CHAPTER I

INTRODUCTION

“Never give up on someone with a mental illness. When "I" is replaced by "We", illness becomes wellness.”

― Shannon L. Alder

“Health is Wealth” as the phrase goes. Health includes both physical and mental health. If one is disturbed its consequences are seen on the other. Mental Health is an essential and integral component of health. One often fails to understand the complex nature of mental health as its effects are only reflected in one’s behavior and not visible as other physical problems are. WHO-The World Health Organization defines mental health as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, is able to make contribution to his or her community.” In this positive sense, Mental Health is said to be the foundation for an individual’s well-being and the effective functioning of a community (Lardis, 2013).

1.1 DEFINITION:

Mental disorders refer to a broad range of conditions of mental health — disorders that affect mood, thinking and behavior. When a person cannot think rationally, behave in a socially appropriate manner it doesn’t just mean that the person is behaving knowingly in that manner, but the person might be affected with mental illness. Anyone at anytime can be affected with mental illness irrespective of caste, gender, culture, age, intelligence or social status. It generally strikes individuals in the prime of their lives, often during adolescence and late childhood.

The term ‘mental disorder’ also known as psychiatric disorder or mental illness, signifies the pattern of behavior or anomaly that causes either suffering or inability to function in day to day life. It can be termed as disability. Mental illness may be defined as a combination of how a person feels, thinks, behaves/acts or perceives. This might be associated with a particular region
of the brain or rest of the nervous system, often in a social context. The scientific study of mental disorders is called psychopathology.

Mental health concerns can trouble many people from time to time. But it becomes a mental illness when the ongoing signs and symptoms cause constant stress and affect a person’s ability to function adequately in day to day life.

Mental illness can make a person lamentable and can create hurdles in their day to day life, such as in the workplace or in any relationship. In many of the cases, symptoms might lead to wasted lives, substance abuse, chronic disability, unemployment, homelessness and suicide.

**Figure 1.1 Cycle of Mental Health**

Source: https://s-media-cache-ak0.pinimg.com/564x/8f/bc/0d/8fbc0d9da4a7ab1aae1b6391df57ccac.jpg

For a mental state to be categorized as disorder or illness, it usually needs to cause dysfunction. Majority of the international clinical documents used the term mental “disorder” while “illness” is also common. It has also been noted that the terminology “mental” i.e. of the mind, is not necessarily meant to connote separateness from the brain or body (Stein, 2013).
In practice there are currently two systems that classify mental disorder:

- International Classification of Diseases, 10th Edition, (ICD – 10) Chapter V: Mental and behavioral disorders, produced by the WHO since 1949, it has gone through many revisions but at present ICD-10 is in practice.

- The Diagnostic and Statistical Manual of Mental Disorders (DSM- VI), published by the American Psychiatric Association (APA) since 1952 and it has gone through many revisions but at present DSM-V is in practice.

Both the systems categorize disorders and provide standardized criteria for diagnosis. Although there are significant differences, their codes in recent revisions deliberately intersect; thus, the manuals are often widely comparable, although significant differences remain.

The mental disorders are divided into two broad categories:

**Minor Mental Disorders** – Obsessive Compulsive Disorder

- Phobia
- Anxiety
- Minor Depression
- Post-Traumatic Stress Disorder, etc.

**Major Mental Disorders** – Schizophrenia

- Bipolar Mood Disorder
- Schizoaffective Disorder
- Major Depressive Disorder, etc.

### 1.2. Prevalence:

The study by the National Commission on Macroeconomics and Health (NCMH) 2001, shows that at least 6.50% of the total population of India has some form of serious mental illness, with no rural-urban discernible differences. Two studies by Reddy and Chandrashekhar (1998)
and Ganguli (2000) provide two different all-India prevalence rates of mental disorder, i.e. 58/1000 population and 73/1000 population. Major proportions of mental disorders come from low and middle income countries (WHO, 2001).

Globally around 400 million people are suffering from mental illnesses. This contributes 12% to the global burden of diseases and an analysis of trends indicates this will increase to 15% by 2020 (World Health Report, 2013). Out of these depression is the major cause for the global burden of diseases. In India around 5 crore people are affected with mental disorder. In 2010, a study conducted in NIMHANS, Bangalore, reported that the burden of mental and behavioral disorders ranged from 9 to 102 individuals per 1000 population. Reason behind such a wide range of prevalence could be that few studies had focused on isolated settings (Math et. al.2010).

Mental illness not just affects day to day functioning of the individuals but the family as a whole because family faces lot of stigma and discrimination from society and lack of awareness makes it difficult for them to handle the illness.

Peoples’ attitudes and beliefs toward mental illness set up the stage for how they communicate and interact with, provide opportunities for, and help support a person suffering from mental illness. How a person with mental illness experience and expresses their psychological distress and disclosure if the symptoms and seeking care is also framed through peoples’ attitudes and beliefs toward mental illness (Kessler, Chiu, Demler, & Walters, 2005).

1.2.1. Myths/ ignorance/ misconceptions about mental disorders around the world:

Misconception is an abstract or general idea inferred or derived from a specific construct which is incorrect but generates certain beliefs which form a wrong attitude among human beings in societies worldwide.

It has been found that there are a lot of misconceptions about mental illness, those that range from the irrational to the confounding to the somewhat plausible. This entire range of
concepts is not yet clarified. All these myths and beliefs make the life of the person suffering from mental illness difficult and harder (Psych-central, 2015).

Before science took hold of public consciousness, mental illness was attributed to things like demon possession or immortality. Even now, many individuals don’t believe that mental illness is a real condition (Milbrath, 2010).

Earlier man used to believe widely that mental illness is the result of supernatural occurrences, viz. demonic or spiritual possession, necromancy, evil eye, wrath of god and thus responses were equally mystical and at times brutal (Davis, 2012).

In the ancient civilizations, mental illness was ascribed to the supernatural phenomena, curse of an angry deity, etc. Most of the illnesses, specifically mental illnesses, were considered to be stricken upon a group of people or an individual as a punishment for their trespasses (Rosen, 1999).

The social stigma attached to mental illness was, and to some extent still is, marked in countries that have strong, irrational views on the honor of the family and beliefs on marriages as a means to create confederation and palliate families of onerous daughters. In a study by Kobauet (2000) it was mentioned that in China persons affected with mental illness were hidden by their families for fear that the community would consider that the state of distress was the result of ill behavior by the individual or/and their relatives. The person who is suffering from mental illness was also considered to have bad luck / fortune which will also negatively affect anyone who has been associated with him/ her, thus scaring away potential suitors, and that lead to the idea that the illness is transmissible.

With respect to the history of Greece, ‘a person affected with mental illness in the family implies a hereditary, incapacitating state in the ancestry origin and menace the family’s identity as an honorable unit. Thus, in these cultures the treatment of such illness meant a life of abandonment or confinement by one’s family” (Blue, 2005).

Homeless persons with mental illness were left alone to wander around the streets as long as they did not create any harm to the society. Those who are convicted, dangerous, ferocious, or
not manageable either in the family, institutions (homes) or on the streets were handed over to the police and were thrown in jails or dungeons or dark cells, at times for the lifelong. During the Middle Ages, particularly in Europe, as a means of teaching the person with mental illness about their disease or as a punishment for their acts of disturbances beatings were administered. Those who were considered to be nuisances were scourged out of the town (Kobauet, 2000).

1.2.2. Attitudes and Beliefs: consequences of misconception.

Attitude refers to the evaluation of various aspects of the social world (Olson & Maio, 2003; Petty, Wheeler & Tormala, 2003). In social psychology attitude is defined as a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor. Renowned psychologist Jung defines attitude as a readiness of the psyche to act or react in a certain way. Attitude is a predisposition or an inclination to respond negatively or positively towards a situation, object, person or certain ideas. It influences an individual’s choice of action and response to challenges, incentives, and rewards (together called stimuli).

There are four major components of attitudes, viz.-

1. Affective- feelings or emotions.
2. Cognitive- beliefs or opinions held consciously.
3. Conative- inclination for action.
4. Evaluative- positive or negative response to stimuli.

Belief is any cognitive content held as true or a vague idea in which some confidence is placed.

Attitudes and beliefs on mental illness are molded by a persons’ knowledge toward mental illness, interacting and knowing someone who is suffering from mental illness, cultural stereotypes on mental illness, stories on media, and familiarity with past restrictions and institutional practices, e.g., employment restrictions, health insurance restrictions, adoption
restrictions (Corrigan. et al. 2004; Wahl. 2003). Supportive and inclusive behaviors can result only when attitude and beliefs are expressed positively, e.g., health insurance restrictions, employment restrictions; adoption restrictions (Corrigan et al., 2004; Wahl, 2003). It may result in aloofness, avoidance, exclusion from daily activities, and in worst case, exploitation and discrimination may result when the attitude and beliefs are expressed negatively.

When such attitudes and beliefs are expressed positively, they can result in supportive and inclusive behaviors, e.g., willingness to marry a person with mental illness or to hire a person with mental illness. When such attitudes and beliefs are expressed negatively, they may result in avoidance, exclusion from daily activities, and, in the worst case, exploitation and discrimination.

In relation to social stigma, studies have suggested that the stigmatized attitudes toward the person affected with mental illness are widespread and commonly held (Crisp, Gelder, Rix, Meltzer, 2000; Bryne, 1997; Heginbotham, 1998). In UK, in a survey (Crisp, 2000) of over 1700 adults participants, it was found that there was a belief that people with mental illness are dangerous, particularly those with alcohol and drug dependence and schizophrenia; some of the respondents believed that some of the problems like bulimia nervosa and substance abuse were self-inflicted; and some of the respondents believed that such persons are less communicable and hard to talk to.

People hold such stigmatized beliefs irrespective of their age, knowledge of mental health or any practical exposure to mental health issues. Recent studies by Wang & Lai (2008) and Reavley & Jorm (2011), on attitudes toward individuals with diagnosis of schizophrenia or major depression conveyed similar findings. In both the cases it was found that a significant proportion of people from the community agreed that people suffering from any of the diseases are dangerous and unpredictable, and would be less likely to employ one having such problems.

1.2.3. Stigma: a negative attitude.
Stigma has been described as a clump of negative attitudes and beliefs that incite the public to avoid, cull, fear and discriminate the people suffering from mental illness (MH, 2003). When the myths and negative attitudes and beliefs lead to discrimination or social exclusion, it causes disequilibrium in the accessibility to the resources that are needed for all to function well, such as, family and friends, employment, educational opportunity, community support, access to quality health care facility (Link & Phelan, 2001; Corringan et al., 2004). These types of disparities and neglect in all grounds can lead to cumulative long-term negative consequences. Whether stigma is experienced as social riddance or secernment or felt as a permeant and underlying sense of being different from others, it can be debilitating for people and poses a challenge for public health prevention efforts. Different opinions exist regarding the implications of different labels associated with describing mental illness (e.g., brain disease) and felt or experienced stigma (Sayce, 1998; Corrigan & Watson 2004; Corrigan, Markowitz, & Watson, 2004; Pescosolido et al., 2010).

**Figure 1.2. Cycle of Stigma.**

Source: [https://cache.concepts.of.stigma.and.its.relevance.in.mental.health/16/638.jpg](https://cache.concepts.of.stigma.and.its.relevance.in.mental.health/16/638.jpg)
1.3. Issues at the community level regarding mental illness

Studies by Pakhale (2012), Ramachandra and Nagarajaiah (2012), Holt and Fondacaro (1997), shows that though the status of mental health service is developing day by day but there is still a huge gap in meeting the requirement. Studies by Corrigan (2008), Marsella (1998), also show that there are a lot of issues in the community as a result of ignorance.

- **Ignorance**: about the illness, its causes, and ways to deal with it. They do not know that by using modern medicines doctors can treat mental illnesses effectively.

- **Fear**: that mental hospitals are places where only dangerous mentally ill persons are treated and restrained.

- **Negative Attitude and Stigma**: persons with mental illness and their family members are often socially secluded and looked down upon by community members who lack awareness regarding the illness.

- **Misconceptions and wrong beliefs**: that mental illnesses are caused by evil spirits, black magic, influence of bad stars and bad deeds committed in the past or present life. As such, they seek the help of faith healers, and magicians who perform pujas, exorcism, etc.

- **Distance/lack of access**: Because of the geographical location of the place of residence and lack of facilities within the region may hamper in accessing psychiatric intervention.

- **Poverty**: Lack of financial resources may refrain individuals from going to hospitals or buying medicines.

*(NMHP, New Delhi, GOI: 1982)*

1.4. Consequences of negative attitudes and beliefs:

Only about 20% of adults with a diagnosable mental disorders/illness (Wang et. al, 2005) or with a self-reported mental health condition (Hennessy et. al., 2002) saw a mental health provider in the previous year. Embarrassment associated with availing mental health services is one of the many barriers that cause people to hide their symptoms and to control them from
getting necessary intervention for their mental illness (U.S. Department of Health and Human Services, 1999; 2001; Greene- Shortridge et. al. 2007; Nadeem et. al., 2007). Stigma poses a barrier for the public health primary prevention efforts, which has been designed to minimize the onset of mental illness, as well as with secondary prevention efforts aimed at promoting early intervention to prevent severity of symptoms over time (Weiss, Ramakrishna, & Somma, 2006).

Stigma can also interfere with self-management of mental disorders (tertiary prevention) (Sirey et al., 2001). Untreated symptoms may have worst consequences for people suffering from mental illness and impact on the family with the burden negatively. For example most people with serious and persistent mental illnesses, mental disorders that interfere with some area of social functioning are unemployed and live below the poverty line, and many faces major hurdles in obtaining decent, affordable housing (U.S. Department of Health and Human Services, 1999). These individuals may need a number of additional social supports, e.g., job training, peer-support networks, etc., to live successfully in the community, but such supports may not be available. Other individuals with depression and anxiety may avoid disclosing their symptoms and instead adopt unhealthy behaviors to help them cope with their distress e.g., alcohol abuse, binge-eating, smoking, etc. These behaviors may increase their risk for developing chronic diseases, worsening their overall health over time. Recent studies have found an increased risk of death at younger ages for people with mental illness (Colton & Manderscheid, 2006).

Attitudes toward mental illness can also influence how policymakers allocate public resources to mental health services, pose challenges for staff retention in mental health settings, resulting in poorer quality of medical care administered to people with mental illness, and creating fundraising challenges for organizations who serve people with mental illness and their families (Kadri & Sartorius, 2005; Pescosolido et al., 2010; Stuart, 2005). State-level factors such as unemployment levels and access to mental health services, and the presence or absence of other state resources may affect public attitudes and merit study.

1.5. Status of Mental Health Services:
In the middle of the 19th century, the term “mental hygiene” (defined for the first time by William Sweetzer) can be seen as the precursor to contemporary approaches to work on promoting positive mental health. One of the 13 founders of the American Psychological Association - Issac Ray (1807-1881) - further defined the term mental hygiene as an art to preserve the mind against incidents and influences which would destroy or inhibit or destroy its energy, quality or development.

A very important figure in the development of “Mental Hygiene” movement was Dorothea Dix (1802-1887). She was a school teacher who intended to accomplish something throughout her life to help those suffering from mental illness, and to bring to light the deplorable conditions into which they were put. This was known as the “mental hygiene movement”. Before this movement, it was not uncommon that people affected by mental illness in the 19th century would be considerably neglected, often left alone in deplorable conditions, barely even having sufficient clothing. Dorothea’s efforts were so great that there was a rise in the number of patients in the mental health facilities, which sadly resulted in these patients receiving less care and attention, as these institutions were largely understaffed.

In the beginning of the 20th Century, the founder of the National Committee for Mental Hygiene, Mr. Clifford Beers (1876-1943), introduced the first outpatient mental health clinic in the United States of America. The movement of Mental Hygiene, related to the social hygiene movement, was associated with advocating sterilization and eugenics of those considered to be grossly mentally deficient and these individuals were then assisted into productive work and contented family life.

References to mental hygiene were gradually replaced by the term ‘mental health’ after the year 1945. Mental health issues and behavioral problems are an increasing part of the health problems over the world. The burden of illness resulting from psychiatric and behavioral
disorders is enormous. In both sides of the globe, psychiatric symptoms are common in the general population.

1.5.1. Mental Health Services in Ancient Vedic India:

In the ancient Indian texts the descriptions of various mental illness are probably the oldest such accounts. The Charaka Samhita and the Sushruta Samhita, the two well-know Ayurvedic manuscripts, have established the roots of modern Indian medicine. The ancient Indian scripture, Atharva-veda, mentions that mental illness may result from divine curses. Descriptions of conditions same as in schizophrenia and bipolar disorder find mention in the Vedic texts. A lifelike description of schizophrenia was also mentioned in Atharva-Veda. Siddha, a traditional medical system that is gaining more recognition in the new era has also recognized various types of mental disorders that thrived in southern India. Great epics such as the Mahabharata and Ramayana had made many references to garbled states of mind and means of coping with them (Weiss, 1986). A classic example of psychotherapy for crisis intervention is the great Bhagavad Gita.

Ayurveda’s another contribution is its knowledge regarding the diet-disease relationship and the association of a disease with a specific physical constitution. The diagnosis was done by the five senses and supplemented by interrogation. According to the physician, Sushruta, the four pillars for the success of therapy are drugs, attendants, the nursing personnel and the patient.

The highest condescension to the science of Ayurveda was given by the Buddhist Kings (400-200 BC) (Sharma, 2006). Close to the roots of Hindu mythology, an Indian physician, Najabuddin Unhammad (1222 AD), transmitted the Unani system of medicine where he described six types of mental disorders, which are -

- Nisyan– Organic Mental Disorder
- Ishk– Delusion of Love
- Muree-Sauda– Depression
- Haziyan – Paranoid
Malikhoria-a-mari – Delirium

Sauda-a-Tabee – Schizophrenia.

Psychotherapy was then known as Ilaj-I-Nafsani.

A formal exposition on mental illness which was called as ‘Agastiyarkiriagai Nool’ was formulated by the great sage named Agastya, in which eighteen different psychiatric diseases with appropriate intervening techniques were described. The various dimensions for a hospital including its placement, details of the equipments required, food and cleanliness, model code of conduct for the medical staff and ward attendants had been described clearly in the Charak Samhita.

The chronicle of psychiatry in India has witnessed major changes in the past. The first gyration occurred when it was believed that mental illness is caused due to sin and witchcraft, and thus, the affected people were kept chained in the jails and asylums. Then with the development of psychoanalysis the etiology of mental disorders was explained. And the third was the advent of community psychiatry (Varme, 1953).

1.5.2. Mental Health Services in Pre-Colonial India:

During the rule of the King Asoka, many hospitals were established for the people suffering from mental illness. Though there is not much evidence for the advent of psychiatry in the Moghul period, there are references to some asylums in the period of Mohammad Khilji (1436-1469). Evidences are present on the presence of mental hospital at Dhar, near Mandu, in Madhya Pradesh, at which time the physician there was Maulana Fazurul Hakim.

In spite of the political instability prevailing in the 1700’s there was development of “lunatic asylums” in Calcutta, Madras and Bombay. It is interesting to observe that these three cities grew up largely in the beginning with the British enterprise which conceptualized the isolation of person suffering from mental illness in the mental asylums and their oversight by trained people in a more synchronized manner. There developed a high need to establish
hospitals to manage and treat the Indian and British ‘sepoyees’ who were employed by the British East India Company, (Sharma, 2006).

The first Governor General, Warren Hastings, introduced the ‘Pits India Bill’ during his rule in 1784. According to that the activities of the East India Company came under the direction of a “Board of Control” and systematic development and welfare actions were taken during the reign of Lord Cornwallis (1786-93) (Nehru, London, Lindsay, Drummond, 1949). It was during the reign of Cornwallis that there is a reference to the first mental health hospital in this part of India, at Calcutta, as recorded in the proceedings of Calcutta Medical Board on 3rd April, 1787. It became the reference point for inception of colonial influence on development of psychiatric care in India (Sharma and Varma, 1984).

1.5.3. Mental Health Services in Colonial India:

The growth of the mental asylums in British India had ‘less conspicuous form of social control’, (Ernst, 1987). In India, mental hospitals were greatly influenced by British psychiatry and catered mostly to European soldiers posted in India at that time. Their functions were less curative and more custodial (Sharma, 1990).

In the early colonial period from 1745 to 1857, till the first revolution for Indian Independence was started, the development of lunatic asylums was apparent. In India, the earliest mental hospital was established in 1745 at Bombay with 30 bedded capacities. One of the first mental asylums in India was started by Surgeon Kenderline at Calcutta in the year 1787. Later on, a private lunatic asylum was constructed which was recognized by the Medical Board under the charge of Surgeon William Dick and rented out to the East India Company (Parkar, Dawani and Apte, 2001).

The first government run lunatic asylum was opened on 17 April 1795 at Monghyr in Bihar, especially for insane soldiers (Varma, 1953). The first mental hospital in South India was started at Kilpauk, Madras in 1794 by Surgeon Vallentine Conolly. During this period, excited patients were treated with opium, given hot baths and sometimes, leeches were applied to suck their blood. Music was also used as a mode of therapy to calm down patients in some hospitals.
The persons with mentally illness from the general population were taken care of by the local communities and by traditional Indian medicine doctors, qualified in Ayurveda and Unani medicine; (Sharma S., 2003).

The mid-colonial period from 1858-1918 witnessed a steady growth in the development of mental asylums. This period was significant for the enactment of the first Lunacy Act (also called Act No. 36) in the year 1858. The Act was later modified by a committee appointed in Bengal in 1888. During this period, new asylums were also built at Patna, Dacca, Calcutta, Berhampur, Waltair, Trichinapally, Colaba, Poona, Dharwar, Ahmedabad, Ratnagiri, Hyderabad (Sind), Jabalpur, Banaras, Agra, Bareilly, Tezpur and Lahore. Techniques of ‘moral management’ systems which were developed and implemented in this period in the west were also adopted in India. Drug treatments for psychiatric conditions were also introduced into India in this period, e.g., chloral hydrate. These were largely aimed at controlling patient behavior and also for allowing the patient some respite from his/her condition through sleep.

The Lokopiya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH) was initially set up as Tezpur Lunatic Asylum under the Imperial British rule in April, 1876.

Mental Asylum at Ranchi first opened in 1918 as a hospital for European patients. The sustained efforts of Berkeley-Hill not only helped to raise the standard of treatment and care, but also persuaded the government to change the term ‘asylum’ to ‘hospital’ in 1920. The Parsees during that period were keen to spend large amounts of money to guarantee care in modern psychiatric institutions for those who were considered insane in their own community. Girindra Shekhar Bose first founded the Indian Psychoanalytical Association in 1922 in Calcutta and Berkeley-Hill started the Indian Association for Mental Hygiene at Ranchi. Central Institute of Psychiatry was one of the first centers outside Europe to start Cardiazol-induced seizure treatment in 1938, Electroconvulsive Therapy (ECT) in 1943 and Psychosurgery in 1947.

The first psychiatric outpatient service, precursor to the present-day General Hospital Psychiatric Units (GHPUs), was set up at the R.G. Kar Medical College, Calcutta in 1933 by Ghirinder Shekhar Bose. The World War II saw a separation of military psychiatry from psychiatry in general in India in which the history of modern psychiatry in India seemed to have returned to its origins.
1.5.4. Mental Health Services in Independent India: The formative years

A new phase of development of mental hospitals started after India’s independence in 1947. A few new mental hospitals, notably at Delhi, Jaipur, Kottayam and Bengal, were added. Mid-1950 witnessed rapid development in the spread to GHPUs in India. CIP also took initiatives in community mental health services as one of the earliest rural mental health clinic was started at Mandar near Ranchi in 1967.

On the recommendation of the Bhore committee, All India Institute Mental Health was set up in 1954, which became the National Institute of Mental Health and Neurosciences (NIMHANS) in 1974 at Bangalore. Combating stigma and widening the social network of patients were regarded as core elements of a successful rehabilitation programme. During the last 50 years mental health activities have moved from care of the mentally ill to include prevention and promotion of mental health. Keeping with the reforms in community psychiatry, the first psychiatric mental health camp in India was organized in 1972, at Bagalkot, a taluka of Mysore.

Mention must be made of attempts by Wig to use yoga as a therapeutic tool. This period also witnessed efforts to define the core elements of an Indian approach to psychotherapy in the form of a ‘guru-chela’ relationship. The efforts continued in the 1960s at NIMHANS as there was widespread international acceptance of such approaches, which are known under the rubric of ‘family interventions’ (Menon SM. et. al., 2003).

1.5.5. Mental Health Services in Independent India: Era of Consolidation

As the Government of India embarked on an ambitious national health policy that envisioned “health for all by the year 2000,” early drafts of the National Mental Health Program were formulated, subsequently adopted by the Central Council of Health and Family Welfare, in 1982. Since its inception, there has been development of a model District Mental Health Program and development of training materials and programs for practitioners and academicians (NMHP, 1982).
1.5.6. Mental Health Services in Assam:

While the rest of the country was making progress in establishing institutes which were offering mental health care and treatment, development took place in Assam with the establishment of the Tezpur Lunatic Asylum in 1876.

1.5.6.1. Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH):

It was initially set up as *Tezpur Lunatic Asylum* under the Imperial British rule in April, 1876. It is a premier psychiatric hospital in Northeast India and one of the oldest hospitals in the country. After Independence the hospital was brought under the Government of Assam. In 1949 Dr. N.C. Bordoloi was the first psychiatrist in the country to receive the Padmashree Award from the Government of India for his dedicated service. With the increase in patient flow, a new Out-Patient Department (OPD) was built in 1987. Subsequently, in 1989, the hospital was renamed as “Lokopriya Gopinath Bordoloi Institute of Mental Health”.

In 1999 the Institute was taken over by the North Eastern Council (NEC) with the aim to develop it as a centre of excellence in the field of mental health care and allied science. Being the premier tertiary care psychiatric institute in the NE region, the hospital was upgraded to a regional institute with the objective of providing better mental health care and developing manpower in the region. In the same year the Institute was rechristened as “Lokopriya Gopinath Bordoloi Regional Institute of Mental Health.” Subsequently, the Institute was brought under the administrative control of the Ministry of Health and Family Welfare, Government of India on June 1, 2007.

1.5.6.2. Mental Health Hospitals in Assam:
The Lokopriya Gopinath Bordoloi Regional Institute of Mental Health is the only Central Mental Health Institute in Assam, and the Gauhati Psychiatric Nursing Hospital and the Vincenza Gerosa Nursing Home are the two private mental health hospitals in Assam. These mental health service institutes in Assam are providing services to the people of the state. Apart from these three hospitals, the Medical College hospitals in Assam viz.- Assam Medical College Hospital, Dibrugarh; Gauhati Medical College Hospital, Guwahati; Silchar Medical College Hospital, Silchar; Jorhat Medical College Hospital, Jorhat; Tezpur Medical College Hospital, Sonitpur; and Fakaruddin Ali Ahmed Medical College Hospital, Barpeta, are equipped with a Psychiatric Ward with indoor and outdoor services with professionals like Psychiatrist, Clinical Psychologist, Psychiatric Social Worker, and Psychiatric Nurses. Among these Assam Medical College Hospital, Dibrugarh and Gauhati Medical College Hospital, Guwahati, are running efficiently in the area.

Apart from the above mentioned mental health service institutes there are some Non Governmental Organizations who are also working in the field of Mental Health. Such as- Ashadeep, a mental health Society, Guwahati; Destination, Guwahati; Prerona, Jorhat; Morigaon Mahila Mehfil, Morigaon; Satra, Darrang; Deshabandhu Club, Silchar; The Ant, Chirang. These organizations are also extending their services to the people of Assam at the community level.

1.5.7. Present Scenario of Mental Health in India:

In spite of the high burden of mental disorders and the fact that a significant portion of this burden can be reduced by primary and secondary prevention, most people in India do not have access to mental healthcare due to inadequate facilities and lack of human resources. India
has 0.25 mental health beds per 10,000 populations. Of these, the vast majority (0.20) are in mental hospitals and occupied by long-stay patients and therefore not really accessible to the general population. There is also a paucity of mental health professionals. India has 0.4 psychiatrists, 0.04 psychiatric nurses, 0.02 psychologists and 0.02 social workers per 100,000 populations (Pathare, 2016).

At least 60 million Indians - a number more than the population of South Africa - suffer from mental disorders, even as the country lags the world in medical professionals and spending on mental health.

Health and Family Welfare Minister J.P. Nadda informed the Lok Sabha in May 2016, quoting data from National Commission on Macroeconomics and Health, 2005, the last report available that at the end of 2005, nearly 10-20 million (1-2 percent of the population) Indians suffered from severe mental disorders such as schizophrenia and bipolar disorder, and nearly 50 million (5 percent of the population) suffered from common mental disorders like depression and anxiety.

**Figure 1.3. Organization of Health Services:**

*Source: Burden of disease in India, National Commission on Macro Economics and Health, MoHFW, Govt. of India, 2005*
The following table shows the ratio of burden of mental illness in India.

Table 1.1. Prevalence of Mental & Behavioral Disorders in India.

<table>
<thead>
<tr>
<th>Disease burden due to mental disorder</th>
<th>8.5% (26% of non-communicable disease burden)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of major mental &amp; behavioral disorders in India</td>
<td>65/1000</td>
</tr>
<tr>
<td>Prevalence of Schizophrenia</td>
<td>3/1000</td>
</tr>
<tr>
<td>Prevalence of Mood disorders</td>
<td>16/1000</td>
</tr>
<tr>
<td>Prevalence of child &amp; adolescent mental health problem (1-16 years)</td>
<td>128/1000</td>
</tr>
<tr>
<td>Prevalence of geriatric mental health problem (above 60 years)</td>
<td>31/1000</td>
</tr>
<tr>
<td>Prevalence of epilepsy</td>
<td>9/1000</td>
</tr>
<tr>
<td>Prevalence of common mental disorders</td>
<td>20/1000</td>
</tr>
</tbody>
</table>

Table no. 1.2. Ideal required number of mental health professionals, (Gogoi 2005)

<table>
<thead>
<tr>
<th>Required Mental Health Professionals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Psychi atrists</td>
<td>1.0 per 1,00,000 population</td>
</tr>
<tr>
<td>2 Clinical Psychologists</td>
<td>1.5 per 1,00,000 population</td>
</tr>
<tr>
<td>3 Psychiatric Social Worker</td>
<td>2.0 per 1,00,000 population</td>
</tr>
<tr>
<td>4 Psychiatric Nurses</td>
<td>1.0 per 10 psychiatric beds</td>
</tr>
</tbody>
</table>

A s mentione d in the above table 1.1. and 1.2. are the data regarding the Prevalence of mental & behavioral disorders in respect to India. But there are no such specific data for Assam.
The following table shows the mental health resources available in Assam.

### Table 1.3. Mental Health Resources in Assam:

<table>
<thead>
<tr>
<th>Item</th>
<th>Availability</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Policy</td>
<td>No</td>
<td>At country level National Health Policy 2002 incorporates provisions for mental health</td>
</tr>
<tr>
<td>Essential Drug List</td>
<td>Yes</td>
<td>Guided by National list of Essential Medicines – 2003</td>
</tr>
<tr>
<td>Mental Health Plan</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental Health Programme</td>
<td>Yes</td>
<td>District Mental Health Programme operational in 5 districts</td>
</tr>
<tr>
<td>Mental Health Legislation</td>
<td>Yes</td>
<td>The Mental Health Act 1987 &amp; State Mental Health Rules 1990</td>
</tr>
<tr>
<td>Mental Health Financing</td>
<td>NA</td>
<td>At country level 1.35% of planned outlay for health</td>
</tr>
<tr>
<td>Regional Mental Health Authority</td>
<td>Yes</td>
<td>State Mental Health Authority constituted but not functional</td>
</tr>
</tbody>
</table>

Source: Burden of disease in India, National Commission on Macro Economics and Health, MoHFW, Govt. of India, 2005

The following table shows the different organizations with mental health services in Assam.

### Table 1.4. The organization of mental health services in Assam
<table>
<thead>
<tr>
<th>Organization of Services</th>
<th>Mental Health Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outpatient</td>
</tr>
<tr>
<td><strong>Tertiary Level</strong></td>
<td></td>
</tr>
<tr>
<td>Mental Hospital</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical College Hospital</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Secondary Level</strong></td>
<td></td>
</tr>
<tr>
<td>District Hospital</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Primary Level</strong></td>
<td></td>
</tr>
<tr>
<td>Community Health Centre</td>
<td>No</td>
</tr>
<tr>
<td>Primary Health Centre</td>
<td>No</td>
</tr>
<tr>
<td>Sub-Centre</td>
<td>No</td>
</tr>
</tbody>
</table>

Source: Burden of disease in India, National Commission on Macro Economics and Health, MoHFW, Govt. of India, 2005

**Table no. 1.5. Mental Health Infrastructure & Human Resource in Assam:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No. of mental health outpatient facility</strong></td>
<td>15</td>
</tr>
<tr>
<td><strong>No. of day treatment facility</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>No. of mental hospital</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>No. of community based psychiatric inpatient unit</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Beds in Mental hospitals per 100000 population</strong></td>
<td>1.36</td>
</tr>
<tr>
<td><strong>Beds in community based inpatients unit per 100000 population</strong></td>
<td>0.47</td>
</tr>
<tr>
<td><strong>No. of psychiatrist per 100000 population</strong></td>
<td>0.18</td>
</tr>
<tr>
<td>No. of psychiatric nurses per 100000 population</td>
<td>0.11</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>No. of psychologists per 100000 population</td>
<td>0.02</td>
</tr>
<tr>
<td>No. of social workers per 100000 population</td>
<td>Negligible</td>
</tr>
</tbody>
</table>

Source: Burden of disease in India, National Commission on Macro Economics and Health, MoHFW, Govt. of India, 2005

On the issue of mental health India spends 0.06 % of its health budget which is less than Bangladesh i.e. 0.44 %. According to World Health Organization (WHO) report 2011, most of the developed countries spend above 4% of their budgets on mental health research, its infrastructure, frameworks and talent pool.

The percentage of suicides caused from insanity came down from 7% in 2010 to 5.4% in 2014; the number of people who killed themselves due to mental disorders was more than 7000. To estimate the utilization patterns and the number of mental health patients, the government has commissioned a National Health Survey through the National Institute of Mental Health and Neuro Sciences, Bengaluru. According to a reply in the Lok Sabha by the Ministry of Health and Family Welfare the study started on June 1st 2015 and 27,000 respondents were interviewed by 5th April, 2016. The report revealed that India is in shortage of health professionals to address the issues related to mental health, particularly in the sub-districts and district levels.

There are 3,800 psychiatrist, 898 Clinical Psychologists, 850 psychiatric social workers and 1,500 psychiatric nurses available nationwide. Which signifies that there are three psychiatrists per million people, as per the data from WHO, that is 18 times fewer than the Commonwealth norm of 5.6 psychiatrist per 100,000 people.

By this record, India is short of 66,200 psychiatrists. Similarly, based on the global average of 21.7 psychiatric nurses per 100,000 people, India needs 269,750 nurses.

The Mental Health Care Bill, 2013, which provides for protection and promotion of the right of person suffering from mental illness during the delivery of health care in institutions and
in the community, was without dissent passed by a voice vote in the Rajya Sabha on August 8th, 2016. The new bill has increased the funding to centers of excellence in mental health, from Rs. 30 crore to Rs. 33.70 crore per centre.

As many as 15 centers of excellence and 35 postgraduate training departments in mental health specialties have also been funded to address the shortage of mental health professionals nationwide.

1.5.8. The Present Research:

Given the wide gap between requirement and existing resources in mental health personnel and services in India, and particularly in the state of Assam, an investigation into whether people of the state are likely to seek out help for mental health issues experienced by them or by their family members and whether they would accept persons with mental illness and respect them as human beings and ensure they live with dignity, seems pertinent. As such, the present research on attitudes and beliefs of the public toward mental illness was undertaken.

The behavior of a person may be predicted by their attitudes and beliefs (Ajzen & Fishbein, 1980). Attitudes and beliefs about mental illness might predict whether people will disclose their symptoms and seek support and treatment. Knowledge and beliefs regarding mental illness can aid in the identification, management and prevention of mental health illness (Jorm et. al.1997). Tracking attitudes and beliefs toward mental illness can serve as an indicator of mental health literacy. For example, in a study in 1996, 54% of the U.S. public attributed major depression to neurobiological causes and that increased to 67% in 2006 (Pescosolido et al, 2010). However, improvements in neurobiological understanding of mental illness were unrelated to negative attitudes but, in some cases, increased the odds of negative attitudes (e.g., need for social distance, perceived dangerousness (Pescosolido et al., 2010). In a study in U.S. by Kobau, Dilorio, Chapman, & Delvecchio, (2010) on adults, only about ¼ of them agreed that people are caring and sympathetic to people suffering from mental illness. When they were asked about how much it would be worth to avoid mental illness compared to general medical
illnesses, the public was less willing to pay for mental health treatment than for the other physical health treatments (Smith et al., 2012).

A study done at Vellore, India, found that respondents felt that marriage contributes to the improvement in the condition of the person suffering from mental illness; they are unaware about the causes of mental illness and believe that its occurrence is caused by God’s punishment, (Varghese and Beig, 1974). The higher economic group and women expressed authoritarian attitudes, whereas men expressed more benevolent attitudes (Sharma et al., 2001). Study done by Bagchi R. et al., (1980), found that heredity is the main cause of mental illness and treatment by traditional methods were preferred. These studies provide important snapshots of attitudes toward mental illness across the globe.

As a society, all individuals need to break down the barriers, like prejudices, misconceptions, myths, that may make intervention in mental health difficult. People suffering from mental illness are far less dangerous than most people suppose. The best therapy for the people suffering from mental illness is to be a part of the community and they should have the same right to have a job as anyone else. Nevertheless, mental illness remains frequently misunderstood and people don’t realize how commonplace it really is.

Many studies done on attitudes and beliefs toward mental illness and toward people with mental illness have revealed negative attitudes. These attitudes and beliefs are often attributed to lack of knowledge regarding mental health issues (Wolf et. al., 1996). Surveys in several countries have found that many members of the public do not correctly recognize mental illness (Jorm et. al., 2000). But there are very few studies done in the state of Assam on the public knowledge about mental illness. Thus, there is an urgent need to have a picture of the attitudes and beliefs toward mental illness at the community level so that the barriers to access help and treatment for people with mental illness may be identified and recognized so that they may be brought under treatment, rehabilitation and mainstreaming in their communities with all their rights.

Although it has been found that the number of mental health professionals in Assam is less than the required ratio, the government and non-government mental health institutes are
rendering commendable services to a large number of persons suffering from mental illness. Since a large number of persons suffering from mental illness throng these service centers, it is assumed that because of these services people probably are being educated to some degree on the causes and signs and symptoms of mental illness. It is also likely that attitudes and beliefs are also probably changing towards more positive outlook.

1.6. RESEARCH QUESTION:

Based upon the issues discussed above research question for the present investigation was raised as – What are the attitudes and beliefs of the public toward mental illness in Assam?

To investigate and delve into the question raised, a research plan was designed which is discussed in the third chapter.

1.7. OBJECTIVES OF THE STUDY:

Main Objective:

- To study the existing attitudes and beliefs toward Mental Illness.

Specific Objectives:

- To find out the difference on acceptance toward mental illness between rural and urban setting.
- To find out the difference on knowledge and exposure toward mental illness between rural and urban setting.
- To find out the difference on stigma and discrimination toward mental illness between rural and urban setting.
To find out the difference on acceptance toward mental illness between male and female.

To find out the difference on knowledge and exposure toward mental illness between male and female.

To find out the difference on stigma and discrimination toward mental illness between male and female.

To find out the difference on acceptance toward mental illness between age groups (21 years to 40 years and 41 years to 60 years).

To find out the difference on knowledge and exposure toward mental illness between age groups (21 years to 40 years and 41 years to 60 years).

To find out the difference on stigma and discrimination toward mental illness between age groups (21 years to 40 years and 41 years to 60 years).

1.8. HYPOTHESES OF THE STUDY:

Ho1: There will be no significant difference in attitudes and beliefs reflecting acceptance toward mental illness with respect to rural and urban setting.

Ho2: There will be no significant difference in attitudes and beliefs reflecting knowledge and exposure toward mental illness with respect to rural and urban setting.

Ho3: There will be no significant difference in attitudes and beliefs reflecting stigma and discrimination toward mental illness with respect to rural and urban setting.

Ho4: There will be no significant difference in attitudes and beliefs reflecting acceptance toward mental illness with respect to gender.

Ho5: There will be no significant difference in attitudes and beliefs reflecting knowledge and exposure toward mental illness with respect to gender.
• Ho6: There will be no significant difference in attitudes and beliefs reflecting the stigma and discrimination towards mental illness with respect to gender.

• Ho7: There will be no significant difference in attitudes and beliefs reflecting acceptance toward mental illness with respect to age group.

• Ho8: There will be no significant difference in attitudes and beliefs reflecting knowledge and exposure toward mental illness with respect to age group.

• Ho9: There will be no significant difference in attitudes and beliefs reflecting the stigma and discrimination toward mental illness with respect to age group.

To test these hypotheses the present research has been carried out and the methodology followed is given in Chapter III.