

## ORIGINAL ARTICLE

**Attitude about mental illness of health care providers and community leaders in rural Haryana, North India**Harshal Ramesh Salve<sup>1</sup>, Surendra Babu<sup>2</sup>, Sanjay K Rai<sup>3</sup>, Rajesh Sagar<sup>4</sup>, Shashi Kant<sup>5</sup><sup>1</sup>Senior Resident, <sup>2</sup>Resident, <sup>3</sup>Additional Professor, <sup>4</sup> Professor, Department of Psychiatry, <sup>5</sup>Professor, Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi.

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**Abstract**

**Background:** Attitude about mental illness determines health seeking of the people. Success of National Mental Health Programme (NMHP) is dependent on attitude about mental illness of various stakeholders in the programme. **Material & Methods:** A community based cross-sectional study was carried out in Ballabgarh block of Faridabad district in Haryana. We aimed to study attitude about mental illness of various stakeholders of health care providers (HCP), community leaders in rural area of Haryana, north India. Study area consisting of five Primary Health Centers (PHCs) serving 2,12,000 rural population. All HCP working at PHCs, Accredited Social Health Activist (ASHA) and community leaders in study area were approached for participation. Hindi version of Opinion about Mental illness Scale for Chinese Community (OMICC) was used to study attitude. **Results:** In total, 467 participants were participated in the study. Of which, HCP, ASHAs and community leaders were 81 (17.4%), 145 (31.0%) and 241 (51.6%) respectively. Community members reported socially restrictive, pessimistic and stereotyping attitude towards mentally ill person. ASHA and HCP reported stereotyping attitude about person with mental illness. None of the stakeholders reported stigmatizing attitude. **Conclusion:** Training programme focusing on spectrum of mental illness for HCP and ASHA working in rural area under NMHP programme is needed. Awareness generation of community leaders about bio-medical concept of mental illness is cornerstone of NMHP success in India.

**Key Words**

Mental Illness; Health Care Providers; Community Leaders

**Introduction**

Holistic state of the health cannot be achieved without healthy mental status [1]. In low and middle income countries, mental illness has major contribution in the Years Lived with Disability [2]. In India, prevalence of mental illness in adults was reported as 58.2, [3] and 73.0 [4] per 1,000 population. Mental illness is associated with social stigma in all populations since long time [5]. Person with mental illness is characterized as dangerous, unpredictable, untrustworthy, unstable, lazy, weak, worthless, and/or helpless in all societies [6].

Traditionally, mental illness is perceived as frightening, shameful, imaginary, feigned, and incurable in the community [7]. Studies from India also have reported similar findings about stigmatization of people with mental illness in the community [8,9]. Government of India (GOI) launched National Mental Health Programme (NMHP) in the year 1982 to address unmet needs of mental health care. The programme aims to provide mental health care at the community level, and to promote community participation in the mental health service development [10]. District Mental

Health Programme (DHMP) under NMHP, envisaged to provide training to health manpower in identification of mental illness, and to generate awareness about mental illness in the community.

Currently, DMHP is implemented in only 123 districts of the country [11]. In the Eleventh five year plan, training of health worker and community workers in mental health care is added in DMHP. National Rural Health Mission (NRHM) is flagship programme of GOI in rural areas. Under NRHM, Village Level Committee (VLC) /Village Health and Sanitation Committee (VHSC), and Accredited Social Health Activist (ASHA) came into existence as a part of community participation. Hence, ASHA, community leaders along with health care providers in rural area are important stakeholders for implementation of DMHP. Positive attitude about mental illness reflects supportive and inclusive behaviors towards mentally ill person. Negative attitude may lead to avoidance, exclusion, exploitation, and discrimination of mentally ill person in the community. Also, the pre-existing attitude of various stakeholders would determine the content of training required to make them an effective vehicle for mental health care in rural area. The differential need, if any, of various stakeholders can be addressed in customized manner if we know their attitude towards mental illness.

### Aims & Objectives

To study attitude toward mental illness of various stakeholders for implementation NMHP in rural area of Faridabad district of Haryana.

### Material and Methods

A cross-sectional study was carried out in the Ballabgarh block of Faridabad district in Haryana from January – June 2013. Study area consisting of 85 villages with population of around 2,12,000 (Year 2012). The study area was served by five Primary Health Centers (PHCs) and one Community Health Center (CHC). Each PHC was staffed by a medical officer/doctor, three to four staff nurses, three Health Assistants, and 10 – 12 health workers. Medical officer and staff nurses provide health care at the PHCs. Health assistants and health workers provide services at the village level. In each PHC, one ASHA was allotted approximately 1,000 population. Community leaders included in the study were village headman (Sarpanch), Chairperson, General Secretary of Village Health and Sanitation Committee (VHSC), and Chairperson (Pradhan) of

women Self Help Group. List of all health care providers, ASHAs and community leaders was obtained from respective PHCs. All these stakeholders in the study area were approached for participation in the study. All health care providers and ASHAs were interviewed at the respective PHCs in monthly meeting. All community leaders were approached in the villages for the interview.

**Study Tool:** Opinion about Mental Illness for Chinese Community (OMICC) scale

Attitude about mental illness was studied by using OMICC scale. Hindi version of OMICC scale was used previously in Indian setting by Salve *et al* [9]. Same version was used in this study. OMICC scale was developed by Ng *et al* [12] on the basis of face validity; building on the scale of Opinion about Mental Illness (OMI) developed by Cohen and Strunning, [13] and small scale survey with mental health professionals.

OMICC scale covers six domains as follows -

1. **Benevolence**—Items related to kind orientation towards people with mental illness
2. **Separatism**—Items emphasize the distinctiveness of people with mental illness and to keep them away at a safe distance
3. **Stereotyping**—Items that fixed people with mental illness in a particular behavioral pattern, mental ability, and mannerism
4. **Restrictiveness**—Items that held a doubtful view on the right of people with mental illness
5. **Pessimistic prediction**—Items that held the view that people with mental illness are unlikely to improve, and that how society treats them, is not optimistic
6. **Stigmatization**—Items that perceived mental illness as shameful, that sufferers should be kept from being known to others.

Factor analysis of the OMICC scale with 34 questions in “six” domains has been reported to yield a Cronbach’s Alpha of 0.866 [12].

**Data analysis:** Data entry was done in Microsoft excel (version 2007 for windows) and analyzed using SPSS version 13 for windows. Analysis of OMICC attitude scale was done like any other likert scale. Responses of this scale were on a five point likert scale. All these responses were coded from one to five except for benevolence domain. For benevolence domain responses were reverse coded. Mean and standard deviation (SD) was calculated for each question. Pooled mean was calculated for each of the five domains separately. Attitude in each

domain was determined on the basis of pooled mean values for the respective domain. Pooled mean values higher than 2.5 was considered as negative in the respective domain.

**Ethical issues:** Written informed consent was taken from the study participants. Permission for using OMICC scale was obtained from the authors. Ethical clearance for the study was taken from Ethics Committee of All India institute of Medical Sciences, New Delhi.

## Results

Line list of study participants that included 280 community leaders, 207 ASHA and 101 health care providers was obtained from all PHCs. Out of them, 251 (89.6%) community leaders, 145 (70.0%) ASHA and 81 (80.1%) health care providers were participated in the study. In total, 467 participants were included in the study ([Table 1](#)). Of the total study participants, 365 (73.3%) were between 25 to 45 years of age, followed by 77 (16.7%) of aged more than 45 years of age.

Results of attitude about mental illness are described separately for each type of stakeholder ([Table 2](#)).

**Community leaders:** Higher pooled mean was reported for stereotyping (3.6), restrictiveness (2.8) and pessimistic predictions (2.7). Community leaders including village headmen were of the view that people with mental illness were of stereotyped symptomatically, and that their role in the society was limited. Also, community leaders believed that mentally ill person didn't have good future.

**ASHA:** Higher pooled mean was observed for stereotyping (3.6). ASHAs in the study area were reported to identify mentally ill person with particular behavioural pattern, mental ability, and mannerism. However, ASHAs were of the view that mental illness was curable. They also felt that mentally ill person had equal rights. ASHA were optimistic towards future of mentally ill person in society.

**Health Care providers (HCP):** HCP in the study included medical officers/ doctors (5), staff nurses (12) and health workers (64) working at health facilities in the study area. Higher pooled mean was reported for stereotyping (3.2). HCP identified mentally ill person with particular behaviour and mental ability. Among health care providers, there was hardly any difference in stereotypical attitude between paramedical staff (health workers, staff nurses) and medical officers (3.3 Vs 3.2). However, all HCP were optimistic towards treatment of mental

illness, right of mentally ill person in the society, and future of mentally ill person.

Across all study participants lower pooled mean for benevolence and stigmatization domain were reported. All community leaders, ASHAs and health care providers reported kind and non-stigmatizing attitude towards mentally ill person.

## Discussion

In this study, we have reported the attitude of community leaders and health care providers in the rural area of Haryana, north India. It is necessary to understand attitude of various stakeholder of the community about mental illness to ensure success of NMHP in the country. In this study, all health care providers reported optimistic, non-stigmatizing attitude towards person with mental illness. NMHP envisaged essential role of HCP of rural area in awareness generation activities and hence their positive attitude is likely to help to implement NHMP effectively [10]. ASHAs and community leaders reported kind and non –stigmatizing attitude towards patient with mental illness is similar to attitude of the general population reported earlier [14,15]. Though ASHAs and community leaders were not in support of isolating person with mental illness in the society. However, restrictive attitude was observed among community leaders when it came to marriage or child bearing. Also, community leaders were pessimistic when it comes to career or job opportunity for person with mental illness. These finding are in agreement with the study reported by Singh AJ *et al* [14] and Karmode *et al* [16]. This restrictive and pessimistic attitude of community leaders can hinder the successful implementation of NMHP.

All study participants, including HCP, reported to be able to identify mentally ill person with few characteristic behavior and mannerism. This might be due to relating mental illness to its severe form only, and lack of knowledge about other milder forms of the disease by the study participants. There is a need for creating awareness about mental illness among all stakeholders of NMHP. Training programme for health care providers working in rural area under NMHP should be focused on spectrum of mental illness. For ASHA and other stakeholders it should be more focused on causes, treatment places, and outcome of treatment and care of mentally ill person in the community.

## Conclusion & Recommendations

In rural Haryana, pessimistic, stereotypical and restrictive attitude towards mental illness was reported among community leaders. Health Care providers and ASHAs reported stereotypical attitude towards mentally ill person. In rural area, ASHA has a pivotal role in linking health system with the general population. Person's attitude about mental illness is reflection of knowledge about mental illness, exposure to mentally ill person and cultural stereotypes about mental illness [17]. Hence, sensitization of ASHAs along with community leaders such as village headman, Chairman of VLC/VHSC and self-help groups in bio-medical concepts of mental illness is essential to implement awareness generation activities under NMHP. Thiruvananthapuram, Kerala model of integrated primary care for mental health has documented that simultaneous increase in public awareness reduces stigma, and encourage people to seek care [18]. Similar findings were reported in the study from other developing country [19,20,21]. Hence, role of health education is pivotal for the success of NMHP. This will not only ensure increased health seeking behavior but also reduce the burden of mental illness in the rural community.

## Limitation of the study

Though cut-off criteria of negative attitude i.e. mean score >2.5 was used in study by Salve *et al* [9] for OMICC, it was arbitrary. It was based on being more than half of the maximum possible score i.e. 5.0. More stringent cut-offs (pooled mean >3) would have to underestimation of negative attitude towards mental illness among community leaders. Possibility of social desirability bias in responding to the OMICC scale could not be ruled out. This might be the reason for positive attitude in stigmatization and benevolence domain of OMICC scale

## Relevance of the study

This study describes attitude about mental illness of frontline health care workers and community leaders who are responsible for the success of National mental Health Programme in India.

## Authors Contribution

HRS, SB: Conceived the study, Data Collection, Data Analysis; SKR, RS, SK - Supervision of Data Collection; HRS, SKR, SK - Drafting the Manuscript; All authors: Review and approval of the Manuscript

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**Tables**

**TABLE 1 DISTRIBUTION OF STUDY PARTICIPANTS BY STAKEHOLDER CATEGORY AND SEX**

Stakeholder category	Males	Females	Total N (%)
Community leaders	98	143	241(51.6)
ASHA*	Not applicable	145	145 (31.0)
Health care providers	23	58	81 (17.4)
<b>Total</b>	<b>121</b>	<b>346</b>	<b>467(100.0)</b>

\*Only female are eligible to become ASHA

**TABLE 2 DISTRIBUTION OF POOLED MEAN (STANDARD DEVIATION) OF OMICC SCALE BY DOMAIN AND STAKEHOLDER CATEGORY**

OMICC domain	Community leaders	ASHA	Health Care Provider
Separatism	2.5 (0.5)	2.4 (0.6)	2.4 (0.6)
Stereotyping	3.6 (0.9)*	3.2 (1.1)*	3.2 (1.1)*
Restrictiveness	2.8 (0.9)*	2.4 (1.1)	2.4 (1.1)
Benevolence	1.6 (0.5)	1.7 (0.5)	1.6 (0.4)
Pessimistic prediction	2.7 (0.8)*	2.5 (0.8)	2.5 (0.8)
Stigmatization	2.0 (0.9)	2.1 (0.9)	2.1 (0.9)

\*Negative attitude (pooled mean > 2.5)