Chapter-6.

Findings, Conclusions and Recommendations

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

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

Findings:-

- Findings from the study that majority of the mentally ill person fall under young age group. 32% PWMIs a young group between 18-27 years of age that were mentally ill. In overall 80% of the mentally ill person from the 18 to 47 year age group has higher prevalence of mental illness. This young adult age group is a productive age group and they faced lot of stress in most of the roles and responsibilities.

- A very large number that is 52% of the mentally ill respondents are illiterate. Their illness could possibly be one of the causes for them not being able to perceive education. This also suggests that one of their basic fundamental rights has been infringed due to their illness. Findings from the study shows that a very large numbers (35.3%) of the mentally ill respondents are illiterate those having server mental illness. Their illness could possibly one of the causes for them not being able to perceive education. It also states since the p-value is more than 0.05% , the null hypothesis is accepted because there is no enough evidence to prove against the null hypothesis (Pearson chi-square =106.0543, df=3, No. of valid cases = 150, Contingency Coefficient = 0.644, P>0.05).
PWMI based on categories of illness and education shows that the majority of identified PWMI (in all the types of illness) were illiterate. Identified PWMI with higher education were in small percentage. Here again the focus is on the vulnerable section of the people with little or no education. Education has strongly correlated with poverty. Education is an important determinant of present and future life opportunities which promote mental health in later life. In any case it is important to realize that the socioeconomic variables beloved by epidemiologists might have different meanings and significance in different societies.

The study shows that Out of the identified people majority are in the age group of 18 to 47. The prevalence of mental illness in the program area seems to be quite high during the most productive years of life, i.e., between 18 to 47 years. Overall it seems that severe mental illness is higher in the age group of 18 to 27 year age than any other age group over 18. Both the variables do not significantly affect each other’s degrees of change. At any age people are likely to having mental illnesses. Chi-square tests: Pearson’s Chi-square = 1.95, df=4, no of valid cases = 150. P>0.05. The test reveal that since the p-value is more than 0.05 Thus from these findings it can be inferred that age and mental illnesses do not have a significant relationship and so the null hypothesis is accepted.

With this p-value (Pearson chi-square = 0.649, df=1, No. of valid cases = 150, Contingency Coefficient = 0.518, P>0.05). It is evident that there is no significance between the two variables and so null hypothesis of no difference is rejected and the alternate hypothesis is accepted which states that women do have greater rates of prevalence of mental disorders. In this study overall in both the mental health conditions were men percentage is higher than women due to unavailability of equal number of male and female respondent. But most of the studies show that the common mental disorders were higher number in women than in men. Here this difference came due to cultural context and gender difference ruling out in the society were usually women hide their illness in the family but more caring for men. Therefore the basic difference we can see in the identification also (89 male & 61 female). There is a gender gap for mental illness with females being up to 40.7 percent more likely to develop some type of mental health condition than their male counterparts. A new study to be published by Oxford University Press finds that women are nearly 75 percent more likely than men to have suffered from depression.
In all 44.7% were males and 55.3% females were in caregiver’s role. From the able findings we can infer that women outnumber men in providing care to mentally ill person irrespective of their gender, women have always played a major role in the family as a care provider in general also. (Pearson chi-square = 1.327, df=4, No. of valid cases = 150 Contingency Coefficient= .094, P>0.05). The null hypothesis is rejected as there is a difference between caregiving by a male and female family member.

Findings from the study infer that women are 74% (mother, sister and wife) who are caregivers. Thus women play an important role in caring of the person with mental illness. But most is shown un-productive services where as they contribute productively indirectly. 51% are mothers who are caregivers, 19.3% are fathers, 2% are brothers, 4.7% are sisters, 18% are wives and 4.7% are husbands. Tests show (Pearson chi-square = 17.275, df= 20, No. of valid cases = 150 Contingency Coefficient= .321, P>0.05) There is no significant evidence to accept the null hypothesis and hence it is rejected.

The higher percentage of unmarried men suffers from common mental illness 14.6% and 16.7% severe mental illness in comparison with unmarried women (6.3% and 11.8%). The data on PWMI according to sex and marital status show that a higher percentage of married men were with mental illness, it is not merely the stresses of family responsibilities that marriage brings to men.

Daily wage earners work in agricultural fields, construction work, carpentry, weaving and NREGA. The study shows that a total of 20 (13.3%) persons (women and men) are not involved in any productive work. It was observed that the PWMI who were in the symptomatic state, had poor family support, little or no enthusiasm of the community to integrate the individual, stigma and hence were unemployed.

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

66.7% families have only one earning members in the family because even if there is another adult in the family s/he would have to stay back at home to look after the mentally ill person. (Pearson chi-square = 6.770, df= 6, No. of valid cases = 150 Contingency Coefficient= .518, P>0.05). There is no enough evidence to accept the
null hypothesis and so null hypothesis is rejected with no significance between the variables.

- 30% of the PWMIs which is the higher number among the total number of PWMIs full under the income group 20001 to 30000 annually. Findings with (Pearson chi-square =2.575, df=4, No. of valid cases = 150, Contingency Coefficient = 0.130, P>0.05), we can infer that there is no significant relationship between both the variables and the null hypothesis is rejected.

- There is a significant relationship between income and type of occupation of caregivers. Most of (30.7%) the respondents’ are in the category of 10,001-20,000 and are agricultural labour who earns a meagre income 39.3%. Mental illness which is chronic deteriorates the economic condition of caregivers. From the findings we can infer that there is a significant relationship between income and type of occupation with these test results (Pearson chi-square = 54.984, df=15, No. of valid cases = 150 Contingency Coefficient=.518, P<0.05). Null hypothesis is accepted.

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

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

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

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

- The highest number of (37.7%) PWMIs who have received treatment from a psychiatrist after which they feel quite better improvement in their condition. (Pearson chi-square =227.027, df=9, No. of valid cases = 150, Contingency Coefficient = 0.776, P>0.05).There is no significant relationship. The alternate hypothesis is accepted.
22.7% get better due to medicines, 7% due to proper guidance and counselling for effective treatments. 57.6% PWMI feel that both medicine and counselling have been effective in treatments of the mentally ill person.

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

Counselling and pharmacotherapy both are important methods for treatment of severe and common mental ill. Even though 22.7% PWMI feel that the medication is the best methods for recovery from mental illness, this is true in case of severe mental disorder they first need medication and then the counselling or psychosocial intervention. In case of CMD they can be treated with counselling and psychosocial interventions.

Almost 78.7% people with mental illness with SMD and CMD access treatment from faith healer, spiritual healer, darga and temple, religious or holy person. It also shows that cultural beliefs are stronger and still exist in the society especially in the tribal communities. (Pearson chi-square = 3.842, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.158, P<0.05). There is significant difference to nullify the hypothesis.

There is a significant relationship between religious treatment and its impact. The more the people access religious treatment the lesser the impact. 67% person with mental illness said that they don’t see any positive impact on the treatment from religious treatment which includes faith healers, spiritual healer’s darga/temple and religious or holy person.

It is evident from the study that most (63.3%) of the people who are mentally ill believe that spiritual healers are the best source of treatment and prefer to go to them in the initial phase and most (38%)of the spiritual healer gives herbal powder in the treatment. Ignorance about these illness lead people to such beliefs. There is a great need to generate awareness amongst the masses, if people have to access proper treatment for mental illnesses.

Finding from the study state that 74.7% PWMIs feel that spiritual healer’s treatment is not useful for them therefore they haven’t prefer the kind of treatment provided by spiritual healers. Depicts a significant relationship and with no effect or difference between the means and thus reject the null hypothesis (Pearson chi-square =52.268,
df=2, No. of valid cases = 150, Contingency Coefficient = 0.508, P<0.05) the 74.7% of PWMIs opine that a psychiatrist treatment is bring better improvement in their life.

- 40.7% PWMIs took treatment from spiritual healer who is located outside the village. It shows that due to stigma attached with mental illness people prefer to take treatment from outside the village.
- The findings from draw from the study that the 74.7% of PWMIs opine that a psychiatrist treatment is bring better improvement in their life. It also shows that people with mental illnesses and the community where CMHD program implemented have become more literate about their mental illness. 25.3% of PWMIs stated that they have taken treatment from spiritual healer which they feel very less resulted in their daily life. In the tribal community spiritual healer has a key role in the all rituals therefore if anything happen they have to go to the spiritual healer first. Even the other side of the reality there were no psychiatric services available nearby and the health services are inadequate.
- Findings from the study shows that mostly (12%) equal number of PWMIs took treatment from faith healers, general practitioners, psychiatrist, home remedies or both either of the treatment in the initial phase of the illness and 50% CHW advise them to take the treatment it shows that community health worker is the person how has community recognition and plays essential role in the life of PWMIs as well as in the community. (Pearson chi-square =247.681, df=20, No. of valid cases = 150, Contingency Coefficient = 0.789, P>0.05). The hypothesis is accepted as there is no significant difference to reject the null hypothesis.
- Most of the 62% people stated that stressful life events are the main caused for mental illness. Day to day stressful life events were play a major role in the life of human being and that stressful life events may lead towards mental illness. Also 13.3% people don’t know the cause of mental illness and 12.7% people feel that mental illness caused by evil spirit. (Pearson chi-square =2.812, df=3, No. of valid cases = 150, Contingency Coefficient = 0.136, P<0.05). There is significant difference between the means of variables and thus the null hypothesis is rejected.
- According to the PWMI most of the people feel that they don’t understand anything (50%) due to their mental illness. 38% people feel that PWMI will never improve. It shows that most of the people still have miss understanding about mentally ill person as well as mental illnesses.
The severe mentally ill people become stabilized (26%) within one and two years form the treatment in Basic Needs program. In the common mental disorder very few people (8.7%) takes almost 3 to 4 years to reduce symptoms because they haven’t take regular treatment therefore it takes a longer time to become stable. Evidence shows that in the case of CMD symptoms reduce within 6 month or maximum period will take 2 years depend on the person and year of illness. Over all 38.7% PWMI become stabled within 6 month of regular treatment. 36% PWMI become stabled within 1-2 year of treatment and 25.3% PWMI become stable within 3-4 year of treatment. (Pearson chi-square =.692, df=2, No. of valid cases = 150, Contingency Coefficient = .068, P<0.05). There is significant difference and the null hypothesis can be rejected.

Overall 74.7% of PWMIs were taken treatment up to 2 to 4 year and the same percentage of PWMIs reach in the stage of stabilization within 2 years of regular psychotropic treatment as well as psychosocial treatment from the community health worker and caregivers. Pharmacological, psychosocial treatment and support of CHW and caregivers is very necessary to bring changes in the lives of PWMIs. (Pearson chi-square =150.000, df=2, No. of valid cases = 150, Contingency Coefficient = 0.707, P>0.05). There is significant relationship and the null hypothesis is rejected which shows that PWMIs with severe mental illnesses take a longer period of time to stabilize.

Most of the people prefer taking treatment from outside the village because of they take treatment in the village that will embarrassing them due to stigma. 63% people first approach to the spiritual healers it shows that mental illness still today people believe that mental illness is caused by evil spirit. People not seen mental illness is illness like other physical illness.

From these findings we can infer that community health workers have played a major role in motivating patients to access proper treatments for dealing with mental illnesses. Which shows that the highest number (50%) of CHW advice to take treatment for mental health problem.

From findings it can be inferred that a large number (87.3%) of person diagnosed with mental illness faced discrimination in their lives due to stigma, misconceptions and illiteracy i.e. lack of awareness about treatment of mental illnesses. The available evidence suggests that persons with mental illness still struggle on a daily basis to access appropriate health care or be treated with respect or dignity when they do enter our health care systems.
- A majority (74.7%) of mentally ill patients has taken treatment of psychiatrist, this is basically due to the community mental health program being implemented by BNI in these tribal areas where these psychiatric services made available on a monthly basis.

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

- 76% people opined that they villagers know about their illness amongst that 26.7% from common mental disorder and 49.3% from severe mental disorder. This evidence clearly shows that severe mental disorders cannot be hiding from the community. This evidence clearly shows that severe mental disorders cannot be hidden from the community. (Pearson chi-square = 2.081, df=1, No. of valid cases = 150, Contingency Coefficient = .117, P<0.05) From the above table we can infer that there is no significant relationship between these above two variables and as severe mental illness cannot be hidden, so the number of people aware about the illness would be more.

- From the study findings we can infer that stress is the major factor that can lead to mental illness as 62% opined the cause of mental illness is due to stress in the life. There is a significant relationship and so the hypothesis could be nullified with these stated values/results (Pearson chi-square =1.201, df=3, No. of valid cases = 150, Contingency Coefficient = .089, P<0.05). The cross tabulation shows that 12% patents attribute their illness once to evil spirit and so either pray to god, take herbal powder or use a locket type called ‘Tabij’ as being treated.

- 38.7% started working within 6 months of treatment of 25.4% started small work with the help of others. 6% started earning their livelihoods within 1-2year of treatment and 25.3% between 3-4 years of treatment. From these finding we can infer that there is a significant relationship between being stabilized and efforts made to earn a living. The lesser the time taken to stabilize the sooner the person can start earning.

- Out of the total caregivers respondents 55.3% females caregivers are involved in the caring of PWMIs as a caregivers which is highest in number than the males. Most of the studies emphasis on that more number of women in the role of caregiver apart from their daily routing works.

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

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

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

- Mental illness impacted more on male rather than female in terms of self-impact. In terms of impact of mental illness on both, self as well as family member there is not much difference (20% males and 18% females) found amongst males and females.

- Mental illness whether common mental disorder or severe mental disorders severely (cumulatively 87.3%) impacted on the family in terms of family become financially weak, increased stressor factors. 12.7% felt that mental illness has negative impact on personal and social relationship.

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

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

- Person with mental illness felt 28% of impacts of fear on his/her work and 16.7 of impact on finding spouse for marriage as well as same percentage of person with mental illness felt that impact of fear on their social inclusion in the community. (Pearson chi-square = 4.488, df= 5, No. of valid cases = 150, Contingency Coefficient = 0.170, P<0.05). The stated p-value suggests the significance of the null hypothesis which shows that fear impacts both male and females differently on various aspects of their lives.

- Person with mental illness felt 28% of impacts of fear on their work amongst that 18% are male and 10% are females and 16.7 of impact on social inclusion in the community amongst that 8% are male and 8.7% are females it shows that social inclusion in the community for female is difficult than the man who has mental illness. The highest number (32.7%) of person with mental illness are engaged in agricultural work amongst that 20% SMD and 12.7% CMD. 23.3% PWMIs engaged in labour work amongst that 15.3% SMD and 8% CMD. (Pearson chi-square = 3.550, df= 4, No. of valid cases = 150, Contingency Coefficient = 0.152, P<0.05). There is significant relationship with p-value less than the significance level of 0.05.

- Research has shown that, even when good programs offer good services, they may be slow to adopt emerging and evidence based practices related to employment and often focuses on more immediate clinical goals at the expense of recovery and rehabilitation related outcomes

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

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

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

- 40.7% females were participated in the community meetings under the CMHD program. 59.3% males participated in the community meeting. 75.3% male and female both are participated two-three times in the community meetings and 24.7% male and female participated more than three times in the community meetings. (Pearson chi-square = 0.567, df= 1, No. of valid cases = 150, Contingency Coefficient = 0.061, P<0.05). It is evident from the stated p-value that women are more participatory. Its shows that most of the people from the community well accommodate in the various activities of the program and they were voluntarily participated in the awareness meetings more number of times.

- The findings from the study shows that out of the total identified 75.3% PWMIs were participated two- three times in the community meetings and 24.7% PWMIs participated more than three times in the community meetings. The participation of people with mental illness in community and social activities was comparably more therefore they feel the CMHD program is useful for them in many aspects and specifically increasing community support. The findings from the study with significance in the p-value shows that out of the total identified 75.3% PWMIs were participated two- three times in the community meetings and 24.7% PWMIs participated more than three times in the community meetings. (Pearson chi-square = 2.485, df= 3, No. of valid cases = 150, Contingency Coefficient = 0.128, P<0.05) The participation of people with mental illness in community and social activities was comparably more therefore they feel the CMHD program is useful for them in many aspects and specifically increasing community support.

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

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

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

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

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

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

- The young adult age group is a productive age group who has higher prevalence of mental illness; therefore it is highly recommended that all the mental health program should be address the psychological needs of these age groups.
- The CMH&D program study findings show that the approach is developmental and that the program is also gender-sensitive. These are fundamental strengths of the program and it should be ensured that these strengths are kept alive in future programs as well.
- It is highly recommended that CMHD program should focused on vulnerable population in the community like…unemployment, illiterate, dalits, tribal, marginalized communities, farmers who have debt …etc.
- Women played a major role in the family as a care provider but their productive contribution not accounted as like domestic work therefore it suggest that identify the needs of women care providers and appropriate support system should be develop to address their needs with gender sensitive manner.
- Strengthen the concern for the mental health of women and girls who bear a disproportionate responsibility for care-giving despite being disadvantaged by gender bias and access to educational and income producing opportunities. Keeping mothers of young children mentally healthy and physically safe is perhaps one of the single most powerful interventions to reduce mental illness and to increase resilience. Simultaneously, it is important to address the psychosocial and health needs of older persons who are also often in care-giving roles.
- It is also recommended that caregivers group should be treat one of the main pillar in the treatment of mentally ill person therefore their involvement in the treatment process helps PWMI to recover fast from the illness.
- It is important to promote case management services for the continuity of care for PWMI in reducing chronicity of illness and caregivers who experience tremendous levels of burden.

- It is recommended the component of ‘livelihood’ activities especially through developing occupational skills and becoming active members of SHGs be strengthened through analysis of already existing information from the program experience, gaining insights and putting these insights into the program planning. The livelihood component needs to look as a treatment part rather than economical part.

- Finding from the study shows that SMDs need long term treatment than the CMDs therefore it is suggested that continue and long term treatment facility should be made available to the people suffering from severe mental illness.

- In the initial stage of mental illness most of the people taken treatment from faith healers, general practitioners therefore it suggest that faith healers and general practitioners should be involved in the mental health program as a main community stakeholder at the community level and build their capacity to deliver psychosocial intervention in the patient friendly manner. First level of treatment they can provide like mental health first aid or psychosocial treatment. In the server mental illness they will refer the patient to psychiatrist.

- It was found that program included both persons with severe mental illnesses (such as schizophrenia, psychosis and bipolar affective disorder) and also persons with minor mental disorders (such as anxiety and depression). Formation of a program environment that brings in all those who need the services within their own familiar area of living is crucial for the success of the program. This is again a basic principle of the program that was in focus and this needs attention in all the future programs as well.

- It is also suggested that the mobile psychiatrist services will be helpful in the remote rural and tribal areas.

- ‘Mental illness is treatable’ this massage needs to spread widely in the community through mental health education in both the stream of education that is informal and formal education.

- It is highly recommended that Counselling and medicines are the most effective treatment in the mental illness. Only psychotropic drug not solved the purpose. Therefore both should be promoted and more emphasized on counselling treatment.
• It is highly recommended that government mental health units should recruit community health workers that provide an environment equivalent to that provided by the "traditional healers".

• It is highly recommended that mental health should be integrated with other aspects in the health field at the level of planning to avoid its neglect in planning.

• It is highly recommended that drugs for mentally ill patients should be made available free of charge or at subsidized prices by government as it is done for drugs of TB or HIV/AIDS.

• Psycho social issues and needs of caregiver and their PWMI have vast scope for research. The results of which would help researchers in sensitizing policy planners, media and the public for legislating and advocacy of services.

• Recovered people with mental illness and their caregivers should be consulted by at least few members of the Annual Planning Committee of the Health Directorate to plan related services.

• All people with mental disorders have the right to receive high quality treatment and care delivered through responsive health care services. They should be protected against any form of inhuman treatment and discrimination.

• Psychiatric services should be made available and decentralized in the Rural and Tribal Public Health System-sub taluka, divisional hospitals, District hospitals, Sub-health centers and secondary and tertiary hospitals.

• Working intensely with partner organizations has been a valuable experience. In this specific experience so far, it was mainly working with Community Based Organizations (CBO) with CBR focus for cross-disability. It is recommended that organizations in the fields of disability, health and development interested in including mental health component in their existing programs.

• Free psychiatric medicines should be provided in the above centers as per WHO norms. (According to the Health Directorate there are supposedly 17 types of medicines available, but only 6 to 7 types of medicines are actually supplied.)

• It's tough enough managing a severe mental illness. So things to do to help maintain stability- good regular sleep patterns and eating healthy scheduled meals will go a long way. If you take medication, take it at the times prescribed by your doctor and mental health professionals recommended staying away from alcohol and drugs, don't make hasty life changing decisions like suddenly quitting your job, moving away from family or friends, or buying something you always wanted but can't afford.
Caregiver burden and burnout are important, prevalent and preventable. Social workers aware of the symptoms and signs can better assess, identify, prevent and intervene in these situations. Such efforts result in improved quality of life for both patients and Caregivers.

Early intervention could result in reduction in morbidity and better quality of life for the patients and their families.

Treatment is focused primarily on the management of symptoms with drugs. Rehabilitation and psychosocial intervention are frequently neglected and rarely available in the rural and tribal area therefore government should fully adopt community mental health and development model and ensure the effective implementation of it.

Caregivers with PWMIs are encouraged not to isolate them because this act encourages the community to do likewise. Instead, they should handle them as other members of the family.

Community members should be encouraged to handle PWMIs as fully human beings because this gesture contributes to the gradual healing process of these people. PWMIs, then, attend and participate in community events. This role could be served by civil society organizations operating at the community level in the mental health field.

In rural and tribal settings stigmatization comes from differences in tribe and culture and therefore there is a need to use forums that unite people to bring messages of PWMIs, for example, worshipping communities and local councils.

The effort of training volunteers at the local level in mental health education needs strengthening so that they help people at this level to understand issues related with PWMIs.

Government needs to put in place a law to protect PWMIs so that those families or community members who mishandle them are dealt with consequently. This law should criminalize those acts which dehumanize PWMIs. The law should also recognize the roles and responsibilities of different stakeholders in the management of mental health.

PWMIs are fully respected as human beings. They are involved in the decisions that affect their health and life; consultations with attendants are made about the treatment of their patients and are involved in productive activities. These best practices need to be scaled up and taken on by whoever is involved in the mental health field.
There is a need to always organize meetings that bring together members of the community and PWMIs to share experiences. Such meetings can be organized by the users associations or volunteers trained for that purpose.

All medical officers should be trained on mental health / illness and inpatient services should be made available at all district hospitals.

Patient-friendly environment needed at the hospitals where psychiatric services provided.

The long-term mentally ill should be made the highest priority in public mental health and a comprehensive system of care that recognizes their heterogeneity needs to be established.

Regularity in undergoing treatment on the part of the PWMI with severe mental illness leading to stabilization, monitoring side-effects of medicines, relapse of symptoms, following-up with necessary action to keep these adverse effects minimal were considered the effects of a strong capacity building input in CMH&D program especially for care-givers, field personnel and the community groups. It is recommended that a resource team in training stake holders and partner organizations should form the core of BNI as training at different levels visualized and implemented in the current program have contributed to the success of the program.

It is also recommended that training materials should be developed on the basis of the rich program experiences, in the form of Handbooks or Manuals for use with Senior Development Practitioners, field staff or grass root level workers.

It is recommended that necessary steps be taken to include tools for collection of basic data and information and also strengthen the skills of the staff in this regards.

It is also recommended that for enabling development of the required skill in documentation incorporating in training programs of the field-staff.

One of the most effective ways to positively affect attitudes is to deliver appropriate messages that will vibrate with target audiences, encourage the public to recognize, acknowledge and release their own problems or those of family members, and provide information that will help the audience to access help. These kinds of initiatives create greater acceptance for conditions and their treatments. One-on-one communication approaches will be effective in creating greater public understanding and reducing stigmatization.
Training programs are needed to raise awareness of the experience of mental illness, sensitize to stigmatizing behaviors, and provide direction to creating more accommodating environments.

The stigmatization of people with mental health problems are policies which are not supportive of recovery and which contribute to the resulting stigmatization. We need a supportive policy framework which ensures the provision of income support, housing, employment, court diversion programs and an accessible and comprehensive treatment system.

The community based services should emphasize on community acceptance, family involvement, and social integration and livelihood opportunities as a key component of interventions while rehabilitating people with mental disorders. Similar approach is required for PWMI for integrating them in to the community. An approach, where in medical inputs are seen as a part of a larger whole including income generation and mainstreaming individuals with mental health problems into the community.

There is a need to robust partnership between government, communities and civil society organizations in order to put in place a psycho-social support and conflict resolution systems that would address the causes of mental illness in rural and tribal area of Maharashtra.

The role played by some civil society organizations in Maharashtra in the mental health field needs to be further strengthened because they have been able to show that mental illness is a curable disease contrary to earlier beliefs.

Government needs further encouragement in its efforts to recruit mental health specialists at the local level so that they can handle mental health related issues.

Disability certificates should be provided for all eligible mentally ill and s/he should get an acknowledgement whenever an application is made.

Community mental health workers should be appointed based on the population of the area.

Police and judicial officials should be given orientation on mental health issues, services and related Acts.

Provide job opportunities for the recovered or stabilized mentally ill persons.

Policies and programs are needed which strengthen the ability of caregivers to effectively provide services and empower PWMIs, families and the communities.

More prominence on Social Action which is one of the least used Social Work methodologies, in practicum and field work training, is necessary in addressing social
issues and problems like human rights violation, stigma, lack of appropriate service, high costs of treatment modalities etc.

- Promoting and establishing Self-Help Groups (SHGs) and self-advocacy building measures, which in turn reduce dependency of Caregivers on the limited human resources resulting in greater empowerment of Caregivers.

- Emphasis and importance on Social Policy and Social Legislations at the course curriculum level, to address medico-legal issues, advocacy rights, benefits accruing from legislations, coordinating with judiciaries, participating in the policy making bodies, creating awareness in the lacunae in the existing laws and creating awareness for amendments for the same. Effective implementation of all legislative measures through caregiver forums.

- WHO (2008) in collaboration with the World Association of Family Doctors brought out a detailed document on how to integrate mental health into the PHC system. Governments make necessary changes in order to integrate mental health into the PHC system.

- The government, public sector, private sector, voluntary sector, families, committed individuals and affected persons need to come together as a broad federation on a common platform.

- Include mental health issues within social services development. Establish strong linkages between social services such as housing, health and mental health services.

- Mainstream mental health issues into education. Ensure that educational opportunities are both available and accessible, and that social barriers that might prevent children with mental and psychosocial disabilities from attending school are removed.

- Include people with mental health conditions in income generating programs. Employment programmes and other poverty alleviation initiatives such as small business grants and social security must reach out to people with mental health conditions.

- Strengthen human rights protections. Using the UN Convention on the Rights of Persons with Disabilities, highlights the need to develop and implement policies and laws that promote the rights of persons with mental and psychosocial disabilities, including the rights to autonomy, liberty, to exercise legal capacity and to live independently and be included in the community.

- Build the capacity to participate in public affairs. Promote and support the development of civil society groups for people with mental and psychosocial
disabilities and facilitate their participation in decision-making processes including policy, planning, legislation and service development.

- Government is playing a limited role in the mental health field and therefore it has always neglected mental health in the planning process. However, the recruitment of mental health specialists at the local health units by government has been acknowledged and should be supported.

- It is recommended that the ‘advocacy’ component should be further strengthened through building in strategies for advocacy with up-dated relevant information such as relevant legislations (Acts), UNCRPD and allocation of Government resources and orienting the partner organizations and primary stakeholders.

- It is also recommended to orient and network with departments like NRHM, DMHP, disability, revenue and judiciary etc...

- It is recommended that concerted efforts should be made in building and strengthening primary stakeholders, namely, PWMI, care-givers and cross-disability federations especially in terms of providing follow-up care, accessing social entitlements, advocate for their rights and linking them to relevant mass movements such as mass disability groups, health movements, tribal, dalit and women’s movements and concerned district and state level government departments and officials.

- It is recommended that BNI and other civil society organizations to take measures to inform funding agencies about CMH&D program experiences and underline the urgent need to include ‘mental health’ as one of the priority areas.