Chapter One

Introduction, Definitions and Concepts of MH and MI

Mental Health (MH):-

The word ‘health’ implies a search for well-being that will enable a person to achieve their life goals. This reflects the great NHS Act of 1948, which rejected the ‘sickness’ model for its citizens because its founder, Nye Bevan, saw positive health, including social and psychological as well as physical health, as a social and a political goal (Foot 1978). Thus, social work and social care are part of that wider view of the ‘healthy’ state, which incorporates all aspects of the person and seeks to serve the citizen at every stage of their lives, rejecting any qualification based on gender, class, age or any ‘other status’ (UN 1948).

Health is a process, which has positive as well as negative aspects, such as good or bad health. Interestingly, the *Shorter Oxford Dictionary* includes the spiritual and moral along with the mental aspects of health, first noted in the seventeenth century whereas health activity, healing and cure were so defined almost a century earlier and a little later as making positive comment or regard, wishing a person ‘good health’. As ‘mental’ is perceived and described as a process that is allied to notions of states of health and ideas of ‘disorder’. At the heart of the concept of ‘mental health’, therefore, is the dual process of mind and body. Within the norm of human experience, we all know how well or ill we feel, when either mind or body is transiently ‘disordered’ or under functioning, which is determined and experienced by the ‘mind’ the sense of self.

Mental health is a state of well-being in which an individual

- realizes his or her own abilities,
- can cope with the normal stresses of life,
- can work productively and is able to make a contribution to his or her community.

The foundation for individual well-being and the effective functioning of a community and it is an integral part of health; there is no health without mental health.

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society.

Mental disorders of concern due to high prevalence and/or severity of condition include, but are not limited to, schizophrenia and bipolar disorder (referred to as severe mental disorders), depression, anxiety, somatoform disorders (referred to as common mental disorders), epilepsy, alcohol and substance abuse disorders and child and adolescent mental health problems. Suicide is an extreme but common outcome for people with untreated mental disorders, particularly depression and substance abuse, which are associated with up to 90% of all cases of suicide in most countries.

Therefore, **mental health** is the balanced development of the individual's personality and emotional attitudes, which enable him to live harmoniously with his/her fellowmen and the capacity in an individual to form harmonious relations with others and to participate in, or contribute/constructively to changes in his social and physical environment.

Mental Illness (MI):

One 'cultural' problem is that knowledge and information are truly beginning to be globalised. For example, while what is recognized as disturbed and disturbing behavior in countries such as India and China, apparently with very different cultural norms, physicians and psychiatrists from that culture, who have been trained in 'Western' medicine, utilize concepts of mental disorder (Lau 1989; Obafunwa and Busuttil 1994). The question then becomes are they fitting round pegs into square holes, and can such concepts have cross-cultural validity? The answer is 'yes', there is a degree of cross-cultural validity, based upon one of the most prestigious and respected non-governmental organizations (NGO), the World Health Organization (WHO). The WHO uses the term 'disorder' to imply 'the existence of a clinically recognizable set of symptoms or behavior, associated in most cases with distress and interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here' (my emphasis). Interestingly, the WHO eschewed the term 'disease' or 'illnesses, thus avoiding any inference as to cause. Hence, even though they acknowledged that the term 'disorder' was not exact, it is preferable to the other two as it avoids inference as to cause, and is essentially therefore a descriptive term of patterns of human behavior and experience that have been found in all cultures. The traditional division between 'neurosis' and 'psychosis' has been maintained. The former concerns 'stress-related and somatic (body) disorders'. This is in contrast to 'psychosis', which mainly indicates the presence of hallucinations (disordered perception)

and/or delusions (false beliefs), or gross excitement and over activity or marked psychomotor retardation.

Epidemiology

Generally, there is lack of comprehensive data concerning the epidemiological aspects of mental illness. However, it is believed that mental illnesses are as prevalent in low-income countries as in the rest of the world and different epidemiological studies have shown that;

- Females have higher rates of mental illness than males, but some mental illnesses like drug abuse are more prevalent in males.
- Income is not well associated with mental illnesses but less severe mental disorders are common in high social classes and more severe mental disorders are found in low social class.
- Mental illnesses are more common in those with large family size and in those who are single rather than married.
- They are seen more in cities than rural areas and the prevalence increase with the size of the city
- There is a general tendency for mental illnesses to be more severe with increasing age.

The 1994 annual report of the Ministry of Health of Ethiopia showed that out of the patients seen at health institutions in one-year period, only 1.4% attended the clinics because of mental illness. Mental illnesses or behavioral problems in children are given even less attention than those of adults in Ethiopia. In 1968, it was reported that only 11 of 18, 978 children who attended clinics showed some form of mental disturbance. In a community study among children, 3 - 4% of those less than nine year-olds, and 5 - 10% of 10 - 19 years suffered from psychiatric illnesses.

Etiologic Factors/ reasons for Mental Illness

There is no known single causative agent for mental illness. One or more of the following factors cause mental illnesses.

- Genetic factors such as abnormalities in chromosomes may cause mental illness.
- Children from mentally ill parents are more likely to develop mental illnesses than children of healthy parents.
- Organic factors like cerebrovascular diseases, nervous system diseases, endocrine diseases, and chronic illnesses such as epilepsy are associated with mental illnesses.

- Social and environmental crises like poverty, tension, emotional stress, occupational and financial difficulties, unhappy marriage, broken homes, abuse and neglect, population mobility, frustration, changes in life due to environmental factors like earthquakes, flood and epidemics are associated with mental illness
- Environmental factors other than the psychosocial ones capable of producing abnormal human behavior include toxic substances such as carbon disulfide and monoxide, mercury, manganese, tin, lead compounds, etc.
- Psychological factors like early childhood experiences of abuse and other psychological trauma during childhood play an important role in the development of mental illness in adult life
- Behavioral factors like indulging in drugs, alcohol, and substances like khat are associated with mental illness.
- Other factors associated with mental illness include nutritional deficiency; infections before and after delivery and birth trauma; road, occupational and other accidents; and radiation accidents.
- The nervous system is most sensitive to radiation during the period of neural development.

Types of Mental Illness

The division is based on Neurosis (which concerned with stress related and somatic or body disorder) and psychosis (related with psychomotor retardation.

- ♣ Minor Mental Illness/Neurosis:
  - ✓ not caused by the organic imbalance
  - ✓ the disorder between the connation, cognition and affection is temporary
  - ✓ It can be cured if we provide non-pharmacological management

  E.g. stress, phobia, mania (mood disorder)

- ♣ Major Mental Illness/psychosis:
  - ✓ Bio-chemical imbalance(this normally act as neuro transmitters so it will have problems)
  - ✓ Endocrine system problems (This is a gland which secrete hormones and other products to mix with blood. So it is problem)
  - ✓ Inability to perceive 5 senses-eye-ear-nose-tactile and olfactory

- ✓ Imbalance between Connation, Cognition and Affection
- ✓ Loss of insight
- ✓ Unable to aware about himself/oneself
- ✓ So the major mental illness is caused by organic imbalance in the brain

e.g. schizophrenia, delusion, hallucination and Alzheimer's etc.

Clinical Features of Common Mental Illness

Mental illnesses have diverse signs and symptoms, which are grouped or clustered together to become a specific diagnosis. These groups of symptoms and signs should be persistent and intense to indicate mental illness.

I. Disorders of perception

The most distinctive phenomena in mental illnesses are disorders of perception. They are:

- Illusion: Misinterpretation of real external sensory stimuli

  E.g. A person looks at a cracked wall and sees branched tree.

- Hallucination: False sensory perception not associated with real external stimuli.

  E.g. A person sees spiders and snakes on the ceiling of his or her room where there are none.

II. Disorder of thinking

- Delusion: Patients may have fixed false beliefs that cannot be corrected by reassuring and are not ordinarily accepted by other members of the particular person's culture.

  E.g. A person believes that an external force controls him or her, as pace man sends him message by radio. The patients may also have exaggerated self-importance.

  E.g. A person believes he is the Prime Minister of Ethiopia when he or she is not.

III. Disorders of emotion

This involves a sustained abnormal feeling tone experienced by patient. Such patients may have low mood, anger, anxiety, or excessive happiness without any reason.

E.g. A person laughs at a sad event like death of a loved one.

A depressed person might feel that life is not worth living.

IV. Disorders of motor activity

These are abnormalities of social behavior, facial expressions, and posturing.

E.g. standing on one leg for a long time.

V. Disorders of memory

This is the inability to retain and recall information (distortion of recall).

E.g. A person suddenly and unexpectedly leaves home and is unable to return.

A person may find it difficult to remember what he or she had for breakfast after few hours.

VI. Disorders of consciousness

This is the impaired awareness of the self and the environment. The level of consciousness can vary between the extremes of alertness and coma.

VII. Disorders of attention and concentration

This is the inability to focus on the matter at hand and failure to maintain that focus.

VIII. Insight

- This is defined as awareness of one's mental condition. Patients who do not have insight do not know that they are sick and thus fail to seek medical attention. People who are mentally healthy may exhibit some of the traits of mental illness when they are under stress and show adaptive behavior that serves to satisfy their basic needs in a socially

acceptable way. Refer to the comparative characteristics of mentally healthy and ill individuals.

Approaches to differentiate Mental health and Mental illness

1. Biomedical approach

Mental illness results from biological factors such as our genes and neuro-chemicals. It views health and illness as opposites, as forming a dichotomy such that one is either sick or well and fit into a specific disease category once specific symptoms. It bases on Diagnostic and Statistical Manual of Mental Disorders (DSM) to determine levels of mental disorder in the general population. The current DSM identifies more than 400 distinct mental disorders. These disorders are assumed to be discrete (i.e., they do not overlap with one another).

2. Mental health continuum

It is viewing mental health and illness in terms of a continuum, with health and illness at opposite ends of the poles and most of us falling somewhere in between. It assesses not only the problem but also its severity and frequency along a continuum. Familial conditions, social causes, unknown conditions, being a part of certain social group/in certain historic period

Mental health _____ mental health problems_____ Mental illness

Risks: risks are probability or likelihood of a future event given conditions or a group of people with similar characteristics is more likely than others in the population to develop a problem.

Risk factors; are factors that may increase the risk of developing mental health problems. Although the precise cause of mental illness is not known, certain factors may increase your risk of developing mental health problems, including:

- Having a biological relative, such as a parent or sibling, with a mental illness
- Social isolation or social exclusion (stigma) - having few friends or few healthy relationships
- The incidence or the impact of negative life events and experiences (stress)
    - A loved one's death or a divorce

- Long-term illness or disability
- Abuse or neglect as a child
- Abusive relationships as an adult
- The impact of deprivation, i.e. economic disadvantage, low educational attainment, quality of living environment

Protective factors; are factors that reduce, moderate, or provide resistance to a future event. Not the opposite of risk but rather affect or compensate for risk. As with risk, can be individual, family, community, or peer group factors.

Diagnosis of Mental Illness

Psychiatry deals with causes and treatment of mental illness and the care to be given to such patients, who are considered abnormal in their behavior. In general, the symptoms are too vast and complex to reach a correct diagnosis of the illness, which it needs to comprise different approaches and models. Within the scope of this module, the best approach to the diagnosis of mental illness is to use the skills of:

1. Detailed history taking
2. Mental status examination.

Meaning and definition Psychiatric Social Work

Meaning

Psychiatric social work is an organized work intended to advance the social conditions of a mentally ill person by providing psychological counseling, guidance, and assistance, especially in the form of social services.

Psychiatry social work incorporates a specialist who utilizes the techniques of both social work and psychiatry to serve the community. Under general supervision, provides clinical social work services to clients in an out-patient mental health center; performs related work as assigned Psychiatric social work is the use of all social work processes in the treatment of patients in a psychiatric or mental health setting.

Psychiatric Social Worker under direction, to provide needed social services to residents with psychiatric, behavioral, emotional, and/or physical disabilities, and to do related work as required. In simple words a 'psychiatric social worker is a specialist who utilizes the techniques of both social work and psychiatry to serve the community.

History of Psychiatric Social Work in the World Scenario

- ✓ Mental health considered as illness because of demons and sins
- ✓ Barbaric treatment during medieval period in the name of cleansing and propitiation (pacify)
- ✓ Common adopted treatments were bloodletting, starvation, blistering, purging (removal), whippings.
- ✓ There was overcrowding in insane asylums, criminal houses, jails, and prisons.

Psychiatric social work or the practice of social work in relation to psychiatry in Ethiopia has followed the pattern set out in the west. In order to understand its development in Ethiopia, it is essential to examine the growth of the field in the United States. The development of this field in Great Britain, however, presents a contrast to that in the United States. In the United States, the model of practice has been primarily curative and therapeutic in orientation as opposed to the British model which emphasizes prevention and a thrust on affecting changes within the social environment. A brief view of the growth of social work in Britain is, therefore, essential for understanding the evolution of the field in its perspective.

Developments in the United States

At the turn of the present century there was a definite shift in the interest among psychiatrists in the United Stated to look at mental health disease from diagnosis and classification perspective to one of understanding the personality of the patient in relation to his social environment. Recognizing the importance of the environmental factor, some psychiatrists make use of 'agents' for obtaining information from relatives about the family background and life experiences of the patients.

In addition to collecting case histories, they were expected to act as intermediaries between the patients and their families so that the treatment as well as their rehabilitation in the

family was facilitated. In 1905 for the first time a social worker was employed in a general hospital, in the neurological clinic of Massachusetts General Hospital. In the following year, the New York Charities Aid Association, through its committee of Mental Hygiene, employed 'after-care agents' for supervising patients discharged from mental hospitals. Encouraged by the work of these 'after-care agents' an increasing number of mental hospitals and clinics in the United States began to employ field workers.

However the real impetus to the development of psychiatric social work was seen in 1913 when the Boston Psychopathic Hospital established a social service department under the leadership of Dr. Earnest Sourthard and Mary C. Jarrett who was appointed Head of the Psychiatric Social Service Department. The term psychiatric social work was used for the first time in the book 'Kingdom of Evils' written by Sourthard and Jarrett. This book spelt out in detail the scope of social service in relation to the mentally ill. By providing placement to students in the newly formed social service department, the need for special training for working with the mentally ill was emphasized. In 1918, a training course for psychiatric social workers was introduced at Smith College, Northamplin, Massachusetts.

During the First World War, a large number of social work personnel were needed to assist the medical officers in obtaining information about the personal and family background of servicemen and also for dealing with the trauma resulting from the war situation. The network of Veterans Administration that came into existence as a result of the war, gave considerable impetus to the growth of psychiatric social work in the united States.

During this period, social workers became increasingly aware of the impact of emotional disturbances on the capacity of the individual to adjust to the environment. The first comprehensive evidence of social workers' interest in the impact of the environment on personality was reflected in the writings of Mary Richmond. In her book 'Social Diagnosis' (1917), she laid emphasis on the personality of the client, his relationship to others and the need for understanding motives behind an individual's behavior. In her later writings, she pointed out more specifically the significance of psychological factors in social maladjustment.

The emergence of the mental hygiene movement toward the beginning of the present century also arouses the interest of social workers in the psychological aspects of the problems of

patients. Increasing concern about the problems of children as well as the pioneering work done by Dr. Willima Healy with juvenile delinquents led to the establishment of child guidance clinics around 1920. Subsequently, the growth of the child guidance movement brought about a new synthesis of specialties' like psychiatry, psychology and social work. The child guidance movement had a significant bearing on psychiatric social work, as it perceived the social worker as an important member of the mental health team with a distinct role. In the child guidance settings, social workers began to enjoy greater freedom of working, planning and implementing the social treatment programs. It was perhaps for this reason that psychiatric social workers preferred positions in child guidance to other fields of during this period.

The American Association of Psychiatric Social Workers came into existence in 1922, initially as a part of the American Association of Hospital Workers and later as an independent body in 1926. The Association made an invaluable contribution in guiding the growth of the field and maintaining the standard of training and education in this area of social work practice. During the Second World War, the Association was intensively involved in working with military personnel and their families. By the end of the war the role of the psychiatric social worker had extended beyond case work services to intervention strategies and assumed the responsibility of implementing a variety of clinical and educational programs. The Second World War had created a general public awareness about the problem of mental illness, its causes and the need to prevent it. This led to the enactment of several legislation resulting in the enlargement of the scope of psychiatric social work. Federal funds were made available for instituting training programs for psychiatric social workers. Gradually, social workers began to be employed by many more psychiatric hospitals and clinics and they came to be recognized as integral members of the psychiatric team. The responsibilities of social workers, however, varied in different settings. Initially, psychiatric social workers were required to obtain the social history of the patient by contracting his family and assisting in the formulation of diagnosis. However due to a shortage of personal, they began to participate in psychotherapy under the medico-legal sanction in advanced courses and training in order to enhance their therapeutic knowledge and skills to become effective psychotherapists.

The emergence of the concept of community mental health programs symbolized an attempt to amalgamate the knowledge gained from both the psychologist and the social sciences. All these developments led to a greater involvement of psychiatric social workers in the treatment and prevention of mental illness. In recent years psychiatric social workers in the United States have became increasingly involved in community mental health programs. They have been instrumental in bringing mental health services into closer contact with the community and in advocating greater participation of the community in the activities of the mental health units. While psychiatric social workers in the United States continue to be important members of the mental health team, their therapeutic role, however, is being less emphasized. In recent years psychiatric social workers have demonstrated increasing involvement and interest in preventive mental health programs. The field of mental health itself has moved into the realm of social welfare, focusing its interventions on the relationship between the individual and social institutions. As a result, social work has come to be recognized as the mainstay of mental health in all community based efforts in United States.

Developments in the UK

In the UK, the history of social work with the mentally ill can be traced to the second half of the nineteenth century when the After Care Association for the Female and Convalescent was established in 1877. In the forties this organization came to be known as the After Care Association for the Mentally Ill and it offered service to those patients who were ready to be discharged from mental asylums. However, it was not until the early twentieth century that public concern for the mentally ill was expressed when the Mental Deficiency Act 1913 was passed. Following the enactment of this Act, a number of voluntary associations were formed to implement the provisions of the Act. The Central Association for Mental Welfare was established to encourage the implementation of the Act and to coordinate the work of the other recently established voluntary associations. Much of the impetus for training of psychiatric social workers came from Evelyn Fox, Secretary of the Central Association for Mental Welfare, who emphasized the need for training as well as the importance of incorporating the teachings of psychiatry in the curriculum of training courses for social workers. Another important factor which highlighted the need for training was concern for

the welfare of children, particularly those shoeing taints of delinquency. The work of Cyril Burt in the area of juvenile delinquency yielded fresh insights into the causes of behavioral problems among children. The child guidance movement offered a new concept of social work practice based on clinical models. As compared to the earlier emphasis on reform, charity and social service, psychiatric social workers depended on psychiatry for knowledge which helped them to be distinct and exclusive from other social workers. The child guidance movement gave an impetus to training in psychiatric social work at the London School of Economics. The course included training for adult psychiatric services as well as for working with psychiatric and mentally subnormal patients. However, despite the introduction of specialized training, there was slow progress in the field.

The passing of the Mental Treatment Act, 1930, a landmark in the development of mental health policies in Great Britain, gave an impetus to the growth of the field. The important provisions of the Act included voluntary admission to mental hospitals, introduction of out-patient services, and increasing involvement of mental hospitals in preventive work. For quite some time the major functions of psychiatric social workers was the supervision of the mentally subnormal and care of patients discharged from hospitals. In 1941, a National after Care Project was launched. This project highlighted the role of psychiatric social workers in community services for the mentally handicapped. For the first time, psychiatric social workers were employed by the local institutions leading to the recognition of their contribution to the field of mental health. The project brought psychiatric social workers closer to social workers working in other fields.

After the Second World War, an attempt was made to recognize the health services in Britain on the basis of the Bevridge Report. The National Health Services was introduced to provide comprehensive health services in all cities. The passing of the National Health Services Act, 1946, shifted the major responsibility of community health care to the local authorities. This radical change in health care was followed by what Jones refers t as the three major revolutions in the field of psychiatry.

1. The pharmacological made it possible to alleviate the disturbing symptoms of mental patients by administering tranquillizers and this making them amenable to other forms of therapy.

2. The administrative revolution brought about by the WHO Model of Mental Health Services (1953) in which a variety of services: in-patient, out-patient, day care, domiciliary care – were recommended as part of community mental health services. Subsequently, these programs were developed and psychiatric social workers began to play an important role in rendering these services.
3. The revolution brought about by a series of reforms in the area of mental health which culminated in the enactment of the Mental Health Act, 1959. This Act, considered a landmark in the history of psychiatry, not only attempted to define mental disorders but also laid down in detail the administrative procedures for the care, treatment and discharge of mental patients.

From 1960 onwards, a general trend towards generic training was observed in Britain. This was a consequence of the publication of two reports – The Young husband Report 1959 and the Report on Health and Welfare recommended the training and employment of two grades of social workers, namely;

- ✓ professionally trained and experienced case workers for undertaking case work in difficult cases and for providing guidance to mental welfare worker, and
- ✓ officers with general training in social work to deal with general problems affecting health and welfare.

The inclusion of mental health work in the social service department was favored for two main reasons: (a) recognition of the fact that mental disorders tended to created a number of social problems for the families which social workers were best equipped to handle, and (b) the belief that non-inclusion of mental health services was likely to create further segregation of the mentally ill when the trend was towards integration of this group into the community.

In Britain, the mentally handicapped were no longer viewed as a segregated group to be treated by a separate provision of social services. They are covered under the general provision of education and medical services for the entire community. It implies a major shift in the policy for the care of the mentally ill form hospital to community care. It also makes social workers less dependent on doctors. Finally, it implies that instead of dealing separately with family members as individuals requiring different form of assistance, social service

covers the whole family as a unit thus avoiding a situation in which several social workers are responsible for different services for the same family.

Social Service Act was enacted in the year 1970; as a result the main branches of the Association of Professional Social Workers including the Association of Professional Social Workers including the Association of Psychiatric Workers were amalgamated/mixture into a single body called the British Association of Social Workers. In UK the emphasis of social services has been on tackling the ills of the society.

Scope of Psychiatric Social Work

Scope is wider and broader Psychiatric Social Workers can work as
Case Managers
Researchers
Rehabilitators
Work in acute psychiatric hospitals
In mental health
In community mental health
In multidisciplinary team
Changing perspectives and trends in mental health and PSW

Focus on

- Mental Health education
- Mental Health promotion
- Mental illness prevention

Knowledge of Psychiatric Social Work

1. Principles, practices and theory of psychiatric social work including trends, standards and terminology;

2. Techniques and methods of psychotherapy and casework including group psychotherapy dynamics;

3. Adult and child psychology, including development and psychopathology;

4. Characteristics and types of mental disorders;

5. Applicable city, state and federal guidelines and laws affecting mental health treatment services and reporting procedures;

6. Community social service, resources, other health, financial, social, recreational, cultural, housing, and legal advocacy services.

Skills of Psychiatric Social Work

1. Assessing and evaluating client mental health status, developing effective treatment plans and making appropriate referrals;

2. Providing on-going psychotherapy and support for individuals, groups and families;

3. Coordinating treatment with other community agencies and services;

4. Performing crisis intervention as necessary;

5. Providing case management services to the chronically mentally ill;

6. Preparing complete and detailed documentation of client visits and other required reports;

7. Maintaining organized and accurate records;

8. Conducting mental health educational programs and/or workshops;

9. Identifying the cultural issues affecting mental health practice;

10. Establishing and maintaining effective working relationships with other clinicians, city staff, community health or other referral agencies and the public.

What is Mental Illness and why psychiatric social workers in hospitals

Mental illness is characterized by chemical imbalances in the brain that usually respond well to a combination of medication and talk therapy. Mental disorders have a biological basis, contrary to longstanding perception that they result from poor upbringing or character weakness. Persons of any age, race, ability level, or socioeconomic status can be affected.

According to the World Health Organization, one in four persons will experience a serious mental disorder at some point in their lives. Among the leading causes of lost productivity and absenteeism in the workplace, mental illness is also expected to be the number one cause of disability worldwide by the year 2010.

Stigma

Historically, there has been a shroud of stigma surrounding mental illness. This stems from a very early distinction in philosophy and treatment of illnesses of the mind from illnesses of the body. Only in recent times have there been widespread efforts to educate the public about the biological basis and effective treatments for mental illness. Still, since stigma remains, mental health treatment is delivered with the highest possible regard for confidentiality.

Spring Harbor and Maine Medical Center's Department of Psychiatry are helping reduce stigma by reintegrating the treatment of mind and body illnesses within the primary-care setting. The model places mental health professionals within select physician offices across southern, central, coastal, and western Maine. Therefore, the doctor to an onsite mental health specialist refers patients with mental health concerns. This evidence-based model helps ensure timely screening, diagnosis, and treatment of psychiatric issues.

Chapter Two

Social Work Roles in Mental Health Service

Classifications of Mental Disorders

The classification of mental disorders, also known as psychiatric nosology or taxonomy, is a key aspect of psychiatry and other mental health professions and an important issue for people who may be diagnosed. There are currently two widely established systems for classifying mental disorders—Chapter V of the International Classification of Diseases (ICD-10) produced by the World Health Organization (WHO) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) produced by the American Psychiatric Association (APA). Both list categories of disorders thought to be distinct types, and have deliberately converged their codes in recent revisions so that the manuals are often broadly comparable, although significant differences remain.

Other classification schemes may be in use more locally, for example the Chinese Classification of Mental Disorders. Other manuals have some limited use by those of alternative theoretical persuasions, such as the Psychodynamic Diagnostic Manual.

The widely used DSM and ICD classifications employ operational definitions. There is a significant scientific debate about **the relative validity** of a "categorical" versus a "dimensional" system of classification, as well as significant controversy about the role of science and values in classification schemes and the professional, legal, and social uses to which they are put.

Definitions

In the scientific and academic literature on the definition or categorization of mental disorders, one extreme argues that **it is entirely a matter of value judgments** (including of what is normal) while another proposes that **it is or could be entirely objective and scientific** (including by reference to statistical norms). However, other views argue that the concept refers to a "fuzzy prototype" that can never be precisely defined, or that the definition will always involve a mixture of scientific facts (e.g. that a natural or evolved function is not working properly) and value judgments (e.g. that it is harmful or undesired). Lay concepts of mental

disorder vary considerably across different cultures and countries, and may refer to different sorts of individual and social problems.

The WHO and national surveys report that there is no single consensus on the definition of mental disorder/illness, and that the phrasing used depends on the social, cultural, economic and legal context in different contexts and in different societies. The WHO reports that there is intense debate about which conditions should be included under the concept of mental disorder; a broad definition can cover mental illness, mental retardation, personality disorder and substance dependence, but inclusion varies by country and is reported to be a complex and debated issue. There may be a criterion that a condition should not be expected to occur as part of a person's usual culture or religion. However, despite the term "mental", there is no necessarily a clear distinction drawn between mental (dys) functioning and brain (dys) functioning, or indeed between the brain and the rest of the body.

Most international clinical documents avoid the term "mental illness", preferring the term "mental disorder". However, some use "mental illness" as the main overarching term to encompass mental disorders. Some consumer/survivor movement organizations oppose use of the term "mental illness" because it supports the dominance of a medical model. The term "serious mental impairment" (SMI) is sometimes used to refer to more severe and long-lasting disorders while "mental health problems" are used as a broader term, or to refer only to milder or more transient issues. Confusion often surrounds the ways and contexts in which these terms are used.

Mental disorders are generally classified separately to neurological disorders, learning disabilities or mental retardation.

ICD-10

The International Classification of Diseases (ICD) is an international standard diagnostic classification for a wide variety of health conditions. The ICD-10 states that mental disorder is "not an exact term", although is generally used "...to imply the existence of a clinically recognizable set of symptoms or behaviors associated in most cases with distress and with interference with personal functions.

F0: Organic, including symptomatic, mental disorders

F1: Mental and behavioral disorders due to use of psychoactive substances

F2: Schizophrenia, schizotypal and delusional disorders

F3: Mood [affective] disorders

F4: Neurotic, stress-related and somatoform disorders

F5: Behavioral syndromes associated with physiological disturbances and physical factors

F6: Disorders of personality and behavior in adult persons

F7: Mental retardation

F8: Disorders of psychological development

F9: Behavioral and emotional disorders with onset usually occurring in childhood and adolescence

The ICD includes personality disorders on the same domain as other mental disorders, unlike the DSM.

Note: ICD 10, is being revised by WHO. (ICD 11 is due by 2018).

Refer www.who.int/classifications/**icd**/revision/en/ for an update. You can also read the beta draft from www.who.int/classifications/**icd11**

DSM-IV

The DSM-IV was originally published in 1994 and listed more than 250 mental disorders. It was produced by the American Psychiatric Association and it characterizes mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual, and which is associated with present distress or disability or with a significant increased risk of suffering. But no definition adequately specifies precise boundaries for the concept of 'mental disorder', different situations call for different definitions" (APA, 1994 and 2000). The DSM also states that "there is no assumption that each category of mental disorder is

a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder."

The DSM-IV-TR (Text Revision, 2000) consists of five axes (domains) on which disorder can be assessed. The five axes are:

Axis I: Clinical Disorders (all mental disorders except Personality Disorders and Mental Retardation)

Axis II: Personality Disorders and Mental Retardation

Axis III: General Medical Conditions (must be connected to a Mental Disorder))

Axis IV: Psychosocial and Environmental Problems (for example limited social support network)

Axis V: Global Assessment of Functioning (Psychological, social and job-related functions are evaluated on a continuum between mental health and extreme mental disorder)

Types of classification schemes

- What are your views on the "categorical" versus “dimensional” debates?

Descriptive versus Somatic

Descriptive classifications are based almost exclusively on either descriptions of behavior as reported by various observers, such as parents, teachers, and medical personnel; or symptoms as reported by individuals themselves. As such, they are quite subjective, not amenable to verification by third parties, and not readily transferable across chronologic and/or cultural barriers.

Somatic nosology, on the other hand, is based almost exclusively on the objective histological and chemical abnormalities, which are characteristic of various diseases and can be identified by appropriately trained pathologists. While not all pathologists will agree in all cases, the degree of uniformity allowed is orders of magnitude greater than that enabled by the constantly changing classification embraced by the DSM system.

Cultural differences

Classification schemes may not apply to all cultures. The DSM is based on predominantly American research studies and has been said to have a decidedly American outlook, meaning that differing disorders or concepts of illness from other cultures (including personalistic rather than naturalistic explanations) may be neglected or misrepresented, while Western cultural phenomena may be taken as universal. Culture-bound syndromes are those hypothesized to be specific to certain cultures (typically taken to mean non-Western or non-mainstream cultures). While some are listed in an appendix of the DSM-IV they are not detailed and there remain open questions about the relationship between Western and non-Western diagnostic categories and socio-cultural factors, which are addressed from different directions by, for example, cross-cultural psychiatry or anthropology.

Criticism

There is some ongoing scientific doubt concerning the construct validity and reliability of psychiatric diagnostic categories and criteria even though they have been increasingly standardized to improve inter-rater agreement in controlled research. In the United States, there have been calls and endorsements for a congressional hearing to explore the nature and extent of harm potentially caused by this "minimally investigated enterprise".

Other specific criticisms of the current schemes include; attempts to demonstrate natural boundaries between related syndromes, or between a common syndrome and normality, have failed; the disorders of current classification are probably surface phenomena that can have many different interacting causes, yet "the mere fact that a diagnostic concept is listed in an official nomenclature and provided with a precise operational definition tends to encourage us to assume that it is a "quasi-disease entity" that can be invoked to explain the patient's symptoms"; and that the diagnostic manuals have led to an unintended decline in careful evaluation of each individual person's experiences and social context.

Some have argued that reliance on operational definition demands that intuitive concepts, such as depression, need to be operationally defined before they become amenable to scientific investigation. One critics states that "Instead of replacing 'metaphysical' terms such as 'desire' and 'purpose', they used it to legitimize them by giving them operational definitions. According

to Tadafumi Kato, since the era of Kraepelin, psychiatrists have been trying to differentiate mental disorders by using clinical interviews. Kato argues there has been little progress over the last century and that only modest improvements are possible in this way; he suggests that only neurobiological studies using modern technology could form the basis for a new classification.

According to Heinz Katsching, expert committees have combined phenomenological criteria in variable ways into categories of mental disorders, repeatedly defined and redefined over the last half century. The diagnostic categories are termed "disorders" and yet, despite not being validated by biological criteria as most medical diseases are, framed as medical diseases identified by medical diagnosis. He describes them as top-down classification systems similar to the botanic classifications of plants in the 17th and 18th centuries, when experts decided a priori which visible aspects of plants were relevant. Katsching notes that while psychopathological phenomena are certainly observed and experienced, the conceptual basis of psychiatric diagnostic categories is questioned from various ideological perspectives.

Psychiatrist Joel Paris argues that psychiatry is sometimes susceptible to diagnostic fads. Some have been based on theory (over diagnosis of schizophrenia), some based on etiological (causation) concepts (over diagnosis of post-traumatic stress disorder), and some based on the development of treatments. Paris points out that psychiatrists like to diagnose conditions they can treat, and gives examples of what he sees as prescribing patterns paralleling diagnostic trends, for example an increase in bipolar diagnosis once lithium came into use, and similar scenarios with the use of electroconvulsive therapy, neuroleptics, tricyclic antidepressants, and SSRIs. He notes that there was a time when every patient seemed to have "latent schizophrenia" and another time when everything in psychiatry seemed to be "masked depression", and he fears that the boundaries of the bipolar spectrum concept, including in application to children, are similarly expanding. Allen Frances has suggested fad diagnostic trends regarding autism and Attention deficit hyperactivity disorder.

- SSRI- Selective Serotonin Reuptake Inhibitor: is class of drugs that are typically used as antidepressants in the treatment of major depressive disorder and anxiety disorders.

Since the 1980s, psychologist Paula Caplan has had concerns about psychiatric diagnosis, and people being arbitrarily "slapped with a psychiatric label". Caplan says psychiatric diagnosis is

unregulated, so doctors are not required to spend much time understanding patients' situations or to seek another doctor's opinion. The criteria for allocating psychiatric labels are contained in the Diagnostic and Statistical Manual of Mental Disorders, which can "lead a therapist to focus on narrow checklists of symptoms, with little consideration for what is causing the patient's suffering". Therefore, according to Caplan, getting a psychiatric diagnosis and label often hinders recovery.

There are ten main categories of disorder listed, containing specific conditions that appear from research to be logically related to each other; these will be discussed separately as a baseline, not least to familiarize practitioners with 'psychiatric' concepts.

1. **Mood disorders** (F30-F39, ICD-10) which include:

– Manic episode; extreme excitements.
– Bipolar affective disorder; mania and depression.
– Depressive episode; ranging from mild to severe.

2. **Schizophrenia, schizotypal and delusional disorder** (F20-F29)

✓ Schizophrenia—the main group in which the person experiences hallucinations and delusions.
✓ Schizotypal disorder which include the mixed category of schizomood affective disorder.

3. **Organic mental disorders** (F00-F09)

Alzheimer's dementia.
Dementia in other diseases.
Dementia or personality disorder related to brain damage.

4. **Mental and behavioral disorders due to psychoactive substance use** (F10-F19)

£ Behavior disorders related to alcohol, which is linked to various substances.

5. **Behavioral syndromes associated with physiological disturbances** (F50-F59)

Eating disorders.
Sexual dysfunction without underlying organic cause and, for us, still somewhat controversial, the 'personality disorders':

6. **Disorder of psychological development** (F80-F89)

- Specific developmental disorders of speech and language.
- Specific developmental disorders of scholastic skills.
- Childhood autism.

7. **Behavioral and emotional disorders with onset in childhood and adolescence** (F90-F98)
    - ♣ Hyperkinetic disorders.
    - ♣ Conduct disorders.
    - ♣ Emotional disorders with specific onset in childhood.
    - ♣ Tic disorders (sudden jerky movement of face or limbs, apparently uncontrollable or impulsive).
8. **Neurosis, stress-related and somatoform disorders** (F40-F48)

≈ Phobic anxieties.

≈ Obsessive compulsive disorder.

≈ Reaction to severe stress—post-traumatic stress disorder.

≈ Dissociative (conversion) disorders.

≈ Somatoform.

9. **Disorders of adult personality and behavior** (F60-F69)

ϒ Specific personality disorders, including ‘paranoid’, ‘dissocial’, ‘emotionally unstable’, ‘histrionic’.

ϒ Habit and impulse disorders—pathological gambling, fire setting, stealing.

ϒ Disorders of sexual preference—not ‘homosexuality’, but fetishism, voyeurism, paedophilia, sado-masochism, etc.—all in today’s ‘cultural relativism’ probably considered controversial.

The next categories might well be considered essentially related to impairment of neurological development. Finally, a term, which seems singularly old-fashioned, stigmatized and inaccurate, ‘mental retardation’, is still used rather than ‘learning disability’:

10. **Mental retardation** (F70-F79)

These are grouped from mild to profound.

The first seven broad categories might reasonably be seen to ‘belong’ to psychiatry and have links with medicine because, as will be shown, there is a range of evidence to show that these conditions have varying degrees of biological features, as well as psychosocial factors. The learning disability categories are now recognized to be reactive to underlying organic conditions. However, the more socially orientated description of ‘learning disability’ was found to be more

useful in seeking to meet the needs of such people, rather than what became, irrespective of intent, the overly passive hospitalization leading to inadvertent social exclusion.

The neuroses, while traditionally belonging to the psychiatric-psychological field, are a different category. They can be thought to be at the end of a continuum of human behavior, spanning what might be assumed to be the 'normal', be it defined socially or as a statistical average or mode, to frank pathology of the psychosis.

The biggest problem, which requires further discussion, is that of the 'personality disorders', which is not to deny such characteristic adult patterns of behavior exist, but raises the question of etiology, namely are 'personality disorders' due to disadvantaged backgrounds, inadequate or abusive parenting, or were people born like that? This is a controversial issue as it reflects the reality of practice, and provides a range of professionals—psychiatrists, physicians, teachers, police and lawyers—with major dilemmas, which requires a chapter of its own.

Taking the ICD guidelines as a whole, there is value in considering the approach, providing throughout that we remember it was produced as a guideline for, without such a framework, we can become very confused and uncertain about what we are dealing with in the hurly-burly of daily practice.

Mood (affective) disorders

The mood disorders reflect the first two of Milton's great triad of madness—moping melancholia and demonic frenzy—translated into depressive and manic disorders.

Depression

Most humans have relatively low moods occasionally, often for no apparent reason, and, on reflection, most of us appreciate that our mood fluctuates mildly during the day. Individuals are usually described as either 'morning' or 'evening' people, depending on the time of day when they have greatest energy. Yet, self-evidently, in certain circumstances, we will feel misery and depression, classically during a period of ill health or in response to a broken relationship or bereavement: a low mood, a sense of misery, or a more prolonged feeling of depression is a natural reaction to misfortune and within the range of normal human experience.

There are two forms of depression; the so-called 'reactive depression' or 'mild depression' is in apparent response to external stressors, such as divorce, serious illness, or bereavement. The second is 'endogenous depression', apparently arising from within but with no apparent

appropriate 'cause'. However, one often finds that this form of depression is associated with a relatively mild trigger stress, but the person moves into a deep, pathological form of depression.

Models of Treatment: family and group

Understanding and intervening on the **effects of the patient's mental illnesses on their families** is crucial in psychiatric social work practice. Understanding the experience of persons who have to contend with a family member /sibling's mental illness (MI) along with the multiple challenges associated with **social status, cultural barriers, and economic challenges** is critical in mental health (MH) interventions. Thus, we need to:

- ♣ Understand as to who is involved in the care-giving and extent of burden, one caregiver or other family members.
- ♣ Definition of primary caregiver: in whose judgment and characteristics of primary care-givers (PCGs)
- ♣ Examining differences in family members' experiences: The amount of burden experienced or in the risk of developing psychiatric symptoms--between key and non-key relatives.

The **perspective and responses of family members** or sibling with illness, parental involvement, and the reciprocity of relationship are related with the impact and evolution of the presence of MI within families. Siblings and other relatives may show **a tendency to detach** themselves from participation in care-giving role and health care service use if they do not well understand the impact of MI on them. There is a wide assumption that **the demand for care-giving tend to fall to one individual** in the family.

Finch (1989) principles that influence which family member is likely to undertake the primary responsibility for care-giving:

- **Genealogical**: Spouse and Parent-child relationship
- **Household membership**
- **Gender**—more women than men (exception for looking after their wives)
- Instrumental (personal care) vs. **supervisory and anticipatory** care for a person with MI

- Little is known about the extent to which care-giving is shared
- **Social support** to caregivers is highly valued because the relatives in multiple caregiver families experience **less difficulty** than relatives who care alone.

Caregivers can be: Lone caregivers, Primary caregivers, and Non-primary caregivers

- **Lone caregivers**: a relative in frequent contact (i.e., face-to-face) with the patient with severe mental illness or the patient has frequent contact with only one relative.
- **Primary caregivers (PCG)**: any relative in frequent contact (i.e., face-to-face) with the patient with severe mental illness or the patient may has frequent contact with more than one relative, a relative who experienced the most care-giving demands
- **Non-primary caregivers (NPCG):** the patient had frequent contact with two or more relatives and relative who experienced less burden compared to primary caregivers.

What do mental health professionals really think of family members of mental health patients? Some studies indicated that mental health professionals working in community mental health agencies thought families as **supportive caregivers, as unsupportive agitators, as in pain, as uninformed and as unequal partners**.

Mentally ill family member, and the experiences and nature of care-giving intervention at family level:

- ✓ The patient's **parent** rather than sibling was identified as care-giver(PCG/ primary care givers
- ✓ **Spouse** rather than child was usually identified as the PCG
- ✓ Co-residence-contact (some studies revealed: the non-primary rather than the PCG who lived with the patient.
- ✓ PCG had more contact with the patient than NPCG
- ✓ The PCG was female rather than male
- ✓ Successful way of indentifying the PCG—self-ascribed status as PCG, just by asking questions, or other they were not.
- ✓ Comparison between PCG and NPCG: PCG experienced more demands of care giving; PCG reported more tension and worry than NPCG; PCG Reported more

urging, PCG appraised care giving more negatively than their non-primary counterparts; and Strong correlation between primary and non-primary caregivers.

- ✓ Comparison between Lone and PCG: Unemployment is high among lone caregivers and they are also more vulnerable to social isolation.

You should document the family members' impressions, hopes, needs, and worries that are related with emotion development and well-being of non-affected family members and/or siblings.

Interventions

- ♣ Interventions should aim at identifying, designing, and supporting either a person who care alone or the wider family/relatives if all involved; and should consider the perceptions of mental health professionals about family-based interventions.
- ♣ Accurately assess the effect of a patient's mental illness on the family
- ♣ Establish contextualized/local criteria to distinguish the primary care-giver, multiple-caregiver families or put explicit criteria for selecting one individual in the multiple caregiver family
- ♣ Consider that a relative who do not live with or have less contact with the patient or is a member of a multiple caregiver also has psychological distress.
- ♣ Greater psychological distress in one relative is likely to indicate greater psychological distress throughout the family.
- ♣ Help the family members to better understand the impact of MI in the family and stigmatize or wrong perceptions through planning and designing health and strengths-based approaches that address the needs of all the family members. Understand the family member's illness, how to cope with the problems caused by the illness, source of support, effects of medication and substance abuse and dealing with mental health professionals.
- ♣ Help the family members to play a critical role and backing each other in the care giving while helping them preserve their own quality of life.

- Promising positive outcome if interventions designed to address the specific needs of multiple and lone care-giver family.
- For lone caregiver, enable them to take up employment and other activities outside the home.
- For multiple caregiver families, more tension that arise from care-giver and focus on the ways of coping with the conflicts and tension.

CHAPTER THREE

APPROCHES OF PSYCHIATRIC SOCIAL WORK PRACTICE

- Social Work Approach to the problem of Mental Illness
- Social Work Approach to problem of Mentally Retarded
- Multi-Disciplinary Approach in Mental Health Settings

Social Work approach to problem of mental illness

(In inpatient care setting, emergency settings, and outpatient services)

In-patient care settings

Psychiatric Social Workers as part of the health care team provide assessment and appropriate interventions. They commonly provide individual, group and family intervention, crisis intervention at the time of crisis, patient/family and out-patient setting. Psychiatric social workers render psychosocial care and other services to patients and their families. Psychiatric social workers often have specific expertise in the areas of Adult psychiatry, child psychiatry, family psychiatry, de-addiction, neurology, neurosurgery, casualty and emergency set up and palliative care and community care.

Guidelines for working with individuals in inpatient care settings

Every patient is evaluated in terms of psychological and social aspects of functioning. Informed consent is obtained prior to starting a planned treatment program. This need to be done at out-patient department for patient requiring IP care under pre-admission counseling. In case patient is admitted under emergency care/mid week admission, it can be done as necessary before patent starts getting formal planned treatment.

- ♣ Preparing a psychosocial treatment plan that is appropriate for the patient's clinical conditions, age, and social-economic status.
- ♣ Clear written guidelines on the indications, rational for use of particular psychosocial intervention strategies.
- ♣ Informing the patients about their progress in each area of bio-psycho- social conditions

- ♣ Friendly, courteous, positive, purposeful and professional approach to the patients
- ♣ Regular meeting with the supervisor, to discuss the individual patient care plan and progress during ward rounds/ review meetings.

Guidelines for working with families in inpatient care settings

- ✓ Involvement of family members in the patients treatment program.
- ✓ Families need to be thoroughly oriented towards various mental illnesses, impact on health, family, occupational, psychological and social functioning.
- ✓ Complete family assessment within the first few days of admission so that intervention can be planned according to family environment, family socio- economic status, living arrangements, interaction patterns, and quality of relationships, family burden, family adjustment, family expectations and social support network.
- ✓ Encourage family members and caregivers to participate in family support, groups and other intervention program for family members.
- ✓ Encouraging family member to visit the patient on a regular basis.
- ✓ Inform the family members about the patient's health progress and conditions.
- ✓ Home visits for improving caring skills, coping skills of family members, office visits and agency visits for the purpose of collateral contacts, resource mobilization and rehabilitation
- ✓ Family members need to be educated on prodromal conditions, early warning signs of relapse, exacerbations, reappearance of symptoms, in terms of acute care management, managing crisis/emergencies and the need for re-hospitalization
- ✓ Preparation of discharge plans which includes maintenance medication, social, occupational and family needs; special areas of attention and specific risks.
- ✓ Standard information sheet to be given to the patients and family members with specific instructions.

Role of Psychiatric Social Worker in Inpatient Care

Psychosocial Assessment

- Self introduction and gathering information on socio-demographic profile of the hospitalized patients. Assessment of help seeking behavior and expectations of hospitalized patients, family members and significant others
- Assessment of families social burden and impact of psychiatric disorders, neurological, and neurosurgical disorders on patients and family members.
- Assessment of patients and family members knowledge and attitude towards psychiatric disorders, neurological and neurosurgical disorders.
- Assessment of the impact of hospitalization on patient and family members.
- Assessment of social support system of the patients and family members and financial resources
- Assessment of family interactions and relationships and dynamics
- Assessment of disability level at the time of admission
- Assessment of functioning level of the patients at the time of admission
- Psychosocial analysis and social diagnosis for formulation of appropriate Psychosocial intervention

Psychosocial intervention in in-patient setting

Intervention to address the negative impacts of hospitalization and depression and realistic expectations;

- ≈ To ease the burden of the family members and significant other in view of the nature of the illness
- ≈ To strengthen and improve the coping strategies, obligations of the patients and family members and to prepare them to continue maintenance treatment.
- ≈ Education to patients and family members regarding illness, treatment, medication management and psychosocial rehabilitation services
- ≈ To strengthen social support network
- ≈ Group intervention program for patients and family members

- ≈ Family intervention program for relationship problems and post discharge care and after care services
- ≈ Preparation of patients and family members for various tests and investigative procedures
- ≈ Pre and post operative counseling
- ≈ Helping family members to make their own decisions and their own discharge plan.
- ≈ Addressing the needs of the patients and family members, pre-admission counseling
- ≈ Referrals to appropriate aftercare services like half-way homes.
- ≈ Pre-discharge and discharge counseling for patients and family members
- ≈ Grief counseling services and Bereavement therapy for family members if patient expires
- ≈ Intervention during discharge and crisis periods

Assessment during post discharge:

Level of understanding information on illness and treatment

- Disability level at the time of discharge
- Global level of personal, family and occupational functioning
- Met needs and unmet need after discharge
- Family burden after discharge

Documentation

Documentation of detailed psychosocial assessment and interventions process and recording the notes and issues discussed during multidisciplinary team rounds and reviews.

Recording of discharge plan and multidisciplinary team members suggestions and inputs regarding the discharge plan.

Recording the progress of implementation of discharge plan and recording the Psychiatric Social Workers discussion with psychiatric social work consultant regarding the discharge plan or patients.

Specific Roles

Activity Scheduling

Group intervention

Case management

Family intervention

Pre-admission counseling

Psychosocial assessment through case history taking and detailed work up

Mental Status Examination

History clarification

Individual and group intervention

Pre-discharge counseling

Psycho-education:

- The reasons why psychiatric patients need information about their diagnosis are that:
- It is the right of every individual to know his/her diagnosis
- It is good professional practice to tell the patients about their diagnosis
- It helps in leading to an open discussion of the ramifications of the disorder
- It helps to know more about the possibility of recovery
- Enables families to decide on the best mode of treatment
- Discuss the fears about illness
- Discussing medications for the patients, its importance and possible side effects
- Remove the guilt feeling of family and provide support to cope with illness
- To de-stigmatize illness

In emergency care settings

- Case work
- Group work
- Administration
- Crisis intervention
- Community work
- Assessment of psycho social problems
- Immediate intervention strategies
- Supportive intervention
- Psycho-education
- Admission planning
- Discharge planning
- Resource mobilization
- Information gathering
- Mediator between professional, patient and family

In Outpatient Care Services

Outpatients constitute a major bulk of the patient load in the hospital that needs special attention from the service providers. Outpatient psychiatric services in mental hospitals and general hospital psychiatry departments have emerged as a need for expanding mental field due to the following reasons.

- ♣ A large number of persons with diagnosable mental disorders are not receiving services from mental hospital.
- ♣ The social stigma attached to mental illness is pernicious and it continues to have horrible effect on patients and family members
- ♣ Mental hospitalization leads to social breakdown and institutionalization syndromes and increases the chances of relapse
- ♣ Majority of persons with mental health problems does not need hospitalization.

Psychiatric social work services in outpatient departments include:

- ➢ Case history taking
- ➢ Independent psychosocial assessment
- ➢ Therapeutic activities at individual, family and group level
- ➢ Problem solving
- ➢ Behavioral modification
- ➢ Family therapy
- ➢ Crisis intervention
- ➢ Task centered case work
- ➢ Remedial and interaction models of group work
- ➢ Psycho-education
- ➢ Material and non material assistance
- ➢ Guidance to identify community resources
- ➢ Referral services
    - Link patient to community
    - Family counseling services
    - Occupational and vocational therapy centers

- Government and non government agencies

Social Work approach to problem of mentally handicapped/retarded

Mental retardation is a generalized, psychiatric disorder, characterized by sub-average cognitive functioning and deficits in two or more adaptive behaviors with onset before the age of 18.

Social Workers in such settings are responsible for developing and monitoring client service plans for mentally retarded individuals. Monitors, reviews and analyzes daily operations and services for adherence to program goals and objectives; establishes and modifies policies and procedures for respective programs; reviews clients service plans to ensure consistency with identified strengths and needs and adherence to established standards; participates in the preparation of annual overall social service plan; consults with superiors on service activities and program effectiveness.

Psychiatric social workers plans, reviews and evaluates operating policies, practices and procedures, establishes work priorities based on program needs and objectives, implements changes to comply with legal requirements. Departmental policies and procedures, and accepted social service principles and practices; provides technical and administrative direction; interprets rules, regulations and policies; meets with subordinate supervisors to discuss program needs, status of operations, problems and strategies for their resolution; prepares and submits periodic operational reports.

Monitors and reviews case management activities performed by contract agencies to ensure compliance with existing standards and regulations; reviews problem or complex cases; confers with subordinate supervisors on case problems; evaluates and determines if recommended course of action is appropriate.

Attends a variety of meetings for the implementation and coordination of program objective; confers with officials of community groups and public and other mental retardation agencies; explains program function, goals and objectives; meets with the appropriate officials; conducts staff conferences and meetings.

Signs

Children with mental retardation may learn to sit up, to crawl, or to walk later than other children, or they may learn to talk later. Both adults and children with mental retardation may also exhibit the following characteristics:

- ✓ Delays in oral language development
- ✓ Deficits in memory skills
- ✓ Difficulty learning social rules
- ✓ Difficulty with problem solving skills
- ✓ Delays in the development of adaptive behaviors such as self-help or self-care skills
- ✓ Lack of social inhibitors.

Diagnosis

According to the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), there are three criteria before a person is considered to have a mental retardation:

• Significant limitations in two or more areas of adaptive behavior (as measured by an adaptive behavior rating scale, i.e. Communication, self-help skills, interpersonal skills, and more)

• Evidence that the limitations became apparent before the age of 18. It is formally diagnosed by professional assessment of intelligence and adaptive behavior.

Mental retardation social worker: General Definition

A social worker in mental retardation settings directs the operations which provides individual program planning and monitoring to both current and former residents of mental retardation centers. Work includes planning, reviewing, evaluating, and coordinating daily operations to meet service goals and objectives. Contact officials, representatives of public and private mental retardation agencies, representatives of professional and community groups and the general public as well as supervision of staff members is a major significance to the work. Work is performed under the direction of an administrative superior.

Required Knowledge, Skills and Abilities

Knowledge of:

The principles, practices, and techniques of social work and its administration as applied to the care and treatment of the mentally retarded.

• The principles, practices, and techniques of counseling and casework as applied to mentally retarded individuals.

• The principles, practices and procedures for social service program planning and evaluation.

• Legal provisions and regulations applicable to the delivery of social services to the mentally retarded individuals.

• The functions and resources of public and private social welfare and related agencies providing services to the mentally retarded.

• Social factors and causes of social maladjustment which result in the need for placement or institutionalization of mentally retarded individuals.

• The principles, practices, techniques, literature and current developments in the field of social service planning for the mentally retarded.

Ability to:

Plan, organize, and coordinate the activities of a social services program for the mentally retarded.

• Evaluate social service programs and make recommendations to improve effectiveness of operations.

• Analyze and resolve complex social work situations and make sound recommendations which are consistent with social work principles.

• Exercise judgment and discretion in applying and interpreting policies and procedures consistent with overall policy and objective of programs.

• Establish and maintain effective working relationships with representatives of private and public agencies, the judiciary, civic groups, associates and the general public.

Multidisciplinary approach in mental health settings

Historically, the practice of psychiatric in-patient care has been characterized by un-disciplinary thinking, and individualistic. However, care of mentally ill persons with complex and interactive health, social and functional needs is best achieved when the knowledge and skills of various mental health disciplines are shared and integrated. Multidisciplinary, collaborative mental health care practice is an effective means to plan, coordinate, and implement care of psychiatric in-patient.

Delivery of mental health service is the concept of working with a multidisciplinary team. The literature related to working with a multidisciplinary team in mental health reveals a widespread belief that collaboration among health care professionals is desirable and results in therapeutic benefits for client outcomes. Furthermore, it is perceived to enhance work satisfaction for health care professionals. Psychiatric social work services in in-patient care offer the opportunity to work closely in a multidisciplinary team with other mental health care professionals such as psychiatrist, clinical psychologist, psychiatric nurses, and occupational therapists. The skills and knowledge of mental health professionals are needed to conduct a comprehensive multidimensional assessment of physical, psychological, social, emotional, functional, and social status of a mentally ill person. Family members are caregivers should be participants in this process. Their contribution to the assessment process, to problem solving, and to identifying and selecting appropriate goals and acceptable outcome is vital.

Multidisciplinary team approaches utilize the skills and experience of individuals from mental health disciplines (psychiatry, psychology, social work, and nursing) with each discipline approaching the patient from their own perspective. Most often, this approach involves separate individual consultations. This occurs in a 'one-stop-shop' fashion with all consultations occurring as part of weekly ward rounds by unit head on a single day. Multidisciplinary teams meet regularly, in 'case conference' to discuss about patient care in all aspect. Multidisciplinary teams provide psychiatric social worker more knowledge and experience to work with patients. Psychiatric in-patient care by its very nature is multidisciplinary because of the many competencies required for promoting optimal levels of recovery from disabling mental disorders. The expert's contribution from professionals and paraprofessionals is every

essential and can individualize a comprehensive array of evidence-based services with competency, consistency, continuity, coordination, collaboration, and fidelity.

Issues of Working with a multidisciplinary team

The following are the issue which arises commonly among new trainees when they come to work in multidisciplinary team for first time. However, this may not applicable to well defined multidisciplinary teams.

- ♣ Definition of problems: The term ‘multidisciplinary’ is not well defined and widely understood.
- ✓ Lack of clarity about the nature and over all functions of each discipline
- ✓ Multidisciplinary/interdisciplinary tensions like professional conflict, lack of respect or knowledge, attitudes of other staff.
- ♣ Supervision issues: lack of support and direction
- ✓ Work pressure like insufficient time, deadlines, paperwork, demand on time, late evening work hours
- ✓ Communication issues between staff and staff and staff and patients

Chapter Four

Psycho Social Rehabilitation for Psychiatric Patients

- Role of psycho-social care givers
- Mental Health Module for Psycho-social care givers
- Problem solving methods of Psychiatric patients

Psychosocial Rehabilitation for Psychiatric Patients

Definition

Psychosocial health services are psychological and social services and interventions that enable patients, their families, and health care providers to optimize biomedical health care and to manage the psychological/behavioral and social aspects of illness and its consequences to promote better health.

Psychosocial Caregivers of people with mental health problems need to:

keep the patient safe
deal with socially unacceptable or aggressive behaviour
prompt the patient to undertake personal hygiene
ensure medication is taken on time
administer or provide finances
ensure the environment is appropriate
liaise with health and other professionals
educate family and friends

Mental Health Module for Psychosocial Care Givers

If person has impaired concentration, fatigue, irritability, crying, worrying, on several days for more than two weeks, this is a disorder not just distress! It is distress if you have only one or two of the above symptoms. However, if you have four or more of above symptoms then its disorder.

Differentiating Between Distress and Disorders

Signs of Possible Mental Disorder

- ♣ Continuous distress without periods of relative calm or rest
- ♣ Four or more of the above distress symptoms for more than two weeks
- ♣ Severe depression; lack of pleasure in life, feelings of worthlessness, self blame, dependency, sleep disruptions and suicidal ideations or attempts

- ♣ Person is not able to stop thinking about what happened, intense intrusive memories, thoughts and images that are fearfully avoided, deeply upsetting or interfere with sleep; nightmares about disasters.
- ♣ Disabling anxiety :persistent worry, paralyzing nervousness, fear of losing control/going crazy
- ♣ Severe hyper-arousal :Inability to relax, inability to sleep, panic episodes, terrifying nightmares, difficulty controlling violent impulses, rage, inability to concentrate
- ♣ Severe dissociation ;feeling as if the world is unreal, not feeling connected to one's own body, losing one's sense of identity or taking on a new identity, amnesia, feeling numb
- ♣ Problematic substance use: abuse or dependency, self-medication
- ♣ Unresponsive and /or disoriented, always seen in deep thinking.
- ♣ Extreme social withdrawal; always avoiding other people, doesn't want contact

Individuals showing the above mentioned signs will require evaluation and treatment by a mental health professionals (Psychiatrist or clinical psychologist). It is important to learn to identify the common signs and symptoms of mental disorders so that they can be referred to specialist teams available in the area.

Mental Health Module for Psychosocial Care Givers

Grief / Bereavement

The experience of grief after loss is one common to human being. The most intense grief usually follows the death of a loved person, perhaps because death is so final and we feel a great sense of loss. Similar reactions occur in many different types of loss (Loss of a limb, home, belongings etc). The intense feelings experienced after loss are a normal, healthy part of the healing process and will result eventually in learning to live with the loss.

What is normal grief?

The ways that we express grief are strongly influenced by social factors. In some cultures people are expected and encouraged to show their grief, but for men after a relatively brief period, people expect them to stop any display of emotion and get on with life'. Some people hold the belief that crying and grieving openly are religiously unacceptable. You may be said to be 'coping well' if you make little fuss or said to be 'breaking down' and 'just not coping' if you continue to show emotion beyond the period others have set for you. In reality, the opposite may be true. Children react differently to a traumatic event. They may show signs of grief at home and school. They become excessively jumpy or are startled easily. They start avoiding physical reminders of the traumatic death/events e.g. places or people related to the death etc. They also

withdraw from important aspects of their environment. Children may show preoccupation with the traumatic events. Immediately following bereavement, most people are in shock. Some people will throw themselves into practical tasks while others will flounder without assistance, finding it difficult to concentrate on tasks. Both reactions are normal. Intense emotional reactions are common in the first weeks following bereavement and include: crying, irritability, anger, guilt, disturbed sleep and appetite, feelings of self blame, related to things survivor may feel he/she should or should not have done in relation to loved one. During the first month or so, such reactions would be acknowledged as being 'usual', but health workers are advised to routinely assess that these symptoms are not becoming disabling.

Orientation on Basic Psycho social skills of Working with Populations Effected by Disasters

Note of caution: these skills cannot be merely learned by:

- reading the materials or
- few days of training, rather learning these skills requires practice under regular supervision

Structured Problem Solving:

There are rarely perfect or ideal solutions to problems, however, the structured problem solving approach aims to identify helpful plans of action available at the time. Structured problem solving often involves helping people find helpful ways of coping. You can help the people find solutions (or ways of coping) for their problems in a systematic manner. They may benefit from such help when their problems are:

- ✓ Severe and novel in intensity (e.g. Loss of number of family members, Loss of all the belongings during the earthquake).
- ✓ Many crisis with compromised stress coping capabilities (e.g. child going missing / physical illness / disability imposing additional stress).

You can help the person by being a concerned individual rather than by being an expert. You should not give them directions just see them and help them out practically if possible.

The Six-Step Method of Structured Problem Solving

Define the problem

Discuss the problem carefully. Let them talk. Try to "put yourself in their shoes. Empathize with them, and try to get full understanding of their problem and its solution.

List all possible solutions / ways of coping

Help the client to come up with as many solutions/ways of coping as possible

Discuss each possible solution / way of coping

Go down the list of possible solutions and encourage the client to assess the main advantages and disadvantages of each one.

Choose the best or most practical solution / way of coping

Support the client in choosing the solution that can be carried out with the present resources (time, money, skills, etc.). Solutions should be carried out in a realistic manner. Take them in confidence.

Plan how to carry out the best solution/way of coping

List the resources needed and the main problems that need to be overcome.

Review how well the solution/way of coping was carried out and praise all efforts.

Continue the problem solving process until you have resolved the problem

Stress Management Strategies

- **Relaxation Training:** Relaxation is useful for reducing physical and mental tension. Relaxation helps people to reduce worry and anxiety, improve sleep, and relieve physical symptoms caused by stress (e.g., headaches, stomach pains, diarrhea, or constipation).

Other relaxation methods

Although progressive muscle relaxation is, the most recognized and documented method of relaxation, other methods can achieve similar results. Other methods include praying**,** Meditation, Physical Exercise, listening to music, reading books, writing, these methods can be useful if they reduce tension for that individual and are used daily.

Grief Counseling

This is a technique, which utilizes the above-mentioned skills but modified to help bereaved survivors (i.e. those who lost their close ones). The person is gently encouraged to talk about his

relatives. This may hasten the process of mourning and its resolution. The following are to be done as a part of helping people grief:

- Approach the person in a gentle assuring manner; ask him/her about the overall welfare of family members and then talk about the deceased person.
- Encourage him/her to share information about the deceased family member (e.g. to show and discuss the photo of a family member).
- Focus on pre-disaster relationship network, with the dead person and the personal meaning of the loss.
- Enquire about survivor guilt in this context and reassure survivors that it is a natural human reaction to feel guilty about being unable to save loved ones.
- Ensure that survivor gets an opportunity to meet other survivors who know something more about the dead person.
- An opportunity to meet other people like nurses, doctors, or persons who extricated the body can be useful when these staff have some basic understanding of how to respond to a person in grief.

Non-Pharmacological Pain Management

1. Relaxation therapies

2. Medication reduction:

- Short-term pain relief leads to a learned behavior that leads to the excessive use of pain medication
- Patients who start relying on their pain medication when not needed may suffer from the side effects of the drugs as well.
- It is therefore important to help patients who need pain medication to take medication on fixed times instead of whenever needed

3. Activities training

- Measure pre treatment levels of activity
- Select targets that are achievable
- Program of step by step increase in activities

4. Psychological Techniques

- ✓ Attention Diversion: attention is diverted to another task (like reading Holy Books)
- ✓ Changing Context: imagining pain occurring while saving a family member or friend and thus linking it with a positive activity.

Identification and Referral of Mental Disorders

Anxiety Disorders: Anxiety Disorders are characterized by persistent and excessive feelings of anxiety. This may or may not be associated with a particular environmental circumstance. It may persist all the time or occur episodically.

Diagnostic Criteria:

The diagnosis of Anxiety Disorder should be made if the following signs and symptoms are present for most days of the week for a period of six months and are causing significant functional impairment.

Physical arousal (e.g. dizziness, sweating, a fast or pounding heart, a dry mouth, stomach pains, or chest pains lump in the throat, restlessness, headaches, tremors, or an inability to relax, sleep disturbance, body aches, fatigue, diarrhea).

Mental tension (e.g. worry, feeling tense or nervous, poor concentration, fear that something dangerous will happen and the patient won't be able to cope).

Psychosocial Management:

- Encourage the patient to use relaxation methods daily to reduce physical symptoms of tension.
- Advise avoidance of drugs or cigarettes and reduction in caffeine consumption (tea, coffee) to cope with anxiety.
- Encourage the patient to engage in pleasurable activities, regular physical exercise and to resume activities that have been helpful in the past.
- Structured problem-solving methods can help patients to manage current life problems or stresses, which contribute, to anxiety symptoms.

Essential information for patient and family:

Stress and worry have both physical and mental effects. Learning skills to reduce the effects of stress (not sedative medication) is the most effective relief.

POST-TRAUMATIC STRESS DISORDER/ PTDS

Post-traumatic stress disorder (PTSD) is characterized by the development of a long lasting anxiety response following a traumatic or catastrophic event like the recent earthquake and accidents. PTSD usually develops after within 3-6 months of the traumatic event (although sometimes longer)

Diagnostic Criteria:

The individual has experienced an extremely traumatic event as the recent earthquake and/or accidents with human and material losses. The individual experiences repetitive and intrusive memories, daytime image, and dreams of the traumatic event.

The individual avoids cues associated with the traumatic event like shaking of the bed or table. The individual does not have full memory/recall of the traumatic event or the individual experiences increased psychological sensitivity and arousal indicated by at least two of the following:

- Sleep disturbance
- Irritability or anger
- Difficulty of concentrating
- Substance abuse is commonly associated with this condition and there are difficulties in carrying out tasks of daily living.

Management

Psychosocial Management***:***

 Educate the patient and family about post-traumatic stress disorder, thus helping them understand the patient's changes in attitude and behavior

 Encourage the patient to talk about the event that triggered this condition and it has to be based on patients' willingness

 Explain the role of avoidance of cues associated with the trauma in increasing and maintaining fears and distress. Encourage the patient to face avoided activities and situations gradually.

 Avoid using drugs or cigarettes to cope with anxiety.

Essential information for the patient and family:

Traumatic or life-threatening events often have psychological effects. For the majority, symptoms will subside with minimal intervention.

For those who continue to experience symptoms, effective treatments are available.

Suffering from post-traumatic stress disorder is not a weakness and does not mean the patient has gone 'mad' or suffer from serious mental illness.

DEPRESSIVE ILLNESS

Depression is a mood state that is characterized by significantly lowered mood and a loss of interest or pleasure in activities that are normally enjoyable. Such depressed mood is a common in the population, which has experienced recent losses. However, depressive illness can be

distinguished from this ‘normal' depression by its severity, persistence, duration, and the presence of characteristic symptoms.

A wide range of presenting complaints may accompany or conceal depression. These include unexplained somatic complaints, worries about social problems such as financial or marital difficulties, increased drug or cigarette use, or (in a new mother) constant worries about her baby or fear of harming the baby.

Diagnostic Criteria:

• Low or sad mood

• Loss of interest or pleasure.

• disturbed sleep

• Poor concentration

• disturbed appetite • suicidal thoughts or acts

• Guilt or low self-worth • loss of self confidence

• Pessimism or hopelessness • fatigue or loss of energy about the future • agitation or slowing of movement or speech

Management

Psychosocial Management:

□□ Identify current life problems or social stresses, including precipitating factors. Focus on small, specific steps patients might take towards reducing or improving management of these problems.

□□Support the development of good sleep patterns and encourage a balanced diet.

□□ If physical symptoms are present, discuss the link between physical symptoms and mood (use the example of Common cold to highlight the link between physical problems and low mood)

□□ Plan short-term activities, which give the patient enjoyment or build confidence. Exercise may be helpful.

□□ Advise reduction in caffeine intake and drug and cigarette use.

□□Involve the patient in discussing the advantages and disadvantages of available treatments. Inform the patient that medication usually works more quickly than psychotherapies. Where a

patient chooses not to take medication, respect their decision and arrange another appointment to monitor progress.

□□Assess risk of suicide. Ask a series of questions about suicidal ideas, plans and intent (e.g. has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?)

Essential information for patient and family:

• Depression is a common illness and effective treatments are available.

• Depression is not weakness or laziness.

• Depression can affect patients' ability to handle life problems.

• Patient needs support and help.

PSYCHOSIS

It is severe disturbance of thoughts and behavior resulting in individual losing touch with reality. This leads to gross impairment of the individual's ability to carry out his/ her responsibilities and day-to-day functions. The individual being not aware of his illness refuses treatment and usually the relatives bring him/her for treatment.

Psychosis can be ACUTE/serious, CHRONIC, or RECURRENT/occurring repeatedly.

Diagnostic Criteria:

- Delusions (Odd, false beliefs)
- Hallucination (Hearing/seeing things in the absence of any sensory stimulus).
- Thoughts being controlled or tampered with by outside agencies, telepathy, magic etc.
- High mood, is unusually cheerful and boastful with excessive energy overactive, over talkative with disturbed sleep, appetite and libido.

Management

Psychosocial Management:

- Minimize stress and stimulation.
- Do not argue with psychotic thinking (you may disagree with the patient's beliefs, but do not try to argue that they are wrong).
- Avoid confrontation or criticism, unless it is necessary to prevent harmful or disruptive behavior.
-

Treatments for Mental Disorders

- ✓ Formal Intervention
- ✓ Evaluation
- ✓ Physician, psychiatrist, psychologist, and psychiatric social worker.
- ✓ Medication
- ✓ Inpatient/outpatient treatment
- ✓ Therapy
- ✓ Support groups

Not all clients with symptoms of mental illness will meet diagnostic criteria. Diagnostic labels can be very useful but should not be limiting and diagnosis needs to be undertaken by trained professionals however important to be aware of symptoms and to be able to communicate with other professionals, clients, and families/careers.

Chapter Five

Overview of Mental Health in Ethiopia

The prevalence of mental health problems and their disabling impinge/effect on individuals' and the country's social development and economic growth. WHO recognized mental health care as one of the priorities and its inclusion in primary health care program transformation from isolation to integration, in general medical care de-institutionalization (to general hospitals and clinics, and to community care).

Mental Health Problems in Ethiopia

Modern psychiatric nomenclature/the term or names applied to someone or something versus identifying syndromes of mental illnesses in traditional Ethiopian societies. Syndromes are given different names in different ethnic languages and inconsistently assigned criteria for the degree of illness. For example,

- "Cherqunyetale" (Amharic) or "maraattu" (Oromifa) denotes a severely mentally ill person unfit for any responsibility.
- "Wofeffe" or "nik" (Amharic) a person is not too reliable, has inconsistent behavior and unusual changes in ones inter-personal communication.
- "Abbsho" an individual who had taken some psycho-active drug (herb) at some earlier period in one's life, show some psychotic-like behavior whenever taking some alcoholic drink.

Prevalence of mental illness in Ethiopia

Limited studies on the prevalence of psychiatric conditions in the Ethiopia though currently it seems, persistently increasing. Most of these earlier studies were done using clinical samples from attendees of outpatient clinics were not community-based studies. The prevalence rates of mental illness found to be similar to findings in other parts of Africa and developing countries elsewhere. The figures could be higher for Ethiopia considering the current global and local stressful situations and the study population size.

- 12% of Ethiopians suffer from mental illnesses (i.e., 9.6 million/80 million populations).

- 2% of the total population (1.6 million/80 million populations) is suffering from the severest form of mental illness or psychosis.
- 10% (8 million/80 million populations) are suffering from milder disorders or neurotic conditions.

Lack of information on mental illnesses, using standard tools of assessment, and the limitation related to using codes for psychiatric out/in-patients and their clinical conditions (i.e., DSM). The five codes: 067 –psychosis, 068 –Neurosis, 069 -Mental retardation, 073 –Epilepsy, and 078 4-All other diseases of the nervous system.

Do you think that the Ethiopian populations on which the hospital data are collected are representative of the country's population? Why?

Issues:

- Awareness or knowledge of the existence of medical alternatives for helping mentally ill patients.
- Refusal to accept medical psychiatric treatment in principle and seek "other alternative treatment".
- Challenges related to availability and accessibility of psychiatric services and drugs to people in need.
- Many mentally ill people do not come to the health care facilities until their illness reaches extreme severity (aggression, destruction, or disruption of peace).

Determinants of Mental Health

1. **Traditional Notion: determinants**

- The etiology of mental illnesses versus physical illnesses.
- Supernatural powers versus controlling the well-being of the individual's mind.

Assumptions related to etiology mental illnesses:

a) Commission or omission sins

b) Doing the forbidden

c) Enmity versus favoritism by supernatural force

d) Minds are dwelt in or possessed by spirit(s) of evil supernatural force(s)

Assumptions related to why/when a person may be possessed by evil spirit(s):

- “Walking alone in the woods”
- “Having sex in the open place”
- “Falling asleep in the meadow”
- “Walking along the river-side around noon-time”
- “Walking in a grave yard”
- “Getting into a long-closed room without blessing self” etc.

Incantation, sorcery, enchantment, and rituals: Magical power used by certain individuals (e.g., offerings are given to them so that they may drive one's enemy mad or protect one from going mad).

- "Debtera",
- "Kalicha",
- "Tenquai"
- "TilaWogi".

♣ **“Buda” (evil eye)** by looking at a person with evil eyes (when eating in front of others or if the victim is child, adolescent, and woman, especially the attractive ones) with very acute onset the victim becomes restless, aggressive, and destructive and shouts incoherently.

♣ **“Danqara”/ “Metet”**: Used by adversaries against each other. "Denqara" is an item (i.e., the bodies of a dead mouse, chicken, cat, or food/grain) with the incantation of a magician ("debtara" or "tanquai ") put on the roof, door, at the gate or in the compound of a person's home or across the path of that person).

♣ **Poisoning through food and drink**. During exorcism at holy water or church healing rituals, one can hear the mentally ill talk, whilst in a trance state, about having been made ill by being poisoned via food or drink.

2. Mental disorders versus physical/psychological/familial/social and other environmental factors: Determinants

Association between stressors and psychiatric symptoms: malnutrition, chronic illnesses, separation, migration, natural disasters, unstable social situations, overpopulation, etc.

Divorced, separated, and widowed people showed a higher frequency of psychiatric morbidity. Positive correlation between chronic illnesses like hypertension, diabetes, epilepsy and chronic liver disease and higher prevalence of psychiatric disorders. War, remarkable environmental changes and associated famine and political torture affected the stability of the mental state of citizens are amongst the highest in causing mental disorders in individuals, because PTSD is the commonest disorder.

> "Post traumatic stress disorder (PTSD) is a condition which has been included in the psychiatric classification of disorders since DSM-111, 1980 {American Psychiatric Association). The major symptoms of this disorder include: a) feeling numb to the world with a lack of interest in former activities, and a sense of estrangement from others, b) reliving the trauma repeatedly in memories and in dreams, and c) anxiety, which may manifest itself in problems of sleep, concentration, and alertness. The disorder may develop immediately after or as late as months after the disaster. One need not experience the unusual stressor for oneself to develop PTSD; simply witnessing others experiencing the stress can also produce the disorder in the witness."

People with PTSD may develop a psychosocial impairment such as alcoholism, divorce, suicide, violence, and difficulty in holding a job. Famine, poverty, migration, displacement (resettlement) and parental loss, etc. are the common ones that are related with mental illness though they are understudied.

The use of the psycho stimulant substance "chat" (Catha edulis), can induce psychoses, and affect physical and social well-being of individuals as well as the economics. Other substances (alcohol and cannabis/hashish) found to be related with various kinds of mental disorders.

Mental Health Care/Services in Ethiopia

Services can be:

- Traditional
- Modern health Services

- ✓ **Traditional**

a) *Wearing amulets*: Writings or inscriptions on goatskin or a piece of paper strip (folded into a tiny bundle) and is worn by the patient. Some healers also give herbs, pieces of hyena skin, lip, palpebrae or skin.

b) *Holy Water*: mainly used by Coptic followers --Bathing in, drinking, sprinkling holy water on the walls and floor of one's home

c) *Herbal prescriptions*

d) *Performing rituals*: e.g. Slaying a cock of particular texture (as prescribed by the healer), moving the carcass round oneself a particular number of times, and then throwing it towards a particular (prescribed) direction.

e) *Exorcism by prayer*

f) *Exorcism by fumigation* (e.g., for "buda").

- ✓ **Modern (Western) mental health care**

a. Psychiatric centers: few in number and poorly staffed

b. Services available: out-patient and in-patient service.

- Basic occupational therapy
- Counseling and simple psychotherapy.
- A drug and alcohol treatment unit
- Other sub-specialty services: Child and adolescent units, and forensic units.
- Day care centers, rehabilitative services, occupational and other therapeutic services are limited due to limited of trained staff and materials in the various specialties.

C. Training in Mental Health: very limited.

Strategies for Developing Mental Health Care Systems in Ethiopia

Need to focus on preventive and curative aspects and rehabilitative strategies. Thus, the health care system and its structure should strategically work on the following:

1. Address stigma associated with mental illnesses at micro, mezzo and macro level

2. Availability and accessibility of service centers (scarcity).
3. Increase knowledge and awareness of the spectrum of mental disorders: severe and mild
4. De-centralization of mental health services to clinics or hospitals
5. Pre and post-training on various basic clinical and psychosocial and other specialty areas
6. Integration of the preventive, curative, and rehabilitative services.
7. Put in place proper planning, monitoring and evaluation
8. Develop MIS and basic statistics on the prevalence of major mental health problems and care-giving
9. Availability and accessibility of essential drugs.
10. Develop and effectively implement national mental health policy to:
    - Recognize mental illnesses as early as possible.
    - Determine priorities of services and effective ways of working on them.
    - Enhance family or community-based mental health care to the mentally ill
    - Involve the community in the preventive, therapeutic and rehabilitative programs
    - Doing various researches in various areas of psychiatric problems and care-giving and found the mental health care on the contextualized experiences.