Human Rights Violations Among People With Mental Illness; Rural vs. Urban Comparison

Vijayalakshmi POREDDI[1], Rama CHANDRA[2], Reddemma KONDURU[3], Suresh BADAMATH[4]

Summary

Background: Human rights violations are commonly reported against people with mental illness and have remained a major research issue in recent times. Objective: The present study was aimed to compare psychiatric patients' perceptions of human rights needs between rural and urban settings.

Methodology: A descriptive study design was carried out among 100 recovered psychiatric patients based on the Clinical Global Impression-Improvement Scale (CGI-I scale), at a tertiary care center. Participants were selected through a random sampling method. Data was collected through face to face interviews, using a structured questionnaire. Data was analyzed and interpreted using descriptive and inferential statistics.

Findings: The present study highlighted the significant differences in meeting their basic human rights needs in a physical needs dimension i.e. availability of hot water for bathing ($\chi 2=8.305$, $p<0.40$) and provision of clean clothes to wear ($\chi 2=8.229$, $p<0.42$) were rated higher in rural participants than participants from those in an urban setting. Similarly, in the ethical needs dimension, merely 13% of the rural participants reported that they never/rarely experienced sexual advances by family members ($\chi 2=9.949$, $p< .019$).

Conclusion: Our findings revealed that human rights violations among mentally ill are evident across rural and urban environments. Thus, there is an urgent need to change the attitude of the general population towards people with mental illness through awareness campaign. In addition, educating the public about the human rights of mentally ill is also essential.

Key words: Human rights, mentally ill, needs assessment, rural, urban

INTRODUCTION

Human rights are universal legal guarantees protecting individuals and groups against actions and omissions that interfere with fundamental freedoms, entitlements and human dignity (UN, 2006). However, human rights violations are commonly reported against people with mental illness and have remained a major research issue in recent times. The prevalence of mental disorders in India is high, as in other parts of the world (Michelle et al., 2010). It has been estimated that at least 58 per 1,000 people have a mental illness and about 10 million Indians suffer from severe mental illness (Weiss et al., 2001, Math et al., 2007, Khandelwal et al., 2004). Nevertheless, considering the fact that 72.2% of the population lives in rural areas, with only about 25% of the health infrastructure, medical man-power and other health resources, it may be surmised that the number of people affected with any mental and behavioral disorder would be higher in rural areas (Gururaj et al., 2005). Further, with the population increase, changing values, life-style, frequent disruptions in income, crop failure (NationalCommissiononFarmers, 2006), natural calamity (drought and flood), economic crisis (Chatterjee, 2009), unemployment, lack of social support and increasing insecurity, it is fearfully expected that there would be a substantial increase (Pathare, 2011) in the number of people suffering from mental illness in rural areas. Epidemiological surveys have also reported that 75% of psychiatric disorders occur in rural India. About 80% to 90% go undiagnosed and untreated (Divya, 2010, Mehta et al., 1985). In Indian culture,

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[1-2-3]Nurse, Trained Nurses association of India, Karnataka, Bangalore. [4]MD., Assoc. Prof ., Indian Psychiatrists association, Karnataka, Bangalore.
E-mail: *pvijayalakshmireddy@gmail.com*

family is regarded as the most important structure in caring for vulnerable family members including those with mental illness and 80% of the mentally ill live with their families, and merely 5% to 10% receive professional psychiatric care. Furthermore, as the majority of Indian population lives in remote rural areas, about 75% of families who care for their mentally ill kin have little to no access to medical facilities (Prafulla et al., 2010). However, the bulk of available research in India focuses largely on religious and traditional modes of intervention which are still widely practiced, especially in rural areas, where mental health services are almost non-existent (Kulhara et al., 2000, Padmavati et al., 2005, Patel et al., 1997).

Conversely, in 2006, India was among the many countries that signed the UN Convention on the Rights of Persons with Disabilities, which includes people with mental impairment (Bharathi and Swaminathan, 2010). India also has a Mental Health Act and the Persons with Disability (PWD) Act, which provides treatment, protection against human rights abuses, and equal opportunities for the mentally ill. Despite having the National Mental Health Program since 1982 and the National Rural Health Mission, there has been very little effort so far to provide mental health services in rural areas (Kumar, 2011). Stigma and human rights abuses continue and the lack of awareness about the symptoms of mental illnesses and the myths that surround it result in people with mental illnesses being subjected to inhuman practices by traditional healers and unlicensed practitioners (Bharathi and Swaminathan, 2010). However, the weak compliance with human rights laws is evident from the fact that patients continue to be kept under inhuman conditions in mental asylums. In 2001, 27 patients died in a fire at Moideen Badhusha Mental Home at Erwadi Dharga, a small town in Tamil Nadu in southern India, because they had been fettered and could not escape. Today, 9 years later, and despite the existence of laws against such practices, nothing has changed (Bharathi and Swaminathan, 2010). Indeed, it is a collective failure of the responsibility of different sections of society, due to indifference, lack of concern, and disregard for the plight of people with mental illness. Further, a recent survey (SEVAC, 2006) found an obvious correlation between mental illness and human rights violations and reported that human dignity is almost absent in the life of people with mental illness.

In India, with its cultural diversity and mix of rural and urban environment, there is a need to understand the experiences of human rights violations among people with mental illness at the family and community level. Further, very little research currently exists on human rights violations among people with mental illness in an Indian setting. Hence, this research attempts to address the numerous published reports of the subjective experiences of human rights violations and its consequences, undergone by psychiatric patients in rural and urban environments. Exploring these issues can enrich debate on human rights violations against these vulnerable populations, providing a basis for intervention.

METHODS

This was a descriptive study carried out at a tertiary care center among recovered psychiatric patients from August 2010 to November 2010.

Participants were selected through a random sampling method from the outpatient follow-up cohort. These patients' detailed evaluations had been done by a junior resident, later discussed with the senior consultant regarding diagnoses and management. All of the diagnoses were performed as such. Among them, the patients who met the inclusion criteria were interviewed. The study criteria included recovered psychiatric patients with a diagnosis of either Schizophrenic or Mood disorders based upon the criteria of the International Classification of Disorders Version 10 (ICD-10). In the present study, recovered patients meant they should score 1 (very much improved) or 2 (much improved) on the CGI-I scale (Clinical Global Impression–Improvement) (Guy 1976). The study sample comprised of 100 recovered psychiatric patients and covered an age span of 18–60 years. Recovered persons with mental illness who were symptom free may be the true representative of the target population and they can discuss the experiences they underwent during their illness period. The tools used in the study were:

(a) *Clinical Global Impression- Improvement Scale* (Guy, 1976)

The Clinical Global Impression-Improvement Scale is a standardized assessment tool used to rate the severity of illness, change over time, and efficacy of medication, taking into account the patient's clinical condition and the severity of side effects. The CGI-I is rated on a 7-point scale, with the severity of illness scale using a range of responses from 1 (normal) through 7 (amongst the most severely ill patients). Researchers decided to use this scale to recruit only recovered patients. The main reason to recruit recovered patients was because they could defend their rights and verbalize the experiences that they had undergone. The definition of recovered means they should have scored 1(very much improved) or 2 (much improved) on the CGI-I scale (Clinical Global Impression–Improvement).already explained in above paragraph

(b) *Socio demographic schedule*

This included age, gender, educational status, marital status, employment, residence, religion, monthly income, type of family, diagnosis, and duration of illness (in months).

The definition of urban and rural was per the 2001 census of India.

In the 2001 Census of India, the definition of an urban area was adopted as follows: (a) All statutory places with a municipality, corporation, cantonment board or notified town area committee, etc. (b) A place satisfying the following three criteria simultaneously: i) a minimum population of 5,000; ii) at least 75 per cent of male working population engaged in non-agricultural pursuits; and iii) a density of population of at least 400 per sq. km. (1,000 per sq. mile). The rural are of those who had a population less than 5000 and density of less than 400 per sq. km. (1,000 per sq. Mile).

(c) *Needs assessment questionnaire* has two sections in order to capture the selected dimensions.

Section A was to assess the human rights needs in the family domain, developed by the researchers based on the Universal Declaration of Human Rights (UN, 1998) and a review of the literature. This tool had 57 items under 5 dimensions, i.e. physical, emotional, religious, social and ethical needs. This scale was a four point (ordinal) scale and was rated from 0 to 3 i.e. never to always. There were no right or wrong answers.

The items in the physical needs dimension (18 items) focused mainly on article 25 in the UDHR document which assessed the right to a decent life, including adequate food, clothing, housing, and medical care services (Example: availability of light, electricity, safe drinking water, food common for family members, etc).

The items in the emotional needs dimension (17 items) were based on article 5 (No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment) and 12 (No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honor and reputation), in the UDHR document and evaluates the emotional needs of the persons with mental illness (Example: family environment helps to maintain dignity, commenting on physical appearance, privacy in terms of opening mail, monitoring phone calls, etc).

Religious needs dimension (4 items) mainly focused on article 18 (Everyone has the right to freedom of thought, conscience and religion) in the UDHR document and dealt to assess the religious rights of persons with mental illness (Example: Forcing to practice other religious and witchcraft / black magic activities, etc).

The items in the social needs dimension (8 items) were based on articles 13 (Everyone has the right to freedom of movement) and 20 (Everyone has the right to freedom of peaceful assembly and association) of the UDHR document and measures the social and economic rights of the persons with mental illness (Example: Allowing the participants to go out of their home, keeping them away from going to a job or school by their family members, allowing them to handle money, etc.).

The items of the ethical needs dimension (10 items) were based on articles 1, 2, 3, 16, 17 and 26 of the UDHR document which mainly assessed the right to equality in dignity, right to live in freedom and safety, right to marry, right to own property and right to education.

In section B, the researchers used a modified version of "Taking the Human Rights Temperature of your community" based on UDHR documents to assess human rights needs of people with mental illness in the community domain (Flowers et al., 2000). This scale contained 25 items with a five point scale and was rated from 0 to 4 i.e. 'don't know' to 'always'. The above mentioned instruments were developed in the English language and administered in the format of a face to face interview.

This tool was modified to suit Indian context (related to mental illness), without losing the essence of the questions. For example, "my community is a place where residents are safe and secure," was modified as "my community is a place where mentally ill patients are safe and secure." Item numbers 12, 17, 18, 21 and 22 were completely changed as suggested by the experts. According to the Indian constitution and international covenants (ICESCR and ICCPR), right to vote, right to continuing education, and the right not to be discriminated against were given more importance and exploring these issues were more relevant to the present study.

Validity and Reliability of the Tools

The tool was validated by eleven experts from various fields including nursing, psychiatry, psychiatric social work, psychology, human rights, and statistics. The final tool was modified according to the suggestions of the experts. The scale's reliability assessment was done by using the test-retest method. The researchers administered the tool on ten recovered psychiatric patients at the follow-up outpatient department over a 2 week period and it was found that the study was feasible, and necessary modifications were done. The reliability coefficient for the structured questionnaire was 0.96.

Data was collected by the primary author through a face to face interview, in a private room at the treatment facilities where the participants were recruited. The interview took approximately 45 minutes to complete. The researchers educated the family members in groups regarding the rights of people with mental illness.

Ethical Consideration

The study protocol was reviewed and approved by the Ethics Committee of the concerned hospital. On introduction, verbal explanation of the research aims and methods were provided to all participants. Questions were invited from participants. Participants were asked to sign consent forms, or if illiterate to provide thumb prints in the presence of a witness. Participants' confidentiality was respected.

Statistical analysis

Responses of the negatively worded items were reversed before data analysis. The data were analyzed using SPSS version 16 and the results were presented in narratives and tables. Descriptive (frequency and percentage) and inferential statistics (chi square test) were used to interpret the data. Wherever numbers were less in a category, those categories were clubbed while doing chi-square analysis. The results were considered significant at $p < 0.05$.

RESULTS

The study population consisted of 100 recovered psychiatric patients of whom 46% were from a rural setting. Mean age (X ± SD) for participants was 35.39 ± 11.26 years and specifically for the urban participants was 34.07 ± 10.25 years (range, 18-60 years). However, no significant difference was observed. Similarly, the average income (X ± SD) of the rural participants was 1.69 ± 1.29 and for the urban participants was 1.94 ± 1.32. The number of men from both areas (rural 52.2%, urban 53.7%) was slightly higher than women from rural (47.8%) and urban (46.3%) areas. Similarly the number of literate participants (58.7%, 55.6% rural and urban, respectively) was higher than illiterate participants both from rural (41.3%) and urban (44.4%) areas. Most of the sample population was married and were Hindus. The number of participants' with recovered Schizophrenia disorders was higher from urban (44.4%) than rural (32.6%) areas (Table 1).

Table 2 shows the perceptions of the participants regarding the Needs assessment questionnaire. Concerning physical needs dimension, there was a significant relationship observed between participants from rural and urban areas regarding whether there was an availability of hot water for bathing (χ^2=8.305, p<0.040). The majority (88.9%) of the urban participants were more likely to have hot water for

Table 1. Socio-demographic characteristics of the study population

Variable	Group	Rural n=46 (%)		Urban n= 54 (%)		χ^2-value	df	p-value
Gender	Male	24	52.2	29	53.7	.023	1	.879
	Female	22	47.8	25	46.3			
Education	Illiterate	19	41.3	24	44.4	.100	1	.752
	Literate	27	58.7	30	55.6			
Marital status	Married	32	69.6	36	66.7	1.740	2	.419
	Unmarried	14	30.4	16	29.6			
	Divorced	-	-	2	3.7			
Employment	Employed	29	63	29		.890	1	.346
	Unemployed	17	37	25				
Religion	Hindu	43	93.5	43	79.6	5.037	2	.081
	Muslim	1	2.2	8	14.8			
	Christian	2	4.3	3	5.6			
Income	B P L	12	26.1	10	18.5	.829	1	.363
	APL	34	73.9	44	81.5			
Family type	Joint	15	32.6	16	29.6	.105	2	.949
	Nuclear	26	56.5	32	59.3			
	Extended	5	10.9	6	11.1			
Diagnosis	Mood disorders	31	67.4	30	55.6	1.463	1	.227
	Schizophrenic disorders	15	32.6	24	44.4			
Duration of illness	< 60	26	56.5	25	46.3	1.039	1	.308
	> 60	20	43.5	29	53.7			
CGI – I Scores	Very much improved	20	43.5	30	55.6	1.006	1	.315
	Improved	26	56.5	24	44.4			

*p< .05

bathing than rural participants. Similarly, the most stark difference between participants from the urban and rural areas was the urban participants (90.7%) had more access to provisions such as clean clothes than participants from rural areas (χ^2=8.229, p< .042). Perhaps unsurprisingly, participants from rural and urban areas similarly perceived the statements in the emotional, social and economic, and religious needs dimensions. In the ethical needs dimension, more participants from the rural (n=40, 87%) than urban (n=40, 74.1%) areas reported a positive response to the statement 'family members making sexual advances towards you' (χ^2=8.229, p< .019). Participants from rural and urban areas equally perceived the statements in the community domain (Table 3).

DISCUSSION

To our best knowledge, this study may be the first such research to compare human rights violations between rural and urban areas in the population of recovered psychiatric patients from a developing country. The results of the present study showed that irrespective of a rural or urban setting, human rights violations among mentally ill are evident across both areas. The previous studies, which were mostly conducted on the symptomatic and in-patient population, had contradictory results (Arvidsson, 2001, Terry A Badger, 2003, David et al., 2002, Perreault et al., 2005). However in the current study, all participants were well aware of their diagnosis and were currently in a recovered state. This was achieved by predefined criteria of recovery using the CGI-I scale. A recent study (Lawska et al., 2006) explored the asymptomatic patient's expectations from others, but it was only in the psychological dimension.

In the present study, 54% of the participants were from an urban area and supports the earlier studies which have shown that the urban psychiatric morbidity rate was marginally higher than the rural morbidity rate (Murali, 2001). 'Alternative mental health systems' such as ayurveda, faith and religious healing, and native medicine is an integral part of the people in India and they access it in times of need, especially in rural areas (Halliburton, 2004) where mental health services are not easily accessible (Kapur, 1975). In addition, in developing countries like India, a vast majority of people attribute the symptoms of mental illness to supernatural phenomena, drug use, stressful life events, heredity or personality deficiencies (Srinivasan and Thara, 2001). In the present study, the number of men was marginally higher than women who utilized mental health services both in rural and urban areas. A meta-analytical study (Murali, 2001) also revealed that the rate of morbidity was higher in women than in men in the year 1972 and this trend did not change significantly for 20 years. Many other studies conducted in different parts of India have also shown this greater vulnerability of women to mental illness (Ajay, 2000, Sethi and Manchandra, 1978, Dube, 1970, Nandi et al., 1975). Community surveys, from the 1970s to the 90s have recorded a greater female morbidity (Davar, 1999). In India however, the health care services are marked by gender-based inequity of access to hospital care. Findings from a recent study, conducted in two psychiatric facilities in Andhra Pradesh, are presented which provide further confirmation of this pattern of gender differences in mental health care (Vindhya, 2001).

There was a statistically significant difference between rural and urban participants related to the availability of hot water for bathing (χ^2=8.305, p<.040). Regarding the urban participants, 48 (88.9%) had hot water for bathing compared to the participants from rural areas. Similarly 68.7% of the urban participants had provisions to wear clean clothes (χ^2=8.229, p<.042). The most probable explanation for these findings can be 75% of the Indian population lives in rural areas and about 80% of this population is dependent on agriculture for its livelihood. Also, the majority of them are daily wagers and landless laborers. In addition, a poverty estimate about India shows that 44.2% of the population earns below $1 per day and 86.2% below $2 per day (HumanDevelopmentReport, 2000-2001). In this context it could be argued that the rural population in a developing country like India is deprived of basic needs such as safe and potable drinking water, nutrition, housing, sanitation and access to medical services. However, the persons with mental illness were further disadvantaged in meeting those needs.

The current study revealed that the majority (78.3%) of the rural participants were more likely to be victims of sexual abuse than urban participants (χ^2=9.949, p<.019). Sexual violence has a profound impact on the physical and mental health of an individual. Women coming from a rural background in India are more vulnerable to sexual abuse compared to their counterparts in urban areas. This is because of their vulnerability due to lack of education, exposure and opportunity, and the nature of Indian society. However, people with mental illness, especially women, are clearly among the least powerful members of society and are highly vulnerable to sexual victimization. In an Indian context, very few studies have reported on sexual coercion among women with mental illness in India (Chandra et al., 2003a, Chandra et al., 2003b). They found that sexual abuse was from a relative more often a spouse, but also occasionally from an uncle, cousin, or brother-in-law, which is contradictory to the popular belief that the safest place for a woman is her own family. Moreover, the high rates of child sexual abuse involving family members illuminates the fact that, although many homes provide the socially approved love, support and bonding, they can also be the venue for violent victimization and sexual abuse. However, research exploring the prevalence of

sexual coercion among people with mental illness is urgently needed.

In addition to serving as a foundation for future studies in this area, the present study also has certain limitations: the study was restricted to the people with mental illness who attended the outpatient department at a tertiary care center and a smaller sample size made it difficult to generalize the findings. The type I errors may be high due to the item wise chi-square analysis. Future research should focus on a larger sample size exploring the influence of cultural factors and a qualitative approach for a depth of understanding of human rights issues among these disadvantaged populations.

CONCLUSION

The findings of the present study showed that in a majority of areas, human rights violations among the mentally ill are present systematically in both urban and rural settings with few differences in physical and ethical dimensions. Hence, there is an urgent need to change the attitude of the general population towards mental illness which in turn helps to protect the rights of people with mental illness. Mental health professionals can play an important role in disseminating correct information regarding the nature of mental illness and the human rights of people with mental illness. The government should also take active steps to provide minimum mental health care which is accessible, available, and affordable to the underprivileged sections of the rural population.

Table 2. Responses of the Participants Needs Assessment Questionnaire, Family

Statement	Response	Rural n = 46		Urban n = 54		χ^2-value	df	p-value
		n	(%)	n	(%)			
PHYSICAL NEEDS DIMENSION								
Basic facilities Adequacy of light for you.	Never/rarely	1	2.2	1	1.9	2.477	2	.290
	Some times	4	8.7	1	1.9			
	Always	41	89.1	52	96.3			
Electricity facility available in your room.	Never/rarely	0	0	0	0	.027	1	.870
	Sometimes	2	4.3	2	3.7			
	Always	44	95.7	52	96.3			
Availability of hot water for bathing	Never/rarely	9	19.6	6	11.2	8.305	2	.040*
	Some times	5	10.9	0	0			
	always	32	69.6	48	88.9			
Safe drinking water	Never/rarely	4	8.7	5	9.6	4.925	2	.177
	Sometimes	4	8.7	0	0			
	Always	38	82.6	49	90.7			
Separate room	Never /rarely	32	69.6	29	53.7	3.765	2	.288
	Sometimes	1	2.2	3	5.6			
	Always	13	28.3	22	40.7			
Food Food common for all family members	Never /rarely	5	10.9	4	7.4	.817	2	.665
	Sometimes	6	13.0	5	9.3			
	Always	35	76.1	45	83.3			
Eating food along with your family	Never/rarely	11	23.9	14	25.9	.921	2	.820
	Sometimes	15	32.6	15	27.8			
	Always	20	43.5	25	46.3			

Serving in same utensils/plates	Never /rarely	6	13.1	8	14.9	.152	2	.985
	Sometimes	8	17.4	10	18.5			
	Always	32	69.6	36	66.7			
Availability of adequate food.	Never /rarely	4	8.7	4	7.4	2.665	2	.446
	Sometimes	13	28.3	10	18.5			
	Always	29	63.0	40	74.1			
Personal hygiene Allowed to use toilet facilities.	Never/rarely	2	4.3	2	3.7	.088	2	.957
	Sometimes	4	8.7	4	8.7			
	Always	40	87.0	48	88.9			
Provision of sanitary napkins/clean clothes.	Never/rarely	14	30.4	5	9.3	8.229	2	.042*
	Sometimes	5	10.9	12	22.2			
	Always	27	58.7	37	68.5			
Availability of toiletry things (soap, comb, oil etc)	Never /rarely	8	17.4	12	22.3	4.742	2	.192
	Sometimes	15	32.6	9	16.7			
	Always	23	50.0	33	61.1			
Wear or buy clothes according to your choice	Never /rarely	30	65.3	29	53.7	2.335	2	.506
	Sometimes	8	17.4	11	20.4			
	Always	8	17.4	14	25.9			
Medications Supervision of taking medications.	Never /rarely	22	47.8	34	63	4.705	2	.195
	Sometimes	12	26.1	6	11.1			
	Always	12	26.1	14	25.9			
Purchasing medications	Never/rarely	18	39.1	16	29.7	2.824	2	.420
	Sometimes	12	26.1	11	20.4			
	Always	16	34.8	27	50.0			
Getting free medications.	Never /rarely	7	15.2	16	29.7	4.421	2	.21
	Sometimes	1	2.2	3	5.6			
	Always	38	82.6	35	64.8			
Aware of side effects of medication, report to the doctor.	Never /rarely	39	84.8	44	81.5	2.864	2	.413
	Some times	3	6.5	4	7.4			
	Always	4	8.7	6	11.1			
Attending of other health needs.	Never /rarely	8	17.4	9	16.7	1.617	2	.656
	Sometimes	17	37.0	15	27.8			
	Always	21	45.7	30	55.6			
Emotional Needs Dimension Listening to your sufferings.	Never/rarely	15	32.6	20	37.0	.823	2	.844
	Sometimes	18	39.1	20	37.0			
	Always	13	28.3	14	25.9			

Show care for you.	Never/rarely	13	28.3	14	26.0	1.938	2	.585
	Sometimes	18	39.1	28	51.9			
	Always	15	32.6	12	22.2			
Understanding of your feelings.	Never/rarely	18	39.1	25	46.3	4.468	2	.215
	Sometimes	16	34.8	19	35.2			
	Always	12	26.1	10	18.5			
Feeling that you are separated from family because of the illness.	Never/rarely	20	43.4	21	38.9	2.971	2	.396
	Sometimes	8	17.4	17	31.5			
	Always	18	39.1	16	29.6			
Family environment helps to maintain your respect and dignity.	Never/rarely	21	45.6	21	38.9	2.274	2	.517
	Sometimes	9	19.6	14	25.9			
	Always	16	34.8	19	35.2			
Helping you in worries.	Never/rarely	18	39.1	24	44.5	4.317	3	.229
	Sometimes	11	23.9	19	35.2			
	Always	17	37.0	11	20.4			
Feeling guilty about illness.	Never/rarely	33	71.7	27	50.0	5.306	2	.151
	Sometimes	8	17.4	14	25.9			
	Always	5	10.9	13	24.1			
Accompanying to hospital for follow-up (if required).	Never/rarely	17	37.0	12	22.3	3.333	2	.343
	Sometimes	8	17.4	14	25.9			
	Always	21	45.7	28	51.9			
Facing of any expressed emotions from family members	Never/rarely	25	54.3	26	48.2	.903	2	.825
	Sometimes	10	21.7	11	20.4			
	Always	11	23.9	17	31.5			
Commenting upon physical appearance.	Never/rarely	31	67.4	27	50.0	4.348	2	.226
	Sometimes	4	8.7	12	22.2			
	Always	11	23.9	15	27.8			

Table 3. Responses of the Participants Needs Assessment Questionnaire, Community

Statement	**Response**	**Rural n = 46**		**Urban n = 54**		**χ^2-value**	**df**	**p-value**
		n	**(%)**	**n**	**(%)**			
Safety and security of mentally ill.	Don't know	1	2.2	4	7.4	6.423	4	.170
	Never	12	26.1	12	22.2			
	Rarely	14	30.4	23	42.6			
	Often/Always	19	41.3	15	27.8			
Receiving equal information and encouragement about career opportunities.	Don't know	7	15.2	9	16.7	1.993	3	.574
	Never	20	43.5	19	35.2			
	Rarely	10	21.7	18	33.3			
	Often/Always	9	19.6	8	14.8			

Not discriminated because of their mental illness.	Don't know	2	4.3	3	5.6	1.499	4	.827
	Never	31	67.4	37	68.5			
	Rarely	8	17.4	8	14.8			
	Often/Always	5	10.9	6	11.1			
Accessibility of health services to all equally at affordable cost.	Don't know	4	8.7	4	7.4	1.123	4	.891
	Never	6	13.0	8	14.8			
	Rarely	10	21.7	8	14.8			
	Often/Always	26	56.6	34	62.9			
Opposing discriminatory or demeaning actions, slurs.	Don't know	4	8.7	6	11.1	4.334	4	.363
	Never	17	37.0	12	22.2			
	Rarely	14	30.4	24	44.4			
	Often/Always	11	23.9	12	23.3			
Helping the violator to learn how to change his or her behavior.	Don't know	2	4.3	3	5.6	2.124	4	.713
	Never	15	32.6	20	37.0			
	Rarely	16	34.8	20	37.0			
	Often/Always	13	28.3	11	20.4			
Helping the patient's development and when they are in need.	Don't know	0	0	0	0	2.631	3	.452
	Never	23	50.0	24	44.4			
	Rarely	10	21.7	17	31.5			
	Often /Always	13	28.3	13	24.1			
Resolving the conflicts through nonviolent ways.	Don't know	6	13.0	3	5.6	6.428	4	.169
	Never	10	21.7	15	27.8			
	Rarely	9	19.6	18	33.3			
	Often/Always	21	44.6	18	33.3			
Responsiveness to complaints of harassment or discrimination.	Don't know	19	41.3	25	46.3	3.818	3	.282
	Never	14	30.4	10	18.5			
	Rarely	5	10.9	12	22.2			
	Often/Always	8	17.4	7	13.0			
No wondering homeless mentally ill	Don't know	0	0	5	9.3	6.862	4	.143
	Never	36	78.3	37	68.5			
	Rarely	4	8.7	8	14.8			
	Often/Always	6	13.1	4	7.4			
Not subjected to degrading treatment or punishment.	Don't know	2	4.3	0	0	6.548	4	.162
	Never	27	58.7	34	63.0			
	Rarely	15	32.6	13	24.1			
	Often/Always	2	4.3	7	13.0			
Cured mentally ill are treated like any other citizen.	Don't know	4	8.7	6	11.1	2.768	4	.597
	Never	18	39.1	16	29.6			
	Rarely	10	21.7	17	31.5			
	Often/Always	14	30.4	15	27.8			

Personal space and possessions are respected.	Don't know	0	0	0	0	1.988	3	.575
	Never	15	32.6	18	33.3			
	Rarely	13	28.3	15	27.8			
	Often/Always	18	39.1	21	38.9			
Welcomingw mentally ill from diverse back grounds and cultures.	Don't know	0	0	1	1.9	1.815	4	.770
	Never	17	37.0	20	37.0			
	Rarely	13	28.3	11	20.4			
	Often/Always	16	34.8	22	40.8			
Expressing beliefs and ideas without fear of discrimination	Don't know	1	2.2	0	0	2.900	4	.575
	Never	21	45.7	30	55.6			
	Rarely	15	32.6	12	22.2			
	Often/Always	9	19.5	12	22.3			
Hiring to work without any discrimination.	Don't know	5	10.9	11	20.4	5.452	4	.244
	Never	15	32.6	22	40.7			
	Rarely	13	28.3	11	20.4			
	Often/Always	13	28.3	10	18.6			
Allowing to public places like church, temple and parks etc.	Don't know	1	2.2	1	1.9	7.444	4	.114
	Never	3	6.5	11	20.4			
	Rarely	6	13.0	13	24.1			
	Often/Always	36	78.2	29	53.7			
Allowing to vote.	Don't know	0	0	0	0	2.432	3	.488
	Never	7	15.2	12	22.2			
	Rarely	6	13.0	6	11.1			
	Often/Always	33	71.8	36	66.6			
Encouraging in decision making processes to develop rules and policies.	Don't know	4	8.7	2	3.7	1.614	4	.806
	Never	30	65.2	35	64.8			
	Rarely	5	10.9	8	14.8			
	Often/Always	7	15.2	9	16.7			
Participating in cultural life of community.	Don't know	0	0	2	3.7	3.653	4	.455
	Never	8	17.4	14	25.9			
	Rarely	14	30.4	16	29.6			
	Often/Always	24	52.2	22	41.7			
Encouraging in continuing their education.	Don't know	0	0	4	7.4	4.478	4	.345
	Never	13	28.3	17	31.5			
	Rarely	20	43.5	17	31.5			
	Often/Always	13	28.3	16	29.6			
Not exploited by members of my community.	Don't know	3	6.5	5	9.3	3.871	4	.424
	Never	11	23.9	20	37.0			
	Rarely	18	39.1	14	25.9			
	Often/Always	14	30.4	15	27.8			

working under fair conditions	Don't know	4	8.7	4	7.4	1.446	4	.836
	Never	3	6.5	6	11.1			
	Rarely	15	32.6	21	38.9			
	Often/Always	24	52.2	23	42.6			
Able to live and work in the community.	Don't know	0	0	2	3.7	4.088	4	.394
	Never	5	10.9	4	7.4			
	Rarely	12	26.1	19	35.2			
	Often/Always	29	63.0	29	53.7			
Taking responsibility to ensure that other individuals do not discriminate and to promote the safety and well-being of my community.	Don't know	0	0	0	0	1.520	3	.678
	Never	3	6.5	6	11.1			
	Rarely	22	47.8	21	38.9			
	Often/Always	21	45.7	27	50.0			

*p<.05

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