Community Based Rehabilitation and People with Mental Illnesses

1. Introduction:

Through out the world people with mental illness are denied their basic human rights, especially the right to access treatment, rehabilitation and appropriate mental health care[1][2]. People with mental illness and their families experience discrimination and exclusion from economic and social activities. Due to stigma, people with mental illness and their families are often ridiculed and isolated, trapping them in a cycle of poverty. A lack of access to information about their rights and support to exercise these rights perpetuates and deepens this marginalization. People with disabilities also experience stigma, discrimination and social exclusion. However, the situation, in the case of people with disabilities has improved in many countries through CBR initiatives. Including people with mental illness having psychosocial disabilities[3] (in CBR programme seems an ideal answer to address the needs and rights of people with mental illness along with other people with disabilities.

Goal:

People with mental illness participating in society and having access to generic services as well as appropriate support they may need and which they consent to.

Purpose:

To enable development practitioners to include mental health issues in CBR programmes through increased understanding of people with mental illness, recognising psychosocial disabilities, appreciating the similarity in approaches, cost effectiveness and etc.

Outcomes:

By including people with mental illness in CBR programmes, the following outcomes can be achieved:

- People with mental illness advocate for their rights and entitlements as equal and full participants in the disability movement
- People with mental illness participate in their own development and the development of communities in which they live
- People with mental illness are listened to and are able to consent to or refuse treatment in circumstances that are not life-threatening.

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[1] UN Convention on the Rights of people with disabilities, New York UN 2006

[2] UN resolution 46/119, principles for protection of persons with mental illness and the improvement of mental health care (1991)

[3] Since psychiatric disorders manifest themselves in social context, disability due to them is generally termed as psychosocial disability

- People with mental illness have access to appropriate community-based treatment and support.
- Families of people with mental illness are provided with the support
- People with mental illness and families of people with mental illness are able to earn their livelihoods.
- Community health workers include mental health issues as an integral aspect of their work
- People with mental illness are able to access health care and educational services within and outside of the community
- People with mental illness participate in the social, cultural and religious life of their communities as they choose.
- People with mental illness fulfil their roles as community members, family members, parents and citizens

Key concepts

Understanding mental health:

Health is defined as a state of complete physical, mental, social and spiritual well-being and not only the absence of disease or infirmity by WHO[4]. Mental health is an essential part of general health. Mental health is broader than lack of mental disorders. Mental functioning has a physiological underpinning and is fundamentally interconnected with physical and social functioning, physical health is considerably influenced by mental health and well-being. Positive mental health is not merely the absence of illness, but also the capacity to be happy, to be able to deal satisfactory with given life situations and to be useful and creative. It is a state of mind that allows you to be comfortable with yourself, have a good quality of life, feel good about your relationships with others and meet the demand of every day life[5].

Mental health is as important as physical health to the overall well being of individuals, societies and the economy of the country. Mental health has been defined variously by scholars, how ever the concepts of mental health remains: subjective well-being, perceived capabilities, self determination, competence, interpersonal relations and self actualisation of one's intellectual and emotional potential.

Understanding mental illness:

Mental illness is not a personal failure, it happens to everybody at one time or the other in life. Mental illness is a group of disorders characterised by significant disturbances in thinking, emotions, and perceptions; resulting in long term or

[4] WHO official definition of health - http://www.medterms.com
[5] Manual of mental health care for women in custody, department of psychiatry, NIMHANS 1998

short term psychological and behavioural symptoms affecting the daily routine of the person and in certain cases lead to psychosocial disability[6].

Advances in behavioural science have proven that mental and behavioural disorders are treatable like any other physical illness[7]. World wide, there is an understanding that the interaction of biological, social and psychological factors can lead to behavioural and mental disorders. Unfortunately, in most countries mental health and disorders are low priority, with no services in the community for treatment and well-being.

Prevalence of mental illness

Mental, behavioural and social health problems are an increasing part of health problems in the world. The Who estimates that mental and behavioural disorders constitute 12% of the global burden of disease. Worldwide, nearly 450 million people have a mental or behavioural disorder[8].

Epidemiological studies reveal that 1 % of the population live with severe mental disorders while 10 – 15% lives with common mental disorders[9]. The number of people with mental illness will increase substantially in the coming decades for the following reasons. Firstly the number of people living in the age groups of risk for certain illness is increasing because of the changes in the demographic features. Thus there has been increase in the number of person with mental illness in the age group of 15- 45 years. Secondly, there has been substantial increase in the geriatric population having mental health problems, as the life expectancy is increasing. Thirdly, there is an overall increase in the rate of depression seen in all age groups as an effect of the changing socio- cultural-economic and political situation of the modern world[10],[11].

Burden of disease ? of illness?.

Though the burden resulting from psychiatric, psychosocial, and behavioral disorders is enormous; it is grossly under represented by conventional public health statistics. Nearly 10% of Disability Adjusted Life Years (DALYs) across all age groups are due to depressive disorders, suicides and alcohol related problems.[12] Depression ranks third among men and second among women, yet

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[6] Taly and Murali (2001) Foundations and Techniques in Psychiatric Rehabilitation, manual for CBR workers and caregivers, National Institute of mental health and Neuro sciences,
[7] World Health Report 2001, Mental health: New Understanding New Hope Geneva, WHO 2001
[8] World Health Report 2001, Mental health: New Understanding New Hope Geneva, WHO 2001
[9] Mental Health Atlas 2005, World Health Organization, Geneva - 2005
[10] Janardhan and Naidu (2007) Mental Health in India: an over view, CHC publication, circulated during national assembly on health of Janaarogya Andolona.
[11] Janardhan (2006), Community Mental Health and Development model evolved through consulting people with mental illness in Mental health by the people Edited by Murthy 2006.
[12]The Disability Adjusted Life Year or DALY is a health gap measure that extends the concept of potential years of life lost due to premature death to include equivalent years of healthy life lost by

mental health budgets of most of the countries are less than 1% of the total health expenditure[13].

One in four families is likely to have at least one member with a behavioural or mental disorders. These families not only provide physical and psychological support but also bear the stigma and discrimination associated with illness. It was estimated in 1990, mental and neurological disorders accounted for 10% of the total DALYs lost due to all diseases and injuries. This was 12% in the year 2000, by 2020 it is projected that the burden of mental disorders will be increased to 15%. According to the estimates from WHO, mental disorders will be among the leading cause of global disease burden by 2020, at which time, depression alone is expected to become the second highest cause of death and disability world wide[14].

Mr T is 40 year old and has been living with schizophrenia for 20 years. Unsuccessful treatment left him with violent behaviour. Unable to cope with his beatings, his aged parents migrated to a neighbouring village leaving Mr T alone. He survives at the mercy of villagers, who provide food whenever he ends up in their homes. Mr T's disabling condition led to not paying attention to his personal hygiene, a dislike of socialising with others. This isolated him from the mainstream society. Because of his psychosocial disability, the community discriminated against him and would not allow him to engage in productive work or in any income generation activity.

Mental health care and societal beliefs

Mental health care has always been influenced and determined by contemporary beliefs. Traditionally, mentally ill people in many countries were cared for in temples and other religious institutions, based on the belief that mental illness is a form of spiritual affliction and could thus be cured by religion. Superstition combined with inadequate mental health services in the community have left people with mental illness subject to various harmful treatments including black-magicians, village quacks and witches resulting in physical abuse in the name of treatment. Often times people with mental illness are kept outside the margin of the community: chained up, locked in back rooms, wandering in the streets, shut away in closed wards of asylums, hospitals, etc. In many countries mental health issues are not part of public health or rehabilitation programmes.

This example should go under the poverty and mental illness section

Mr C, who is 50, had suicidal tendencies. He tried to drown himself and to electrocute himself. Luckily, there was someone around and he was saved both the times. Mr C's

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virtue of being in states of poor health or disability. The DALY combines in one measure the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of 'healthy' life and the burden of disease as a measurement of the gap between current health and an ideal situation where every one lives in to old age, free of disase and disability.

[13] World Health Report 2001, Mental health: New Understanding New Hope Geneva, WHO 2001

[14] World Health Report 2001, Mental health: New Understanding New Hope Geneva, WHO 2001

family spent a lot of money for his hospitalization and medicines. He stopped eating, and does not talk to anyone. The family became poorer and poorer. Mr C's health status meant his family had to have someone by his side all the time. His wife worked day and night to make ends meet. Lakshmi, his daughter discontinued her studies so that she could care for her father.

Stigma and Discrimination

People with mental illness live with stigma which often results in the abuse of their human rights. This stigma often times includes isolation of the person's family as well.

Mrs K lives in a village ,in north India. She is middle aged and the mother of two children. Her husband is a rickshaw puller with meagre income. Mrs K developed depression because she and her husband were unable to sustain the family. Quite religious by nature, she believed that God would change the scenario one day. To support her belief she never missed attending the village temple. But days passed and her family became poorer leaving her more depressed and desperate. She started to stayin temple for hours and neglected her family. Unable to identify her illness and suspecting that she was practicing witchcraft and could harm the children in the village, the villagers threatened her husband. The husband was not able to halt his wife's religions fervour. The husband and other family members were continuously harassed. Ultimately, the villagers isolated the family, denying them access to all services and facilities of the village. The family was not even allowed to draw water from the village well.

The story above is not an isolated incident. It is the fate of many people with mental illness all over the world. Most people with mental illness live at home without any treatment because their families don't recognize the illness or they are embarrassed to be recognized as related to someone who is mentally ill (in many places commonly called 'mad'). The very thought of someone in the family getting mentally ill is a big shock and people do not want to believe it. Hence family members first go to temples, black magicians, witches and faith healers, wasting financial and other resources. Family members often fear they will be disgraced and will lose the status and acceptance they enjoy in the community. The stigma is so tremendous; people feel ashamed and deny the illness. Stigma is the first and foremost element that shrouds the realm of mental illness.

Due to stigma, people with mental illness become victims of discrimination and human rights abuse. The discrimination is seen from the family members and goes right up to the policy makers and state authorities. The general attitude of the public is that of apathy.

Discrimination manifests in many ugly, inhuman and humiliating forms:

- physical and sexual abuse
- harmful treatment such as chaining and locking up in rooms
- social isolation of both the individual and the family

- denial of property of rights
- legal separations
- women with mental illness bear the brunt
- family members not getting marriage alliance and isolated

MS S, a woman with mental illness, lives with her brother and sister-in-law. Her parents are no longer alive. The family lives in abject poverty and work as daily wage labourers in somebody else's agricultural field. They will have no food to eat if either the brother or his wife stay home to care for S. One day, to their shock and dismay, they discovered that S was pregnant. They later found out that she was sexually abused by a local doctor. Before the local NGOs could file a case against the doctor, he covered it up by giving some monetary compensation to the family and paying for an abortion.

Mr M, a brilliant student, failed in his 2nd pre university course. Since then, he started wandering in the forests and became so violent that his own siblings were scared of him. Because of his behaviour, the community suggested his parents throw him out of the house on to the streets. The family decided instead to lock him up in a room with manacles on his legs and hands. Mr M was left to do everything (eating, shitting, sleeping) in the room. His father used to carry the shit with his hands. The whole family was stigmatized. Their home was called the mad person's home. Nobody showed interest in fixing up an alliance with this family. The engagement of a family member was broken because of the stigma.

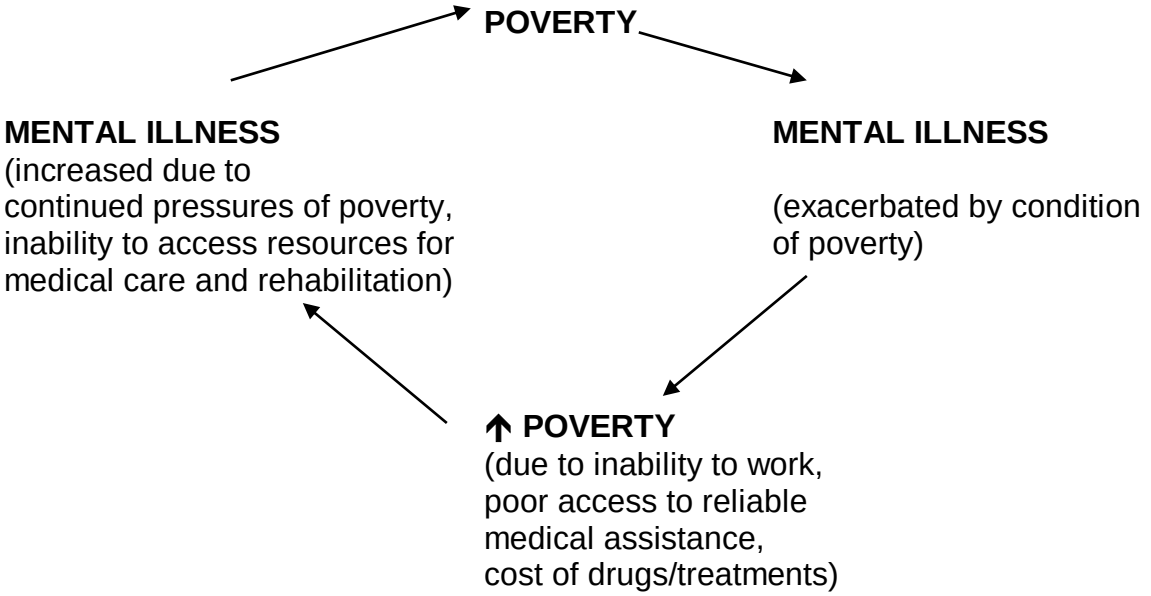
Mrs L aged 38 year old, married, developed mental illness, the husband left her believing that she brought ill luck to the family. Having no parents she became a destitute. Even the relatives disowned her. She was wandering in the streets, some times with out cloths on her. She suffered physical pain because of stone throwing by children. She was also sexually abused. She survives picking up eatables from the garbage.

People with mental illness are treated as second-class citizens with no adequate facilities or provision from the government. As a result, they face chronic ill health and the families experience economic and social burdens. In certain cases this leads to social destitution.

Poverty and mental illness

Poor people with mental illness are not only vulnerable due to their condition, but also vulnerable because they are poor. Poverty can be both a consequence and to some extent a cause of their condition. One of the main reasons that people find it hard to accept others with mental illness as equal members of their communities is that they do not see them as capable of contributing to the household or the community. For decades, researchers have shown that poverty

and mental illness are correlated; the lower a person's socio-economic status, the greater his or her chances are of having some sort of mental disorder. Poverty exacerbates mental illness. It is this vicious circle that community based mental health services aims to break:



Mental illness and disability:

If a person is unable to perform an activity because of disease/illness or due to bodily impairment, the person is considered as disabled. Though psychiatric disorders do not cause any physical impairment, they can stop a people from doing many activities that are expected of them. The disability in psychiatric illnesses is dynamic being influenced by the nature of illness, phase of the illness, treatment status and social support network available to them. All people with mental illness do not develop psychosocial disabilities. People with **Psycho-social disabilities** are unable to maintain personal hygiene; experiencing difficulties in interpersonal relationships and the communications; inability to participate in social functions and the roles; and finding difficulties in engaging in productive activities.

Suggested Activities

Promote community based mental health services

UN documents addresses disability specifically disability arising from mental illness in UN standard rules on equalization of opportunities for people with

disabilities[15], and the UN convention on rights of people with disabilities[16]. There is international focus of human resources for health care. The theme of the World Health Report 2006 (WHR 2006) is **Working Together for Health[17]**.

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

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

Work with DPOs and service users to advocate for access to treatment

4.1 Access to treatment

The community based organization, SACRED, included mental health programme in to their existing CBR programme. *People with mental illness had to travel 100 kilometres to attend the mental health camp conducted by the National Institute of Mental Health And Neuro Science because there were no services available in that district. With the support of the federation of people with disabilities, people with mental illness were successful in sensitising the district authorities and advocating for the availability of mental health services with in the district. Of course the struggle took more than three years*

Similar experience in Koppal and Raichur districts, people with mental illness and their caregivers were travelling 8 hours to reach Karnataka Institute of Mental Health, Dharwad for assessment, diagnosis and treatment services. Organizations of people with disabilities promoted by CBR programme of Samuha have sensitised the authorities and successful in getting the services with in their district. Awareness building among family members and community complemented the efforts.

[15] UN Standard rules on Equalization of opportunities for people with disabilities (Resoultion 48/96) New York, Geneva, UN 1997
[16] UN Convention on the Rights of people with disabilities, New York UN 2006,
[17] World Health Report 2006, working together for health Geneva, WHO 2001

Include people with mental illness and their families in livelihood programmes

A tale of market

Mr. S a beneficiary of the mental health programme implemented by BasicNeeds India (BNI)[18] partner in Tamilnadu shares his experience. S suffered from mental illness but has now recovered sufficiently to be able to run a small enterprise selling cooking ingredients on his bicycle. He rides about 35 kilometres per day on a regular set of routes and has built up a network of established customers. At the outset, he spent a good deal of time working out the various ingredients that were likely to be in greatest demand, such as pepper and coriander, and the quantities required. He sells small packets tailored exactly to the needs of low-income customers who purchase their requirements daily and at affordable prices. He earns 2 US dollars a day.

Before he became mentally ill, Mr V he worked for thirty years in the weaving industry. He gave it up and concentrated in overcoming his illness with the support of his family. Following treatment and ongoing assistance from an NGO, he decided to set up a small business supplying snacks to travellers using the bus shelter in his village. He starts preparing the food at 5.00am and sells from 8.00am until noon and than he rests. Trade has been consistently good and he earns 3 US dollars a day. This income although modest, is comparable to others in his village. He describes himself as having a completely new beginning. He is confident and contented, enjoying the relative freedom of the work that he does now. The local village council was instrumental in his success, allowing Mr V to use the bus shelter, which is a favourable location for his business

Promote community mental health services

Mental health professionals in several low-income countries are actively promoting Community Mental Health (CMH) and are attempting to influence their governments to initiate measures to bring mental health into the primary health care system. CBR programmes can work with mental health professionals, local health centre staff and users of mental health services to promote community mental health services. Many mental health problems can be effectively resolved by working together with people who experience mental illness in their own homes and communities and using resources and support networks that are available to them. Awareness raising campaigns and large-scale dissemination of knowledge and skills would help in reducing the stigma attached to illness. Building knowledge and awareness among families can make the real difference, in ensuring that people with mental illness are integral members of the family and community, participating in all social and cultural activities.

[18] BasicNeeds is an organization working in community mental health and development in developing countries of Asia and African countries.

Inclusion of mental health in to CBR:

There are a number of reasons why mental health should be integrated into community based rehabilitation programmes:

- Community processes, full participation, equal opportunities, social inclusion, gender, diversity and a focus on rights are some of the key common elements of CBR work. Community mental health work is no different so the programmes integrate well together.
- The high prevalence of psychosocial disabilities emerging through mental illness and its impact on communities, societies and economies means that CBR workers are confronted with the issues in their work. CBR programmes can have a positive impact on the lives of people with mental illness, their families and on the situations in which people live by including people with psychosocial disabilities in their programmes.

BasicNeeds India in southern India, has been successful in including people with mental illness in 21 CBOs and NGOs, carrying out CBR work. In the process awareness has been raised in the communities and among local and district level government authorities. Many people recovering from mental illness and their family members have joined disability self- help groups. In 16 districts CBOs, NGOs and DPOs have been successful in bringing mental health services to district and block levels. People with mental illness, along with other people with disabilities are now able to access their entitlements under poverty alleviation schemes.

- there are a limited number of mental health professionals and mental health services in low-income countries, making a CBR strategy which empowers community level stakeholders to take action an important strategy
- the emerging trend away from vertical health programmes to integrated, multipurpose health programme models favours primary level services and community based strategies
- there is an increasing recognition of the importance of early detection and treatment of mental illness in order to prevent chronic conditions
- the goal of continuity of care and inclusion of people who are mentally ill into the community is more readily achieved when there is an existing community based strategy
- the prevalence of mental health problems among people with other disabilities means that a mental health component in the CBR programmes brings added value

Establish linkages

Development and changes in the concept of CBR over the last two decades has influenced the thought of inclusion of mental health in CBR programmes. The CBR strategy shifts rehabilitation interventions to homes and communities of

people with disabilities. Basic services are provided or facilitated by CBR workers who are minimally qualified non professionals but who are highly qualified change agents. The main goal of rehabilitation has become broader and focuses beyond the individual, to the family and communities in which people live. CBR recognizes that breaking down barriers to inclusion in society is as important to the mission of the CBR programme as is the functional rehabilitation of individuals with disabilities. Thus the universal mission of CBR is:

1. To enhance activities of daily life of disabled persons
2. To create awareness in disabled person's environment to achieve barrier free situations around him and help him in meeting all human rights.
3. To create a situation in which the community of the disabled persons, participates fully and assimilated ownership of their integration in to the society. The ownership lies in the affected persons.[19],[20]

he above mission is no exception for people with mental illness. CBR programmes can link with mental health professionals, users of mental health services, DPOs and SHGs to broaden the scope of the CBR programme to include people with psycho social disabilities and to promote community mental health services

Indicators of readiness

In order to begin a mental health component in the CBR programme, the following readiness indicators should be demonstrated:

1. Organization's willingness to work with mental illness
2. Basic understanding of the mental health concept/problem
3. A match of context between current CBR activities and mental health and development needs
4. Resource stability of the organization [21]

Advantages

The advantages of including people with mental illness in existing CBR programmes are:

1. Meeting the needs of most disadvantaged group.
2. This promotes faster integration of people with mental illness into the mainstream societal activities.
3. Promotes good mental health in the community and leads to early identification.

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[19] Maya Thomas and M.J. Thomas (2003) Manual for CBR planners, Asia pacific Disability Rehabilitation Journal.

[20] S Pruthvish (2006) Community Based Rehabilitation of persons with Disabilities, Jaypee publishers

[21] Shoba Raja, Director Policy & Practice, BasicNeeds – CBR MH success indicators research study report

4. Inclusion of people with mental illness in CBR programme would be cost effective.
5. CBR strategies and approaches very much fit in meeting the needs of people with mental illness.
6. Encourages innovative use of the resources that already exist (for example street theatre troops, advocacy groups, etc.)
7. Inclusion would ensure coverage of all people with disabilities.
8. Mental health problems of people with disabilities are addressed, which adds value to the existing CBR programme.
9. An environment would be built where in all disadvantaged groups including people with mental illness fully participate in their own development and the community in which they live in.

CBO

The project head during one of the meeting expressed that because of inclusion of the mental health programme, the credibility of the organization has increased, the organization got more recognition in the community and also in the district administration. The organization leaders were invited to become members of the government constituted boards. District authorities were appreciative and requests were received to extend mental health services to other parts of the district.

Self help groups

Self-help groups are a common feature of CBR and development work. A self-help group of women were clearly working hard to be strong in the face of personal tragedy and unrelenting poverty. Comprising twelve members, they came together with the support of CBR worker to promote savings of Rs.100 per month per person so that individuals can accumulate enough to buy a buffalo. This would then be a source of regular income, the milk being sold to a cooperative at a guaranteed rate per litre. One of the women had lost her husband to a snakebite the previous week and so the group was rallied around to support her and her three children.

The link comes from the member living with schizophrenia, who has been accepted as treasurer for her literacy skills (despite only having stabilised her schizophrenia during the previous year). And she also derives benefit as any other marginalized member of the group. Together the group advocates for meeting the individual, group and community needs.

This way they play an important role in integrating people with mental illness in main stream and provide mutual support to people in crisis.

Seek out alliances for training and mutual support

Local community organizations staff like community rehabilitation workers/field staffs, coordinators of self-help/user groups and other programmes, lay volunteers/ animators, nurses, and health workers; who are not professionals in mental health or health care provide a variety of services. Many of these informal community-care providers have little or no formal mental health care training, but

in many low income countries they are the main source of community mental health provision. They are usually accessible and generally well accepted in local communities. They can help with the integration of people with mental disorders into community activities and the other developmental activities of their own organizations, and thus play an supportive role in meeting the treatment needs of people with mental illness.

For example In Tanzania, there are only 11 psychiatrists for a population of 3,45,69,232 scattered 945,087 kilometres. The mental health services reach communities through nurses in a few parts of the country. These services can go a long way in improving the living conditions of people with mental illness and supporting them to lead a life of dignity. They are also acting as link between the mainstream mental health care and the community based mental health services. They are important component of an alliance of mental health care world wide.

Some of the important roles of the CBR and the community development work force are:

- awareness raising and dissemination of information;
- identification of people with mental health problems and referral to health services;
- crisis support;
- home based support - supportive care, including basic information and counselling;
- helping in the activities of daily living skills and community reintegration;
- formation of caregivers groups/associations;
- advocating for the rights of people with mental illness;
- preventive and promotive services;
- Organising affected people to advocate for meeting their needs.

Mr M, a young volunteer from a youth group in Jalahalli, took initiative in supporting a woman who is mentally ill and destitute in his village. He witnessed a shop keeper physical abusing (pushing) her for entering his restaurant. Mr M took this abuse seriously. With the help of an NGO he took her to the mental hospital for treatment, following guidelines of mental health act for the involuntary admission. After her discharge, he spoke with the woman's relatives and made arrangements for her stay and for her livelihood. People like Mr M, volunteer to support NGOs in their work. NGOs also experience stabilised people playing the role of volunteers and advocates. Always people inspired by good work voluntarily offer assistance.

Caregivers Associations

People with mental illness and their caregivers are encouraged to form an association of their own. This provides a platform for them to discuss various problems they share and find solutions. For example, Mr B's, family experienced unwelcome reactions of neighbours towards their son. Mr B was wandering in the streets and his parents had to find him and bring him back. The caregivers' association in the village took the responsibility to explain the illness to others. Mr B has now returned to work as a labourer and is maintaining full-time employment.

Another caregivers association took the decision to advocate for their right to treatment. The association members met the district authorities, explained to them the need for treatment to be made available at their block level[22]. People with mental illness and their families decided to voice their needs rather than depending on the local organizations. This resulted in the deputation of a psychiatrist to conduct mental health camps in the local health care centres on a monthly basis, with medicines being distributed during these camps..

Street theatre
Street theatres play a major role in generating awareness in the community. Some organizations also have formed puppet shows troops. Street plays can provide knowledge on; causes, treatments and symptoms of mental illness. The purpose is to demystify the subject and to raise the awareness of the public on mental health issues. Street theatres can also highlight the important roles and responsibilities of families and the community, which could go long way in rehabilitating people with mental illness. The street theatre performances can be followed by question and answer sessions, where people can ask specific questions.

Broaden understanding of the issues

Development practitioners need basic understanding of mental disorders**.** This includes understanding the symptoms of mental disorders and how they affect the behaviour, need for treatment - medical and psychosocial interventions. It is essential to consult people with mental illness and their family members to listen to their experiences, needs aspirations to understand that particular individual and the family. Training can be provided in basic competencies, such as counselling- listening and communication skills and the need to maintain confidentiality, managing conflict of interests when dealing with individuals as well as their families, maintaining a neutral stance and dealing with disturbing emotions.

"The wounds that can not be seen are more painful than those that can be treated by a doctor"- Nelson Mandela

The list of potential care providers should be moved up and the following paragraph could possibly be incorporated into the conclusion (except there needs to be more emphasis on the active role of the individual with mental illness rather than an exclusive focus on the family and community roles.

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

[22] Districts are further divided in to blocks as revenue divisions.

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

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

Conclusion:

It has been tested and proved that inclusion of mental health issues in CBR programmes is possible, cost effective and help building an environment where in people with all disabilities access their entitlements and enjoy equal opportunities for full participation in their own communities.

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