Empirical Study on the Challenges to Community Reintegration under Mental Healthcare: An Analysis With Reference to SDG 2030

Prof. Shirish Kulkarni[a] , Ms. Rini Jincy Paul[b]

[a] Professor, Symbiosis Law School, Symbiosis International (Deemed University), Pune
[b] Development Associate (Fundraising), Educate Girls NGO, Mumbai
[a] prof_shirishk@rediffmail.com

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Abstract: Background: Mental healthcare today has extended beyond treatment at mental hospitals to include community reintegration and rehabilitation. However, beyond the protective walls of institutional care lie neglect, stigma, poverty and lack of resources which often leaves mentally ill patients in a vicious cycle of relapse, re-admissions and discharge from hospitals. This is just tip of the iceberg when it comes to the pitiful plight of mentally ill persons and mental healthcare across the world especially in developing and under-developed economies.

Aim: This empirical study was designed to collect data of both quantitative and qualitative nature on the socio-economic background of patients admitted in two state mental health institutions in Maharashtra, India though a review of patient case files. The study also adopted a method of co-operative inquiry and assimilated opinions from psychiatrists and psychiatric social workers to comprehend the challenges to community reintegration of patients and possible solutions.

Methods and Materials: Data collection was carried out at Thane and Yerwada Regional Mental Hospitals. 30 case files of discharged or discharge eligible patients were referred for background information on type of illness, instances of relapse, occupation and activities during admission. The sample was picked through random stratified sampling method. The second set of data was collected through questionnaires with open and closed ended questions to seek opinion of psychiatrists and psychiatric social workers on the situation of mental healthcare at the state mental health institution and possible suggestions.

Findings: The data collected from the patient case files indicate certain socio-economic patterns and nature of illness as possible barriers to receipt of quality mental healthcare and community reintegration.

The data collected from the psychiatrists and psychiatric social workers corroborate the challenges indicated in data collected from patients as they also highlight the issues of socio-economic background of the patients, lack of sufficient counseling due to unavailability of family members, stigma, causes for frequency of relapse among the patients, giving fake address and information by family of the patient, refusal of family to take the patient home post discharge and lack of awareness. The data also suggested introduction of family wards in mental hospitals to improve treatment and process of community reintegration of mentally ill patients.

Conclusion: Mental health is a priority under Sustainable Development Goals of 2030 and to achieve it there is imminent need for significant contribution in terms of funds and expertise. Community living for the disabled including mentally ill persons is a right under UNCRPD as well as Mental Healthcare Act of 2017 and therefore it is the responsibility of the state to formulate and enforce measures for adequate treatment and community reintegration of the mentally ill.

Keywords: community reintegration, justice, mental health, sustainable development

1. Introduction

Sustainable development for a long time now has been synonymous with the environment and its protection. In September 2015, during the United Nations 70th Session of the Assembly, Sustainable Development Goals (SDG) 2030 agenda was passed. To the astonishment and definite validation of various advocacy groups and the medical community, the much anticipated and necessitated subject of mental health was included among the 17 sustainable development goals. This major stride taken in recognition of the importance of mental health, facilitated the support of the world community towards the widespread issue of mental illness and set in motion an overhaul in national policies on mental illness and mental healthcare across numerous countries of the world. However, a question that is yet to acquire a thorough answer is where does mental health fit into sustainable development and vice versa. Sustainable development is rooted in the belief that the future should not be compromised owing to contemporary greed. Therefore any action of the present generation that warrants a pending catastrophe must be monitored and controlled in a manner that will be sustainable for the future generation.

Mental illness is a phenomenon which if left unchecked will spiral out of control and spill into the diaspora of future generations, with a negative impact on their potential for growth, productivity and sustainability. This in turn will consequentially have a direct impact on the economic development of a nation which is deemed to be of utmost importance for the present and future generations. The COVID-19 pandemic and world-wide lockdown, has brought to the forefront the magnanimity of mental health and psychiatric disorders. According to a study published in Lancet in November 2020, about 6% adults developed some form of psychiatric ailment for the first time, post COVID-19 positive diagnosis which is almost twice the number of non-COVID positive patients diagnosed with mental illness for the first time.

The statistics on mental health across the world population remains grim with 300 million affected by depression, about 60 million suffering from bipolar affective disorder (BAD), and 23 million diagnosed with schizophrenia. Therefore, it would be ill-advised and almost foolhardy to ignore or underestimate the subject of mental health of citizens by national governments and its policy-makers.

Brundtland Commission (previously named as World Commission on Environment and Development) set the stage for uniting countries across the world with a focus on sustainable development. The commission was set up in 1963 December by then UN Secretary General Javier Perez de Cuellar with the former Norwegian Prime Minister, Gro Harlem Brundtland as the Chairperson of the Commission. This commission was established in the backdrop of unachieved goals set by the 1972 Stockholm Convention. The innumerable challenges to curbing poverty in third world countries were to be addressed by fostering development and industrialization in these countries without adding to the existing burden on the environment. This gave rise to the idea of developing a consensus between economic development and environmental protection. Several questions were deliberated on like attributing the destruction of environmental basis in low income countries to the global economic system, destructive economic growth or lack of economic development and modernization. Brundtland Commission's report "Our Common Future" has given a noteworthy and considerable discussion on prominent global issues such as population explosion, food security, irreversible damage to the ecosystem, urbanization and economic development.

increasing world population and human resources, food security, extinction of species and their genetic material, economic growth and urbanization. The Commission also defined Sustainable development as a concept which is "***to meet the needs of the present without compromising the ability of future generations to meet their own needs***". The Brundtland Report proposed to set-up a conference to review and follow up on the progress made with respect to decisions taken and identify needs across the expanse of the world in order to provide the necessary solution or aid and maintain the growth of nations as well as human progress. This proposal led to the Earth Summit in 1992 in Rio de Janeiro wherein 172 governments and thousands of NGOs participated. This was followed by the 1997 Kyoto Protocol, Copenhagen Climate Change Conference in 2009 which failed to establish a consensus among the key players. Agenda 21 was the outcome of the 1992 Rio Conference under which chapter six talked about '*Protecting and Promoting Human Health*'.

Over a decade into the millennium in 2012, the direct and important linkage between human health and development received its due recognition at the United Nations Conference on Sustainable Development or the **Rio+20 Summit**. The conference document titled "*The Future We Want*" states that health is a pre-condition and indicator of sustainable development. The most important factor to be considered is that the document also touched upon the global burden and threat of non-communicable diseases (NCD) including mental illness as a major challenge to achieving sustainable development in the 21st century. Rio+20 put forth the need for ***a universal health coverage including policies on prevention, protection and promotion of public health***. This could be beneficial in the light of statistics that indicate 150 million people are unable to afford essential medical services. The universal health coverage aims to counter poverty and build a resilient and healthy communities across the world.

And lastly, coming to the conference that has Contemporary importance is the landmark Sustainable Development Summit held in New York in September 2015. The historic agenda titled, "*Transforming Our World: The 2030 Agenda for Sustainable Development" was adopted at the Summit.* The Sustainable Development Goals (SDGs) were developed and drafted by the Open Working Group set up under the Rio+20 conference held in 2012. The Open Working Group maintained a transparent and participatory process in drafting the SDGs by taking into account the voices and suggestions of various stakeholders. Through the MyWorld survey more than 8 million votes were received with approximately 70% participants below the age of 30 years. The SDGs received support from governments, civil society and business class across the globe. The agenda lays down 17 SDGs with 169 related targets which will be monitored and reviewed based on a set of global indicators.

The 2030 Agenda in its vision states that, "…. A world with equitable and universal access to quality education at all levels, to healthcare and social protection, where *physical, mental and social well-being* is assured". Advocacy groups for mental health have appraised the inclusion of the term "mental wellbeing" in the vision of 2030 Agenda. The cost of mental health disorders amounts to about 4% of the worldwide GDP, and the international community is finally paying attention and willing to contribute resources for the welfare of persons with mental illness.

The WHO Mental Health Gap Action Programme (MhGAP) initiated in 2008 sought to address the glaring divide between the need and availability of resources to cater to the rising burden of various forms of mental disorders. The aim of MhGAP is to list out specific activities and provide a framework of programmes for policy makers, etc. enabling an increased access and facilities for mental health needs. Subsequently, the "Mental Health

Action Plan of 2013-20" also called for a shift in the outlook of discrimination and stigma against mental health disorders. WHO has been very proactive with formulating policies and orchestrating such initiatives in the area of mental health especially in the Low and Middle Income Countries (L.M.I.C.)" however, the comparative merits and demerits of these efforts remain a moot point.

Ross G. White et al. (2016) has picked out **two issues that limit the successful implementation of mental health policies and initiatives across the globe**.

1. *Lack of evidence based findings in the determination of a "good or desirable outcome" for mentally ill persons*
2. *Lack of substantial and all-encompassing theoretical guidelines on addressing the existing global inequality and inequity related to mental health*

Mental health and mental illness are on distinct continua as proposed by various theorists. Mental health is not merely the absence of mental illness, instead the Mental Health Action Plan 2013-2020 has defined mental health as ***"a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."***

This definition is in keeping with the SDG Goal to "promote wellbeing for all".

Research conducted in Zambia and India has highlighted "conceptualizations of wellbeing are influenced by the particular social, political and cultural contexts in which people live." It has also been suggested that ***qualitative methods should be used to develop a localized understanding of wellbeing through an exploration instead of forming generalized assumptions.*** However, despite the increasing number of studies probing the efficacy of "mental health interventions", an outcome is judged as favourable based on a narrow outlook of merely reducing the symptoms of mental illness. Post treatment care of a mentally ill patient has been one of the most complex and yet neglected areas of mental healthcare. Dr. Greenblatt Milton, Director of Research at the Massachusetts Mental Health Center in Boston and Asst. Clinical Professor of Psychiatry at Harvard talks about ***five principal areas of rehabilitative efforts for mentally ill patients that is: the patient's own psyche, his vocational and educational capabilities, his family, and the social and recreational aspects of the community to which he will return.*** Community rehabilitation or reintegration is an inseparable aspect of mental healthcare and substantial focus should be directed towards achieving quality and efficacious community care services for the mentally ill.

The capabilities approach pioneered by Amartya Sen in the 1980s attempted to bring a shift in welfare economics from prioritising the efficiency with which a goal can be achieved (the means) over the goal itself and instead emphasized on utilities such as accessibility to resources, assets and income). Capabilities approach (CA) primarily focuses on enabling individuals to exercise their freedom and pursue things that are inherently valuable to that individual. In the context of community reintegration of mentally ill persons, capabilities approach provides a theoretical basis for developing a practical framework eligible to be implemented which could include sufficient access to medical care, alongwith social, educational, economic and political support which will give individuals with mental illness the **freedom, ability and opportunity** to flourish within a community as well as contribute towards the community. The core and driving force of this aspirational framework is the right to community reintegration of a person with mental illness which has been recognised explicitly under international as well as national legislation and policies.

2. Community Reintegration Of The Mentally Ill Promoting Sustainable Development

The United Nations Convention on Rights of Persons with Disabilities accorded the general principle that persons with disabilities, including persons with mental disorders have a 'right to full and effective participation in the society.' This includes participation in cultural, recreational, political and public activities as well as a non-isolated and inclusive housing environment. The convention vigourously promotes social inclusion to prevent stigma against persons with disabilities with the aim to 'provide a global momentum for making social integration a measurable outcome of interest for social policies and health programmes". Reintegration has not been explicitly defined by WHO however, WHO (2004) has provided that '***social inclusion for an individual means access to supportive relationships, involvement in group activities and civic engagement'***. The mhGAP (2010) has recognized that promotion of social inclusion of persons with mental illness requires cross collaboration among health, employment, education, social and other relevant sectors. However WHO has not yet set up a mechanism to evaluate the efforts made towards community reintegration at an individual level.

At the national level, numerous countries have legislated frameworks and policies that emphasize on social integration as the ultimate goal of psychiatric services. India under its recently passed legislation Mental Healthcare Act of 2017 has explicitly provided for right to community living of persons with mental illness.

However, the means to enforce such a right has not been provided and it continues to remain a challenge for the state governments to ensure the enforcement of such a right. It is acknowledged that "care for the mentally ill has moved out from the custodial settings in most part of the world but with lack of appropriate and sufficient psychosocial set up, staff, resources and other related necessities like counselling of patient and families adequately, the patient might even end up on the streets in a situation far worse than anticipated under custodial settings.

Since the inception of the community psychiatry movement, numerous models have been developed for rehabilitation and reintegration of mentally ill persons. In America, Clubhouse and Fountain House models have been commonly adopted and deemed successful. The Fountain House project was also successfully replicated in Lahore, Pakistan. In India, the Ministry of Social Justice and Empowerment deals with rehabilitation of mentally ill persons and they have encouraged NGOs in the country to take up initiatives like setting up halfway homes for the mentally ill. Some of the known models for Psychosocial Rehabilitation Services adopted by state mental health institutions as well as Non-Governmental organisations in India are:

1. Day Care – NGOs and state mental health institutions
2. Residential Rehabilitation – halfway homes based on "therapeutic community model"
3. Home based rehabilitation
4. Community based rehabilitation (CBR) – chronic mental illnesses

The Mental Health Act of 1987 which governed the administration of mental hospitals in India did not provide for a regulatory mechanism for setting up rehabilitation services and halfway homes for the mentally ill and this in turn has given room for grave human rights violations under the garb of such services. The Erwadi incident in 2002 and the plight of Delhi's Asha Kiran Home for mentally challenged women and children are glaring examples of such violation. These are the few reported cases which were brought into light by the media. But there is more to the situation than what meets the eye. Such revelations necessitate the creation of active watchdogs similar to the ones in place for profit making entities like companies and financial institutions to keep a check on agencies, organisations and institutions providing care for the disabled and vulnerable. The 2017 legislation has failed in this regard as it does not address the regulation of non-governmental organisations providing care and services to the mentally ill. The legislation only provides for the set-up of a Mental Health Review Board which will take decisions on treatments to be offered at government facilities.

3. Mental Health: Cultural And Biomedical Factors

According to a 2012 Lancet Report India has one of the highest suicide rates for youths ages 15 to 29 and according to a 2015 National Crime Records Bureau (NCRB), every hour one student commits suicide in India.

Sociologist Samata Deshmane, a successful sociologist from Karnataka, India states that, *"People are struggling to cope with the transformation in society whether they express it or not. It is well known that humans are social animals. However, the current society is more focused on individualism wherein beyond the superficial connections of caste and religion people are only self-serving and competitive, depriving each other of a cushion while dealing with various struggles."*

Under community based studies carried out in 11 developing countries, "significant associations between poverty indicators and common mental disorders were found" in all but one study. However, research in developing countries on mental illness are mainly influenced by tools and methods developed in the western countries i.e. assessing the intensity of the mental health condition of a patient through individual symptoms and taking a biomedical approach to the psychiatric disorder. We have not analyzed the effectiveness or cultural relevancy of applying the concepts of mental illness developed in the Western countries to the low or middle income countries like India. This in turn has largely compromised the understanding and local categorization of mental disorders. (Jadhav, 2009)

In the Indian context, it is crucial to establish the linkage between the severity of mental disorders and social stigma. The medical anthropological approach can address mental health through the lens of socio-cultural influences and popular opinion on preventive measures, treatment, etc. 'Culture' is indicative of power and its intermediaries and anthropology focuses on social stratification on the basis of gender, ethnicity, etc., accessibility to material and immaterial things (e.g. basic necessities, education, social security, etc.), representation and perception of different forms of diseases, cultural outlook on concepts of feminism and masculinity, and attitude towards maintaining a healthy lifestyle. Formation of a cultural system with these elements also lays down evident expectations of various actionable tasks and responsibilities. Consideration of the relational aspect of these elements is called a 'thick description' which are based on meticulous fieldwork inclusive of various techniques such as participant observation, unstructured interviews, etc.

Mental illness is largely treated through biomedical intervention however; an improved understanding of mental illness and "the existing social response" may bring up essential social factors that will eventually shape the prognosis of a severe mental illness. A discovery and inclusion of such nature will bring in newer avenues for public health interventions for mental illness to go hand in hand with and complement the prevalent biomedical treatment (Krieger, 2008). Kleinman has reiterated time and again *that biomedical intervention is not an exclusive and comprehensive solution to mental illness.* It has been vociferously argued that "non-mental illness factors, chiefly multi-dimensional poverty, may have a significant bearing on the ability to address the issues of mental disability at both the individual and the household level."

4. A Study Conducted In Maharashtra, India On Mentally Ill Patients In State Mental Health Institutions

A study has been conducted at Regional Mental Hospital, Thane and Regional Mental Hospital, Yerwada in the state of Maharashtra, India. Under this study, a sample size of 30 patients (20 male and 10 female) whose treatment was completed and were about to be discharged from the hospital were interviewed and their files were reviewed for socio-economic and demographic details along with opinions of 10 psychiatrists and 10 psychiatric social workers on the challenges and solutions to mental health and community reintegration.

The relevant data (quantitative and qualitative) gathered under the study is mentioned below:

a. The files reviewed indicated the level of activity of the patient in the hospital in various tasks like ward activities and occupational therapy indicating their preparedness to be integrated into the society post discharge. (66.7 per cent participated in recreational activities, 76.7 per cent participated in ward activities and 33.3 per cent participated in occupational therapy)

b. The interview with the patients also revealed that the patients were fine with being treated in the hospital but they did not like the tag of being a "mentally ill person" and the fact that they were kept against their wishes in a mental hospital.

c. It was also observed that in case of 73.3 per cent of the sample, the families did not visit the patient during their stay in the hospital.

d. Another factor which popped up under the study was the number of patients who were admitted to the hospital more than once due to a relapse. In the sample size of 30, 10 per cent of the patients have been admitted to the hospital more than 10 times and 30 per cent have been admitted up to 9 nine times in the hospital.

Under the study, 10 psychiatrists and 10 psychiatric social workers were also interviewed to comprehend challenges faced in dispensing mental healthcare under state provisions. The relevant findings are as follows:

Responses from Psychiatrists

a. When asked about the economic background of the patients admitted (given options: below poverty line, lower middle class, middle class and upper middle class) the responses were equally divided between below poverty line and lower middle class.

b. 6 out of 10 responses from psychiatrists indicated that families were ashamed of the mental illness of patients.

c. 7 out of 10 psychiatrists opined that relapse of episode of mental illness among patients occurs "very often" and 5 out of 10 attributed the cause of relapse to "neglect in care at home".

d. 6 out of 10 psychiatrists opined that "lack of finance" and "lack of awareness" are challenges to the rehabilitation and reintegration of mentally ill patients.

e. 7 out of 10 psychiatrists attributed stigma against mental illness to cultural/religious beliefs.

f. 6 out of 10 psychiatrists opined that family members should accompany patients in the mental hospital during treatment.

g. 10 out 10 psychiatrists opined that the family ward system (families of the patient admitted stay with the patient in the hospital during the course of treatment) implemented in NIMHANS, Bangalore should be implemented in all mental hospitals.

Responses from Psychiatric Social Workers (PSW)

a. 6 out of 10 PSW responses indicated that families of patients admitted "very often" give fake address and phone numbers.

b. 7 out of 10 responses indicate that "no response from relative" is a major challenge at the time of discharge of patient from the hospital.

c. 7 out of 10 responses attributed poor socio-economic conditions as a cause for relapse among patients.

d. 9 out of 10 responses indicated that there is no programme available for the rehabilitation and reintegration of a mentally ill patient post discharge from the hospital however, one response indicated day care facility at the hospital as an available programme for reintegration of patients.

5. Challenges To Community Reintegration Of Mentally Ill Persons

Seshi Kumar D. (2011) noted that "community" though widely used in psychiatric care, there is no "general agreement" about its meaning. Kay Pranis (2017) used the word community broadly to refer to groups of people with some common interest and common experience and who are not part of the formal justice system. He stated this in terms of "Community and the Justice System" however; in the context of mental health we can say "community and the designated mental healthcare providers". Community care of the mentally ill was seen as early as in the 13th century among the Belgian Community at a place known as Gheel provided shelter to them under community sponsorship. In 1946, the merger of three separate organizations facilitated the formation of the National Association for Mental Health in UK. This organization worked through the Provisional Council for Mental Health of UK during the Second World War which was tasked by the UK government with providing national aftercare services to military personnel discharged from service on psychiatric grounds. Further, this service was made inclusive for civilians as well which marked the beginning of community mental health care. "Community re-integration can be critical for people with serious mental disorders or it can be just an empty phrase, a rhetorical nod in the right direction but offering little guidance to consumers and families, public and private agencies, or County and State Mental Health Administrators in what to do next in order to make the concept come alive in their communities."

"Attachment, social integration, reassurance of personal worth, reliable alliances are integral components of social support that effectively integrate individuals into the broader social context." However, numerous studies have indicated various challenges to the successful implementation of this novel and magnanimous concept. Some of the challenges identified have been enumerated hereinbelow:

1. The vision of policy makers to provide increased accessibility and a holistic and comprehensive treatment is a reality yet to be achieved and continues to remain an aspiration.
2. Employment programmes, training facilities within the community for mentally ill persons are limited in nature.
3. There is lack of sufficient institutional care facilities for persons with chronic illness at the governmental as well as non-governmental level. Home based rehabilitation and care is inadequate.
4. Government funding is insufficient to implement rehabilitation and reintegration policies for the mentally ill.
5. Stigma against mental illness is still prevalent and stands in the way of a person who tries to return to his normal life.

6. Community Reintegration Of Mentally Ill Persons: Justice And Sustainable Development

Supported employment programme is an essential component under community reintegration of mentally ill persons. From the study conducted at Yerwada Mental Hospital it was gathered that they do not have a programme designed for employment of mentally ill persons post treatment and discharge from the hospital. In India there is a chronic lack and a significant need for studies on suitable employment opportunities for mentally ill persons in the Indian context. Razzano et. al. (2005) conducted a multisite, longitudinal study of 24 months of supported employment interventions to examine the relationship of patient clinical factors to employment outcomes. The study indicated that clinical factors were associated with individuals' ability to achieve competitive jobs and to work 40 or more hours per month. Poor self-rated functioning, negative psychiatric symptoms, ad recent hospitalizations were almost consistently associated with failure to achieve employment outcomes. The study concluded with the suggestion that it is necessary to primarily understand sub-group variations in employment outcomes, identify predictors of employment including the clinical factors, tailor services to fit consumers' needs better to improve the effectiveness of vocational training. For example, negative psychiatric symptoms and similar illness features should be considered in designing vocational programmes and workplace environments for mentally ill persons in the community.

Mental health has been given priority under Sustainable Development Goals for 2030. And community reintegration has been established as an essential component of mental health over decades through the deinstitutionalization movement. Employment is one of the essential factors of reintegration. Supported employment programmes have been shown to be effective in promoting employment among people with severe mental illness. (Bond et al. 2001; Cook et al. 2005, Crowther et al. 2001) in line with WHO's Mental Health Action Plan 2013 – 2020 two key indicators have been highlighted for improvement in services of mental healthcare:

1. To ensure that service coverage for people with severe mental disorders in each country will have increased to at least 20% by 2020 (including a community oriented package of interventions for people with psychosis; bipolar affective disorder; or moderate-severe depression).

2. To increase the amount invested in mental health to at least 5% of the total health budget by 2020, and to at least 10% by 2030 in each low and middle income countries. (Thornicraft & Patel, 2014)

Community oriented intervention is essential to any suggested improvement in mental healthcare and such improvements require a significant increase in the investment in the mental healthcare sector. Community reintegration will create an opportunity for the mentally ill persons to not only be a burden on the economy but through effective employment programmes they can self-sustain and also contribute to the economy in return. Besides, the United Nations Convention on Rights of Persons with Disabilities and the Mental Healthcare Act of 2017 provide for securing the right to community living of mentally ill persons. Therefore, community reintegration of mentally ill persons is an imperative to improvement in mental healthcare services. To successfully secure and enforce the rights of mentally ill persons, there is an imminent need to develop effective psychosocial programmes including housing, social living and employment. The psychosocial programmes must be developed sensitive to the needs and realities of the Indian socio-economic conditions.

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