Chapter – 5

FINDINGS, SUMMERY AND CONCLUSION
CHAPTER- V

FINDINGS, SUMMARY AND CONCLUSION

Mental health is vital to the overall well-being of individuals in all societies. Mental health is an integral and essential component of health. Health and mental health are closely interwoven and deeply interdependent. Mental health problems are increasing and it is important to anticipate and prevent the problems to avoid minor problems from becoming chronic and to rehabilitate those who were already mentally ill. The report of the expert work group of National Mental Health Programme presents a pathetic picture of the present situation. According to these experts about 10 million Indian citizens (approximately 10-20 per thousand population) are affected by serious mental disorders at any point in time.

Stress is seen as major cause of worry as far as mental health is concerned. Studies show that there is constant increase in stress, especially in urban population. Globally, mental disorders account for 13 percent of the burden of diseases. In India overall life time prevalence rate of mental disorders is 10-12 percent (National Institute of Mental Health). Ignorance, stigma and lack of doctors have long marred mental health care in India. Stressful life style also leading cause for depression, mental health is the much neglected segment is now gaining importance in the country’s medical scenario. Studies stated that 6.7 % population suffer from mental disorders. Most of them > 90 % mental disorders untreated. Poor awareness about symptoms of mental illness, myths and stigma related to it, lack of knowledge on the treatment availability and potential benefits of seeking treatment are important causes for the high treatment gap.

In addition alcoholism and drug abuse are also on the rise. There has been a sharp increase in the drug dependency rate in cities among college students and other specific areas. Health for all by year 2000 A D remains still unachieved and a 10 years extension is provided to achieve the aim.
Meanwhile newer health problems are emerging and mental health problems are on the rise. Much planned hard work and intensive – aggressive approach is needed to achieve the aim as far as mental health is concerned. Conscious and planned integration of mental health principles to the teaching programmes of health professionals is an important need today.

After the independence, efforts were made to improve the access to mental health services by increasing the number of mental hospitals and opening of psychiatric units in general hospitals and bringing mental health care out of the confines of mental hospitals reduced the stigma associated with treatment of mental illness, removed legal restrictions on admission and treatment and facilitated the early detection of associated physical problems. Most importantly, it ensured that the family was involved in the care of the patient in order to improve the efforts of family members to provide care to the patients at home after discharge from the hospital. Some states like Kerala and Tamil Nadu have a district psychiatric unit in all districts. Today the concept of mental health care provided as an integral part of health care system has been accepted and implemented by all states.

There are also a large number of people with emotional problems manifested through marriage breakdown, suicide and violence which do not come into the picture of mental illness. Suicidal rate is growing higher. Kerala, especially Trivandrum, has taken an important place on the world map of suicide according to the latest statistics. According to the report, the cases of serious mental disorders each year in India are estimated to be approximately 100,000 – 250,000. It is, therefore a serious state of affairs in India as far as mental health problems is concerned.

The research study aimed at to find out the information pertaining to socio-demographic profile of the mentally ill and their family members, the causes, types of mental illness, behaviour, social factors, sexual relationships,
treatment, progress of the disease, problems faced by the patient and family members, recovery, stigma, and attitude of the people towards mentally ill.

The profile of the mentally ill shows that mental illness commonly observed in younger age groups, Hindus, married, illiterates as well as literates, coolies, low income groups and rural people, nuclear families. The causes are hereditary, first child in birth order, death of loved persons, childlessness, head injuries, alcoholism, marital disharmony, hormonal disturbances, loss of property, debts, exam failure, love failure and shock. This study results stated that multiple factors are responsible in causation of mental illness.

Family members also have little knowledge about mental illness. They may believe that it is a condition that is totally disabling the person’s physical and mental capabilities. Awareness regarding mental illness was poor among family members to cope with mental illness. Even when all members of the family have the knowledge to deal with mental illness, the family is often reluctant to discuss with others because they do not know how people will react because of misconceptions towards mental illness.

STATEMENT OF THE PROBLEM

Mental disorders have an economic impact on societies and on the quality of life of individuals and families. They are common, affecting more than 25 percent of people at some time during their lives. They are also universal, affecting people in all countries and societies, individuals of all ages, women and men, the rich and the poor from urban to rural environments.

Mental illnesses cause massive disruption in the lives of individuals, families, and communities. It is estimated that one in four families has, at least one member currently suffering from a mental illness. These families are required not only to provide physical and emotional support but also to bear
the negative impact of stigma and discrimination present in all parts of the world.

There is a wide gap between availability and implementation of effective interventions e.g. in India, treatment rates for schizophrenia and epilepsy are reported to be 20% of all cases in need of treatment, compared to 80% for the same disorder in the West. Discrimination occurs when a person is treated differently from another person in the same or similar circumstances. It is a result of belief in the stereotypes of people with experience of mental illness leading to prejudice, which in turn leads to discrimination.

People with experience of mental illness often rely on family members as part of their support mechanism. The relationships with family members may be the closest relationship that we have. Discrimination against and stigma of, people with experience of mental illness is widespread. It has an impact on the self-esteem and recovery of people with experience of mental illness as well as affecting all aspects of people’s lives. Although some nations have been successful in fighting against stigma and increasing acceptance of the mentally ill, lack of awareness is very evident in India and other developing countries.

Mentally ill people are labelled as “different” from other people and are viewed negatively by others. Stigma remains a powerful negative attribute in all social relations. Stigma and discrimination discourage people to seek diagnosis and treatment. If they disclose that they experience serious discrimination from their loved ones and people around them. Stigma and discrimination are part of complex systems of beliefs about the mental illness.

Mental illness has been shrouded in stigma and superstition since a long time in India, instead of offering help to the mentally ill. Most of us treat them with suspicion, ignorance, or cold-hearted apathy. Mental illness is rising at epidemic rates around the world, including India. WHO predicts that 20% of
India’s population, will suffer from some form of mental illness by the year 2020. The rising crime rate, rampant corruption and general unrest in people are clear signs that mental health and wellbeing need our attention. This careless attitude towards mental health is mirrored by the Government and medical institutions where mental health is regarded almost as an afterthought. Barely 1-2% of health budget is dedicated to mental health, in comparison to 10 to 12% in other countries. Psychiatry is not considered lucrative like other medical specialities. Psychology too is misunderstood and ignored field in our country. It is not a surprise then that, young people choose not pursue mental health as a profession and we continue to treat mental illness like the white elephant in the room.

The major barriers to effective treatment of mental illness include lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of services. Policy makers, Insurance companies, Health and Labour policies and the public at large - all discriminate between the physical and mental health problems. Hence there is an urgent need to educate the public about causes, treatment and prevention of mental illness. A better understanding regarding mental illness amongst the public would presumably lessen stigmatization and encourage prompt utilization of available mental health services, which in turn leads to improve the quality of life by promoting positive attitude towards mental illness. The value of the mental health in primary health care has been noted worldwide and focusing efforts in this area has become a priority. India, which has had a lead in formulating the National Mental Health Programme in 1982, one of the first among the developing countries, and initiating the integration of mental health in primary health care nearly quarter century ago, has still not done enough. There is also the larger problem of the chronic mentally ill in the community. The stigma of mental illness awaits major initiatives to fight the discrimination experienced by the patient and their families.
India started training to primary health care workers in 1975, forming the basis of the national mental health programme formulated in 1982. Currently Government supported 25 districts level programme in 22 states. The positive aspects of the NMHP is the enhanced recognition and services being available to large population. However the programmes and initiatives have not really spread to the population. One of the important goal of NMHP is integration of mental health in primary health care. Even today, the mental health services are not integrated in primary health care. Mental health services in India are neglected area which needs immediate attention from Government, Policy Makers, Civil Society or Organizations. NMHP and NRHM programmes shown very little efforts so far to provide health services in rural areas. ASHAs under NRHM is an opportunity to provide mental health services at door steps in rural areas.

There view of available literature brought for the fact that there had been only small scale studies were found which had touched the fringe of the mental illness covering very small sample. There had been virtually no empirical study about the mentally ill in the state of ‘Andhra Pradesh except for one study one community based study on the elderly in Chittoor District. There had been no study on the mentally ill in Anantapurmu District till date. In the context of the growing incidence of mental illness worldwide and the threat for India to have 25 per cent of its population to go mentally ill 2020, it becomes necessary to estimate the incidence of mental illness as prevalent in various places, so that the care and support systems can be evolved to cope up the challenges that await us by 2020. Places with peculiar topography and geographical and climatic conditions, which have bearing on the physical and mental health of people calls for research and evolving suitable interventions.

To address these vital missing research gaps that the present intensive study tries to understand deeper into the causes, types of mental illness, treatment, recovery percentage, relapse of the disease, attitude of people
towards mental illness and it also tries to understand the stigma and the problems faced by the family members of mentally ill in a drought prone area of Anantapuramu District of Andhra Pradesh.

OBJECTIVES OF THE STUDY

1. To document the Socio- Economic and Demographic background of mentally ill patients in Anantapuramu District.
2. To identify the causes and incidence of mental illness in Anantapuramu District.
3. To understand the types and treatment of mental illness in Anantapuramu District.
4. To identify the reasons for the delay in accessing the treatment in Anantapuramu District.
5. To study the difficulties faced by family members of mentally ill in Anantapuramu District.
6. To study the association between Socio-Demographic variables of mentally ill and knowledge levels of family members of mentally ill.

HYPOTHESES

The following hypotheses were formulated while pursuing the above objectives

1. Multiple factors commonly observed as causation of mental illness.
2. There is significant association between Stigma and Mental illness.
3. Demographic variables of mentally ill significantly influence the knowledge levels of Family members of mentally ill.

i. There is significant association between age of mentally ill and knowledge levels of family members of mentally ill.
There is significant association between the gender of the mentally ill and the Knowledge levels of the family members of the mentally ill.

With respect to Religion, there is significant association between religions of mentally ill and knowledge levels of family members of mentally ill.

There is significant association between Caste of mentally ill and knowledge levels of family members of mentally ill.

With respect to marital status, there is significant association between marital status of mentally ill and knowledge levels of family members of mentally ill.

There is significant association between knowledge levels of family members of mentally ill with their current residence.

With regard to type of family, there is significant association between type of family and knowledge levels of family members of mentally ill.

FINDINGS OF THE STUDY

The following are the major findings of the study:

FINDINGS RELATED TO DEMOGRAPHICAL VARIABLES OF MENTALLY ILL

- The age wise distribution of data shows that a sizable section of the respondents (23.50%) are affected with mental illness between the age group 15-25 years which means they have been affected by mental illness in very young at the most productive part of their lives.

- It is observed that out of 400 sample, males (53.50%) and females (46.50%) currently are suffering with illness. These findings suggested that Women are more affected than Men when we relate it to their share in population of 2011 census of Anantapuramu District.

- The religion wise distribution of mentally ill patients, shows that majority of patients (92.25%) were professed Hinduism.
• Majority of respondents (51%) are from Backward Classes. This may be due to their numerical preponderance in Anantapuram District.
• Majority of respondents (64.75%) are currently married. Married people are more affected than unmarried.
• Among marital relations, familial tendency increases the risk of mental illness, which is commonly observed in consanguineous marriages.
• It was found that majority of the respondents (40.25%) are illiterates. The study shows that illiteracy rates predominate among the respondents.
• Occupation wise distribution of respondents shows that major section of patients (50.50%) are coolies.
• It was observed that Majority of respondents (58.75%) are in the low income group of below Rs.5000 per month. Anantapuram District being a drought prone area, majority of them are Coolies and they are in the bracket of low income group.
• The place of residence show that the majority of patients (80.25%) are from rural areas who subsequently shifted to urban and suburban areas because of occupation, parents transfer and higher education. Currently (66%) are residing at rural area.
• Majority of them (76.25%) hail from nuclear families. The inference drawn from this study stated that nuclear families are more vulnerable to mental illness than joint families where the presence of elders who always advised the young and supportive when problems cropped up.
• Birth order wise, data collected from the family members of mentally ill specify that majority of mentally ill respondents (46.25%) are the first child in the birth order and (31%) are second child in family.
FINDINGS RELATED TO MENTAL ILLNESS

- Among the 400 mentally ill patients, it is observed that a sizable section of respondents (36.50%) are suffering with depression.
- As per the data related to depression, among 146 depressive patients, 54.79% are women and 45.21% are men. Women are suffering with depression more than men.
- It was observed that (47.25%) are suffering with mental illness since 1-5 years. There are about 13.75 who are ill for more than 5-10 years while there are 11.75 per cent who are ill for more than 10 years.
- The data collected from the respondents regarding the age of onset of disease, it was found that in 22.25% of patients disease started between 21-25 years of age and started between 15-20 years in only 1.25 percent. Hence, data suggest that onset of illness started in young and middle Ages.
- The researcher observed that with regard gender wise onset of mental illness, 56.38% men and 43.38% women had the onset when they were between 15-25 years; 40.79% of women, 59.21% men had the onset when they were between their 26-35 age group. Hence men are suffering more than women in young age.
- It was noticeable that the onset of mental illness is more among women 50.29%, when they are between the age 36-55 years of age and for 49.71% of men when they are in their 36-55 year. The findings of the present study reveal that men are prone to more mental illness in all ages than women. Men have suffered more during 56-65 years of age than women. Men are more prone to mental illness their young, and old ages, whereas, women are more prone during their middle age.
- Among the mentally ill, (64.75%) are showing no improvement in terms of cure from disease condition.
The exact causes of mental illness wise distribution reveals that majority of mentally ill patients (38 %) suffered from social problems. Physical illness wise, (6.75%) are suffering with physical illness like etc. heart disease, hysterectomy, chronic headaches and neurological problems. The findings of the study indicate that physical illness is also one of the cause for mental illness.

Contributory causes for mental illness wise majority of respondents (62.75%) were not reported related to contributory causes for mental illness.

It was observed that (5.25%) were attempted suicide after illness and (0.50%) only attempted suicide before illness. The study results suggested that suicidal attempts were reported higher after illness than before illness.

Excessive anger commonly observed in majority of mentally ill respondents. Emotional state, determine human behaviour. Anger can cause a person to be rude and sarcastic. It is observed that (10.25 %) are showing anger. Disorders of emotion interfere with human efficiency like lack of concentration, lack of appetite, increased risk of accidents, lack of sleep, palpitation, etc. Anger is a negative emotion, intensive negative emotions if persists repeatedly they endanger mental health. Good, pleasant emotions contribute to good health. Majority of mentally ill respondents’ exhibit anger, violence to self or others, quarrel, delirium, tantrums, depression etc. due to severity of illness.

The sleeping pattern wise distribution respondents showed that majority of Respondents (64.50%) are reporting difficulty in getting sleep. Only (5%) are experiencing mixed symptoms.
• Majority of respondents (51%) are having normal appetite. Appetite pattern altered depends up on the type of mental illness.

• The responses from study participants stated that (25.25%) are suffering with constipation and (1%) are suffered with diarrhoea. The majority of people (73.75%) have regular bowel movements.

• It was observed that increased urination was noticeable among (4.75%) and Bed wetting observed in (1.75%) of respondents.

• It was observed that (47.25%) are with excessive and (43%) respondents are talking very little.

• The nature of talk distribution of respondents shows, that majority (76.50%) are talking in understandable manner.

• Thought wise distribution of respondents showed that majority (80.25%) have reported of having peculiar thoughts.

• It was found that majority of respondents (37.75%) are experiencing visual hallucinations that is seeing things. Auditory hallucinations that is hearing voices reported in (19.50 %) and it was found that (24%) are talking to self, (9.75 %) are laughing to self, (2.75%) are weeping to self, (2 %) are wandering in the streets,(4.25%) respondents are having all the above characteristics.

• It was observed that majority of respondents (69.75%) are having average mental concentration.

• It was noticed that most of the respondents (45.75%) are not having memory loss, (34%) are having remote memory loss.

• Development wise data shows that majority of respondents (55.75%) are having good growth and development, (44.25%) are having average growth and development. By and large majority of the respondents show signs of normal growth.

• The performance in studies wise distribution of respondents showed that majority of the respondents (62.34 %) had been average in studies.
People with low intelligence are more predisposed to schizophrenia, hysteria and personality disorders. Highly intellectual people also prone to get mental illness.

- Relationship wise distribution of respondents, shows that majority of respondents (97.91%) are cooperative with teachers and peers. It was noticed that (76.99 %) are cooperative with their play mates.
- The responses indicate that majority of respondents (13.75 %) are smokers and (8.75%) are reported delinquent behaviour during adolescence.
- Among the married respondents (42.86%) are having two children. (10%) are not having children while (26.07%) are having more than three children.
- It is found that most of the respondents (30.50%) reported to have been treated leniently by their parents while (26.50%) are treated very strictly.
- The type of work wise distribution stated that major section of respondents (67.73%) are doing strenuous work, while (26.20%) people are doing heavy work.
- Among the respondents it was reported that (36.98%) frequently changed job because of current mental illness.
- The job satisfaction of the respondents shows that major portion of the respondents (59.42%) were somewhat satisfied with their jobs.
- It was observed that major section of respondents (43.25%) are watching Television, talking with other etc. (31.25%) are having habit of listening to music. Only few (7.25%) are not having any hobbies. Exercises are beneficial for the improvement of mood state.
- The study data suggested that (58.75%) are not having habit of drugs, smoking, alcohol and tobacco. Only (14%) are addicted to mixed habits like smoking and alcoholism. (8.25%) are alcoholics.
• Politics also plays a major role in creating stress because of conflicts between the groups, failure in the elections etc.

• It is noticed that among 400 respondents (65.50%) are having normal in relations, (19.75%) are always friendly and lovely with others.

• Among 400 respondents, 280(70%) are married. Sexual history in relation to marital relations reveals that majority of respondents (48.93%) are said that they have very much satisfied sexual relations with their partners. (23.21 %) are somewhat satisfied.

• Among 400 respondents, major section (54.29 %) were married between the 21to 30 years of age.

• The age difference between the couple wise major section of respondents (48.93%) are having age difference from one year to five years. Age difference six to ten years observed in (39.64%) and (10%) are having age difference above the 10 years.

• Majority (98.93%) are do not have any extra marital relationships. Extra marital relations results in marital disharmony which is also an important risk factor for mental illness.

• The religious attitude wise distribution of respondents shows that (64.75%) are showing moderate religious attitude. (6.25%) are rarely follow.

• It was noticed that majority of respondents (67.25%) are average, (23.75%) are loner and only (9 %) are group rendered. Majority of respondents are having average relationship with others.

• As far as the personality of the mentally ill are concerned, anxious personality noticed in28 percent.

• The responses collected from the family members regarding contact of the doctor immediately. Majority of respondents (60.25%) are not consulted the doctor immediately.
• It was found that behavioural changes among mentally respondents (73%) are noticed by family members and (18.75%) are noticed by self.
• It was observed that (43.98%) are having stigma to take mentally ill to get treatment at hospital because of fear of isolation.
• The treatment wise distribution of the patients shows, that majority of patients (99%) are receiving Psychotherapy, drugs and relaxation therapies.
• The recovery percentage after treatment wise distribution of respondents showed that 25-50% recovery after treatment was noticed in (34.50%) respondents.
• Majority of respondents (55.50%) are not going to doctor. (44.50%) are only going to doctor whenever they get side effects with drugs.
• It was opined by the family members of mentally ill that among 400 respondents 128 respondents that is (32%) are agreeing that they stop the drugs. Among them, (42.97%) were stopped taking drugs because of feeling better.
• Most of the respondents (68%) are agree that treatment was given regularly to the patients.
• The responses indicate that, (45.25%) are only taking drugs with doctors’ advice. (34.75%) are agree that drugs need to be stopped after feeling better with drugs. Nearly more than half of respondents are not consulting the doctor to stop the drugs.
• The family members of mentally ill (58.50%) are facing discrimination. Among which, majority (48.29%) are facing discrimination by family members. These findings concluded that most of the parents not bringing mentally ill patients to the hospitals in early stage.
• The type of ill treatment wise distribution respondents of mentally ill and their family members showed that majority of them (61.10%) are
facing avoidance from others and (26.92%) were labelled as mentally ill.

- It was noticed that most of the respondents (64.25%) are feeling shy to share about illness. Among which majority (50.97%) have fear of avoidance and (38.13%) have fear of labelling.

- Majority of the family members (88%) are showing interest towards care of the mentally ill. It was observable that family members did recognise the need for treatment and attitude of people have also started to change slowly in favour of the mentally ill.

- It was found that majority of the mentally ill (66.19%) are getting good care from the family members.

- The expenditure wise data for care of mentally ill reveals that majority (51%) are spending amount between 1001-5000 Rupees. Majority of patients getting treatment at free of cost from the Government hospitals.

- Social gathering wise data suggested that majority of respondents (49%) are not at all participating in social gathering. It was only (21.75%) who are only participating in social gathering.

- It was noticed that majority of the families (63.75%) are getting external support that is (76.47%) are getting very much external support. Only (29.96%) are getting less external support. The social support is very important for humans to survive in the society particularly for the mentally ill. The family members might become frustrated with the long drawn care of the mentally ill. In such a situation the external support from outside can go a long way in strengthening the familial support. External support encourages the family of mentally ill to get the early diagnosis and treatment.
In the light of above findings the main causes of mental illness is noticed in Anantapuramu are young and middle age respondents, illiteracy, unemployment, low income, married having rural back ground and nuclear families related to backward classes.

SUMMARY

In the view of the above findings, researcher has made an attempt to the issues raised earlier in the statement of the problem.

The first issue raised was to understand the socio demographic back ground of mentally ill patients. The data suggested that socio demographic variable mainly influence the behaviour of people. Majority of the people suffering from mental illness in younger ages and middle ages, both sexes, Hindus, married, illiterates, coolies, low income groups, rural people and nuclear families.

The second issue raised was to identify the causes and incidence of mental illness. Mental illness was not caused by single factor which is caused by multiple factors. Majority of patients suffered with mental illness due to social and psychological factors such as family problems, economic problems, marital disharmony etc. hormonal factors in menopausal women and postnatal mothers. Strenuous work, lack of job satisfaction, mal adjustment at work place, pressure from mother in-laws etc. hereditary, loss of loved persons, debts etc. The above findings of the present study suggested that mental illness not caused by single factor. Multiple factors are incriminated in causation of mental illness. Hence the research hypotheses is accepted

The third issue raised was to understand the types and treatment of mental illness. The findings reveals that majority of respondents (36.50 %) are suffering with depression. (28.25%) were diagnosed as mania. (19.75%) are suffering with schizophrenia. (7.75%) are diagnosed as psychosomatic illness and minor section (7%) are suffering with neurosis. Others (0.75 %) are
suffering from alcoholic withdrawal syndromes, and puerperal psychosis. The inference drawn from the above findings concluded that majority of patients suffer from Depression, the exact cause for Depression was unknown. Probably a combination of physical, genetic and environmental factors are involved such as depression occurs due to stressful events, such as the death of loved one, after delivery of the child, having a long lasting illness such as cancer, heart diseases, headaches, menopausal disturbances, chronic pain, alcoholism, lack of support from family members etc. People with depression may have abnormal level of brain chemicals which leads to depression.

The study findings indicates that majority of respondents (99%) are on psychotherapy, drugs and relaxation therapies. Minor section of patients (1%) were receiving psychotherapy, drugs, relaxation therapies and ECT. When they are not responding to drugs, psychotherapies and other therapies ECT was used in severe cases.

The fourth issue raised was to identify the reasons for delaying the treatment. The study results suggest that majority of patients were not coming to hospital to take treatment at an early stage. The main reason was associated with stigma and discrimination, lack of knowledge and myths. Majority of family members seeking medical aid from religious people and folk healers. These factors considered as a major barrier to the treatment and care.

There is significant association between the stigma and mental illness. Stigma is the major barrier for delaying the treatment. Hence the formulated hypothesis is accepted.

The fifth issue raised was to study the problems faced by family members. Family members of mentally ill faced stigma and discrimination in the society. Economic problems because of unemployment due to mental illness and frequent loss of job. Rural population not having access to mental health services. Repeated hospitalization causes high physical and emotion
burden among family members. The study findings suggested that the knowledge levels are also poor among the study subjects. The majority of study subjects had a misconceptions towards mental health. There is an urgent need for public awareness if mental disorders are to be recognised early in the community and appropriate interventions sought, the level of mental health literacy needs to be raised. Further, public understanding of psychiatric disorders causes, manifestation, treatment, and prevention. The Knowledge about mental disorders facilitates to modify the misconception about mental illness and to promote positive mental health. The findings of the study suggested that family members of mentally ill facing more problems than that of physical illness.

The sixth issue was to study the association between the Socio-Demographic variables of the mentally ill and the knowledge levels of the family members of the mentally ill. The knowledge or attitude of family members’ of respondents as presented in Table No 4.74 reveals that among 400 family members, 333 (83.25%) have moderate level of knowledge, 48 (12%) have low level of knowledge, 19 (4.75%) have high level of knowledge. The majority section of family member’s responses were undecided. The mean value is 1.93 and standard deviation was 0.403.

The demographic variables like age, religion, marital status, current place of residence of mentally ill have statistical significance at p < 0.01 level, Significance at p< 0.05 level, which could be due to increased awareness regarding mental illness. Other variables like gender, caste and type of family of mentally ill have no significant association with knowledge level of family members of mentally ill. The hypothesises which states that there is significant association between the demographic variables of mentally ill with the knowledge level of family members of mentally ill. The association of demographic variables with level of knowledge by using Chi-square test revealed that there is no significant association between selected
demographic variable with knowledge level of family members of mentally ill. Based on these findings, the hypothesis is rejected.

1. With regard to family members of the mentally ill aged between 15 – 25 years of age who are 20.25 percent have moderate level of knowledge and 2 percent have high level of knowledge. Similarly family members of the patients aged between 36 – 45 years age group 4.25 percent show low level of knowledge.

The Chi – square obtained is 18.119, p < 0.01, which shows 1% significant association between age of mentally ill and knowledge levels of their family members based on these findings the hypothesis was accepted.

2. With regard to Gender, majority of the family members of male patients 43.50 percent have moderate level of knowledge levels, 1.50 percent have high level of knowledge and 6.75 percent have low level of knowledge. Among the family members of the female patients 3.25 percent have high level of knowledge.

The Chi – square obtained is 2.005, which shows that there is no significant association between Genders of mentally ill and the knowledge levels of their family members. Based on these findings hypothesis is rejected.

3. With respect to Religion, majority of the family members of mentally ill being Hindus, 77.25 percent have moderate level of knowledge, 11 percent have low level of knowledge and 4 percent showed high level of knowledge.

The Chi – square obtained is 18.650, p < 0.05 which shows 5% significant association between religions of mentally ill and knowledge levels of their family members. Hence the formulated hypothesis is accepted.
4. With regard to Caste, majority of the family members of mentally ill belongs to backward class shows that, 43.75 per cent of them have moderate level of knowledge, 5.75 per cent have low level of knowledge while 2 per cent have high level of knowledge. The Chi – square obtained is 7.740 shows that there is no significant association between Caste of mentally ill and knowledge levels of their family members. Based on these findings hypothesis is rejected.

5. With respect to Marital status, majority of the family members of currently married mentally ill 214 (53.50%) have moderate level of knowledge, 9.25 per cent, have low level of knowledge and 2.50 per cent have high level of knowledge. The Chi – square obtained is 12.231, p <0.01, which shows 1% significant association between marital status of mentally ill and knowledge levels of their family members. Hence the hypothesis is accepted.

6. With respect to current place of residence, majority of the family members of mentally ill belongs to rural 54.25 per cent have moderate level of knowledge, 9.75 per cent have low level of knowledge and only 2 per cent have high level of knowledge. But it was observed that 2.50 per cent have high level knowledge who live in urban areas. The Chi –square obtained is 11.330, p<0.05, which shows 5% significant association between current residence of mentally ill and knowledge levels of their family members. Hence the hypothesis is accepted.

7. With regard to type of family, majority of the family members of mentally ill related to nuclear family 64.25 per cent have moderate level of knowledge, 8.5 per cent have low level of knowledge and 3.50 per cent have high level of knowledge.
The Chi – square obtained is 1.295, shows that there is no significant association between type of family of mentally ill and knowledge level of their family members. Hence the formulated hypothesis is rejected.

The inference drawn from these findings stated that major section of family members have negative attitude towards mental illness and also undecided. These findings suggest that lack of knowledge among family members about mental illness and treatment results in non-coping process of patient and family members which in turn leads to impaired productivity and diminished quality of life for patient and family members.

CONCLUSION

The social, biological, physical and psychological strengths of the past are slowly being replaced by a fragile life pattern of people, making them more vulnerable to social, physical, mental and psychological problems at all ages. Multiple factors are responsible in the causation of mental illness. Demographic variables are closely linked with behavioural changes. Many prejudice and superstitious beliefs are also observed among family members of mentally ill towards mental illness. The findings suggest that mental illness is affecting people in all ages, women and men, married or unmarried, all religions, all castes, illiterates as well as educated, high or low income groups and rural or from urban areas. Majority of respondents belong to rural area, there is poor access to mental health care services in rural areas. Hence basic mental health care to all needy people especially the poor from rural, slums and tribal areas should be provided. Mental disorders are not treated equally like any other physical disorders. Mental illness is found to be high in nuclear families and among the first born child. Attitude scale scores shows that majority of family members of mentally ill have negative attitude towards mental illness, which is the major barrier to seek treatment in time and to
continue the treatment in convalescence period. Lack of continuation in taking treatment results in relapse of the mental illness. Hence there is an urgent need to educate the public about the causes, treatment and prevention of mental illness. A better understanding regarding mental illness amongst the public would presumably lessen stigmatization and encourage prompt utilization of available mental health services, which in turn leads to improve the quality of life by promoting positive attitude towards mental illness. There should be provision for guidance at pre-primary, primary, and secondary schools, premarital and marital guidance in the social field, child guidance psychiatric clinics in all teaching and other major and district hospitals in order to promote mental health and to lessen the impending global burden of the disease by 2020. Government must take initiation to implement the mental health policies at all levels. Mental disorders are not treated equally like any other physical disorders. There is an urgent need to integrate the mental health in primary health care most effectively. Successful intervention programmes and rehabilitative services for the mentally ill and their families are needed for the prevention, early detection, prompt treatment, and lessen the severity of illness in the community.

SUGGESTIONS

Based on the findings of the study the following suggestions are made. Complete cure of mental illness is possible like any other physical illness by prompt recognition and detection in an early stage and continuity of treatment.

The information received from the Government of Andhra Pradesh was, unfortunately, incomplete in several aspects. The complete data related to mental illness was not available from health statistics at Anantapuramu District. Hence data collected from the records of in-patients and out-patients of Psychiatric Department of Government Hospital, Anantapuramu. These
statistics are used to estimate the average incidence of mental illness at Anantapuramu District.

• There is a need to maintain mental illness statistics like any other physical illness by the Health Department in order to identify the mental illness at an early stage and to prevent the mental illness and to improve the quality of life.

• The State needs to expand the scope of community-based mental healthcare through District Mental Health Programme. Community-based services is the core activity in the plan of action. Currently most districts do not have trained professionals, mental health infrastructure to provide essential mental health care.

• Training facilities for psychiatrists as well as other mental health personnel such as clinical psychologists in order to meet severe shortages of trained manpower.

• Mental health issues related to women, children and aged more neglected than mental health in general. These groups are more vulnerable for mental illness than others. Hence more focus should be placed on these vulnerable groups.

• Improvement in the education of the public about mental illness and provision of the opportunity for personal contact with mentally ill people are considered to be important measures for promoting the acceptance of the mentally ill.

• There is emerging evidence of a high level of social distance and stigmatization towards mental illness in Anantapuramu district hence there is need to incorporate anti-stigma educational programmes in to the Mental Health Policy, should include community education regarding the causation, manifestation, treatment and progressive of mental illness to lessen the stigma and discrimination.
• Establishment and maintenance of community support systems for non-institutionalised patients.

• Community Mental Health Care facilities are needed to avoid long standing hospital stay. Community based services can lead to early treatment and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities. Follow up treatment can be continued as out-patient with in the community to reinforce the intra-family bonding and to improve the patient condition rapidly.

• Screening programmes should be carried out for early identification of cases.

• Multipurpose health workers and health supervisors need to be trained for management of psychiatric emergencies, maintenance treatment for chronic psychiatry disorders.

• Partial hospitalization more suitable for chronic psychiatric patients, neurotic disorders, personality disorders, drug and alcoholic dependence like Day care centres, half way homes, day hospitals, day treatment programmes, sheltered work shop, de-addiction centres and suicide prevention centres etc. All these facilities not available sufficiently at Anantapuramu District. These facilities should be available at all levels like Districts, Taluks and Towns.

• Intensive therapeutic efforts should be used at the hospital level to prevent long stay in hospital. Involvement of family members in treatment delivery.

• Vocational rehabilitation should be encouraged for mentally disabled person to secure suitable employment.

• Research, social change and training activities should be carried out at all levels.
• Family support system should be strengthened through economical incentives to the people below poverty line and middle-income level families to compensate the family for the loss of the earning capacity of the patient and family care givers in looking after the patient.

• Strengthening of family system to maintain harmonious relationships among family members. Families are primary care providers. They need help from the government and the society.

• The results of this study underlined the need for education programmes for the relatives of the patients, and the demands of the relatives concerning treatment modalities with psychosocial components.

• Provision of mental health care facilities at gross root level.

• Strengthening individuals, family and group coping abilities to prevent occurrence of mental disorders.

• Primary prevention of mental illness should be focused to strengthening the individual, family and group coping abilities. Family members need health education regarding growth and development and characteristics of mentally healthy individuals and mental illness which helps in identification of behavioural problems at an early stage.

• Developing visiting nurses to support family members and involve the family members in the planning of mental health programmes

• Growth and development mainly influence the behaviour of the child, there is a need to educate the teachers regarding growth and development to identify the behavioural problems at an early age and interaction need to be developed between the teachers and parents.

• Faulty parent child relationships should be corrected by guidance and counselling and to promote positive mental health among children in order to prevent behavioural problems.
Utilization of self-help groups: Self-help groups are composed of people who are trying to cope with a specific problems. The members have the same disorders and share their experiences with one another and they help in overcoming maladaptive pattern of behaviour that traditional mental health professionals have not generally dealt with successfully.

Lay public opinion has to be taken into account of in mental health care planning to make the mental health service more acceptable to the consumer and their social network.

A mental health first aid training appears to be an effective method of improving mental health literacy.

Initiatives that increase knowledge and positive attitudes about mental illness among the general population may improve the extent to which individuals seek help for and disclose a mental illness.

Psychotherapy, occupational therapy, behavioural therapy and recreational activity units should be organized in the hospital so that idling is prevented and helps to develop positivity and to remove the negative feelings.

Separate counselling units with specialized counsellors should be established to enhance the quality of life and facilitates for behavioural modification at hospital level and community level.

Mortality among people with serious mental illness increased, there is an urgent need for utilization of effective psychiatric treatment modalities.

Awareness should be created regarding harmful effects of smoking, alcohol and other substance abuse through mass media in order to prevent mental illness.

Involvement of Non-Government Organizations: They can specially play an important role in change the attitude of people towards mental
illness and early identification of mental illness by conducting health education programmes through mass Medias like Posters, Radios, Televisions, News Papers, Film Shows etc. to develop awareness regarding causes, early signs and symptoms of behavioural problems and prevention of mental illness.

- The Government Organizations and Non-Government Organizations should coordinate with each other to promote mental health and prevention of mental illness.
- Community participation should be encouraged in identification of mental health programmes at an early stage by participate in decisions about their mental health care needs and other programmes.
- Strengthening families and communities for the care of mentally ill.
- Stress management: Relaxation techniques should be used in stress management. These techniques like yoga, meditation, massage, laughter therapy, music, dance therapies etc. need to be practiced to remove the negative feeling and to promote positive mental health.
- Qualified psychiatric nurses should be available for psychiatric units in General and District Hospitals to provide specialized quality of care to the patients.
- High priority needs to be given to increase the psychiatric manpower at the diploma, master’s, and doctorate levels.
- Essential psychotropic drugs should be provided and made available constantly at all levels of health care.
- A comparative study can be carried out between selected areas of rural and urban areas of Anantapuramu District.
- A comparative study may be carried out on social problems faced by family members of mentally ill in different states of our country.
- A comparative study can be conducted on effectiveness of National Health Programmes in different states of country.
• Experimental study can be done on knowledge and practices among family members of mentally ill.
• Prospective studies can be carried out to meet the challenges towards mentally ill such as change the attitude of people regarding causes, treatment, rehabilitation, impact of stigma and supportive systems.
• There is urgent need to carry out Epidemiological studies on mental illness and mental health services to identify the incidence of mental illness in Andhra Pradesh. These studies will provide information to policy makers to understand the severity of mental illness and strengths and defects existed in mental health services.
• Research should be focused on emerging problems like alcoholism, child mental health, geriatric mental health, adolescent health, urban health and behavioural factors studies.
• Analytical studies can be carried out to prevent the occurrence of mental disorders, this issue requires an urgent attention.