UNIT 2 MENTAL HEALTH, MENTAL DISORDERS AND MENTAL DISABILITY

Contents

2.0 OBJECTIVES

This unit aims to provide you with an understanding of the concept of mental health and psychiatric disorder. At the end of the unit you should be able to:

- explain the meaning of mental health;
- understand the various psychiatric disorder;
- explain the legislations related to mental health;
- indicate the various steps involved in mental health care i.e.– rehabilitation, promotion and prevention; and
- the role of psychiatric social worker.

2.1 INTRODUCTION

Majority of psychologists and social workers have agreed that "complete maturity" terms may be used as mental health. Physical, sexual, and intellectual maturity is achieved generally around the chronological age of 20 years. It is also well known that after this age, much changes are not observed in these areas as far as growth is concerned. But attaining maturity in physical, sexual and intellectual areas only is not the complete maturity. Besides these areas, the inclusion of emotional, social and role understanding are of utmost importance, which together could be considered complete or comprehensive maturity or mental health.

2.2 MENTAL HEALTH

Definition of Mental Health

Psychologist, social workers and psychiatrist have defined mental health in different ways. H.B. English, a Psychologist defined as "mental health is a

relatively enduring state wherein the person is well adjusted, has a zest for living, and is attaining self-actualization or self-realization; it is a positive state and not mere absence of mental disorder". Karl Merringer, a Psychiatrist says that "let us define mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment – or the grace of obeying the rules of the game cheerfully, it is all of these together. It is the ability to maintain an ever temper, an alert intelligence, socially considerate behaviour, and a happy disposition. This, I think, is a healthy mind". W.W Boehm, a social worker defined as " Mental Health is a condition and level of social functioning which is socially acceptable and personally satisfying". In general, such definitions emphasize both the individual and the social setting in which he functions.

However finally we can define mental health as "the optimal development and functioning of the individual consistent with the long-term well being and progress of the group". This definition implies the development of adequate, integrated persons who have sound attitudes and values and high degree of stress tolerance (Coleman-1964).

Characteristic of a Mentally Healthy Person

There are three main characteristics of a mentally healthy person:

1) He feels comfortable about himself, that is, he feels reasonably secure and adequate. He neither underestimates nor overestimates his own ability. He accepts his shortcomings. He has self-respect
2) He is aware of his rights towards others. This means that he is interested in others. He develops friendship that is satisfying and lasting. He considers himself a part of a group without being submerged by it. He has the ability to trust others. He takes responsibility for his neighbours and his fellow-men.
3) A mentally healthy person is able to meet the demands of life. He reacts to the problems as they arise. He is able to think for himself and takes his own decisions. He sets reasonable goals for himself. He shoulders his daily responsibilities. He is not bowled over by his own emotions of fear, anger, love or guilt.

Check Your Progress I

Notes: a) Space is given below for your answer.
b) Check your answers with those given at the end of this unit.

1) Define mental health.

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2) Spell out any two characteristics of a mentally healthy person.

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2.3 MENTAL PSYCHIATRIC DISORDER

Mental disorder and mental deficiency may be observed on the basis of deviation from abnormality. It implies deviation from some clearly defined norms. Several criteria have been proposed to understand the abnormality because defining abnormal behaviour has proved to be a most difficult one. These criteria or norms are as under:

- Statistical norms
- Personal adjustment
- Personality integration
- Personal maturity and growth

Group Well-being and Progress

Deviation from normality may be identified on the basis of above norms, which are already discussed in one way or the other under the Unit 1.

Here, we will try to understand the mental disorder or abnormal behaviour on the basis of the social science approach.

A Tentative Definition

The social science have not yet provided a sufficiently comprehensive and integrated picture of man's nature and behaviour to allow us to see just what a "model" man would be like. Most of the social scientists would agree that normal behaviour will represent the "optimal development and functioning of the individual consistent with the long-term well-being and progress of the group." Such a norm includes the concept adjustment, integration, maturity, fulfillment, and social well-being. From this point of view abnormal behaviour encompasses a wide range of maladjustive reaction–including alcoholism, unethical business practices, juvenile delinquency, racial discrimination, psychoneurosis, psychoses, drug-addition, peptic ulcers and sexual deviations. All are indicative of some sort of biological, psychological or social maladjustment which impairs the functioning of the individual and /or the well-being and progress of the group. The simplest way to conceptualize a mental disorder is as a disturbance of :

i) Cognition (i.e. thought), or

ii) Conation (i.e. action) or

iii) Affect (i.e. feeling) or any disequilibria between the three.

Another way to define a mental disorder is as a clinically significant psychological or behavioural syndrome that causes significant distress (Subjective symptomatology) or loss of freedom, and which is not merely a socially deviant behaviour or an expected response to a stressful life event (e.g. loss of a loved one). Conflicts between society and the individual are not mental disorders. A mental disorder should be a manifestation of behavioural psychological, and/or biological dysfunction in that person (Definition modified after-DSM-IV).

Classification of Mental Disorders

Psychiatry is a fast growing branch of medicine, which has seen rapid changes in classification to keep up with a conglomeration of growing search data dealing with epidemiology, symptomatology, prognostic factors, treatment methods and new theories for causation of psychiatric disorders.

Although the first attempt to classify madness or mental illness can be traced back to Ayurveda, as indicated in Charak Sanhita - Bhoot Vigyan and Unmad, Plato (4th century BC) and Asclepiades (1st century BC) Classification in Psychiatry has come ever since.

There are two major classification in Psychiatry: (i) International Classification of Diseases (ICD-10th Revision 1999). It is WHO's classification for all diseases. Chapter 'F' classifies psychiatric disorders as Mental and Behavioural Disorders. (ii) The other classification is made by American Psychiatric Association as Diagnostic and Statistical Manual of Mental Disorders IV Edition Text Revision, 2000 (DSM-IV-TR-2000)

Mental and Behavioural Disorders (ICD-10; from F-00 to F-99)

1) **Organic (Symptomatic) Disorders and other Organic Mental Disorders:** This group includes mental and behavioural disorders due to demonstrable cerebral disorders either primary or brain pathology or secondary brain dysfunction due to systemic diseases.
2) **Psycho-active Substance Use Disorder:** This group includes mental and behavioural disorders due to the use of one or more Psycho-active Substances.
3) **Schizophrenia, Schizotypal and Delusional Disorders:** This group includes disorders characterized by prominent disturbances of thought, perception, affect and/or behaviour.
4) **Mood (Affective) Disorders:** This group includes mental and behavioural disorders characterized by a prominent disturbance of mood.
5) **Neurotic, Stress Related and Somatoform Disorders:** This group includes mental and behavioural disorders that are labeled as neurotic or psychoneurotic disorders, with an emphasis on psychological causations.
6) **Behavioural Syndromes Associated with Psychological Disturbances and Physical Factors:** This group includes mental and behavioural disorders that are called psychosomatic disorders. The term psychosomatic is no longer used because its use implies that the association between the psychological factors and physical disorder is etiological. Also it presumes that the psychological factors are not important in other medical illnesses and physical disorders.
7) **Disorder of Adult Personality and Behaviour:** This group includes mental and behavioural disorders that are the persistent expression of an individual's characteristic life-style and mode of relating to self and others.
8) **Mental Retardation:** The group include disorders with arrested or incomplete development of the intellectual abilities and adaptive behaviour, which may or may not be associated with other physical or mental disorder.
9) **Disorders of Psychological Development (Child Psychiatry):** This group includes mental and behavioural disorders with an onset during infancy or childhood and characterized by an impairment or delay in the development of functions that are strongly related to biological maturation of the central nervous system.
10) **Behavioural and Emotional Disorders with Onset usually Occurring in Childhood and Adolescence.**
11) **Unspecified Mental Disorder (Multi-Axial Classification):** Labeling

the patient with a diagnosis is not enough. This degrades the individual to just another case and does not direct attention to the whole individual.

This method helps in a more holistic assessment of an individual patient. Recently, ICD-10 has also brought out its own multi-axial classification version:

Cognition

For
normal
function an
equilibrium usually
maintained between
these three

Affect **Conation**

Check Your Progress II

Notes: a) Space is given below for your answer.
b) Check your answers with those given at the end of this unit.

1) Describe various traits of normal person.

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2.4 EXTENT OF THE PROBLEM IN THE INDIAN CONTEXT

India is the second largest country of the world. The mental health and prevalence of mental disorders is comparatively high as usual in any developing country.

The total population of the country is 1027 million as per the report of 2001. The World Health Organization indicated in its Atlas : Mental Health Resources in the world-2001 that prevalence of Psychiatric (mental) disorders is 5.8% (58/1000) of Indian population out of them 1% to 2% are severe mental illness. It is also highlighted that incidence is observed 35 per 1,00000 population. The Psychoneuroses and Psychosomatic disorders are traced 2 to 3% and Mental Retardation is 0.5 to 1.00% of all the children. Similarly 1% to 2% of all the children suffer from Psychotic Disorders.

It shows that about one fifth of the patients with physical ailment are also facing psychosocial and emotional problems of a degree taken into consideration for professional help by psychiatrists, social workers and psychologists, in out-patient or in-patient departments of government and private hospitals.

Manpower Available in India

The prevalence of mental illness as shown above is very high and a large number of population of mentally ill patients and organic patient with psychosocial

and emotional problems need much more number of qualified psychiatric nurses, physiotherapists, occupational therapist and other trained staff, as the objective of treatment of mental and organic patients is to provide them total health. There are 3500 qualified psychiatrists in India. It means there are only 0.3% psychiatrists to serve 10 million population as compared to 3.96% psychiatrists in the world to serve the same population.

According to WHO Atlas there are 5,03,900 doctors (1999) to serve the total population of the country. The large majority of Indian population is rural but most of the doctors/physicians and almost 100% of psychiatrists are with their head quarters in urban areas.

There is 0.1 clinical psychologists serving 10 million population and the same is the case regarding the psychiatric social workers. There are only 0.1 psychiatric social workers to serve 10 million Indian population as compared to 8.64 in the world for the same population. Similarly there are only 0.1 psychiatric nurse to serve 10 million population when 12.6 nurses are serving same population in the world. There are 7,37,000 nurses in India out of them only 800-900 are trained as psychiatric nurse.

There are 40 postgraduate centres for psychiatry in the country. Very few of the 140 medical colleges in India have a psychiatric departments.

There are only 200 seats for MD in Psychiatry and Diploma in Psychological Medicine against 13000 seats for doctors per year (1990).

Community Psychiatry

The community psychiatry movement has been hailed as the third psychiatric revolution. The first revolution was the age of enlightenment when mental illness was viewed as a result of sin and witch craft, the second revolution was the development of psychoanalysis, which offered hope for a causative explanation of mental disorders.

As a policy for the developing countries, World Health Organization recommended the delivery of mental health services through primary health care system in 1975.

Gerald Captain (1967) defined the basic model of community mental health, and emphasized on the following characteristics of community Psychiatry.

1) Responsibility to a population for mental health care.
2) Treatment close to a patient in community based center.
3) Provision of comprehensive services.
4) Multidisciplinary team approach.
5) Providing continuity of care
6) Emphasis on prevention as well as treatment
7) Avoidance of unnecessary hospitalization.

Check Your Progress III

Notes: a) Space is given below for your answer.
b) Check your answers with those given at the end of this unit.

1) Enumerate the characteristics of community psychiatry.

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2.5 EXISTING MENTAL HEALTH SERVICES IN INDIA

There are 48 Government mental hospitals in the country, which provide 19000 beds for mental patients. On the other hand there are around 3000 beds in private psychiatric hospital. There are around 5000 beds for mental patients in general hospital psychiatric units in the country.

Total health beds in India = 8,70,161 (as per report of 1994-1995). Thus there are 0.3 psychiatric bed in India for 10,000 population as compared to 4.36 psychiatric beds for 10,000 population in the world.

National Mental Health Programme and Policy

The Central Council of Health and Family Welfare (India) formed an expert group in 1980 which recommended about the implementation of National Mental Health Programme. The group submitted the report in August 1982. The National Mental Health Programme appeared almost simultaneously with the National Health Policy (1993). The objective of NMHP are as under:

1) To assure availability and accessibility of minimum mental health care for all in the foreseeable future particularly to the most vulnerable and under privileged sections of population.
2) To encourage application of mental health knowledge in general health care and in social development.
3) To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

The following three aims specified in the NMHP in planning mental health services for the country:

1) Prevention and treatment of mental and neurological disorders and their associated disabilities.
2) Use of mental health principles in total national development to improve quality of life.
3) Application of mental health principles in total national development to improve quality of life.

Two strategies, complimentary to each other, were planned for immediate action:

1) **Centre to periphery strategy:** Establishment in all district hospitals, with out-patient clinics and mobile teams reaching the population for mental health services.

2) **Periphery to centre strategy:** Training of an increasing number of different categories of health personal in basic mental health skills with primary emphasis towards the poor and the underprivileged, directly benefiting about 200 million people.

The mental health care service was envisaged to include three component or sub programmes: treatment, rehabilitation and prevention.

A) Treatment Sub-programme

1) **Multiple levels were planned. Village and subcentre level:** Multi-purpose works (MPW) and health supervisors (HS) under the supervision of medical officer (MO) to be trained for:
   i) management of psychiatric emergencies.
   ii) administration and supervision of maintenance treatment for chronic psychiatric disorders.
   iii) diagnosis and management of grandmal epilepsy, especially in children.
   iv) liaison with local school teacher and parents regarding mental retardation and behaviour problems in children.
   v) counselling in problem related to alcohol and drug abuse.
2) **Primary health centre (PHC):** Medical Officer aided by health supervisor to be trained for:
   i) supervision of multi-purpose works performance.
   ii) elementary diagnosis.
   iii) treatment of functional psychosis.
   iv) treatment of uncomplicated psychosocial problems.
   v) management of uncomplicated psychosocial problems.
   vi) epidemiological surveillance of mental morbidity.
3) **District hospital:** It was recognized that there should be at least one psychiatrist attached to every district hospital which should have 30-50 psychiatric beds. The psychiatrist in a district hospital was envisaged to devote only a part of his time in clinical care and greater part in training and supervision of specialist health workers.
4) **Mental hospital and teaching psychiatric units:** The major activities of these higher centre of psychiatric care include:
   i) Help in the care of difficult cases,
   ii) Teaching,
   iii) Specialized facilities like occupational therapy units, psychotherapy, counselling and behaviour therapy.

B) Rehabilitation Sub-programme

The components of this sub-programmes include maintenance treatment of epileptics and psychotics at the community levels and development of rehabilitation centers at both the district level and the higher referral centers.

C) Prevention Sub-programme

Prevention is to be community based with the initial focus on prevention and control of alcohol related problems. Later problems like addictions, juvenile delinquency and acute adjustment problems like suicidal attempts are to be

addressed. The other approaches designed to achieve the objective of the National Mental Health Programme are:

1) Integration of basic mental health care into general health services.
2) Mental health training of general medical doctors and para-medical health workers.

A number of activities were planned under action plan for implication of national mental health programmes in 7th Five Year Plan, like community mental health programmes in primary health care level in states and union territories; training of existing primary health centre personnel for mental health care delivery; development of a state level mental health advisory committee and state level programme officer, establishment of regional centres of community mental health care delivery; formation of National Advisory Group on mental health; development of task forces for mental hospitals and mental health education for undergraduate medical students; involvement of voluntary agencies in mental health care; identification of priority areas (child mental health, public mental health education and drug dependence); mental health training of at least one doctor at every district hospital during the next five years, establishment of a department of psychiatry in all medical colleges and strengthen the existing ones and provision of at least 3-4 essential psychotropic drug in adequate quantity at the primary health centre level. District mental health programe was started in 1995 as a component of national mental health programme.

At the same time the National Mental Health Programme draft proposal for the 10th Five Year Plan is also being prepared, with a plan to extend the District Mental Health Programme to 100 districts.

The WHR-2001 has made the following ten recommendations for action:

1) Provide treatment in primary care
2) Make psychiatric drug available
3) Give care in the community
4) Educate the public
5) Involve communities, families and consumers
6) Establish national policies, programmes and legislations
7) Develop human resources
8) Link with other sectors
9) Monitor community mental health
10) Support more research

Check Your Progress IV

1) What are the objectives of National Mental Health Policy?

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2.6 LEGISLATIONS RELATED TO MENTAL HEALTH

There are certain legal aspects and Act related to mental health, for example; admission of a mentally ill person in a mental hospital, crime committed by a mentally ill person, validity of marriage witness, will consents, right to vote, drug dependence etc.

Indian Lunacy Act, 1912

The Indian laws related to mental disorders were based on British Acts such as English Lunacy Act, 1890.

This act had 8 chapters. Chapter 1 defined a lunatic as "an indict or person of unsound mind". In chapter 3 five categories of admission methods were mentioned–voluntary, reception order with petition, reception order without petition, inquisition (Judicial), and as a criminal lunatic.

There was a board of visitors appointed by Government for admission of voluntary patients and their care, treatment and discharge (except in criminal cases.)

The Mental Health Act, 1987

The Mental Health Bill became the Mental Health Act-14 of 1987 on 22nd May 1987. It came in force by the orders of Government of India on April, 1993.

There are 10 chapters consisting of 98 sections. Chapter-I (Preliminary) deals with the various definitions. The Act uses the term mentally ill persons and defines it as a person who is in need of treatment by reason of any mental disorder other than mental retardation.

The term "mentally ill prisoner" is used instead of "criminal lunatic". The 'Psychiatric hospital' replaced the term 'mental hospital'.

Chapter-II provides establishment of Mental Health Authority to regulate and coordinate mental health services at centre and state levels.

Chapter-III lays down the guidelines for establishment and maintenance of psychiatric hospitals and nursing homes. There is a provision for a Licensing Authority who will process applications for licenses. The license has to be renewed every 5 years.

There is a provision for separate hospitals for:

I) (i) Those under the age of 16 years, (ii) those addicted to alcohol or other drugs which lead to behavioural changes, (iii) mentally ill prisoners, and (iv) any other prescribed class or category.

Chapter IV deals with the procedures of admission and detention in psychiatric hospitals or nursing homes. The following methods has been incorporated in this regard. (I) Voluntary admission (i) by patients request, if he is major, (ii) by the guardian, if he is minor.

II) Admission under special circumstance. This is an involuntary hospitalization when the mentally person does not or can not express his willingness for admission. Admission is made on the relative/friends request in writing and medical officer in charge of the hospital is satisfied. The duration of admission can not exceed 90 days.

III) Reception order on application

IV) Reception order without application on production of mentally ill persons (e.g. wandering, dangerous, ill-treated or neglected) before magistrate.

V) Admission as in-patient after judicial inquisition

VI) Admission as a mentally ill prisoner.

In addition the magistrate can order detention of an alleged mentally ill person for not more than 10 days pending report by medical officer.

Chapter V deals with the inspection, discharge, leave of absent and removal of mentally ill persons.

Chapter VI deals with the judicial inquisition regarding alleged mentally ill person possessing property custody of his person and management of his property.

In case the patient is observed by court, incapable of looking after himself and his property an order can be issued for the appointment of a guardian.

Chapter VII deals with the liability to meet the cost of maintenance of mentally ill persons detained in psychiatric hospital or nursing home.

Chapter VIII is aimed at the protection of the following human rights of mentally ill persons:

i) No mentally ill persons shall be subjected during treatment to any integrity or cruelty.

ii) No mentally ill persons under treatment shall be used for the purposes of research unless:

   a) Such research is of direct benefit to him

   b) A consent has been obtained in writing from the person or from the guardian.

iii) No letters or communications sent by or to a mentally ill person shall be intercepted, delayed or destroyed.

Chapter IX deals with the penalities and the procedure while chapter X provides for miscellaneous section.
In addition the state mental health Rules -1990 and the control Mental Health Authority Rules-1990 have also been passed by the Government of India on December 29, 1990.

Check Your Progress V

Notes: a) Space is given below for your answer.
b) Check your answers with those given at the end of this unit.

1) Write a short note on the existing legislations related to mental health in India:

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2.7 REHABILITATIONS, PREVENTION AND PROMOTION IN THE AREA OF MENTAL HEALTH

Rehabilitation

Prologue

There are a number of psychiatric patients suffering from various mental disorders who are unresponsive to our traditional chemical treatment and whose problems are elusive. Their dependency on family causes much burden. The family feels ashamed but helpless. The society abhors them by labeling and stigmatizing.

However the obvious and practical constraints in restoring the chronically mentally ill persons to their premorbid personality profile inside the clinical arena need not make us feel inadequate in offering our therapeutic endeavours. Instead we should look for an alternative strategy to combat the problem and lend our shoulders to share the burden of the families and society. The strategy is Psychatric Rehabilitation. Due to cartain reasons it rarely finds its real meaning in practice. The inputs are mostly human resources. These could be mobilised only through intellegent manipulation, skillful taping and dedicated work. The process often becomes a reality only when motivated team members of mental health discipline work together, drawing their personal differences for the sake of attaining common objectives which are conceived for our psychiatrically disabled patients. This has to be done in order to hand them over back to our society as its productive members. Thus enhancing their self-esteem and healing their broken egos (G. Gopalakrishnan, President, the World Association of Psychosocial Rehabilitation (Indian chapter).

Concept

The conservative concept of rehabilitation has conditioned our cognitive process to restricting it to concrete appliance and job assignment for the physical handicapped. Our clients with psychiatric disabilities are comparable with those with physical disabilities who are crippled with diseases and deformities. In addition, their potential is further hampered by amotivation, diminished social skills and dormant psychopathology.

Therefore, rehabilitation also refers to the process designed to help the handicapped individual making maximal use of their residual capacities and enable them to obtain optimal satisfaction and usefulness in terms of themselves, their families and their community. It strives to mantain dignity and self-respect in life which is as independent and self fulfilling as possible.

Process

The concept, the ideas, principles and theories surrounding psychiatric rehabilitation are put into practice by persons with unique skills through a special programme and system supports. The over all mission of psychiatric rehabilifation is to assist in the reintegration of the psychiatrically disabled into the community and to maintain the ability of the erstwhile psychiatrically disabled to continue functioning in the community. Rehabilitation goals are always linked with the environment and therapy aims at improving the client's skills generating the resources needed by them to function in special environment. All our efforts

should be directed to ensure that the disabled persons possess the physical, emotional and intellectual skills needed to live, learn and work in their own environment. Dr. G. Gopalkrishnan indicated two aspects addressed by the approach towards rehabilitation.

i) Develop particular skills in the clients which they need to function in their environments; and

ii) Develop the environmental resources needed to support and strengthen the clients present level of functioning.

These skills when integrated into a "Comprehensive Rehabilitation Programme" aiming at reinforcement and support for the use of these skills in the community, are bound to have significant impact on our patients' psychiatric rehabilitation outcome. It does required a professionally trained psychiatric social workers and occupational therapist capable of assessing, tapping and teaching the skills, that need to be taught as well as individualising the way in which the skill are taught.

Principles

The whole process of psychiatric rehabilitation should work around the set of principles as proposed by Anthony Cohen and Cohen (1982).

i) Client involvement is necessary in all phases of the rehabilitation process.

ii) Newly learned skill behaviours are usually situation specific.

iii) Each client must have individualized skill goals.

iv) The reduction of a client's personal and environmental discomfort does not automatically result in improved client skill.

v) The restrictiveness of an environment is a function of the characteristics of both the environment and the client.

vi) Increased client dependency can produce improved client functioning.

vii) Hope is an essential ingredient of the practice of rehabilitation.

Areas

The above discussion indicates that rehabilitation means restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable. It is the process of enabling an impaired person to renew old skills or to achieve new skills that will enable him to live in the general society to the greatest extent that his particular condition and circumstances will allow (Sharma 1986). The issue of psychosocial rehabilitation is much more complex than physical rehabilitation as psychosocial rehabilitation need a deep understanding of social milieu and culture in which psychosocial rehabilitation services are to be organised. The rehabilitation process needs different skills and expertise of psychiatric social worker with different handicapped at different social milieu. However, a team approach is a must.

Prevention

Prevention is very important aspect of total management of psychiatrically ill persons as well as the normal one. Our understanding of mental development, mental health, and of the effects of stress has increased far faster than it has been applied. Mental symptoms are still widespread and our knowledg is only beginning to be systematically disseminated. Frustration is increasing due to industrial development, urbanization, needs and ways of its fulfillment,

unrealistic goals of life, parental attitude and behaviour in bringing up their children, social and cultural changes, increase in demands of time, environmental hazards, feeling of independency and generation conflict in the family and community etc.

We have to follow the following principles to make our mind healthy for prevention from frustration, tension and mental deficiencies:

1) We try to keep our mind free from tensions, though it is not easy due to sociopsychological and environmental situations but an individual is required to avoid the reasons as much as he can.
2) If the situations creating tension are unavoidable the individual needs to seek help from a competent person to get free from such tensions and frustrations.
3) It is advisable to avoid complicated social situations by entertainments, games, outing, yoga and other such recreational activities.
4) There must be creative thoughts and useful ideas in mind. The individual is required to have certain positive activities to think over in mind; but it must be under self-control. The psychiatrist, social workers, psychologists and other members of psychiatric therapeutic team are given proper education and training for diagnosis, treatment, prevention and rehabilitation of psychiatrically ill persons; they have to play an important role in the prevention of psychiatric problems. They have to impart community health education programmes in the urban and rural areas. There is social stigma against the mental illness. The psychiatric social workers are expected to launch particular programmes to remove the stigma and the misconceptions widely accepted by the people that mental illness is a result of Witchcraft, Goddess effect or magic etc. such misconceptions must be removed by using certain methods of media. Similarly the mental health education must include the information and facts of mental disorders such as etiology, causes, place of treatment, available services etc. These methods will be very useful in the prevention of mental problems.

Promotion of Health

Health promotion is the "process of enabling people to increase control over, to improve health". It is not directed against any particular disease, but is intended to strengthen the host through a variety of approaches (intervention) the well known intervention in this area are:

i) Health Education

This is one of the most cost-effective intervention. A large number of diseases could be prevented with little echo medical intervention, if people were adequately informed about them. Our constitution states that "the extention to all people of the benefit of medical, psychological and related knowledge is essential to the fullest attainment of health". The targets for educational effects may include the general public, patients, priority groups, health providers, community leaders and decision-makers.

ii) Environmental Modifications

A comprehensive approach to mental health promotion requires environmental intervention etc. Environmental interventions are non-clinical and do not involve the physician.

iii) Nutritional Intervention

These comprise food improvement of vulnerable groups, child feeding programmes, food satisfaction, nutrition education, etc., the factors which are also good for mental health.

iv) Life-style and Behavioural Pattern

The conventional public health measures or intervention have not been successful in making life-style reforms. The action of prevention in this case, is one of individual and community responsibility for health, the physician and in fact each health worker acting as an educator than a therapists activity. It is of paramount importance in changing the views, behaviour and habits of people.

Since health promotion comprises a broad spectrum of activities, a well-conceived health promotion programme would first attempt to identify the "target-group" or sick-individual in a population. Goals must be defined near and alternative means of accomplishing them must be explored. It involves "organizational, political, social and economic interventions designed to facilitate environmental and behavioural adaptations that will improve or perfect health.

Role of Social Service in a Total Institutional Process (The Functions of Social Workers)

The community social worker is after all the lynch pin of community care. Worker may be the first person to contact the patient and family in distress and can then provide a range of services from intensive personal casework to practical advice on total treatment plan. The social worker has an important role to guiding the patient through the system of care. He can make a referral to a psychiatrist or draw the patient to the attention of the psychiatric practitioner.

The committee indicated the functions of social workers in relation to institutional process are given below:

1) Intake

The Social Worker:

i) interprets the hospital facilities and programmers to the patients and his family.

ii) helps the family with problems that arise from the patients admission.

iii) formulates plan which might reduce the urgency of hospitalization or prevent ill advise in admission.

iv) begins a relationships with the family which will facilitate their functions in treatment and foster hospital plan.

2) Reception

The process of helping the patient to accept his hospitalization and to make maximum use of the hospital therapeutic potential. In relation to this the social Worker :

i) participates in explanation of hospital procedure.

ii) explains to the patient his role in maintaining the patients family and communities.

3) Diagnosis

The process of analyzing the patient situation with a view to determining the

cause of his disorder. This involves the collection and analysis of physical, psychological and social data. The social worker obtains the social history which includes informations about the patient's past and present sound environment and his response rate. The history constantly reformulated is a product of a purposeful relationship with the patient, his family and other community resources and is responsible in treatment as well as diagnosis.

4) Treatment

The process of applying remedial matters to restore the patients to normal function. The psychiatrist may utilize the skill of psychiatric social work both with the direct work and with those significant in his life in an effort to strengthen the patients social relationship and to resolve environmental problem that are contributing in the mental disorder.

5) Preconvenience

The process of helping the patient to make general and specific depress for his release from the hospital. In relation to this, the social worker helps the patient with his possible ambivalence concerning release his future relationship with his family and with the community. Specifically he may help the patient to formulate plans for living arrangement, employment etc.

6) Family Care

This is the placement of patient with family other than their whole care and treatment. The social worker finds homes, interprets the patient's needs to the family, supervises the arrangements to maintain the standards of care and facilities to the patient's social adjustment.

7) Convalescent Care

The process of assisting the release of patient to make a satisfactory community adjustment.

Here the social worker would on an extra-mural basis continue to offer help with the same problems towards which pre-convalescent assistance was directed.

Check Your Progress VI

Notes: a) Space is given below for your answer.
b) Check your answers with those given at the end of this unit.

1) What are the major areas of rehabilitation required to rehabilitate the mental patients ?

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2.8 LET US SUM UP

In this unit we have discussed the concept of mental health. Psychologist defined as, "mental health is a relatively enduring state wherein the person is well adjusted, has a zest for living and is attaining self-actualization or self-

realization". We also had a brief look on the Mental-Psychiatric Disorder, Neurosis-mild mental disorder whereby a person is in contact with reality and his insight is intact.

Psychosis: Where a person is not in reality with contact and his insight is not intact.

We also had a brief look at the problem in India, which shows that about one-fifth of the patient with physical ailment are also facing psycho-social and emotional problems of a degree taken into consideration.

We tried to understand the existing mental health services in India. We also tried to understand the rehabilitation, prevention of mental illness and promotion of mental health. In addition to this the social work intervention in mental health care services i.e. intake, reception, diagnosis, treatment, preconvenience familiy care and convalescent care, were also dealt with.

2.9 KEY WORDS

Behavioural	:	Way of behaving or manner
Cognition	:	The mental processes
Affect	:	To have an effect on someone or something
Convalescent	:	Regain health after illness
Legislation	:	A group of laws, process of legislating
Adaptive	:	To charge something
Mental Health	:	Mental Health is the optimal development and functioning of the individual consisting with long-term well-being and progress of the group
Community Psychiatry	:	To make the community conscious and aware about the management of mentally ill person.

2.10 SUGGESTED READINGS

Tred Gold, Roger and Wolff, Heinz (1975), UCH Handbook of Psychiatry, Duckwoth.

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2.11 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress I

1) The optimal development and functioning of the individual consistent with the long-term being and progress of the group.

2) a) He feels comfortable about himself.
   b) He is able to meet the demands of life.

Check Your Progress II

1) a) A person is free from strain and conflict.
   b) He has the self identity.
   c) He is well adjusted to the society.
   d) The person who is mentally, emotionally and physically sound.

Check Your Progress III

1) a) Multidisciplinary team approach.
   b) Emphasis on prevention.
   c) Avoidence of unnecessary hospitalization.
   d) Treatment close to a patient in community based centre.

Check Your Progress IV

1) a) To assure availability of minimum health care for all.
   b) To encourage application of mental health knowledge in general health care and in social development.
   c) To promote community participation in the mental health service development.

Check Your Progress V

1) The Mental Health Bill became the Mental Act-14 of 1987. It came in force by the order of Government of India on April 1993. There are 10 chapters consisting of 98 sections. This defines the mentally ill person, their human rights, guidelines for psychiatric hospitals and nursing homes, procedure of admission, inspection, discharge and judicial inquisition.

Check Your Progress VI

The major areas of rehabilitation are:

1) a) Social rehabilitation
   b) Psychological rehabilitation
   c) Vocational rehabilitation.