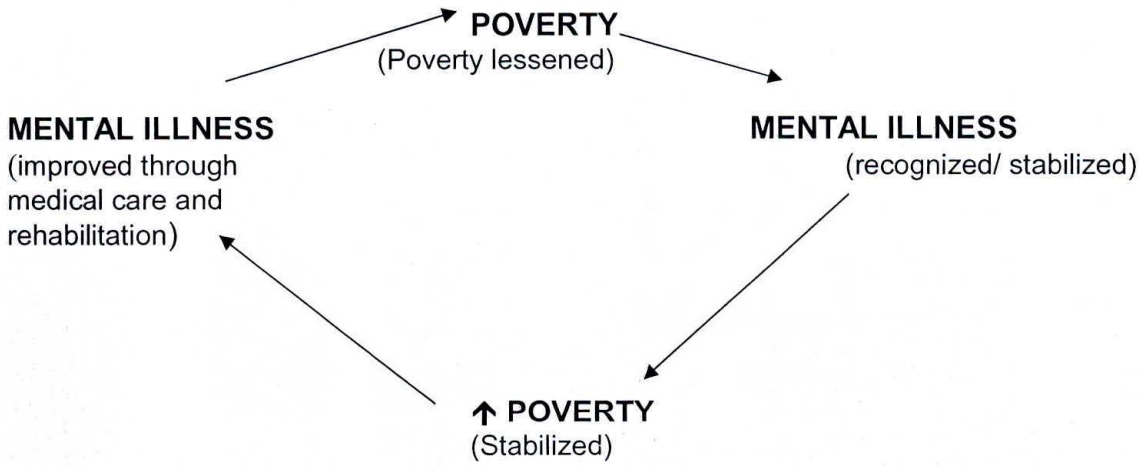


This is the reality of the debt trap in the specific context of the family unit affected by mental illness.

> *"One of the main reasons that people find it hard to accept mentally ill people as equal members of their communities is that they do not see them as capable of contributing to the household or the community. In poor rural communities the 'value' attached to an ability to earn income is great and often is the defining factor for a person's standing within the family". "Mental illness causes severe stigma for the whole family and carers are also severely neglected due to their association with a mentally ill person. Bringing financial stability to the family unit and providing a productive role for mentally ill people is critical so that they are able to take care of their basic needs for food, nutrition, health, and education".*

Caregivers continue to express during our consultation process a desire to address the financial burden caused by the cost of caring for the mentally ill person. There is a real need to increase the family's income in order to cope with the additional stresses created by the search for a 'cure', the need for regular medicines and the loss of a former or potential income source. In turn, mentally ill people themselves express the wish to get back to work or take up new income generating opportunities, both as a means of activity and also to alleviate the stress on their families. Since it may not be possible for a person to return to a former employment, though that must be a key objective, there is a need to explore other suitable options, taking into account individual skills and capabilities as well as local opportunities and markets. Support is required to ensure the long-term sustainability of a particular work placement or trade, not only in material/financial terms but also in the context of the person's illness.

The importance of the model outlined above is that it demonstrates how a poor person can spiral downwards through mental illness and presumably by interaction with mental health specialists can also spiral upwards. If we take this further, we could imagine the following cycle:



Sustainable Livelihoods: A definition

Introduction

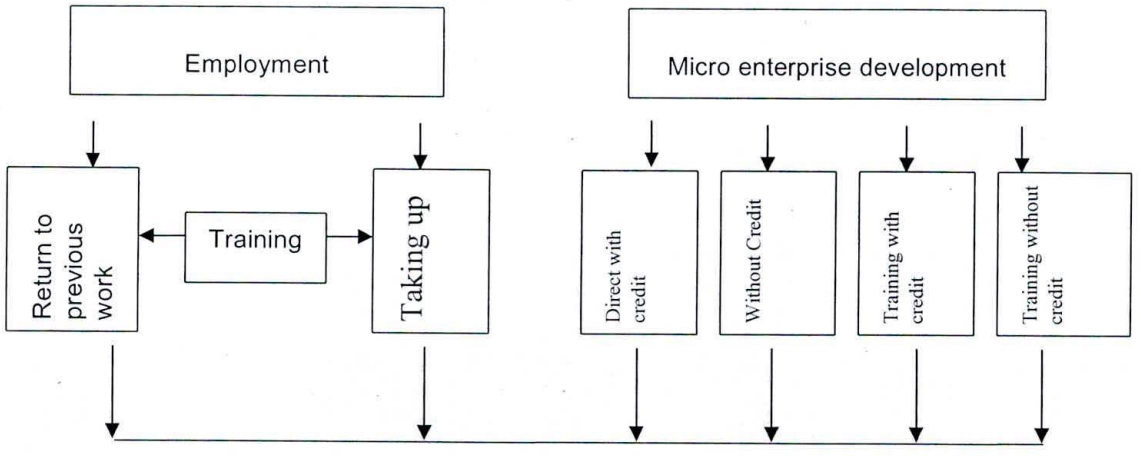
The concept of sustainable livelihoods is inextricably linked with an understanding of poverty in its broadest sense – not only access to material and economic assets but also to basic human rights, dignity, autonomy and social inclusion in a sustainable manner.

Singh and Gilman (1999) define sustainable livelihoods as those, "derived from people's capacity to exercise choice, access opportunities and resources, and use them in ways which do not foreclose options for others making their living, either now or in the future."

The meaningful work model:

The importance of the meaningful work model is that it demonstrates the concept of stabilisation leading to a reintroduction to choice for the mentally ill person. In our experience, many have demonstrated on the ground a willingness, indeed eagerness, to exercise that choice and return to a form of employment. However, it is necessary to recognise that this choice is circumscribed by constraints of poverty that, equally, exist for 'normal' people in poverty. As a consequence of this, it is imperative that we work within the community to extend, in a sustainable way, the range of choice available and to deepen the ability of the options available to address poverty.

The whole thrust of the work therefore is to:
(a) return mentally ill people to a range of options that exist in the community
(b) where possible collaborate with organisations/structures that are seeking to extend the range of those options (or to get mentally ill people recognised as potential participants within existing options).



Meaningful work

Programme Focus

The primary unit of Basic Needs India sustainable livelihood intervention is the family of the mentally ill person seen as a whole unit. The intention of the intervention is to enable the mentally ill person and their family to improve the family's assets in a way that directly incorporates the mentally ill person's own contribution and participation.

By family assets, we mean:

Asset Category	***Breakdown***
Natural	Land Water Livestock
Human	Aspirations Motivations Interests Capabilities Experience Knowledge Skills Networks
Financial	Income Savings Collateral

The programme focus is to identify appropriate and feasible ways within each family unit (and within the wider community) to enhance the stock of these assets in a manner that is consistently sustainable over time, that has a qualitative and quantitative impact on the family's life situation and poverty; and, crucially that enables the mentally ill person to make an identifiable and consistent contribution. This contribution should not only be seen to enhance the family's stock of assets, including that of the mentally ill person, but should support that person in the appropriate management and recovery from their illness. In other words, it should provide meaningful work, which is recognised by the family as a whole and is, in the broadest sense, therapeutic.

Process

Approach:

The main approach that Basic Needs is developing first recognizes the importance of stability, by facilitating access to mental health services, promoting participation in the existing self help groups (SHGs) and providing support for the household.

Once stabilized, mentally ill people are encouraged to choose to take up productive employment. Initially, this may be non-remunerative, domestic work. We recognize this as being of both intrinsic value as well as being an important stage of signaling to family and the wider community that the person is stable and potentially available for employment or other income generating activities.

In our pilot projects, the ratio of people returning to previous employment to those taking up new income generating activities is of the order of 3.5:1. We recognize that the return to previous employment may be the simplest, least stressful and lowest risk option facing a mentally ill person and is to be encouraged. We must, however, recognize that if poverty is a contributing cause to the development of mental illness (as well as often creating a constraint on its successful identification and treatment) a return to prior employment, though improving the family's poverty situation, may not be a satisfactory long-term developmental outcome. Thus, we seek to build on this important and valuable intermediary step by supporting the mentally ill person's access to services that aim to address their life in poverty through extending the possibilities of enhancing family assets through microfinance (credit & savings) and employment training opportunities.

For some people, where recovery takes longer or during possible relapses, we aim to involve the caregiver in income generation activities, while always maintaining a holistic approach to the household seeking the inclusion of the mentally ill person at all times to the maximum extent possible while always maintaining appropriate sensitivity to their prevailing condition.

We aim to orient both SHGs, micro-finance and employment training institutions, so that they are encouraged to provide access to support, credit and savings and training to mentally ill people in ways that minimize risk and allow for the needs of a mentally ill person, ways that especially recognize their potentially fluctuating stability and the importance of minimizing stress.

Session 2 b

Income expenditure analysis

Model of income and expenditure analysis:

Expenditure of family X having two children – rough estimate of the monthly expenses

1. Expenses for the grains – 500 Rs
2. Expenses for groceries – 400 Rs
3. Expenses for milk – 150 Rs
4. Expenses for snacks – 160 Rs
5. Expenses for the vegetables – 140 Rs
6. Expenses for firewood/kerosene – 200 Rs
7. Expenses for Non veg food- 400 Rs
8. Expenses for flowers/agarbathi/camphor- 100 Rs
9. School and tuition fees – 300 Rs
10. Expenses for buying fodder for the animals - 800
11. House rent – 500 Rs
12. Expenses for entertainment (cable charges, movies, exhibitions, circus)- 400 Rs
13. Expenses for ironing clothes – 80 Rs
14. Expenses for washing clothes – 120 Rs
15. Expenses for smoking/alcohol – 500 Rs
16. Electricity bill/telephone bill/mobile bill /water charges– 350 Rs
17. Expenses for the travel – 200 Rs
18. Expenses for buying face creams, powder & other make up equipments – 150 Rs
19. Expenses for the cloths – 300 Rs
20. Expenses for unpredictable things (illness, festivals etc)– 200 Rs

5800 rupees for one month

Income source

Income for X family:

Income from agriculture: food grains worth rupees 18000 per year- 1500 rupees per month

Income from the collie work (men) 100*15 days 1500 rupees per month

Income from the collie work (women) 80*12 days 960 rupees per month

Income from cows/buffalos 80* 30 2400 rupees per month

Session 3

Sustainable Livelihoods: 20 minutes

1. Trainer invites participants to share attitudes of families/community with regard to people with mental illness (in the context of involving them selves in productive activities).
2. Trainer invites participants to share reasons for low status for people with mental illness in the community in small groups of 4.
3. Trainer invites group to presentation and categories the responses in the black board.
4. Trainer summarizes the responses of the participants and links same to the self worth of people with mental illness.

Trainer notes: attitudinal problems in the community (including us- .already formed opinion that mentally ill people can not lead a normal life.), same need to be dropped/reflected.

Bus Game: 10 minutes

1. Trainer invites 2 participants to be volunteers to be the bus driver
2. Trainer gives various options like (all men in one bus, all women in one bus, all those who have passed 10^{th} class exam in one bus, rest in other bus, All those who are in debts will be in one bus etc)

80 minutes

1. Trainer asks the participants to write their family income (from all sources) for the month in their note book.
2. Trainer asks the participants to list down the expenses for one week, trainer gives example like money spent for milk, flowers, groceries, fuel, fire wood, for their travel etc.
3. Trainer asks participants to divide their monthly income by 4, so that they can arrive at weekly income.
4. Trainer asks the participants to compare the expenses to their income.
5. Trainer asks participants to priorities the expenses more essential to less essential.
6. Trainer asks the participants how much was the relevant expenses in the last week.
7. Trainer invites 6 volunteers (three men and three women) to share their expenditures list.
8. Trainer invites participants to comment on the life style and the expenses of every day
9. Trainer asks participants to reflect on the expenses for the family functions (marriage, naming ceremony, death ceremony, puberty function, birthday celebration etc). How much is the relevant expenses, in comparison with the olden times?, How the relevance of the religious functions loosing? How people are exhibiting their income in the family functions?. What are the facilitating factors and what are the barriers (reasons for failures)

Trainer notes: direct and indirect expenses. Think about productive work not been considered as income. If you buy chicken in the shop we would value it, if same been got from the home. On the expenditure side reflect on spending on essential and non essential things. When you spend on non essential things you will not have money for spending on essential things. Reflect on the essential spending like, health, good nourishment, education etc. Making savings as a habit to be self reliance/ self sufficient etc.

Session 3

From Dependency towards Self Reliance – A Basic Needs India paradigm.

Poverty is more than low income and wealth is more than material possessions". Poverty being the cause and effect of mental illness has to be addressed from three stages that is the past, present and the future. Basic Needs India Trust from its inception in 2001 has tried to tackle and deal with the issue of mental illness from a curative perspective with the identification of people with mental illness, treatment and follow up procedures. Working in partnership with other NGOs certainly has had a proven impact on the community. Any intervention aimed at upliftment and empowerment of the marginalized and the poor should have a sustainable component to it wherein the people will carry on with the activities and become progressively independent and self-reliant.

This paper will focus on the Basic Needs India experience in facilitating the community towards economic empowerment. Here the word "empowerment" conveys the meaning that people be enabled "to get what they want on their own". To base the program on local reality is clearly a fundamental success. Based on the local reality it is evident that starting business development services amidst the mentally ill population will be more difficult than in favourable contexts. Keeping this in the background the economic activities should be initiated and implemented.

Society for Community Organization and Rural Development (SCORD) a partner organization of Basic Needs India which works in the Tanjore district of Tamilnadu initiated the Micro Enterprise Development Program (MEDP) in its project area with the help and support from Jan Sakthi Sansthan (JSS) a central government project. The preliminary discussions bore fruits whereby JSS identified the potential entrepreneurs for different trades and assured that the JSS team would provide training for the community. Some of the areas which were of interest to the community are

a. Sambrani (agarbathi / incense stick) production and sales unit
b. Animal Husbandry (Goat and Sheep rearing)
c. Computer education
d. Tailoring and Embroidery
e. Color powder whole sale business and distribution

JSS has assured that training will be provided and appropriate support will be given during the initial phase.

The step to come forward to collaborate with SCORD for the cause of mental illness is a welcome measure. At the same time it is paramount to look into certain factors which are of much pragmatic significance.

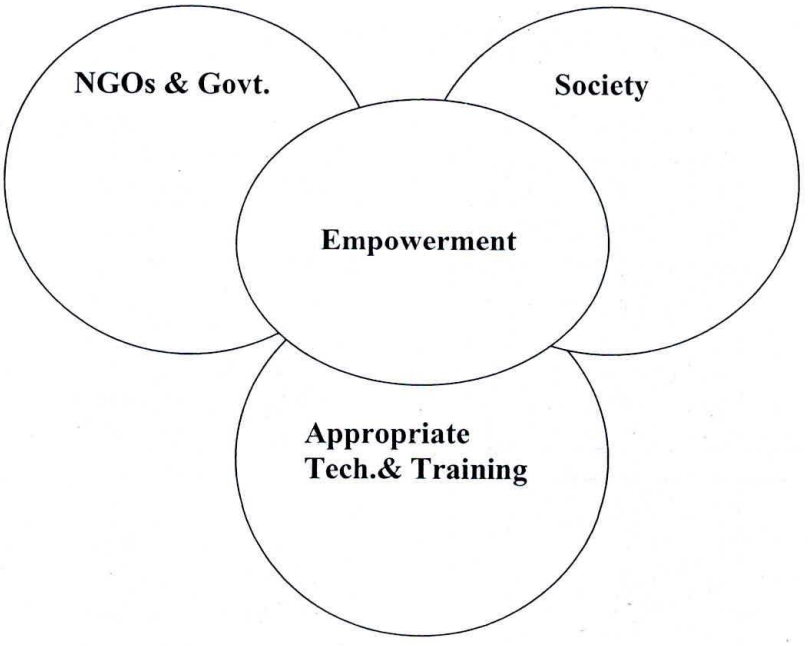
From a Mental illness perspective Micro Enterprise Development Program has to be considered as a part of the rehabilitation process and not as a separate intervention. Adhering to this view means to accept that MEDP would certainly promote recovery among the mentally ill but won't be totally successful in developing micro enterprises. Considering MEDP as a part of the rehabilitation process, it will have a negative effect

on the sustainability factor. It will be a Herculean task for the stabilized people with mental illness to gain a shift from a no loss-no gain to a profit-making zone. Ostensibly this shift will happen after a considerable period of time whilst the time they reach that position the competition will be high which would hinder their survival in the market.

To consider the time spent for identification of potential entrepreneurs from the community is paramount step. A set procedure has to be followed. Providing appropriate choice and preferences through continuous motivational support to the people invariably substantiates the "bottom-up" approach towards development. In our pilot projects (Basic Needs india) the study conducted by Nicholas Coloff and Dr.Anil revealed that the ratio of people returning to previous employment to those taking up new income generating activities is of the order of 3.5:1. Comparatively speaking the return to the previous employment may be the simplest, least stressful and lowest risk option facing a mentally ill person. This fact is recognized and encouraged by Basic Needs India. Though the previous employment reduces poverty to a certain extent it is felt that it is not practicable to suffice the absolute needs in the long run. In order to create a long term development outcome emphasis should be given in the areas like capacity building and motivational training, extracting more grant and credit facilities as support measures and aiming for collaboration with other departments and institutions.

It is absolutely necessary to strike a balance between the rehabilitation model (considering the activities as activities by itself to keep the people with mentally illness occupied) and the standard business model. There has to be a common consensus in proportionately sharing and adopting the significant features from both the models.

Since there is an already existing Micro Finance set up (SHG model) at the grassroots level the same can be used as a platform to carryout the needs assessment so that appropriate plans can be framed for the economic activities in consultation with the people with mental illness and their family members. This above-mentioned exercise would help us to understand the gap between the needs of the people with mental illness and the existing program and the services. It would also reveal if they have access to the services, awareness about the legalities and its implications and the level of support from the society. A holistic approach through sectoral coordination addressing mental illness will beyond doubt have a ripple of effect.



As a first step to assess the house hold economies would result in analyzing the financial burden of the family thereby addressing the needs and creating forward linkages with the banks and other financial institutions. Technology harnessed wisely through appropriate training will enhance human potential and people with mental illness certainly are not an exception. As already said the ultimate goal of this venture is to reclaim the mentally ill persons to normalcy and get them integrated in the Social mainstream. While doing so the guiding principle will always have to be "help to help themselves" as a permanent remedy and relief. The purpose of help should not be paternalistic, making them perpetually dependent on others. On the other hand make them stand on their own legs in the long run. Help in the form of Governmental, non-Governmental and technological aids will all be like crutches only. The crutches have to be removed at one stage and this will be for their own good. In this context the Chinese saying is very appropriate to be remembered. "Instead of giving people a fish a day, teach them fishing" is the philosophy of the whole paradigm. "From dependency to Self-Reliance" is the thrust of our mission.

Session 4

Livelihood Interventions: 60 minutes

1. Trainer divides the participants in to four groups.
2. Trainer asks participants in the small group to list out the various livelihood options/interventions seen at the community level.
3. Trainers ask the participants to reflect in groups on whether these interventions are able to meet the financial needs of the individual or families.
4. Trainer asks group to discuss on why income generation activities provided was not able to meet the financial requirement of the individual/ families.
5. Trainer invites group to present the group discussion.
6. Trainer summarizes and concludes the discussion on how the livelihood interventions should meet the financial requirements of the family.

Trainer notes: consultation with the affected person and the family is the key intervention. Self employment, group activity, family occupations are the options. Any new initiatives, the affected person or the family should be given training to acquire the required skills.

Session 4

Self Reliance- Basic Needs India's Experience

Background

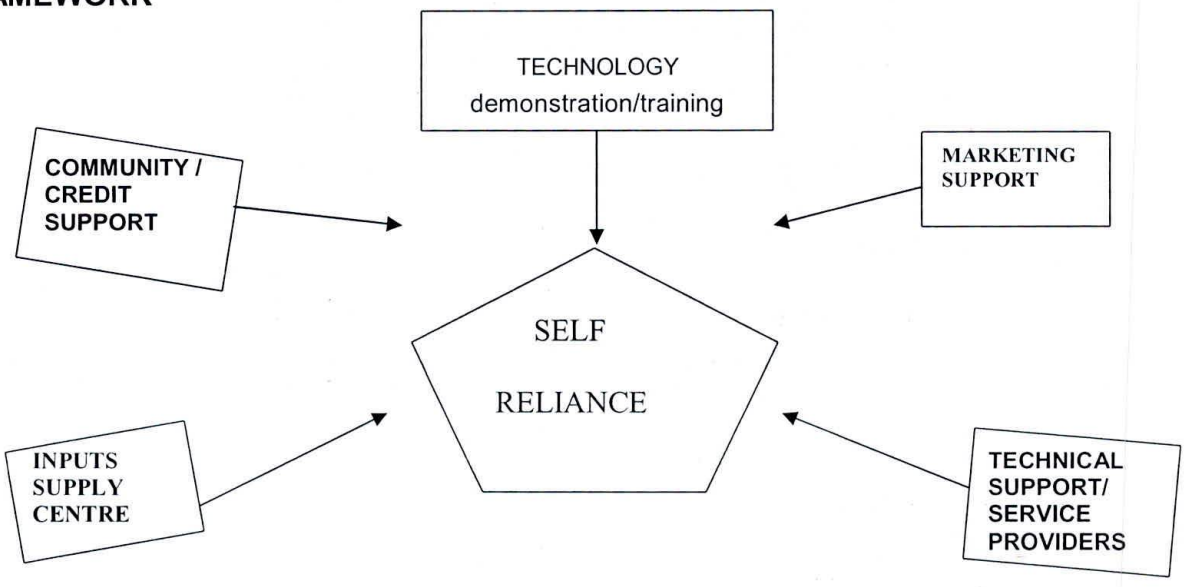
Basic Needs India (BNI) is a collaborative network involving groups such as community based organisations (CBOs), non-governmental organisations (NGOs), research institutes, statutory bodies and local community resources which are concerned for the well being of the people with mental illness. The belief is that through capacity building of the mentally ill, their carers and these organisations, the mentally ill can become self-reliant. This in turn will result in integration into their own families and the main stream where they will be recognised as capable and contributing people within society. Such capacity building will become a factor in the process of overall poverty reduction amongst the communities with whom Basic Needs India is working. The above ethos necessitated exploratory visits, meetings with concerned people and a consultation workshop with mentally ill, their carers and CBOs. Through this process, the income generation module evolved with three clear purposes.

Sustainable Livelihood to BNI Means: At Basic Needs India our understanding of livelihood/income generation/self-reliant programme is as far as livelihood is concerned family as a unit, people with mental illness are involved in gainful occupation, not sitting idle/just brooding and warranting the care givers getting freed and people with mental illness getting into meaningful occupation and earning money there by there is a recognition for people with mental illness within their own family and community and are involved in their own development process in the process meeting their own basic needs and exercising their basic rights. In so doing it doesn't create a further stress on mentally ill person and it is to release the stress or it should be therapeutic. Don't ever measure people with mental illness productivity/incomes.

Purposes of livelihood :

- To enable people with mental illness to participate in a sustainable self- reliant income generation programme leading them to exert their full potential within their own communities;
- To enable people with mental illness to engage in activity, which is physically, and mentally rewarding which thus in turn promotes improved physical and mental well being;
- To enable the families of those with severe mental illness to undertake income generation activities, which will serve to augment existing family income, thereby alleviating the financial burden of caring for a person with health needs;
- To reduce drug intake over a period of time as people become successfully rehabilitated with in their community.
- To provide an opportunities for families to come out of economic burden

FRAMEWORK



In the move towards self-reliance, the following factors are essential components:

1) **Technology** – the interested person should see the activity being carried out and/or undergo a period of training to acquire the skills associated with that activity

2) **Community/credit support** – financial, material and other support is invariably required and should preferably be available from within the person's immediate community or through locally available networking opportunities

3) **Input/supply centre** – materials/resources/equipment regularly required for the activity should be available within the local area in order to maximise the income ultimately available from the activity

4) **Technical support/service providers** – where necessary, for example in the case of animal husbandry activities, a trained person with the necessary technical skills should be available in times of need

5) **Marketing support** – there should be a viable, local and sustainable market for any goods produced as a result of the activity

6) **Care giver or family member will be associated in above process** – by product of involving family member will be in case of relapses care will be carried out in business proposition

The choice of the activity in 1) is dependent on the availability of the factors listed in 2) – 5).

PROCESS

Pre-requisite: Stabilisation of mentally ill person – means regular intake of medicine, found improvement in association with CBO's staff and Secondary partner

Ideal time: To start livelihood intervention

- **Group formation of people with mental illness and their care givers**
  People with mental illness and/or their caregivers will join groups formed at circle level (5-6 villages). This process will be facilitated by Basic Needs India and carried out by the local CBO. These groups will be the initial forum for identifying and initiating local income generation activities and will provide an ongoing support and self-monitoring facility for the members. This group will meet once a month (minimum).

- **Foundation training to groups along with CBO staff**
  Participatory training to strengthen the groups will be carried out covering areas such as the importance of group formation, group characteristics and behaviour (including ground rules) and potential development and achievements of the groups

- **Identification and assessment of their capabilities as well as their needs**
  With the technical support of Basic Needs India staff, local CBO staff will identify the existing skills of the members as well as explore their interests. Their existing abilities, mental health condition and potential as well as their social and economic needs will be considered carefully in this process.

- **Based on their capabilities identification of local viable trades**
  Following on from the above step and taking into account the factors listed above (Framework) possible trades will be identified and proposed to the individual as a potential income generation activity. To enable this, thorough research of local resources will be carried out and a directory of resources for training and accessing finance will be compiled.

- **Technical training in specific income generation activity**
  Individual members (or small groups of individuals where appropriate) will be provided with access to the necessary exposure and training required for them to undertake the chosen income generation activity. This training will include not only the immediate skills necessary to carry out the trade but also associated skills such as planning, marketing etc.

- **Networking with Micro Finance Institutes (MFIs) or credit support to the groups through CBOs**
  Basic Needs India staff will train the local CBOs in methods of accessing credit from local banks, agencies such as National Agriculture Bank and Rural Development (NABARD) and other MFIs. The CBOs in turn will facilitate members of the groups to access funds from these sources.

- **Monitoring of progress and evaluation of income generation module**

CBO's and Secondary partner staff will be trained to carry out continual support and monitoring of the progress of members in their chosen income generation activities. Basic Needs India staff in turn will monitor the support given and evaluate the effectiveness of the technical and other supports (as listed in Framework). Mid-course corrections will be carried out as necessary and the process will continue.

- **Review:**
  Of the entire module, lessons learnt, quality of the programme, if necessary mid course corrections and needs to be diversified. The whole property/resources will be owned by CBO's or Secondary partner and groups reflections of their own experiences

- **Institutional training to groups along with CBO staff**
  Participatory training targeted at developing the vision of the groups towards forming their own independent association/federation at taluk/district level which will in turn network and work for change in the provision of services for and attitudes towards people with mental illness, ultimately leading a move towards basic rights.

- **Documentation and Dissemination:** of the whole process for larger audiences

ACTIVITIES:

Training:

- On income generation and where it fits in the process of rehabilitation of people with mental illness and their caregivers to CBO's staff and secondary partner
- On assessment of people with mental illness and their caregivers skills, capabilities and their interest in the area of income generation
- On how to facilitate the people with mental illness and caregivers enter into the existing SHG's groups and /or initiating new groups as necessary
- To CBO's/ Secondary partner staff regarding the process and benefit of farming federation and supporting towards this goal
- Where federation already exists orientation of members on income generation module and facilitating their active involvement in supporting and monitoring overall process
- Facilitating the process of exploring local viable trades including the option which may support local CBO's/ Secondary partner towards economic sustainability
- Training on Agriculture, horticulture, animal husbandry and allied activities to people with mental illness and their care givers with CBO's/ Secondary partner staff
- Identifying appropriate people/institution/organization to support training in other areas/profession and facilitating CBO's/Secondary partner staff to support people with mental illness and carers in training process.
- Sensitisation of companies/institution/organizations to the possibilities of integrating people with mental illness/caregivers into the training programme or work place

- Identification of local/state level micro-finance institutes (MFI's) and orientation regarding Basic Needs India approach
- Facilitating linkages between intending CBO's /Secondary partner
- Along with CBO's / Secondary partner staff exploring the possibilities of utilizing the services from interested MFI's to support individuals/ groups in income generation activities
- Strengthening existing system of CBO"s/ Secondary partner to monitor and evaluate income generation activities which in turn feeds into overall Basic Needs India PMS
- Half – yearly review of the program with CBO's staff / Secondary partner to enable necessary mid-course correction or strengthening of process
- Annual meeting of all stake holders involved in income generation module for review and planning
- External evaluation during third quarter of 2003
- Dissemination of experiences and learning to stake holders and wider audiences through reports and case studies and use of websites and journals

Session 5

Trade analysis : 60 minutes

1. Trainer gives input on trade analysis and share the trade analysis format
2. Trainer divides participants in to three groups, ask them to do trade analysis for 3 people, (a mentally ill woman wanted to grace cow, a mentally ill men wanted to open a tailor shop, a mentally ill men wanted to start a welding/puncture shop)
3. Trainer invite group to make presentation of the trade analysis of each group
4. Trainer summarizes the presentation on trade analysis.

Trainer notes: market, quality (nil rejection) timely deliveries, exposure to seasons, prevailing trends, fluctuations in input output (sensitivity and alertness in business)

Session 5a
Selection of an income generation activity

Questions to be asked

- What materials or equipment would be required for production?
- How much would they cost?
- Who would buy the product?
- How much would they pay?
- How far away they live?
- Will there be transportation problems?
- What storage problems we may have?
- What skills and knowledge would we need?
- What facilities or land would be required?
- How long would it take us to get started?
- How long will it be before we start to make a profit?
- Where could we get help or assistance?
- What will be the long term/short term benefits to the community?
- How can the community be involved in the project?

Session 5b

Identification of trade – a feasibility study profile

I. Personal data:

1. Name of the members :
2. Age :
3. Address :
4. Education status :
5. Disability :

6. Family constellation table

Sl No.	Name	Relationship	Age	Occupation	Income	Remarks

II Data on trade

1. Desired trade:

2. Experience / skills related to the proposed trade:

3. Feasibility

   (a) Raw material:

   (b) Support from family / anybody in the family has already involved in the trade? /The kind of support that the family would extend to this person for the trade:

   (c) Anybody in the village is involved in this trade? / Their experiences / the risk involved in this trade:

   (d) Marketing prospects:

   (e) Profit ratio:

4. Details of investment:

   (a) Amount required for investment:

(b) Financial sources:

Individual contribution: Rs. Loan Rs.

(C) **Loan**: Bank ☐ Organisation ☐ Government scheme ☐

(d) Rate of interest:

(e) No. Installments for repayment:

(f) Installment amount:

(g) Subsidy if any:

5. Details of re-investment strategies: If yes, how much?

III Details of sangha activities:

1. Name of the sangha to which the member belongs:

2. Number of meetings held in sangha:

3. Number of PWDs in the sangha: Male: /Female: /Children

4. Total amount of savings in the sangha: Rs.

5. Utilization of savings:

6. Details of loans given to members for income generation:

7. Details regarding attendance of the member in the sangha:

8. Details of participation of the member in sangha activities

9. The total savings of the member:

10. Details regarding the member's borrowing & its repayment status: (from Sangha)

Sl No	Date	Nature of Credit	Amount	Amount repaid	Current status

11. Details regarding loans obtained for income generation & repayment records:

Sl No	Date	Trade	Amount	Amount repaid	**Current status**

12. Details regarding the progress in the trade:

13. Details regarding the reasons & priority for the loan recommended for the member:

14. Relationship with the other members in the sangha:

15. Details of discussions & opinions of the sangha regarding the proposed trade for the member.

16. Details of recommendation & guarantee by the sangha:

IV Action from federation/Organisation

1. Details regarding the meeting & the reason for recommendation by the trade committee:

2. Details regarding the modifications/alterations by the committee, if any:

3. Final amount agreed to be given for the trade:

4. Details regarding the conditions for repayment/default:

5. Details regarding the follow-up measure:

Date: Signature:

Chapter 6

Documentation and Advocacy

Trainees should be able to:

1. *Gain an overall understanding of documentation-types and importance*
2. *Develop format (individual file) for documenting*
3. *Learn and use the various legislations and provisions related to persons with mental illness*
4. *Have an understanding on human rights and international developments in disability (UNCRPD)*

Number of sessions: 6

Session 1: Need for documentation

Session 2: Individual file format and the quarterly report

Session 3: Advocacy

Session 4: Mental health legislations in India

Session 5: Provisions available for people with disabilities

Session 6: Human rights and UNCRPD

Session 1:

Need for documentation: 30 minutes

1. Trainer asks the group to reflect on what is documentation
2. Trainer writes down the responses on the black board.
3. Trainer asks what are the types of the documents to be maintained
4. Trainer writes down the responses on the black board.
5. Trainer invites the participants to summarize the discussion on relevance and possible uses of documentation.

Session 1

DOCUMENTATION

Documentation generally refers to the act of recording information, or the act of collecting and organising documents.

Documentation is a process consisting of several activities, namely:

- Determining what information is needed and establishing means for acquiring it;
- Recording the discovered information and storing such in appropriate containers (called documents) or collecting already-existing documents containing the needed information;
- Organizing the documents to make them more accessible; and
- Actually providing the documents to users who need the information.

USES

1. Establishment of historical records
2. Standard-setting for purposes of quality control
3. Direct assistance to victims
4. Pursuit of justice
5. Human rights education

TYPES

A document is a carrier or container of information. An equivalent term is information material, or simply material. A document or material can be:

1. Textual or non-textual
2. Published or unpublished

A) Textual and Non-textual documents

A document or material is textual if it contains mainly written words. The following are examples of textual documents: books, periodicals, statistical reports, legal documents such as affidavits, catalogues, patents, and administrative records. The information is usually printed on paper. The texts of many documents are now increasingly being stored in electronic form such as files saved in computer diskettes.

Non-textual documents may contain some text but the most important part is the information presented in some other form. Examples of non-textual documents are photographs, maps, sketches, sound recordings, video recordings, artistic works and monuments, films and slide shows.

B) Published and Unpublished documents

Documents may be published or not.

A **published document** usually has the following characteristics:

1. Made available to the public, such as by selling

2. Printed and packaged in a regular form such as a book, magazine or any other form of publication
3. Produced with numerous copies
4. Available through established means of distribution such as bookstores and newspaper stands
5. Carries a set of information such as title, name of author, name of publisher and other related information that provides a unique and accurate description of the document as a physical carrier of information. This set of information is referred to as bibliographic description.

Some documents may not be printed and distributed, but are made available to the public through websites on the Internet. There are numerous forms of unpublished documents, each form used for a specific purpose. For instance, an affidavit is mainly used in legal procedures. A data entry form on the other hand facilitates data retrieval and collation of statistical information

Grey literature refers to documents which, while also available to the public, do not conform fully to the above set of characteristics. For instance, only a limited number of copies may be available, and not through the usual means of distribution. Common examples of grey literature are conference papers, public statements and denunciations, occasional reports by human rights organisations, speeches and declarations, brochures, etc. Many of these documents are reproduced in limited quantities, such as by photocopying. Non-governmental organisations account for a large amount of grey literature, especially in situations where they had to establish alternative information dissemination channels as their access to the mass media is limited.

Session 2:

Individual file format and the quarterly report : 100 minutes

1. Trainer introduces the concept of case study, individual files and life stories
2. Trainer brainstorm with the group to arrive at the broad areas for case study format (personal details, occupational history, marital history illness related, premorbid personality, family details ,environment and statistics etc)
3. Trainer divides the participants in to 4 groups, they are expected to list down the areas of information under each group and give a rationale (basis) for all the details that they will require or what purpose will the information serve.
4. Trainer invites group to make presentation on their discussion. The other groups would contribute and clarify so that all have similar understanding.
5. Trainer summarizes the discussion reading out the format arrived for individual file and the copy of the format for individual files will be shared with the participants.
6. Trainer shares with the group copy of the quarterly report and agree up on the quarterly report format and also include a section for the "changes tracked (follow up information)" so that all partners have same understanding on the reporting.
7. The data base on the system will be displayed through LCD, and its use in filling the quarterly report will be shown to them.

Session 2a

CASE STUDIES: Is defined as detailed analysis of a person or group, especially as a model of medical, psychiatric, psychological, or social phenomena.

In our NGO Context, it is an in-depth study of one person. In a case study, nearly every aspect of the subject's life and history is analyzed to seek patterns and causes for behavior. The hope is that learning gained from studying one case can be generalized to many others. Unfortunately, case studies tend to be highly subjective and it is difficult to generalize results to a larger population.

INDIVIDUAL FILES: Is a comprehensive set of information on a person cover various aspects like physical, mental, emotional, psychiatric details. The information collected should give an over all picture of the person's situation .The file must also include indicators that can be followed up on regular intervals to check if the client is making progress or not. For examples, change in behaviour, symptoms etc.

LIFE STORIES: An account of the series of events making up a person's life as explained by the person in question. The idea is to bring out the qualitative dimensions of information that tends to be missed out some times in case files. The life stories are written up in a more reader –friendly format .This can then be highlighted in awareness building and advocacy campaigns.

Session 2 b

Guidelines for collecting information on the individual and the family/face sheet

a) Individual & family member's details like name, age, sex, marital status, education, occupation, number of children, number of earning persons and dependents etc.

About individual illness

a) History of illness – when it started, since how many years, how it started
b) Causes/triggering factors
c) Symptoms
d) Type of illness
e) Understanding on the illness by the individual & the family
f) Treatment process/efforts medical including local/faith healing

Social aspects of the family

a) Type of family – nuclear or extended family
b) Other social problems/difficulties like history alcohol/substances
c) Single parent's family, broken families, marital conflicts if any, divorce and extra marital relationships etc.
d) Cultural beliefs and practices of the family

Family dynamics

a) Relationships within the family
b) Impact of positive and negative relationships on the individual
c) Human rights violation like not providing treatment, property rights, abusing and assaulting, chaining and locking etc.

Impact of the illness on the individual and the family

a) Social impact – stigma, marginalization/discrimination, isolation within the family and community
b) Economic impact/burden – earnings and expenditures, number of earning persons and dependents, savings, education of children, rent, family maintenance, food clothing etc.
c) Due to mental illness any physical health hazards within the individual
d) Psychological situation of the family

Treatment process prior program intervention

a) In depth understanding on the treatment process – medical and other methods tried by the individual and the family, if he/she is on treatment which hospital, from how many months/years person is on treatment, whether it is satisfactory and supportive

b) Why the efforts put by the family failed

Program interventions

a) Since how many years the family is in the program, how the individual and family is identified/ included in to the program
b) Over all program interventions (Individual, family and community) like education & awareness on illness, right treatment and follow up, counseling, skill training/livelihood supports, self help groups, inclusion of PWMI and family members in to community groups, federations etc
c) Impact and out come of the program interventions (Individual, family & community) in various areas like situation of illness, understanding on the illness, changes in the social aspects, family dynamics, economic situation, knowledge and information like part of self help groups, community groups and federation

Session 2b

Tracking changes through individual case files – model 1

MENTAL HEALTH – INITIAL ASSESSMENT FORM

Date **Cluster Area**

Field Staff ***Field Coordinator***

INDIVIDUAL DETAILS

Name **Client number**

Age **Sex**

Education

Marital status

Residential address

Manner of identification/Referral source

Informant(s) during interview

IS CLIENT UNDER MEDICAL TREATMENT? IF YES

Name of hospital
Hospital registration number

Name of consulting doctor

Dates of identification
Diagnosis and medications

PRESENT COMPLAINTS (Number each complaint)

Family

Individual

HISTORY OF CURRENT ILLNESS

When and how did the illness start and develop? (Recent major life events, relevant marital history, history of mental illness, relevant medical history e.g., head injury, alcohol or tobacco use)

Care and treatment given so far

CLIENT'S FUNCTIONAL PERFORMANCE
Client's current daily activities

Personal hygiene/Self care (Ability to manage bathing, grooming, dressing, toileting, etc.)
Home management (Ability to manage cooking, cleaning, shopping, finances, childcare, etc.)

CLIENT'S OCCUPATION, SKILLS, and INTERESTS (Include income if appropriate)
Past

Present

ATTITUDES AND BELIEFS
CLIENTS

i Understanding of illness
ii Beliefs about others

FAMILY'S

i. **Understanding of illness**

ii. **Acceptance of individual**

iii. **Support and supervision provided to involve individual in family activities and functions**

COMMUNITY'S

i. **Understanding of illness**

ii. **Acceptance of individual**

iii. **Support and supervision provided to involve individual in community activities and functions**

iv. **Active resources created to support individual**

SOCIAL SITUATION

FAMILY (Circle members that client resides with)
Extended or nuclear family

Name	Relationship	Age	Education	Occupation /Income	Skills	Remarks

Primary caregiver
Difficulties and needs experienced by the caregiver and support needed

OBSERVATIONS DURING THE VISIT

CLIENT (Facial expressions, restlessness, strange movements, rate of speech, mood, level of cooperation, ability to answer questions, hygiene, smell of alcohol or tobacco)

FAMILY DYNAMICS

GOALS (Goals that you will be addressing)
Client's goals

Caregiver's goals (Goals of the Staff involved with the individual and the family)

ADDITIONAL INFORMATION

Follow up

Signature

Session 2 c

Individual file format: model 2
Status Report of person with Mental illness –

Date: **Staff:**

Identifying information

Name of Person:

Address:

Age/ Date of Birth:

Sex:

Marital Status:

Religion:

Caste:

Occupation:

Avg. Monthly Income:

Information Given by: Self / Parent / Sibling / son or daughter / relative / other

Personal History

Educational Level:

Other skills/training:

Occupation:

Hobbies / interests

Description of personality before illness

Description of Relationship with:
Spouse/family

History on Mental illness

Symptoms and onset

Causes according to person and family

Family history of mental illness

Treatment taken previously & duration

Current status

a) Physical

Sleep

Appetite

Daily living skills

b) Mental

Behaviour/ Speech/ Emotions/ Feelings

Person's activities at home

Activities outside the home

Family and Social information

Family constellation

Sl	Name	Relationship	Age	Edn	Occupation	Remarks

Any disability/mental illness in the family:

Marital Life – duration and relationship

Economic status of the family

Combined family income

Cultural Beliefs

Attitude towards person with mental illness/ how does family members relate to mentally ill person

Primary carer

Other family problems

Attitude of Community towards him/her

Community support

Date of inclusion in the CMHD programme:

I. CMH

Diagnosis

Present treatment and date of commencement

Regular/ irregular

Side effects

II. Sustainable Livelihoods

Livelihood activities/skills

Total Hours of work per day

Present Income

Livelihood source of family

Total Income of family

Membership in SHG/ other group

Loans/schemes availed

Other remarks

III Capacity Building

Participation in family decisions

Participation in social / community life

Community support

Present Needs of person:

Action plan:

Quarterly Follow up Report

I. Changes in symptoms and medication

II. Participation in Livelihood activities

Changes in income levels

III. Participation in Family life (describe quality and level of participation)

Participation in community life

Changes in attitude of people/community

Session 2 d

Reporting Period:

Partner:

A. Community Mental Health

	Severe mental illness		Common mental illness		**Total**
	Male	Female	Male	Female	
Total Number Identified in the area (brought forward)					
New cases identified during the quarter					
Number actively on treatment brought forward					
New cases referred for treatment during the quarter					
Total					

II	***Source of Treatment***	SMD	CMD	Total
	1. Camps 2. Private practitioners 3. District hospitals 4. Local medicine 5. Any other (Specify)			

	SMD		CMD		Total	
	Male	Female	Male	Female	Male	Female
Side effect						
Relapse Brought forward During the quarter						
Number stabilised Brought forward During the quarter						
Regularity 1. Regular with medication 2. Irregular with medication 3. death						
Drop outs Brought forward During the quarter						

B. Livelihoods

I.	PWMIs				Caregivers		**Total**
	SMD		CMD				
	Male	Female	Male	Female	Male	Female	
Number actively in livelihood (stabilization) activity as on 1st quarter							
New cases involved during the quarter							
Total							

		PWMIs				Caregivers		Total
		SMD		CMD				
		Male	Female	Male	Female	Male	Female	
	Consultations to discuss livelihood issues							

II	***Source of Support*** **A. People gone back to previous work** 1 Agriculture 2 Collie 3 Animal husbandry **B. Taken up new activity with the financial support:** 1 2. ***c. From financial institutes*** 1 2 **d. From partners through SHGs** 1. 2. **e. Directly from partner NGO** 1. 2. 3. ***f. Accessed government schemes*** 1. 2. **g. Taken up new activity without financial support** 1. 2. **h. Number of people with mental health problems undergone vocational training** 1. 2.							

C. Capacity Building

I.	PWMIs				Caregivers		**Total**
	Major		Minor				
	Male	Female	Male	Female	Male	Female	
Number actively in SHG activity as on 1st April 2009							
New cases involved during the quarter							
Total							

II		Number	PWMI	Caregivers	Staff	Others
	Number of consultation held with:-					
	Number of awareness workshop for:- a. b. c. d e.		NA	NA	NA	NA
	Number of cultural and other events conducted 1.Sports 2.Rallies 3.Street theatre 4.Exposures 5.Outings		NA	NA	NA	NA
	Marriage of people with mental illness		NA	NA	NA	NA

D. Advocacy and policy

	Advocacy	*Programmes*		Description / Narrative
	Efforts made to address the following and by whom - Human rights abuse - Meeting government officials - Demonstrations - Others			
	Celebration of events *World Mental Health day* Any Other			

RESEARCH

	Number of individuals files updated	
	Number of life stories	
	Staff meetings (mental health	
	Review meetings (planning and review)	

Session 3

Advocacy: 30 minutes

1. Trainer shows video on mental health advocacy and ask participants what they thought and felt about the video
2. Trainers notes down the responses on the board
3. Trainer gives the definition of advocacy
4. Trainer invites participants to share some of their experiences on advocacy activities.

Session 3

ADVOCACY:

Advocacy is a means of supporting and helping people to speak up or act for them selves. The key aim of mental health advocacy is to empower people who use mental health services and to protect their rights as citizens by helping them to get their views across. Empowerment is an essential aspect of advocacy. It supports and promotes people's rights to speak and act for themselves and to regain some control over their lives

Advocacy support is needed in the mental health services because people who use them can feel and can be dis-empowered by the rules, procedures and people providing the services. Decisions are taken that affect their daily lives and well-being, for example:

- Being detained in hospital under a section of the Mental Health Act.
- Being prescribed medication which has adverse physical side effects.
- How much money they are entitled to receive under any welfare scheme.
- Provision of suitable accommodation.

Advocacy can involve

- Listening and giving information.
- Encouraging the client to speak on their own behalf.
- Liaison with different agencies.
- Mediating so people understand each other.
- Representing or acting on behalf of someone.

Some examples of advocacy:

Within hospital:

- Difficulties in communicating.
- Feelings of loss of respect and dignity.
- Sense of being powerless.
- Lack of information about medication, side-effects and entitlements.
- Lack of support when feeling confused, frightened or intimidated.
- Difficulties getting a diagnosis.
- Supporting at CPA's, Mangers Hearings, Mental Health Review Tribunals.

Within the community:

- Practical problems in accessing benefits, accommodation and other services.
- Lack of understanding of severe mental illness.
- Discriminatory attitudes and fear.
- Pressures at work, college and other environments.

- Strain within the family.
- Difficulty getting a second opinion or a medical review.
- Problems with police and courts.

There are a number of ways of delivering advocacy services. The main ones are:

- **Legal advocacy**, which is provided by legally qualified advocates, usually solicitors.
- **Citizen advocacy**, which involves long-term, one-to-one partnership between user and advocate. This kind of advocacy tends to be more common in the learning disability field that in mental health, but may have some role to play in the latter, particularly for people with both kinds of problems or organic difficulties.
- **Formal advocacy** usually refers to schemes run by groups which are not, by and large, user-led. Co-ordinators are salaried and often advocates are paid. They usually are prepared to act for both carers and service users. They are sometimes involved in giving informed choices and mediating for clients.
- **Peer advocacy**, where advocates are themselves, mental health service users.
- **Self-advocacy**, which involves people speaking out for themselves

Session 4:

Mental health act and People's with Disability Act: 60 minutes

1. Trainer introduces the concept on mental health and legislation, list out the legislations related to mental health
2. Trainer distributes paper on the summary of Mental health and disability act to the participants
3. Trainer divides participants in to four groups, two groups would read on the mental health act, and two groups would work on the disability act.
4. All the participants in the group would read the paper and would write down the summary of the acts
5. Trainer invites groups to make presentation on the summary
6. Trainer sums up the discussion sharing relevance of these acts in the CBR context.

Chapter 9: Research and Manpower development

Government and local authorities shall promote and sponsor research in order to prevent disability, develop assistive devices to rehabilitate the disabled, identify jobs and develop disabled friendly structural features in factories and offices.

Chapter 10: Recognition of institutions for persons with disabilities

Within six months of this Act being passed, persons running establishments or institutions for persons with disability shall apply under this Act for a certificate of registration of the institution.

Chapter 11: Institutions for persons with severe disabilities

Persons having disability of 80% or more are considered to be persons with severe disability. The Government shall establish and maintain institution for them. Where private institutions exist which meet Government standards, they shall be recognized as institutions fit for persons with severe disabilities.

Chapter 12: The Chief Commissioner and Commissioners for persons with disabilities

The Central Government shall appoint a Chief Commissioner for the implementation of the provisions of this Act. The Chief Commissioner shall coordinate the work of the Commissioners (in the States), monitor the utilization of funds given by the Central Government Commissioners appointed by the State Governments shall have similar responsibilities at the State level. The Chief Commissioner and the Commissioner shall take up complaints regarding deprivation and non-implementation of laws, rules, orders and instructions issued by the Government or local authorities for the welfare and protection of Rights of persons with disabilities.

Chapter 13: Social Security

The Government shall, within their economic limits, make schemes and undertake rehabilitation measures for persons with disabilities, and grant financial assistance to NGOs to undertake rehabilitation programmes for persons with disabilities. The Government where possible, shall give unemployment allowance to persons with disabilities registered with the special employment exchange for more than two years, and who could not be placed in any gainful occupation.

Chapter 14: Miscellaneous

Anyone attempting to commit fraud and avail of benefits meant for persons with disabilities can be punished up to two years imprisonment, and a fine up to Rs.20,000.

The Government shall have the authority to make the necessary rules and regulations to carry out the provisions of this Act. These rules and regulations shall be issued in the form of Government Orders (GOs) which have the approval of both houses of Parliament.

Session 4 b
Mental Health Act, 1987

The enactment of the Mental Health Act, 1987 is a mental healthcare delivery in India. It is not simply a. cosmetic improvement over the outdated Indian Lunacy Act 1912, but represents the conclusion of lenghty presentation by the Indian Psychiatric Society to the Government of India. This Act came into force in April 1993, as per the Government of India order, even though it is still in hibernation in some States.

The *Mental Health Act* is 'an act to consolidate and amend the law relating to the treatment and care of the mentally ill persons, to make better provisions with respect to their property and affairs and for matters connected with or incidental thereto.

The *Mental Health Act* has the following objectives:

1. To regulate admission to psychiatric hospitals of psychiatric nursing homes, of mentally ill persons who do not have sufficient understanding to seek treatment on a voluntary basis and to protect the rights of such persons while being detained.

2. To protect society from the presence of mentally ill persons who have become a danger or nuisance to others.

3. To protect citizens from being detained in psychiatric hospitals or psychiatric nursing home without sufficient cause

4. To regulate responsibility for maintenance charges of mentally ill persons who are admitted to psychiatric hospitals or psychiatric nursing homes.

5. To provide facilities for establishing guardianship or custody of mentally ill persons who are incapable of managing their own affairs.

6. To provide for the establishment of Central Authority and State Authorities for mental health services.
7. To regulate the powers of the Government for establishing, Licensing and controlling psychiatric hospitals and psychiatric nursing homes for mentally ill persons.
8. To provide for legal aid to mentally ill persons at State expense in certain cases, the Government of India has constituted a Central Mental Health Authority. Before implementing the Mental Health Act in the States, the States have to take action regarding the following:
    i. To establish a State Mental Health Authority.
    ii. To spell out guidelines for establishment of private psychiatric hospitals and nursing homes.
    iii. Formation of a Board of Visitors.

In the Mental Health Act, 1987, a modest attempt has also been made to bring mental illnesses on par with physical illnesses, thus reducing the stigma attached to mental illnesses. The Mental Health Act has modified certain terms and definitions. The Act uses the term mentally ill

person instead of lunatic, mentally ill prisoner, instead of criminal lunatic. Other new terms are psychiatric hospital instead of lunatic asylum, psychiatric nursing home and psychiatrist. New terminology and definitions are given in Chapter 1. The Mental Health Act has 10 chapters in total, consisting of 100 sections.

Chapter 2 deals with establishment of mental health authorities at the Center and at State levels. These authorities will regulate and coordinate mental health services under Central and State Govern-respectively.

Chapter 3 lays down the guidelines for establishment and maintenance of psychiatric hospitals and nursing homes. Also, there is a provision for a licensing authority who will process applications for licenses. No private psychiatric hospital or nursing homes will be allowed to function without a valid license, which has to be renewed every five years. There is also a provision for an inspecting officer who will inspect the psychiatric and
nursing homes to prevent any irregularities

Chapter 4 deals with the procedures of admission and detention in psychiatric hospitals or nursing homes. In addition to the five methods allowed by the *Indian Lunacy Act of 1912,* one more method have been incorporated.

Chapter 5 deals with the inspection, discharge, leave of absence and removal of mentally ill persons.

Chapter 6 deals with the judicial inquisition regarding alleged mentally ill persons possessing property, custody of their person and management of their property. If the court feels that the alleged mentally ill person is incapable of looking after both himself and his property, an order can be issued for the appointment of a guardian, If however, it is felt that the person is only incapable of looking after his property but can look after himself a manager can be appointed.

Chapter 7 deals with the liability to meet the cost of maintenance of mentally ill persons detained in psychiatric hospitals or nursing homes.

Chapter 8 is aimed at the protection of human rights of mentally ill persons. It provides that:

1. No mentally ill person shall be subjected, during treatment, to any indignity (whether physical or mental) or cruelty.

2. No mentally ill person, under treatment, shall be used for the purpose of research unless:
   i. Such research is of direct benefit to him.
   ii. A consent has been obtained in writing from the person (if a voluntary patient) or from the guardian/relative (if admitted involuntarily).
   iii. No letters or communications sent by or to a mentally ill person shall be intercepted, detained or destroyed.

Chapter 9 deals with the penalties and the procedure, while *Chapter 10* proves for miscellaneous sections.

The positive qualities of the new Act

The admission procedure are simplified to some extent

The two new provisions of the *Mental Health Act* in Admission procedure are:

1. Admission of minor (below age 18) by the parents/guardian.
2. Admission under special circumstances (maximum 90 days).

The old barbaric terminology has been changed with respect to psychiatric patients and hospitals.

The establishment of Mental Health Authorities, both at the Centre .e State is a welcome step. These authorities are expected to n as friend, philosopher and guide to the Mental Health Services .Provisions have been made for establishing separate hospitals se who are under the age of 16 years and also for those who are addicted to alcohol and other drugs and for other special groups. Emphasis on outpatient care has been made to safeguard the human of the mentally ill person. Stringent punishment has also been led for those who subject the mentally ill to physical and mental indignity within hospitals.

Critical view about Mental Health Act 87

1. The notion of a care in the community has not been addressed in the current legislation. No effort has been made to provide after care services for the discharged patients. There seem to be no thinking over the alternative to hospital care.

2. Psychiatrists, running private psychiatric nursing home are facing too many medico-legal problems, difficulties and interference in the administration with regard to:
   a) Getting and renewing licences.

   b) Board of visitors control over their nursing home.

   c) Constituting a medical board for their day to day hospital procedure like issuing certificates for admission to and discharge and leave absence etc.

3. Patients examined by psychiatrists and admitted in a psychiatric nursing home should not be compelled to undergo further examination by medical and/or non-medical visitors. It goes against the fundamental rights of a citizen or his family and such a exposure of any responsible citizen or his family and disclosure of his psychiatric illness to the knowledge of the public may amount to indignity and cruelty.
4. In the present act the matter of consent and competence has not been adequately addressed.
5. Does an involuntary admission (Eg: admission through a reception order) necessarily imply competence? Can drugs and ECT be given without any informed consent? What is the statutory criteria for competence? Who will judge competence doctors or the judges?

Session 5

Provisions available for people with mental illness:

45 minutes

1. Trainer asks participants to list out the provision available for the marginalized people in the state.
2. Trainer asks participants to brainstorm on how needs of people can be met from the existing provisions from the government.
3. Trainer shares with the participants their experiences of availing benefits from the poverty alleviation schemes.
4. Trainer shared about 3% reservations for people with disabilities in all the government schemes.
5. Trainer concludes the discussion inviting comments how to educate the government official/ panchyaths/community on the allocating 3 % of funds for the disabled.

Session 5

Provision available for the people with disabilities in southern states
(will be sending it later)

Session 6:

Human rights and UNCRPD - 90 minutes

1. Trainer introduces the concept of human rights, define what rights are.
2. Trainer divides participants in to three groups, each group would discuss on the needs of different age groups (0 – 18 years, 19 year- 35 years, and 36- 80 years).
3. Trainer distributes the small KG card boards asks group to convert their needs in to their rights in the card boards.
4. Trainer asks group to brainstorm on the rights of people with mental illness.
5. Trainer asks group to reflect on how rights of people with mental illness been denied in the community.
6. Trainer shares with the group on the rights of people with mental illness
7. Trainer divides the participants into three groups again
8. Trainer distributes 3 different Role plays and gives 20 min time for preparation.
9. Each group will come and perform the role play for not more than 5 – 7 min each. (areas covered are Health, inclusion in Community and Home and Family)
10. Reflections from the group on each role play.
11. Trainer introduces UNCRPD and UN Conventions by distributing the papers.
12. Trainer makes a short (5 min) power point/poster presentation on UNCRPD and UN Convention.
13. Trainer asks group to list out incidence of denial of rights, and asks group to brainstorm on the needs/ services required for the person to lead life with dignity.
14. Trainer invites participants to reflect as an individual about the rights they are entitled are they enjoying these rights.
15. Trainer invites participants to list down what the group learnt about UNCRPD and UN Conventions

Session 6 A

HUMAN RIGHTS

Human rights are rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible.

All human rights are indivisible, whether they are civil and political rights, such as the right to life, equality before the law and freedom of expression; economic, social and cultural rights, such as the rights to work, social security and education, or collective rights, such as the rights to development and self-determination, are indivisible, interrelated and interdependent. The improvement of one right facilitates advancement of the others. Likewise, the deprivation of one right adversely affects the others.

The basic rights and freedom, to which all humans are entitled, often held to include the right to life and liberty, freedom of thought and expression, and equality before the law.

Human rights entail both rights and obligations. States assume obligations and duties under international law to respect, to protect and to fulfill human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfill means that States must take positive action to facilitate the enjoyment of basic human rights. At the individual level, while we are entitled our human rights, we should also respect the human rights of others.

RIGHTS OF THE PEOPLE WITH MENTAL ILLNESS

The people with mental illness have a right to

- The same fundamental rights as their fellow citizens including the rights to a decent life, as normal and full as possible
- Legal safeguards against abuse
- Appeal
- Necessary treatment in the least restrictive set up and the as far as possible to be treated and cared for the in the community
- Rehabilitation
- Personal autonomy, privacy, freedom of communication
- Education
- Economic and social security
- Training
- Family and community life
- Employment
- Protection against exploitation ad discriminatory, abusive or degrading treatment

Find below a more detailed explanation of the rights enjoyed by all the citizens of the country and this includes persons with mental illness

1. **Right to inclusion**
   - Inclusion in disability
   - Entitlements across sector for \persons with psycho social disabilities
   - Right to form support groups and associations
   - Right to inclusion in any development process
   - Right to life free from Stigma and discrimination in all walks of life
   - Right to dignity
   - Right to find inclusion in mainstream life

2. **Right to information**
   - Relating to policy and law
   - Services , resources structure
   - All types of treatment
   - Consent in medical non medical research

3. **Right to life**
   - Right to violence free environment
   - Right to bodily integrity

4. **Right to food security**
   - Right to nutritious food

5. **Right to political participation**

   - Right to vote and contest elections
   - Right to hold public office
   - Right to be a member of statutory bodies: state national level committees MHA

6. **Right to Liberty**
   - Minimise involuntary treatment and maximize participation
   - Right to least restrictive environment
   - Right to free movement

7. **Right to livelihood**
   - Right to poverty alleviation and employment
   - Right to free vocational and skills training
   - Right to entrepreneurship and alternative employment
   - Right to equal wages as any one else

8. **Right to integrated, quality mental health care**
   - Right to rational, affordable and accessible medication
   - Right to non drug approaches, addressing well being and not just symptom reduction
   - Right to quality health care
   - Right to information about diagnosis, prescriptions and treatment – both medical and non medical
   - Right to early psychosocial intervention for especially children and young adults
   - Right to have different means and services in the community including bare foot workers
   - Right to quality time
   - Right to privacy
   - Right to standardized comprehensive and multi- axial assessment and care
   - Right to continuity in care
   - Right to socially and technically audited system of care
   - Right to non-hierarchical and non abusive forms of care
   - Right to be respected
   - Right to confidentiality
   - Right to dignified treatment
   - Right to decide who is one's family/support system

9. **Right to self determination**
   - Right to Family, love, relationships
   - Right to positive identity construction
   - Right to choose treatments

- Right to consent to treatment-medical/nonmedical
- Right to refuse treatment- medical/non medical
- Right to autonomy

10. **Right to Inclusion in Law & Policy Making**
    - Right to legal aid
    - Right to grievances redressal
    - Right to participation in review of acts and rules relating to mental health
    - Right to laws which enable rehabilitation
    - Right to inclusion in all statutory decision making bodies
    - Right to be recognized as equal before law
    - Right to necessary assistance
    - Right to simplified procedures in accessing justice

11. **Right to Well Being**
    - Right to Health
    - Right to Play, recreation and leisure activities
    - Right to participate in social, cultural and community life
    - Right to well being at all 3 levels- preventive, promotional and curative
    - Right to self understanding, self care and self growth
    - Right to routine, recognition and resilience
    - The role played by care givers be recognized

12. **Right to socio economic security**
    - Housing
    - Insurance
    - property

13. **Right to education**
    - Right to continuing free education beyond the age of 18
    - Right to non discrimination in all educational settings

14. **Right to rehabilitation**
    - Right to non custodial care
    - Right to safe environments

Session 6 b

UNITED NATIONS CONVENTION on the RIGHTS of PERSONS with DISABILITIES (UNCRPD)

1. Adopted on 13 Dec 2006,
2. Opened for Signature on 30th Mar 2007
3. India signed on 30th Mar 2007 and ratified on Oct 2007
4. The Convention on the Rights of Persons with Disabilities received its 20th ratification on 3 April 2008 and the Convention and its Optional Protocol have come into force 30 days later (3 May 2008)
5. It is a Human Rights Convention
6. Objective
    a. To promote, protect and ensure that **All human rights and freedoms of all people with disabilities are enjoyed, promoted and protected**
    b. The dignity of people with disabilities is respected
7. The Convention, in Article 1, further does not limit to only the 7 disabilities (Blindness, Low vision, Leprosy-cured, Hearing impairment, Loco motor disability, Mental retardation and Mental illness) that have been mentioned in the Persons with Disabilities Act but has opened up a wider definition as - ***"People with disabilities who have long-term impairments, for example, physical, psycho-social, intellectual and who cannot get involved in society because of different reasons, such as attitudes, language, stairs, and laws, which prevent people with disabilities from being included in society."*** This broad based definition and the recognition of various barriers posed by society assists us to develop a more holistic and sensitive approach in addressing the discriminations faced by persons with disabilities in society.
8. The CRPD is quite a long document (50 articles!)
9. **Articles 1 to 9 - General Application** – Purpose, definition, principles, women with disabilities, children with disabilities etc
10. **Articles 10 to 20 – Civil Political Rights** – Right to Life, Equal before Law, Freedom from Torture, Exploitation, Violence, Abuse, Liberty of Movement, Being included in the Community
11. **Articles 21 to 30 - Socio Economic Cultural Rights** – Education, Health, Livelihood, Social Protection, Participation in Cultural life
12. **Articles 31 to 40 - Implementation and Monitoring Measures** – Data collection, reports
13. **Articles 41 to 50 - Rules that govern the operation of the Convention** – translations, amendments
14. Further, this convention by design is not limited to only Govt. establishments. The Convention states that private businesses and organizations that are open to the public have to take initiatives to ***"eliminate barriers that people with disabilities face in buildings, the outdoors, transport, information, communication and services"***.

15. What are the expectations from this Convention
    a. Increase the visibility of PWD
    b. Clarify the human rights of PWDs, and ensure governments make legislative and programmatic changes for its implementation
    c. Establish systems for comprehensively monitoring the human rights situation of persons with disabilities
    d. Establish systems for international cooperation, through which governments, disability organizations and other actors can share knowledge and ideas and work together to improve the lives of PWDs.

Session 6 c

UNCRPD

Rehabilitate Disabled Persons		Rehabilitate Society
Charity, Medical treatment	⇨	Rights
Adjustment to the norm	⇨	Acceptance of differences
Exclusion	⇨	Inclusion, participation, citizenship
Little consultation	⇨	'Nothing about us without us'

The CRPD and the Right to Work
Shift in focus

Segregated employment	⇨	Open Labour Market
Petty trading	⇨	Small enterprises
No legal provisions	⇨	Coverage by employment laws
Limited choice	⇨	Work freely chosen or accepted

Session 6 d

Role Play

1. Getting health care:
Actor: a person needing health care
Co-actors: the person's friend and a nurse or doctor
Scene: the local clinic
A person with a disability needs treatment for a minor injury. The nurse looks only at the person's friend. The nurse asks the friend about the problem. The nurse does not ask the person who has the problem. The person tries to talk anyway, but the nurse keeps talking to the friend.

2. The teaser
Actor: a lady worker who is being teased
Co-actors: a worker who is teasing and two workers who are watching
Scene: the workplace
A worker is busy doing her job. Another worker comes up and starts teasing her. She says, "You are slow." Two other workers are watching. They do not know what they should do. The teaser will not stop the teasing.

3. The meeting
Actor: a person trying to speak at a meeting
Co-actor: a person who keeps interrupting
Scene: a community meeting
A person is trying to speak at a meeting about buses. They want to tell how they need more buses. They want to tell about how they can't get a job without a way to get there. It is their turn to speak, but another person keeps interrupting.

4. One small step
Actor: someone who uses a wheelchair
Co-actor: the manager of a store
Scene: a store
A person who uses a wheelchair likes to shop. His favorite store is not accessible. There is a small step in front of the door. So, the person needs to have a friend along to help. Or he must wait until a stranger comes along to help. The person is meeting with the store manager to talk about this human rights problem.

Chapter 7

Project implementation

Trainee would have an understanding on

1. Advantages/ merits of including mental health in to development work
2. Consultation
3. Importance of home visits and Individual rehabilitation plan
4. Tracking changes through individual case files
5. documenting baseline
6. Reviews and evaluation
7. Understand the difference between ethics and life principles
8. Understand the different ethics involved while working with people and emotional issues.
9. Understand the need for empathy.
10. Understand some professional work ethics.

Number of sessions: 8

Session 1: Merits of including mental health in development activities

Session 2: Consultation

Session 3: Importance of home visits and individual rehabilitation plan

Session 4: Tracking changes in the individual files

Session 5: Base line

Session 6: Networking and Alliance building

Session 7: Work ethics

Session 8: Reviews and Evaluation

Session 1

Merits of including mental health in to development work -45 minutes

1. Trainer divides the participants in to 3 groups.
2. Trainer asks groups to discuss on 'mental health a development issue?' 'Can it be included in the CBR programme', if yes how they would include in their existing CBR programme?.
3. Group presentation.
4. Trainer shares BNI experiences with the partners and its merits of including mental health.

Session 1

Community mental health and development approach:

People and the community are the biggest resources available for the community mental health services. Many of the mental health problems can be effectively dealt by the people and within resources available close to them. Large-scale dissemination of knowledge and skills to people would help in reducing stigma attached to illness. Building knowledge and awareness of families can make the real difference, their by PWMI become integral part of the community, participating in all social and cultural activities.

Strengths of development approach for meeting the needs of people with mental illness in their own communities:

1. Promotes community participation and community ownership of the programme. Ccommunity participation encourages planning, developing and monitoring the programme.
2. Active involvement of mentally ill people and their families in all their issues of concern instead of them making passive recipients
3. Integration of mental health in the development process including transfer of skills to home and the community thus minimising the need for qualified professionals. This is more cost effective
4. The medical approach alone is not a comprehensive approach. Unless special focus is given to the expressed needs of people with mental illness and their families, recovery will remain inadequate.
5. Promotes better social integration and mainstreaming by ensuring that people with mental illness have access to same benefits and services as others in the community where they are working.
6. The integration implies high degree of collaboration between different sectors, such coordination work better local.
7. Mental illness can be treated with simple, relatively inexpensive drugs. Only a small percentage requires institutional care, hence majority can be treated and taken care in the community.
8. Early diagnosis prevents unnecessary investigation and promotes early recovery, resulting in attitude change in the community that most disorders can be treated in the community.
9. Increased coverage because interventions are decentralized.
10. Negative attitudes / stigma attached towards illness will be challenged as there are more chances/opportunities for people with mental illness to recover and lead a good quality of life.

Session 2

Consultation - 90 minutes

1. Trainer divides participants in to two groups
2. Trainer assigns the group to do a role play on consulting community members, while one group performs the role play other group will be observer.
3. Trainer instructs group to decide one animator, who would facilitate the discussion
4. Trainer allows group to have discussion and decide on the script for the role play, agree up on the group to be consulted.
5. Trainer invites the animators to share about the community group with whom he/she is consulting and on the issue.
6. Trainer invites group to perform role play on consulting the community
7. Trainer invites comments from the observer to share their observations on the role play and in particular the animation
8. Trainer invites other group to perform the role play, and observing group would share their comments on the role play and in particular the animation.
9. Trainer summarizes the discussion sharing his comments and on the skills of the animation.

Session 2

Consultation

Objective: To get to know people, their understanding of themselves, their present status and encourage participants to express/voice their feelings, needs and aspirations. In the context of people with mental illness, the participants would include people with mental illness, family members (caregivers) and community workers.

Pre-consultation: Notice of meeting stating starting time, venue and purpose reaches the participants well in advance. Ensure travel plans and escort facilities where required. Ensure both women and men participate in the consultations.

Logistics: The right venue and environment help participants to interact with each other. Drinking water, toilet facilities, refreshments, enough newsprint, marker pens, etc., are other essential requirements. Participants feel familiar and comfortable.

Process: A trained facilitator/animator would undertake the process. S/he would adhere to the topic guides. For the first consultation the topic guides would include:

- Greetings & ice breaking
- Introduction to the day's proceedings
- Introduction of participants
- Permission to process documentation and photographs
- Setting of Ground Rules for the conduct of the programme
- "My World" constituency mapping exercise
- Explanation and debriefing of mapping exercise
- Needs discussion (group exercise) followed by presentation & discussion in a big group
- "What Next?" again group exercise followed by presentation and discussion
- Debriefing – facilitator, key people from the organization and process writer

Process writer would be outside the circle and simply captures the content, context and even the movements and moods of people.

Facilitator/Animator sticks to the sequence eliciting participation from every one. Does not break the silence instead uses the silence to get life to the group. When required asks participants to repeat what s/he said so that the group understands the depth and intensity of that particular statement. Animator encourages reflections, debates among the participants without losing the sight of purpose and good use of time. One has to be sensitive to emotions and at the same time not to focus on one person so that others lose interest meaning sensitive to every one.

Group sizes need to be appropriate for every one to participate and their needs, if any, have to be met in time. After each presentation clarifications to the queries have to be drawn from the participants themselves. Persons with behavior problems may get up and go out. Some one should mind them but not force them to behave themselves in the group.

Points to remember (for Animator):

- Communicate in the common understandable language
- Not to misinterpret information/expressions
- Listen with attention
- Mind your body language
- Position yourself appropriately e.g. not showing your back while talking
- Repeat their expectations/decisions made e.g. have I heard you saying 'you want to get married'.

Close: Thank the participants for their frank sharing, especially for the commitments made/action plans arrived, and any appropriate things done by them during the day. End with the hope they have brought in. All the materials presented by the participants get collected by the process writer.

Debriefing: The facilitator/animator, process writer and the key staff from the organization debrief on every aspect of the day's proceedings and that becomes the part and parcel of the process document.

Session 3

Importance of home visits and Individual rehabilitation plan: 120 minutes

1. Trainer divides the participants in to 4 groups
2. Trainer provides case studies (at the time of identification by the field staff) and asks the groups to prepare follow up plan based on their learning experience and their field experience.
3. Trainer ask one of the group to play a role play about the case study given to them, and the CBR worker visiting them, would design the individual rehabilitation plan along with the family.
4. Presentation by 3 groups
5. The trainer discusses each case study and helps them to make individual rehabilitation plan reflecting community mental health and development activities.
6. Trainer would ask the group to observe the role play and document the proceedings of the home visits.
7. Role play by the 4th group
8. Trainer invites comments from the group on the role play – 'home visits'
9. Trainer shares his experience on the Home visits.

Session 3 a

Case study I

Muniyamma is 45 years old married and living in one of the slum communities in Bangalore. She is basically from Tamilnad and migrated to Bangalore some decades back. Her life started as a daily wage worker at construction sites and she lost her parents when she was very young. Life is very hard to live as unmarried single women in the urban area, her situation also made her to think and she decided to get married. Finally the community in which she was living supported her and she got married to a person who was living in the same community who is also an orphan living alone. After few years of marriage she gave birth to a baby boy and the family was a happy family. Few years later unfortunately the child developed some health problems and in spite of all kinds of efforts he could not survive and she lost her son. With this incident her dreams were shattered and she was mentally disturbed. She lost her hopes in life and she became hopeless in life. Adding to the situation her husband developed blood sugar and Asthma and he was struggling for his life. Poverty and lack of family support really shook the couple and they could not take proper care and treatment and within a short period after the death of the child he also passed away. Muniyamma who was full of sorrow from the childhood could not gulp the situation (death of her husband) and she became mentally ill. She developed severe mental illness and she started wondering in the communities, not aware of personal hygiene and many times she wondered without clothes in the community. She used to bring all garbage from roadside to her house and the house was stinking like anything. Not aware of her appetite and meaning to her life. In and around community is though sympathetic towards her they are not able to support her because even community is confused on her behavior and the situation. Some times they provide food for her and the old clothes. Community is aware that she is in a serious condition and the reasons for her situation. But they are not aware that she is having illness. Looking at her wondering behavior and unhygienic appearance no body wants to talk to her and few times police took her to beggar home in Bangalore, where they will keep these kinds of beggars and wondering persons temporarily and send them back to their communities. So to conclude she is mentally ill, living alone and though community is aware of the situation they are not able to support.

Case study II

Sunitha 34 years old married woman and having two children. Daughter is 6 years old and son is 3 years old. Her husband Raja is a laborer in a whole sale market in Bangalore. His job is to load and unload the goods from the lorry. He is a hard worker and earns reasonably fare amount of labor/money every day. But he is addicted to alcohol and most of his earnings are spent on alcohol. Left out money is given to the family maintenance. They don't have a house, not even a hut and they are living on the roadside. A small place on the road side very next to the market is occupied and covered with plastic bags and they are living in that thatched place. One day Raja was beating Sunitha very badly and one of the shop owners who was watching the scene went and stopped Raja and scolded not to beat his wife. But Raja suddenly reacted and said she is mad and she never listens to me and at times when she is out of control she gets beatings. Next day morning hearing about the situation one of the development workers of the organization who was doing some development work for the laborers in the community intervened and interacted

with Raja. He started narrating the story and he said my wife some times suddenly starts beating the children and shouting without reason and through out night she will be talking to self. Many times when she goes to the toilet she had complaint that she saw her mother's spirit who is no more. The story was interesting and the development worker started digging the story and asked Raja when she behaves like that what is your response? He said some times I also felt she is possessed by her mother and I took her to some faith healers and tried my level best to treat her. Taking her to faith healers requires fare amount of many, the faith healers demand money for each visit. So I decided instead of taking her to faith healers, why not the same treatment can be given by me and I started treating her with neem leaves along with beatings when ever she behaves like that. It was interesting and at the same time sad to hear about their understanding on her illness. Later the development worker interacted with Sunitha and she narrated the story. When she was 14 years old she saw her mother dieing. Sunitha's mother developed extra marital relationships and husband could not accept and he poured kerosene and set fire and she was shouting and flames were seen. Sunitha was the witness to the situation but she could not support her mother. This incident was the triggering for her illness. She developed mental illness after the marriage or when she was a child is not clear. But at present she is having severe mental illness. She is hallucinating and has the feeling of possessed by her mother and not interested in taking care of the children. Always shouts and quarrels with her husband. Raja is more worried about her behavior, children and she also expressed the fear and insecurity and sexual exploitation during his absence as she is not aware and the place is a market area full of alcoholics.

Case study III

Shankarappa 24 years old studied up to PUC suddenly started telling the family members that he could see the God. Lord Venkateshwara and Narasimha are visible to him. Even in dreams he could see Thirupathi temple. At the same time he also shared with the family that a king cobra with 5 heads spiting blood out if its mouth is visible in front of his eyes and he is very afraid and he could not concentrate on his work and his daily activities. Family is astonished and surprised at the same time they were confused what is going on. Immediately looking at the situation his brother Seenappa took him to temple and they offered Pooja and the family had the feeling that some rituals and religious practices will solve the problem. Even after performing some rituals and practices the situation was the same. The second thought which developed in the family is some body has done black magic and some evil spirit is possessing Shankarappa. They also approached faith healers and the outcome was the same. One of the BNI partner organization staff identified the person and asked the family to come and attend consultation meeting. During the consultation meeting Shankarappa expressed the same feelings and it was very clear that he has developed severe mental illness. He was looking very afraid, aggressive and suspicious about his brother and the group. He was restless and agitated. Later the development worker visited his family and started interacting with the family. According to the information given by the family members Shankarappa is a very innocent and hard working boy and after completing his 12^{th} standard he joined some private company and was working since 2 years. Few months back suddenly an astonishing change occurred in his behavior as mentioned above. Neither the family nor the neighbors are able to find out the causes/reasons for his abnormal behavior. Few weeks later he was taken to the hospital forcefully but he is not ready to

take medicines and symptoms got worst. With great difficulty the development worker was able to relate with Shankarappa and he came to know that he left the job because in the company where he was working one cheque was missing and the company started suspecting and blaming Shankarappa. So out of humiliation and frustration he left the job. He narrated another story saying he was staying with his friends for about a year while working in that company and with the influence of his friends all the five including him one day had sex with one of the sex workers in the city and later he developed some infection in the genital organ. So he is confused and at the same time afraid.

Case study IV

Lawrence, a 20-year-old boy discontinued his studies as he was not able to pass his 7th standard since the age of 15. He started working as a helper under a contractor at the construction sites. He was honest in all his dealings and gave his earnings to his parents. He had lot of friends where he was living. His evenings were spent in the company of his friends, playing cricket, football etc. One of his friends was in love with a girl residing in the neighborhood. His friends used to tease that girl often. One day a group of 5 youth attacked Lawrence and his friends unexpectedly. Lawrence was also badly assaulted as he was part of the group. He had a head injury and was hospitalized. Few weeks later he developed excessive fear and was not ready to go out of the house. He would scream constantly and sound very abnormal.

Lawrence's sister speaks of the incident and what followed. "He was an ok boy. Did not do well in the school and discontinued his studies. He started learning carpentry and the trainer was also a contractor. Hence, he had no problem in getting work. One day he did not feel normal. He was disoriented, speaking unnecessary things and behaving abnormally. We took him to various healers and offered prayers in the church but there was no improvement. One day he ran away from home. We searched all over but did not find him. I think after more than two months his brother found him in another part of the town. When he was brought home, my heart sank and I wept. Every one was in tears. He was in his underwear and had an old coat on him. Even now if I think of that scene, some thing happens in my stomach."

Session 3b

Individual Rehabilitation Plan

Individual rehabilitation plan has to be developed for each individual; hence it is different for each individual. While planning the individual rehabilitation plan, need to involve person and the family in the planning phase. Down below is given the areas to be considered while planning for the Individual rehabilitation plan.

The plan must include

- Information about the illness and about current circumstances
- Details about any treatment received previously and its outcome
- Information on the functional impairment caused by your illness
- Details about the what need to be done (goal, contact persons, follow-up methods and responsibility for care)

Medical rehabilitation

- Identification of person with mental illness
- Rapport building with the person and the family
- Educating family about the illness
- Motivating families for taking treatment
- Assessment – history of the illness
- Consultation of person with mental illness and in the larger groups
- Referral for the assessment diagnosis and treatment
- Educating them about the need for taking treatment
- Dealing with side effects of medicines
- Follow up services
- Home based support
- Monitoring the medication
- Psycho-education
- Bare foot counselling and psychotherapy services
- Dealing with drop outs
- Identifying relapses and referring back for care services
- Understanding and assessment family dynamics
- Attending caregivers meetings
- Documentation of individual files

Economic rehabilitation

- Dealing with the negative symptoms
- Motivating the person for involving in house hold chores
- Helping the person involving in productive work
- Involving in group activities
- Encourage the person to go back to previous work
- Discussion with the employer about the condition of person with mental illness (reasonable accommodation)
- Involving in income generation activity like cow/goat/ramlamb rearing
- Linking groups to banks for micro credit loans
- Skills assessment
- Referring for vocational training
- Encourage savings

Social rehabilitation

- Integration in to self help groups
- Involving in family activities
- Involving in community activities
- Awareness programmes in the community
- Accessing poverty alleviation and disability schemes
- Resource mobilization in the communities (world mental health/world disabled day)
- Educating community about the 'rights' of the individual
- Educating families and the communities about their entitlements and the government responsibility in meeting the needs of people with mental illness
- Formation of care givers forums
- Formation of affected groups/ forum so that they can create platform for raising their voices

Session 4

Tracking changes through individual case files: 60 minutes

1. Trainer invites participants to share on the different types of documentation they would maintain in their work.
2. Trainer lists down all the responses on the black board.
3. Trainer asks the participants why they are documenting?, how it will be used? (based on the list prepared).
4. Trainer shares the types of documentations maintained for the community mental health and development programme.
5. Trainer asks the three volunteers to share the documentation of the role play (previous session).
6. Trainer shares his observations on the documentation and shares on the expected documentation in the individual files (changes at individual, family and community in the process of rehabilitation)
7. Trainer shares on the individual format, takes them through the format. Distributes some models of the documentation (local language)

Session 4

Importance of documentation

- Records of the home visits made by the field staff helps to see the overall progress of the client.
- Keeping a stock of medicines helps to purchase the medicines according to the need and to prepare a statement of budget to buy those medicines.
- Life stories - will be a wealth of information - narrating the process of interventions, efforts put in, results and impacts.
- Consolidation of reports at different levels provides information to make action plans and work out on budget allocation.
- The impact of the work can be used as tools for designing training. It becomes the source for research and advocacy.
- Proper documentation at every level will help to run the programme smoothly. It sets the pattern and it is easy for transition when the other person comes in or takes over the work.
- The quality of service can be measured.
- Sometimes this information raises thought provoking issues.

The list of documents

- Profile of the service user\case history\photographs
- The details of identification, treatment and stability
- List of dropouts and the reason for it.
- Baseline data (to use as secondary data).
- Photographs before and after stabilization.
- Individual intervention plans with follow-up details.
- Process documentation of the events.
- All training reports (consisting 5 W and 1H).
- Identification and Mapping of the organization.
- Documenting the key learning at every stage of implementation (impacts, failures and challenges).
- Review and Action plans.
- Evaluation report of the programme.
- Reports on the activities of sustainable livelihoods.
- Registers showing stock of medicines.
- Report of the existing knowledge and practices of the community, which later can be used as a base for research study.
- Annual Reports
- Records of the loans sanctioned.
- Video presentations, clippings and other training materials.
- Successful Life stories.

Some challenges in documentation work are as follows:

- Time management
- How to write or who has to document what?
- How to use these documents at the field level?
- What to document and what not to document?
- Why we need to document?

Refer back to the advocacy and documentation chapter on individual file format

Session 5

Documenting baseline: 45 minutes

1. Trainer brainstorm with the group on what is base line? and why base line?
2. Trainer writes down the responses on the black board and summarizes with the definition of base line and its importance
3. Trainer divides the participants in to three groups and asks them to come out with a draft format of areas of information required to be collected for base line
4. Trainer invites group to share their discussions
5. Trainer helps groups to arrive at the format for base line document.

Session 5

Base line format:

Text of Baseline Information

1. Review of Literature
   A. Policy – Mental Health Policy 2002 (Government of India)
      - similar Policy at State Level (if available)
   B. Legislation
      Mental Health Act 1982
      PWD Act
      RCI act
      DMHP
      (Who is responsible for implementation) State Government – Key People
      - Ministers/State secretaries
      - Government Departments
      - Disability commissioners
      - State level Co-ordination committees
      - Task forces
      - Any other state level committees
      - Local MLA/MLC

      District Level – Key people
      - District Commissioners
      - Chief executive officers
      - Chief secretaries for zilla panchayat
      - Dt. rehabilitation officer
      - Asst dir. For women and child development
      - Dt.Health officer
      - Line department heads
      - Corporation heads
      - Special boards
      - Judicial /police heads
      - Any others

      Taluk Level Officials

      Gram panchayat Level
      Panchayats, local MLAs and MLCs, MP

   C. Schemes
      a) SGSY
      b) JRY
      c) PMRY

d) ICDS
e) JANMABHOOMI
f) ADHARA and ASHRAYA
g) GANGA KALYAN YOJNA
h) SCST BC CORPORATION
i) PENSION
j) RATION CARD
k) ID CARD
l) LIONS and ROTARY CLUBS
m) VOLUNTARY NGO SCHEMES
n) WOMENS DEVELOPMENT CORPORATION
o) DRDA
p) ANTHYOAYA

D. Research Studies/Documents Published by Government / Related NGOs / Academic Bodies / Institutions) on the subject
Project area maps / Govt. Administration maps

2. HEALTH RESOURCES - Review of Existing General Health and Mental Health Services in the Area of Operation in relation to population

Population
No of Psychiatrists/Clinical Psychologists/Psychiatric Social Workers/Nurses trained in psychiatry in the area (Give ratio per lakh population)
No. of Govt. Psychiatric Hospitals (No. of posts vs No. present)
No. of Pvt. Psychiatric Hospitals
No. of General Hospitals (Govt. and Private) (Give Bed strength, No of posts available and filled), Dt Hospitals, PHC, PHUs, peripheral centers, Health workers
No of General Physicians /Nurses/Dentists per lakh population
Note: Details such as distance from the area / transport facilities and frequency of visits of the personnel are important)
Traditional Healing methods operating in the area
Alternative Indian Medical Services – Homeopathy, Ayurveda, Others

3. Education resources – Schools, facilities for disabled, Hostels, NGOs, Ashrams

4. Socio Economic Condition of the people

Indicators:
Per capita income
Persons below the poverty line
General literacy rate and female literacy rate
% of girls in school
Human Development Index in relation to Indian avg.
Human Poverty Index in relation to Indian avg.
Housing Conditions in the area
Roads,

Communication – post office, telephones, computers, email facilities, fax
Water
Electricity
Drainage
Occupation and income levels
Livelihood options
Trade Analysis
Religious and culture practices
Customs/myths/traditions

4. NETWORKS IN THE PROJECT AREA
Review of all other services and the administrative links
Government Departments, Schemes and Programmes to benefit the poor
NGOs / Private and Corporate programmes for the poor operating in the area

Government Schemes (with brief information about each, also if any people with mental illness have accessed and benefited from these)
Sanghas
Youth clubs
Co-operatives
Committees
Associations
Informal panchayats
Community Leaders

5. Review of the situation of Persons with Mental Illness
- No identified
- Issues/problems faced by them
- Their needs
- Practices in the family –religious. cultural, Human rights abuses, neglect, overprotection
- Awareness and attitudes

Session 6

Alliance Building: 30 minutes

1. Trainer invites participants to brainstorm on the various stake holders in the community and their participation.
2. Trainer lists down the responses in the black board.
3. Trainer would write the web and put all the responses in the web, keeping people with mental illness in the center and linking all the stakeholders in the web.

Session 6

Networking and Alliance Building

"Coming together is a beginning; keeping together is progress; working together is success."

--- Henry Ford

In the NGO world there is constant talk about networking and alliance building. This is especially true in the area of advocacy. To create positive change in our communities, in society and even in our workplaces, organisations and individuals need to come together to collaborate and achieve common goals. The result of this coming together and collaboration has been called a variety of terms – alliances, coalitions and networks.

What are Networks?

Networks consist of individuals or organisations that share information, ideas and resources to accomplish individual or group goals. Networking is a process of acquiring resources and building power by using or creating linkages between two or more individuals, groups or organisataions. Networks tend to be loose, flexible associations of people and groups brought together by a common interest or concern to share information and ideas. Networking is about seeking multilateral co-operation with other persons or organisations. Some reasons for networking :

- Dissemination of information
- Dissemination of know-how
- Coordination of activities in terms of synergy
- Capacity building of members
- Technical guidance and coordination
- Seek social well being and social progress
- Make use of partners' skills and resources and seek more specialisation
- Stimulate competition in terms of bringing together resources

What are Alliances?

Alliances are groups of people or organisations working together to pursue a single goal or a specific objective. Alliances tend to have a more formalised structure, and their permanence can give clout and leverage.

Alliances may be local, regional, national or international. Some may be formed to achieve one short term objective. The alliance is dissolved when the issue has been solved or the event has been coordinated. While other that focus on more than one but related issues such as nutrition and health, population and environment, etc., will be more permanent in nature and recognize the value of mobilizing together for action over a long time.

In terms of structure, some alliances may be formally organised and highly structured, while others more informal and flexible, relying on volunteers. Alliances are seen as perfect vehicle for NGO collaboration. Alliances are usually strongest if they grow organically out of common interests and unlikely to survive if they are externally imposed.
Working through alliances has many benefits :

- Increased access to decision makers and other contacts
- Improved credibility and visibility
- Opportunities to broaden public support
- Opportunity to strengthen civil society on the whole

Different NGOs have different areas of expertise,. varied resources and attract different stakeholders. Building a diverse alliance increases one's chances of success and proves to the decision makers in power that there is a broad social support for the desired policy change. Decision makers are also more likely to pay attention to alliances, as they bring a stronger voice to the decision making table.

Alliances Checklist:

- **Membership:** Who do you want to work with? What criteria for joining the alliance? A clear statement of principles that defines the purpose, mission, goals and benefits of membership.

- **Commitment:** What are the expectations of the members? Where, when and how does the alliance meet? How to keep the members informed, involved and motivated.

- **Decision Making:** How will the decision making works? The process must address principles of equality and democracy and include opportunities for group discussions, procedures for conflict resolution, methods for delegating tasks and a scheduled rotation of leadership responsibilities.

- **Communication:** How will members communicate, exchange ideas and information quickly and efficiently? There must be a commitment to attend meetings and events. Records of all meetings, decisions and action taken to be organised and available to members. There should be commonly accepted spokespersons for the alliance and a communication plan for crisis situations.

Alliance Building in Mental health Sector

While trying to understand the process of Alliance Building, it will be valuable to ask the following questions:

- What is the nature of alliance one has built around one's work in the mental health sector?
- How did it emerge?

- What is its relevance?
- Who are the players in it currently?
- Can/should there be others one can think of?
- Where does Alliance Building lead to?

In reflecting the above, we may discover that alliance building occurs as a result of shared belief and vision that aspirations of persons with mental illness will be fulfilled, their rights respected and that they live a life of dignity.

Members in the Alliance Building function out of an extreme sense of responsibility, accountability, have respect for each other and their autonomy, and exhibit transparency in action. Alliance Building does not merely arise out of given situation or roles. It is a conviction one develops while engaging with poor and most disadvantaged. With humility one recognizes that affected people themselves exhibit great courage and stamina living against all odds. The enormity of issues faced demands that a large enough force to be created – an alliance in a spirit of collaborating and cooperation.

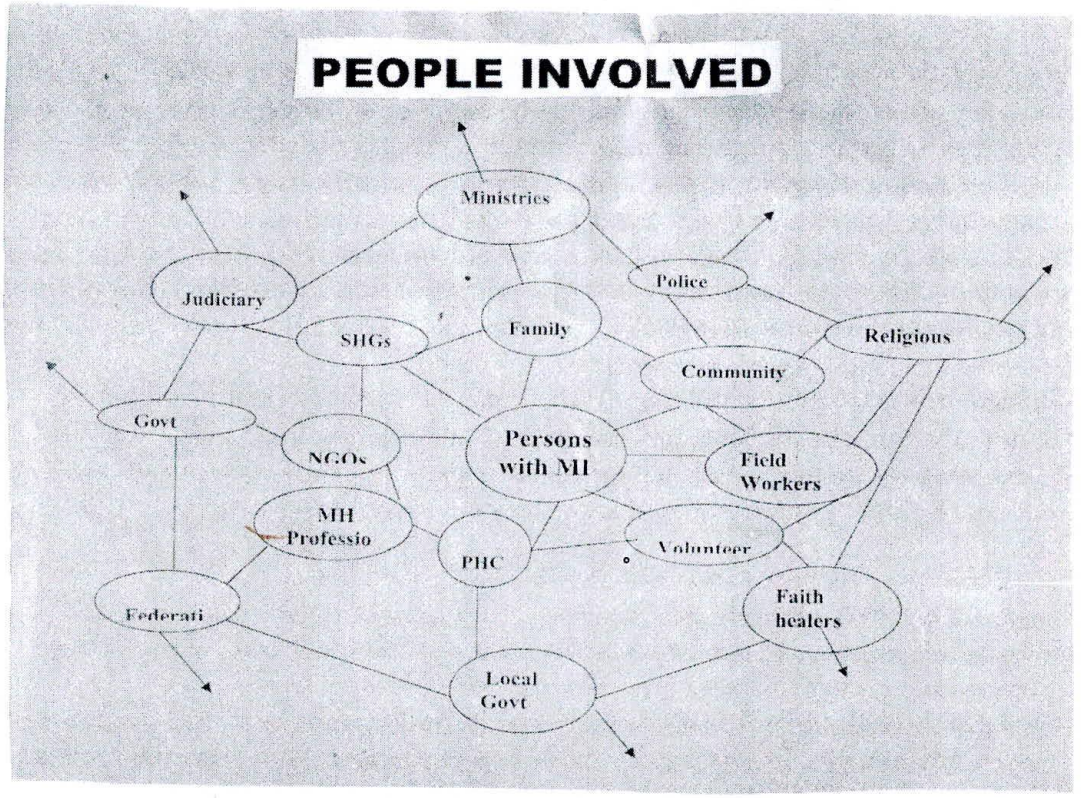
Alliance Building is organic in nature in the context of institutionalization and relates to sustainability of change and people taking responsibility themselves. It is based on the belief that bringing various stakeholders in mental health scenario engaged in short term actions to integrate into long term development processes of strategic planning is crucial. And there is a need to look at the possibility of its replication. Issues of policies and stakeholders remain the focus of Alliance Building.

Various stake holders in the community

- Service users as those people who have mental health issues and are using the services.
- Caregivers and field staff
- SHG members
- Local group leaders like Panchayats leaders
- Local resource organizations
- Government bodies like:
    - Health sector – PHC, Government Hospitals, Taluk and District health centres Panchayats Raj,
    - Education - Anganwadi workers, teachers, SDMC members, etc.
    - Law and Order – Police
    - Social Welfare – Department of Disabled welfare, Department of women and children
- Traditional healers as alternative source of medicine
- Religious institutions
- Donor agencies
- Media
- Hospitals – private and government practitioners, Psychiatrist, Nurses
- Trained Community Counselors

- Women groups, youth groups, farmers groups and so on
- Volunteers and students from community
- Industries and Corporate sector – which is socially responsible, to sustain the project
- Influence makers

  Friends of the movements – Ayurveda, Siddha medicines, and other alternative medicines



Session 7

Work ethics – 120 minutes

Ethics and life principles: (35 min.)

Activity 1:

- Trainer shares the following principles:
  Ten Principles
  1. God exists and loves us.
  2. When I make a mistake, admit it out loud.
  3. People, including me, are basically good and want to do the right thing.
  4. Speak and do what is right calmly.
  5. Consider the effects of present actions on the 10th generation.
  6. Lead by example. Be the first to do what is right.
  7. Do the words I tell others to do.
  8. Let tears out.
  9. Be equally kind to strangers, family and friends.
  10. Say 'no' and 'yes' firmly.

- Participants will list 2 principles in their life that they never compromise on, starting with the trainer.

- Trainer brings to the light of the participants that's life principles basically revolves around them and not something that they impose on others.

- Trainer asks participants to brainstorm on the word "**Ethics**". Lists out their opinions and then writes down the given definition. (*Ethics are considered the moral standards by which people judge behavior)*

- Participants to share one incident from work *(Trainer insists that no names to be mentioned)* where they have expected people to have their life principles and judged them as right or wrong. *(Trainer shares this example where he/she overheard a bus conversation of a young girl talking about boys and how he/she felt that the girl was bad in character)*

- Trainer questions participants if they have a right to judge another persons action without knowing the full background.

Ethics & Emotions: (35 min.)

Activity 2:

- Trainer asks for 5 volunteers from the group for a small role-play. (Trainer does not reveal the story until he gets 5 volunteers) *(One plays the role of a counselor, another plays the*

role of a mentally ill woman who abuses her spouse as she is suspicious feels husband is having an extra marital affair, the others play the role of a field staff taking the person to visit the counselor) 5 min enactment time.

- Trainer checks with the group is it necessary to take prior consent before any conversation and is it important- *as it makes people more involved and less uncomfortable. Also linking it with the right to know what they are getting into.*
- Trainer also sights the example from the field where people sometimes are taken granted, decision are made on their behalf, denial of property rights, enjoying property by the siblings, not taking interest in the treatment process, mixing medicines for a PWMI into their food without their consent, chaining them, locking them etc. Asks participants if they would like that themselves. *(If participants share the reason of interest in individuals well being, trainer asks whose well-being? PWMI or care-giver as it makes life simpler for the care-giver)*
- Now the trainer asks the volunteers to share any discomfort they felt in enacting the roles, especially the PWMI *(actor)*.
- Trainer asks the following questions:
    1. Did you feel comfortable sharing your personal life and issues in front of the field staff?
    2. What would you imagine they would do after listening to your story of abusing your spouse?
    3. How would you role play this scène differently?
- Trainer then talks about privacy and non-judgmental attitude towards clients and their own colleagues.

Empathy: (35 min.)

Activity 3:

- Trainer asks participants to remove their footwear and leave it in one corner of a room, he/she then asks participants to go and wear a pair that does not belong to them.
- The trainer explains that empathy in-short means that they put themselves in another persons shoes, meaning looking at it from their angle, feeling their emotions, etc
- The trainer then asks the participants if they have honestly ever felt like they themselves in place of a PWMI. If yes, how?
- Trainer explains that empathy helps you understand the individual's feelings and helps you be non- judgmental.
- Trainer calls back the volunteers who played the role of field staff and counselor and asks them if while playing their role, they looked at the PWMI (character) without judgment when they explained that they were abusing their spouse, other examples given in the previous exercise. If they say yes, ask how?
- Trainer then explains that when we empathize we also maintain confidentiality.
- Trainer then refers to the issue confidentiality – explaining that it is disturbing for any individual to know that the incidents in their life is being discussed by people who say they want to help them.

- Trainer then explains that the above qualities help to build confidence in people, both on themselves and on those around them.
- Trainer also explains that these also contribute to help a person in overcoming the illness.
- Trainer then asks for reflections from the field from the participants.

Professional Ethics – A Recap: (15 min)
Trainer asks the participants to list what ethics were not followed in the following story:

Shivanna is a 25 year old man. he has been suffering from schizophrenia for 5 long years. He never really liked to go for the treatment and counseling sessions that were arranged by a local social worker who was part of an NGO. He also did not want to take the bitter medicines that were given to here. He was motivated to meet the doctor, got convinced to take medicines for few days. Later family strated mixing medicines in the food, his symptoms got reduced and got stabalised, started involving in agricultural activities.

A few weeks ago, when the social worker visited their village he heard about his engagement. The social worker visited the family to find out about the shivanna. Family informed him about his wedding, said that he is recovered now, does not want to take medicines in future. Social worker was said not to visit them after marriage has his wife would come to know about the illness. Parents were happy that his son was getting married, the responsibility of caring would be shifted to his wife.

Social worker asked the family, has they informed about his illness to the spouse (future wife). Social worker asked many questions including his ability to manage life, wife and sexual abilities, Shivanna was hearing this conversation, he was nervous. Shivann was uncomfortable as the social worker asked many personal questions when people around him are watching and listening. He could see, other people were already whispering among themselves, he felt ashamed, embarrassed and low.

Hints:

1. Name of individual mentioned
2. Medicine and Counseling compelled without consent
3. No Privacy
4. No confidentiality
5. Judgmental attitude
6. Empathy not found.

Trainer wraps up by asking participants to look at their own work experiences and write a small essay to themselves on the above ethics and keep it for personal reflection.

Session 7

General overview on Ethics:

Ethics often refers to moral values that govern the appropriate conduct of an individual or group. It speaks to us as to how we ought to live, how we treat others and how we ought to run and manage our own lives .It helps people differentiate between unacceptable and acceptable behavior, between just and unjust. People learn ethical norms from home, school, and in social settings as they grow up. However, each individual has a different interpretation of these norms based on their individual experiences. To sum up, ethics can be defines as rules for distinguishing between what is morally right and wrong, what is responsible and irresponsible and what is good or bad in general.

Most people think they understand morality and ethics. For instance, if you ask a common person to define morals and ethical behavior, they will most likely define these terms as being right and good versus being evil and bad. When asked for further details of these definitions, the common man is typically unable to specify exactly **WHAT** is good, right, moral, and ethical. However, this will most likely result in a discussion of examples of both ethical and unethical behavior without specifically defining these terms.

Since each person is raised differently with very diverse experiences, each person has a unique definition of morality and ethical beliefs." Additionally, since society is continuously changing their viewpoints and technological capabilities, ethics and morality are also changing accordingly, even if organizations such as religions try to make people believe that morality is constant. Basically, society changes whether we want it to or not. This is further proof that ethics and morality are and will always be imprecise, thus not truly definable.

Yet, the common man still believes that they understand morality. Even those people who think they are very ethical are actually deceiving themselves, because no one can truly know what ethical really is. Thus, they can not possibly be ethical, at least in everyone's opinions.

Alternative ways to describe ethics include:

Ethics is two things. First, ethics refers to well based standards of right and wrong that prescribe what humans ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues. Ethics, for example, refers to those standards that impose the reasonable obligations to refrain from rape, stealing, murder, assault, slander, and fraud. Ethical standards also include those that enjoin virtues of honesty, compassion, and loyalty. And, ethical standards include standards relating to rights, such as the right to life, the right to freedom from injury, and the right to privacy. Such standards are adequate standards of ethics because they are supported by consistent and well founded reasons.

Secondly, ethics refers to the study and development of one's ethical standards. As mentioned above, feelings, laws, and social norms can deviate from what is ethical. So it is necessary to

constantly examine one's standards to ensure that they are reasonable and well-founded. Ethics also means, then, the continuous effort of studying our own moral beliefs and our moral conduct, and striving to ensure that we, and the institutions we help to shape, live up to standards that are reasonable and solidly-based.

Code of ethics for social workers/field staff

1. A social worker or social service worker shall maintain the best interest of the client as the primary professional obligation;

2. A social worker or social service worker shall respect the intrinsic worth of the persons she or he serves in her or his professional relationships with them;

3. A social worker or social service worker shall carry out her or his professional duties and obligations with integrity and objectivity;

4. A social worker or social service worker shall have and maintain competence in the provision of a social work or social service work service to a client;

5. A social worker or social service worker shall not exploit the relationship with a client for personal benefit, gain or gratification;

6. A social worker or social service worker shall protect the confidentiality of all professionally acquired information. He or she shall disclose such information only when required or allowed by law to do so, or when clients have consented to disclosure;

7. A social worker or social service worker who engages in another profession, occupation, affiliation or calling shall not allow these outside interests to affect the social work or social service work relationship with the client;

8. A social worker or social service worker shall not provide social work or social service work services in a manner that discredits the profession of social work or social service work or diminishes the public's trust in either profession;

9. A social worker or social service worker shall promote excellence in his or her respective profession;

10. A social worker or social service worker shall advocate change in the best interest of the client, and for the overall benefit of society, the environment and the global community.

Professional Ethics:

The daily work of social worker poses distinct ethical challenges. Mental illnesses directly affect thoughts, feelings, intentions, behaviors, and relationships – those attributes that help define people as individuals and as persons. The therapeutic alliance between psychiatric social worker and patients struggling with mental illness thus has a special ethical nature. Moreover, because of their unique clinical expertise, social workers are entrusted with a heightened professional

obligation: to prevent patients from causing harm to themselves or others. Social worker may consequently be required to treat people against their wishes and breach the usual expectations of confidentiality. These features of psychiatric practice may therefore create greater asymmetry in interpersonal power than in other professional relationships and introduce ethical issues of broad social relevance. For all these reasons, social worker are called upon to be especially attentive to the ethical aspects of their work and to act with great professionalism.

1. Social worker -patient relationship

It is at the heart of psychiatric practice. Many ethical principles have bearing on this relationship, including respect for persons, beneficence, autonomy, honesty, confidentiality, and fidelity.

2. Professional competence

From an ethical perspective, it is expected that social worker will maintain a sufficient level of professional competence through continuing education, supervision, consultation, or study. It is further expected that social worker will make referrals or delegate care only to persons who are competent to deliver the necessary treatment.

3. Confidentiality

Confidentiality is the obligation not to reveal a patient's personal information without his or her explicit permission. It is important to distinguish between the ethical duty to keep confidences (an obligation created by and owed to the patient) from the legal duty that governs the handling of private medical information (an obligation created by the state). Respecting patients' confidentiality is especially important for social workers because patients entrust them with highly personal and often sensitive information. Patients' willingness to make painful, stigmatizing, or embarrassing disclosures depends on their trust in the social worker and its expectation of confidentiality. Beyond this therapeutic rationale, there are ethical duties that arise from principles of promise-keeping, doing good, seeking benefits, and avoiding harm.

4 .Honesty and Trust

Honesty and trust are elemental values of a profession. Honesty entails the "positive" duty to tell the truth as well as the "negative" duty not to lie or intentionally mislead someone. Derived from core principles of trustworthiness, integrity, and respect for persons, honesty and trust are fundamental expectations for the patient seeking psychiatric care.

Social worker may be occasionally tempted to skirt or "soften" the truth in order to avoid harm to a patient. In general, omission (intentional failure to disclose) and evasion (avoidance of telling the truth) will undermine a trusting and constructive relationship between social worker and patient and is not appropriate. Such behavior undermines trust in the profession as a whole and in third-party interactions in particular. At the same time, out of respect for patient privacy, social worker should reveal only the minimum information necessary during the third party review.

5. Informed Consent

Informed consent is an ethically and legally important process that involves information-sharing (e.g., about the nature of an illness and a recommended treatment) and knowledgeable and authentic decision-making about the individual's health (e.g., by a patient or authorized surrogate). Informed consent for assessment or treatment is obtained if adequate information is disclosed, the patient is capable to make a decision, and does so voluntarily.

6. Therapeutic Boundary-keeping

Boundaries may be described as defining the limits of a profession. There is necessary for a professional distance and respect that ensure an atmosphere of safety and predictability. Appropriate therapeutic boundaries are also necessary for therapeutic efficacy. Social workers are trained to examine and appreciate the significant psychological and social overtones of the treatment relationship. Their expertise consequently gives rise to specific rules that govern the bounds of ethical practice.

They must never exploit or otherwise take advantage of patients. The unique position of power afforded by the therapeutic relationship can be used in ways that are unrelated to treatment. The social worker must therefore limit the relationship with patients to the therapeutic context. This boundary requires that they avoid client interactions that are aimed at gratifying the physician's needs and impulses.

7. Relations with the team

The primary goal in the development/CBR programme is to provide highest standard of care. This derives from recognizable ethical standards of beneficence and fidelity to patients, and draws on the expertise and ethics of professionals who are similarly devoted to mental health.

When social workers assume a collaborative role with other mental health clinicians, however, they must assure that they are fully engaged and not merely used as "figure heads". Decision-making in collaborative treatment approaches must occur in a manner that enhances the care of the patient.

8. Responding to the unethical conduct of colleagues

All have an obligation to recognize and report the unethical behavior of colleagues. Unethical conduct includes a variety of behaviors that violate professional standards. These may include exploitation of a patient, dishonesty, fraud, or behavior meant to demean or humiliate others.

The duty to report unethical conduct is an essential part of a profession's self-regulation. It is the members of a profession who are in the best position to recognize unethical behavior from their colleagues. The unethical practices not only harm patients, but also damage the programme as a whole. Irrespective of the reasons behind misconduct, however, social worker have ethical obligations to learn and follow their profession's standards.

9. Ethical issues in small communities

Small communities pose special ethical challenges to social worker because of the interdependence of the members in the community. Many small communities face great limitations of health care resources, and heightened barriers to care arising from weather, geography, or lack of transportation. Social workers who serve small communities treat patients who may be long-time neighbors, members of their extended family, local officials, or civic leaders. Consequently, the ethical standard of separating personal and professional relationships may be difficult to achieve.

Social worker in small communities may experience greater difficulty in protecting the health information of their patients. When patients describe their own health-related experiences, they may indirectly disclose information about family or community members who may be well-known to them. The consequences of confidentiality breaches may be serious and enduring, particularly given the stigma associated with mental illness. Certain communities may also require sensitivity to cultural practices that are unique to the group. Practices, rituals, and conceptualizations of fundamental medical principles (e.g., familial rather than individual consent) may require social worker to obtain consultation or education on their role in these interactions. Respecting values that may be prioritized differently can be useful in improving the relationship with the patient as well as the entire community.

Session 8: Reviews and evaluations: 30 minutes

1. Trainer asks the participants to brainstorm on why review or evaluation and how it helps us in developing programme.
2. Trainer shares about the need for quarterly review to understand the problems at the field level and how it can be addressed

Chapter 8
Exposure visit

Exposure visit: will be planned for 2 days for the trainees so that they can observe the community mental health and development activities.

Objectives: The trainees will be enabled to

1. Experience the community mental health and development model as is implemented in the field and interact with various stakeholders in the process
2. Gain an insight in to a variety of perspectives dictating field realities like gender, poverty, family dynamics, community participation, community mobilization.
3. Understand the activities of community groups like Self Help Groups, Organisation of Persons with Disabilities and discuss their work, with specific reference to Community Mental Health and Development model.

The field visit :

- The trainer and participants reach the project area of the Host NGO. The head of the host NGO and staff make a presentation about their work.

- The trainer divides the participants into three groups and assigns each group to a resource person from the host NGO who takes his/her group to a particular village.

- In the village, each group interacts with one Community Group and visits homes of two persons with mental illness (preferably one male and one female) accessing services of the community based mental health and development project.

- The participants have :
  - Brief space for sharing, asking questions and clarifications.
  - Additional information where necessary.

Day one: activities

1. Introduction of the participants and the organization
2. Experience sharing from the project director and the coordinators
3. Interaction with the field staff and the trainees
4. Two home visits to people with mental illness (one male and one female)
5. Interaction with the SHG members and their livelihood interventions for people with mental illness.
6. Debriefing with the team
7. Street theater

Day 2 activities:

1. Interaction with the federation members understanding advocacy efforts of the group.
2. Awareness programme (community group meetings
3. Consultation meeting
4. Caregivers meeting
5. Interaction with the volunteers
6. Debriefing with the group

Chapter 9

FIELD SUPPORT

What is field support?

The trainer would visit the programme and support the field staff in initiating community mental health and development activities. After gaining theoretical knowledge on community mental health and development model, the field support will be exposed to community mental health and development programme (where the programme been implemented). The trainer would visit the field of the partner organization, would support them in initiating and reviewing the community mental health and development activities.

What are the guide lines for the field support?

Basic guide line for the field support

1. Need for consulting person with mental illness.
2. Respecting and recognition of the rights of people with mental illness and treat them with dignity.
3. How ever ill/poor the person, he or she has the capacity to manage his or her life.
4. Voices of people with mental illness should guide the programme.
5. Inclusion of people with mental illness in the development processes.
6. Inclusion of people with mental illness in the existing self help groups and federations.
7. People with mental illness and their supporters should be encourage and able to advocate with the authorities for meeting their needs.
8. Mental health is a development issue, it need to included in all the development activities of the organizations
9. Need for active participation of community in creating/designing a caring accommodative and understanding environment to ensure fair treatment to People with mental illness in the community.
10. Beyond meeting the treatment needs of people with mental illness, they also have a variety of psychosocial needs, same need to be addressed using non pharmacological approaches

What will be the field support?

The field staff should establish rapport with people with mental illness, gain their confidence and build positive environment so the voices of people with mental illness are more heard and respected. Field staff should be sensitive to the needs of people with mental illness, should have open attitudes and unlearn themselves in terms of their own attitudes on mental illness. Field staffs need to be oriented on why community mental health, how it would support their main activity, how it will be included in their development work, what are the community mental health and development activities.

How field support will be provide?

The field support/on job training for the field staff need to be provided for 2 days once in four months to the partner organization. The trainer would visit the field of the partner organization and would provide on job training. The trainer spends one day in the field in facilitating and observing community mental health and development activities. 2nd day will be spent with whole team, in providing inputs and understanding difficulties experienced by the field staff in their work, supporting them in identifying the alternatives for dealing with their difficulties.

Some of the support areas in the field are:

1. Demonstrating/conducting consultation
2. Demonstrating animations skills
3. Observing their awareness programmes and giving inputs for improving
4. Supporting difficult families and help them to understand the need to mental health care
5. Differentiation of mental illness and mental retardation
6. Understanding violent behavior, warning signs of violent behaviour
7. Demonstrating respect to people with mental illness and encouraging their voices
8. Similarities and difference of community mental health and development activities and the community based rehabilitation activities
9. How to interact with PWMI and the families
10. Understanding individual and family needs to motivate the individual and family for treatment, joining support groups etc
11. Understanding family dynamics to motivate, neglected and difficult families
12. Assessment of the individual with mental illness
13. Addressing misconceptions within the family
14. Organizing and facilitating caregivers groups
15. Organizing and facilitating community meetings towards mobilizing community support
16. Orienting community groups on mental health issues
17. Reviewing the documentation
18. Meeting the concerned government officials in sensitize them on the needs of people with mental illness
19. Setting us of short term/ medium/long term plans with people with mental illness and their families
20. Demonstration of trade analysis

Some of the areas for the theoretical in puts at the field level based on the field observations:

1. Assessment of people with mental illness.
2. Discussion on the misconceptions of people in the community and how same can address.
3. Need for individual rehabilitation plan for each identified person with mental illness.
4. Documenting individual files and other programme reports.
5. Bare foot counseling/helping skills.
6. Facilitating discussion on why consultation and animation.
7. Helping the field staff to create/use the awareness materials.

8. Differentiation of mental illness and mental retardation.
9. Discussion on needs of the family members and also people with mental illness based on the field visits.
10. Facilitating discussion on trade analysis and local market and livelihood options.
11. Facilitating discussion with the partner organization on the need for Inclusion and networking with other groups.
12. Facilitating discussion on need for engaging with the concerned government personnel for meeting their entitlements.
13. Sharing of the experiences and learning's.
14. Orienting the organization heads and the board members on mental health issues.
15. Orienting field staff on district mental health programme and National Rural Health mission.
16. Orienting field staff on community monitoring.
17. Dealing with emotions and stress management
18. Demonstrating relaxations exercise
19. Base line document and need for base line
20. Demonstrating documentation and help field staff in practicing

Chapter 10
List of energisers:

1. Chat Show (introduction)

Get the group to pair off and take turns in being a chat show host and guest. The chat show host has to find out 3 interesting facts about their guest. Switch the roles and repeat.

Bring everyone back to the big group and ask them to present briefly the 3 facts about their guest to the group. Maybe go round the group randomly so people are less aware of their turn coming up next and panicking about it.

Watch timing on this one as it has a tendency to go on too long if your group likes to chat too much.

2. If I were a...

Ask each person to say what they would be and why, if they were a...

- A piece of fruit
- An historical figure
- A household object
- A cartoon character
- Any other off the wall group you can think of!

Some examples:

I would be a pineapple as I am exotic, sweet and zingy.
I would be a egg-beater as I like to stir things up.
I would be horseas I rush around like a crazy creature

3. The Pocket/Purse Game

Everyone selects one (optionally two) items from their pocket or purse that has some personal significance to them. They introduce themselves and do show and tell for the selected item and why it is important to them.

For e.g people may have a picture of their family or their driving license. They need to explain why they have them in their wallet/hand-bag.

4. Paper Airplane Game

Everyone makes a paper airplane and writes their name, something they like and dislike on it (You may also want to add additional questions). On cue, everyone throws their airplane around the room. If you find an airplane, pick it and keep throwing it for 1-2 minutes. At the end of that time, everyone must have one paper airplane. This is the person they must find and introduce to the group.

5. Seven Up game

Every one counts the number starting from one, when it come to 7 or multiplication of 7, number ending with 7, they should clap, if they say the number than they are out of the game. Finally their will be one winner of the game. Trainer also would participate in the game

6. Three in Common Game

Break the group into 3's. Their objective is for each group to find 3 things they have in common. But not normal things like age, sex or hair color. It must be three uncommon things. After letting the groups converse for 10 - 15 minutes, they (as a group) must tell the rest of the groups the 3 things they have in common.

7. Circle of Friends Game

This is a great greeting and departure for a large group who will be attending a seminar for more than one day together and the chances of meeting everyone in the room is almost impossible. Form two large circles (or simply form two lines side by side), one inside the other and have the people in the inside circle face the people in the outside circle. Ask the circles to take one step in the opposite directions, allowing them to meet each new person as the circle continues to move very slowly. If lines are formed, they simply keep the line moving very slowly, as they introduce themselves.

8. Marooned Game

You are marooned on a island. What five (you can use a different number, such as seven, depending upon the size of each team) items would you have brought with you if you knew there was a chance that you might be stranded. Note that they are only allowed five items per team, not per person. You can have them write their items on a flip chart and discuss and defend their choices with the whole group. This activity helps them to learn about other's values and problem solving styles and promotes teamwork.

9. Decision making

You are in the middle of the sea in a big boat, the big boat started drowning due to technical problem. Along with you and your spouse, you have other co passengers like 17 year old

disabled boy, 30 year old pregnant lady, 65 year old man and his wife 60 year old woman, 20 year old man. The boat was drowning, now only two people can escape by getting in to small boat which carries two people. If given choice for you whom do you send in that small boat and reason out why did you select them?, there is no right or wrong answer in this.

10 Story Time Game

The facilitator starts a story by saying a sentence. It then goes in a circle, each person adding a sentence onto the story-after repeating each sentence that's already been added.

11. Ball Toss Game

This is a semi-review and wake-up exercise when covering material that requires heavy concentration. Have everyone stand up and form a resemblance of a circle. It does not have to be perfect, but they should all be facing in, looking at each other. Through the ball to a person and have tell what they thought was the most important learning during the day. They then throw to other person explaining what they though was the most important concept. Continue the exercise until everyone has caught the ball at least once and explained an important concept of the material just covered.

12. Observe the opposite person

The participants will be asked to divide in to two groups of equal number. One group would act as observer and other group would be acting as statues. Both the groups would be asked to stand in line facing each other. The observer group is given 2 minutes for seeing the person in front of them. They are asked to go out of the room for 2 minutes. The statute group will be asked to make some changes in them (eg like changing the watch from left to right side, removing the buttons of the shirt, changing the hair style, changing the place of pen etc). The observer group is called, they would stand in the line facing their partner, they are asked to tell the changes in their partners.

13. Group untangle

The whole group of teens will assemble in a circle with each person clasping a hand of someone different. *(In other words, they will be holding one person's hand with their left hand and someone else's with their right hand)* **IMPORTANT!** It cannot be the person next to them.

Now that they are in a complete jumble, blow the whistle and give them one minute to get untangled without letting go of each other's hands.

14. Rebel Foot

Ask group members to sit comfortably. Then ask them to lift their right feet off the floor and make clockwise circles, while doing this, ask them to draw the number '6' in the air with their right hands. Their feet will change directions and there's nothing they can do about it. As we said, thinking controls behavior!

15. Blindfolded Animals

This activity can be used to separate people into pairs. With a small group, write the name of however many animals on two different pieces of paper and have the participants draw one out. With a large group, have students count off to a certain number and assign a certain animal for each number. When you say "go", participants will close their eyes and are only allowed to make the noise of their animal in order to find their other group members. Animals such as cows, pigs, dogs, chickens, elephants, cats, and horses all make for a fun, and noisy, activity.

16. Trees Up Here Good –

Group repeats the words and motions of the leader
Leader: "Trees up here good!" Jumps up and puts hands high above head. Others: Repeat
Leader: "Trees down here bad." Squats down and puts hands on ground. Others: Repeat
Repeat this whole cycle 3 or 4 more times, then end on "Trees up here good.

17 Mixing the group with an exercise -

The group will be asked to sit comfortable on their chairs in a circle. Trainer will introduce the game by saying those people wearing slippers need to change their seats, when said all the participants wearing slippers should change, trainer would find his seat. The person who has not found the seat will have to ask people to change their seats giving options like (those who are wearing watches, those having money with them, those having gray hair etc)

18. Enactment what you did

Participants are given a doll asked them to pass it to the person sitting next to him, before passing they are asked to do some thing to the doll. Once they complete, participants are asked to repeat what they did to the doll to the person sitting next to them.

19. Joining together in Groups

The participants move about freely. The trainer calls out a number, for e.g. 'three' or 'seven'. The participants must immediately join together in groups corresponding to the number called out.. Those who are unable to join a group of the correct size are out of the game. The game continues until only two participants remain.

20. Knowing the names of all in the Group

Participants sit in a circle. The trainer asks one of them to start with his/her name. The next person repeats the first one's name and adds his/her own name. The participants go on until the last person repeats all the names.

21. Statues

Participants form pairs. One partner is the clay. The other is the sculptor. The clay stands entirely relaxed, while the sculptor arranges him/her in certain posture. Neither may speak during the game. They then exchange roles. Sculptors may be left to choose the postures or the trainer may specify what is to be depicted, e.g., 'fear', 'anger', 'joy'.

22. Follow the Leader

Participants assemble in a circle. One participant is asked to volunteer to go out. The Trainer asks one to play the role of the leader. The leader performs an action which is followed by others (e.g. clapping hands). The leader changes actions from time to time. The volunteer participant is asked to come inside while the group is engaged in one action initiated by the leader. Volunteer's role is to identify the leader, who initiates /changes actions without being noticed . When the volunteer identifies the leader, he/she goes out. A few rounds may be played.