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Tribal Health Status and Health Governance in India

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Introduction:

The Scheduled Tribes are accorded a special status under the Indian Constitution, which also includes safeguards to protect their rights and culture. Tribal people have remained marginalised in the national psyche despite their large population (104 million according to the Census, 2011). This is due to their marginalisation in politics, socioeconomics, and geography. The tribal people are perceived by the general public as "those semi-naked wild people who live somewhere in the forests and mountains, and who occasionally appear in the news because their children are malnourished." Tribal health care has been included in rural health care despite the long-standing suspicion that tribal people have poor health and unmet needs. It was believed that tribal people shared the same health issues and needs as other people, which contributed to the uniform national pattern of rural

It was assumed that because tribal people share similar health issues and needs, the standard national model of rural health care would also apply to them, albeit with some variations in the population: provider ratio. They weren't taken into account because of the different social systems, cultural differences, and geographic and environmental differences in their daily lives. Unsurprisingly, there are still issues with tribal communities' health and healthcare. But how would the country find out? There were no separate records kept for tribal health. This allowed for a blissful ignorance of tribal health. It is commendable that the two ministries of the Indian government acknowledged that, 66 years after independence and after 11 five-year plans, we must take the health of tribal people seriously.

- **Objectives**

The two objectives of this study, the first of its kind, were as follows.

→ To determine the gap between the current state of health and healthcare in tribal areas.

→ To develop a future road map for quickly closing this gap.

- **Methodology:**

The research study would be used the exploratory research design to explore the status the healthcare of the tribal in India. This study will be used systematic stratified random sample method for the sample selection and interview method for the primary data collection from selected among the research filed as well as secondary data compiled and compiled from articles, publications, and websites will used in the study. The s compiled data of the primary and secondary data sources goals, objective and hypothesis of the research study,the data will be analysed and interpret for social reality of the tribal health anddiscussed thecurrent situation of the tribal health status with results of the proper solutions andsome suggestionsfor its improvement.

Analysis and Discussion

The study is structured using secondary data gathered from websites, articles, and publications. The data were analysed and interpreted in accordance with the objectives of the study and the social reality of the time, leading to a conclusion and some recommendations for improvement.

- **Tribal in India**

The 104 million Scheduled Tribes in India make up 8.6% of the nation's total population, according to the 2011 Census of India. In the past, there has been a propensity to see tribal people as a single, homogeneous group. The history, way of life, state of people's health, as well as their beliefs and behaviours, vary greatly among tribal communities. There are currently 705 scheduled tribes in the nation. These can be categorised into four main groups:

1) **Tribal residents of Schedule-V:**The areas and districts with a predominance of tribal residents (except PVTGs),

2) **Tribal population in North-East India:** The North-eastern states have the highest concentration of tribal people. With 12 PVTGs, Andhra Pradesh has the most PVTGs overall. The communities in this area, as well as their health and developmental problems, are very different from those in the rest of the nation.

3) **Particularly Vulnerable Tribal Groups:** *(some of these regions are protected by the Constitution's under Schedule VI)***:** Primitive Tribal Groups, now known as Particularly Vulnerable Tribal Groups, were identified as some of the STs' poorest of the poor in 1975–1976 and again in 1993 (PVTGs). The following fixed criteria were used to identify these groups:

   i. Preagricultural technology. ii. Extremely low literacy rates.

   iii. Population declines or stagnation. Iv. Subsistence-level economic activity.

There are currently 75 tribes/sub-groups in the nation that fall under the PVTG category. Less than 0.6% of the households in the country are made up of them.

- **Tribal members who reside outside of Scheduled areas.**

Four major language families, including the Austro-Asiatic family, the Tibetan-Chinese family, the Dravidian family, and the Indo-European family, can be used to categorise the languages used by Indian tribes. There are 225 subsidiary languages spoken by the Indian tribal population in addition to 105 different languages (IGNOU, 1990). The majority of STs are currently notified in Odisha (62) with the next highest numbers being in Karnataka (50), Maharashtra (45), Madhya Pradesh (43) and Chhattisgarh (42). With only four tribes, Sikkim has the fewest, followed by Nagaland, Daman and Diu, and Uttarakhand, each with five. Karnataka has the most Scheduled Tribes (50) among the South Indian States, followed by Tamil Nadu (36) and Kerala (36).

Indian Tribal Population Distribution Madhya Pradesh has the largest ST population in terms of numbers. After Maharashtra (over 10 million), Odisha, and Rajasthan, it has over 15.0% of the nation's total ST population (over 9 million each). In fact, the seven states of MP, Chhattisgarh, Jharkhand, Odisha, Maharashtra, Gujarat, and Rajasthan are home to more than two thirds of the ST population. 18 The North Eastern states, particularly Mizoram (94.4%), Nagaland (86.5%), Meghalaya (86.1%), and Arunachal Pradesh (68.8%), have the highest concentration of tribal people.

The nation's tribal population still resides primarily in forested and hilly regions. In contrast to the national forest cover of 21.23 percent, according to the ISFR 2013, over 37 percent of the area in the 189 tribal districts of the nation is covered by forests. According to the 1991 Census, the viscosity of population in the slated areas of Andhra Pradesh was 125 persons per forecourt kilometre as against 194 persons per forecourt kilometre in non-Scheduled areas. Yet, unexpectedly, no analysis has been accepted in recent times to see at the public position the viscosity of population in ethnical areas vis-a-vis non-tribal areas, to understand how the schemes and morals need to be revised.

- **Socio-Economic Conditions:**

The ethnical societies in India are considered as the weakest sections of the population in terms of common socio-profitable and demographic factors similar as poverty, ignorance, lack of experimental installations and acceptable primary health installations.thus, it's observed that ethnical people have remained borderline, with poor health, unmet requirements and a poor population provider rate. The lines remain underprivileged due to colourful factors like geographical and artistic insulation, lack of proper health installations, incapability to satisfy introductory requirements, lack of control over coffers and means, lack of education and chops, malnutrition, lack of sanctum, poor access to water and sanitation, vulnerability etc.

- **Rights over Natural Resources: -** Of the sections58, wherein the timber cover is lesser than 67%, sections 51are ethnical sections. thus, a large section of the ethnical population has been dependent on timbers for their livelihood. Yet till the preface of the Forest Rights Act, 2006 (explained latterly) they were totally denied access to these timber coffers, performing in malnutrition, poverty and extreme privation. Three States with substantial ethnical populations in Odisha, Chhattisgarh and Jharkhand have considerable mineral reserves. Together they regard for 70% of India's coal reserves, 80%of its high-grade iron ore, 60%of its bauxite and nearly 100%of its chromite reserves. According to the Centre for Science and Environment, about half of the top mineral- producing sections are ethnical sections and these are also sections with a high timber cover. Unfortunately, much of this timber land has been diverted for mining purposes performingin environmental declination,loss of livelihood, and relegation of ethnical

communities. During 1951-1990, nearly 40 of the2.13 crore people displaced due to heads, mines, diligence, wildlife sanctuaries etc belonged to slated lines.

- **Occupation and Work Participation Rate (WPR):** A large proportion of slated lines are collectors of timber yield, huntsman-gatherers, shifting tillers, pastoralists and vagrant herdsmen, and crafters. The poor profitable status of the ethnical population can be caught on from the fact that for 86.57 ST homes the yearly income of the loftiest earner is lower than Rs 5000.
- **Poverty:** The Commission on Macro-Economics and Health set up by the WHO in 2000 easily articulated the liaison between poverty and ill- health." It demonstrated that impoverished people par take a disproportionate burden of avoidable deaths and suffering; the poor are more susceptible to conditions because of malnutrition, shy sanitation, and lack of clean water, and are less likely to have access to medical care, indeed when it's urgently demanded. The serious illness can bankrupt families for numerous times as they lose income and vend their means to meet the cost of treatment and other debts. Illness also keeps children down from academy, dwindling their chances of a productive majority." As per the poverty rates estimated by the quondam Planning Commission, the population of slated lines below poverty line has come down from47.4 in 2009-10 to45.3 in 2011-12 in pastoral areas. In civic areas also, it has declined from30.4 in 2009-10 to24.1 in 2011-12.35 Overall,40.6 ST population lived below poverty line as against 20.5 of them on-tribal population in the country.

State of Health and Health Care in Tribal Areas:

The ethnical people in India form a heterogenous group- there's huge diversity not just in their societies and life, but also in their socioeconomic and health conditions. Yet, the one congruity among ethnical communities in India is that they've poorer health pointers, lesser burden of morbidity and mortality and veritably limited access to healthcare services. In deed in a progressive state like Kerala, ethnical groups bear an advanced burden of light (46.1 vs. 24.3), anaemia (9.9vs.3.5) and goitre (8.5vs.3.6) compared to non-tribes. There's also a near complete absence of data on the health situation of different ethnical communities. Of the little available," utmost of the substantiation on the health of slated lines is available either at the accrued position, failing to regard for the diversity among Scheduled Tribe groups, or

focuses on the health of a specific Scheduled Tribe, making it delicate to say as inter-tribal inequalities in health".

Health Indicators among the Tribal People:

The health indicators among the tribal people in India which measure are follows

- ✓ **Life Expectancy:** The IIPS analysed data from the public Census 2011 to estimate, by circular styles, the life expectation and IMR for the ST and the non-ST population in India. These estimates, as published in the Lancet 201650, show that Life Expectancy at birth for ST population in India is63.9 times, as against 67 times for the general population. This LE for ethnical people is likely to be an overrate because child deaths are under reported amongst tribals more frequently than in general population. Utmost of the old ethnical people doesn't know their age or the date of birth. Hence, the age of the old existent recorded in the Censes might be guess work, thereby furnishing advanced estimate of age and the life expectation of ethnical people.
- ✓ **Reproductive, motherly, New-born, Child Health and Adolescents (RMNCHA):** Due to the poor civil enrolment system in the country, it's veritably delicate to get dependable estimates of fertility and mortality. While some data is available at the state position, it isn't disaggregated by population groups.

 Motherly Health:

No recent estimates for motherly mortality among the ethnical women are available. We do know that early marriage, early child birth, low BMI and high prevalence of anaemia are critical reasons for high motherly mortality. According to NFHS, the teenage ethnical girls had begun travail the loftiest among all social groups. The Rapid Survey on Children 2013-14 reveals that, further than 30 ST women in the 20- 24 times age group are married before they turn. Alarmingly nearly 50 adolescent ST girls between the periods of 15 and 19 times are light or have a BMI 50 opcit of lower than18.5. This proportion is advanced than all other population groups. In combination with obstetric haemorrhage, anaemia is estimated to be responsible for 17- 46 of cases of motherly deaths. colourful studies and checks have shown a high frequency of anaemia among ethnical women. NFHS 3 shows that 65 ethnical women in the 15-49 times age group suffer from anaemia as against46.9 other women.

Likewise, ethnical women continue to do hard labour for much longer during gestation as compared to other social groups. All this puts the ethnical mama at threat during gestation. One way to attack this is by provision of full prenatal care and safe delivery services to pregnant women. A full ANC includes a minimum of 4 ANC check- ups, one tetanus toxoid injection and iron and folic acid supplementation. While there has been a sharp rise in the prevalence of enrolment of gravidity across population groups, the full ANC content remains poor, particularly for the ethnical woman.

* **Child Health:** The child health pointers for the listed lines are poor, and worse than the general population.
* **Child mortality in tribal population:** Estimates of IMR and Under-five Mortality rate Since the Sample Registration System failed to give the estimated child mortality rates in ethnical population, this commission reckoned on two estimates. circular estimate grounded on the Census 2011, furnishing the IMR pertaining to the time 2008. This showed that the ethnical IMR was 74 as against the 62 for rest of the population in India, an excess of about 20 percent. It's grounded on the whole population data (104 million ST) hence the estimates are precise. But, because it's laterally calculated, the validity may be limited. also, it's formerly 09 times old, and doesn't give the time- trend. The global comparison of IMR in Tribal and indigenous populations in different countries. The ST IMR in India is loftiest in the world among the indigenous populations, next only to the Federally Administered Area.

 The estimated number of tribal child deaths in India in 2011.

1. **Infant deaths:** As per NFHS-3 (2005-06), IMR- ST was 62.1 with reference period of five- times antedating the check. It assumed that estimate refers to time 2004. As per NFHS-4 (2015-16), IMR- ST was 44.4. Again, it refers to time 2014. thus, the difference of the two was 18 and it should be divided by 10 times. It means direct average periodic decline in the IMR was1.8. To get the IMR estimate for 2011, we should add 44.4 *1.77. So, it comes around49.7 as on 2011.
2. **Under five child deaths:** In the same way, the under- five child deaths in ethnical population can be estimated from the U5MR- ST of 96 in 2004 (NFHS-3) and of 57 in 2014 (NFHS-4). The periodic rate of reduction was3.9. The IJ5MR in the time 2011 is

decided to be 69 per 1000 live births. When applied to the estimated live births in ST in 2011, the estimated number of ethnical under five child deaths in the country in 2011.

3. **Other Child Health Indicator:** The Rapid Survey on Children 2013-14 shows that the loftiest chance of children with birth weight lower than2.5 Kgs is set up among the ethnical population21.6 for STs as against19.6 for SCs, 18 for OBCs and17.6 for others. CES 2009 showed that mindfulness of peril signs among new born was smallest among ST women compared to all other groups challenging health education in the original language. still, early breastfeeding practices were stylish among ST women.

 Family Welfare and Reproductive health:

Contraceptive use (presently wedded women aged 15- 49 using any styles) among the ST population at each India position has been close to the non-ST population. There are two possible reasons for this. First, it may be that the ethnical population has access to contraception, and are regulating their fertility. Second, the sterilization dominated, incitement driven family planning programme of the government may be attracting the poor. In either case, the result is that over time fertility has gone down indeed in those sections where the ethnical population is large (like in Odisha). While the TFR for STs at3.1 was advanced than the general population (2.4), NFHS data revealed that the wanted fertility was the same as the relief position of fertility. This indicates a demand for contraceptive services.

- **Nutrition:** The food habits and life patterns of the ethnical population differ vastly from the non-tribals and from each other. Indeed, within the same ethnical group, the food consumption pattern varies across different seasons-from extreme privation during the spare season to high input in the post-harvest period. Problems of poverty are compounded by lack of sanitation, access to healthcare and frequent affections leading to rampant undernutrition. Recent times have also seen a social, profitable and artistic transition among the ethnical people. Lack of access to timbers, loss of livelihoods, migration, acculturation and a growing reliance on the public distribution system have limited the salutary diversity. This change has been associated with the preface of life conditions leading to a' double burden of complaint.
- **Daily Nutrient Intake Cereals and millets form the bulk of ethnical diets:** On an average, their input dropped by about 50g/CU/ day between the alternate (1988- 90) and

the third NNMB checks (2008- 09). The extent of drop was maximum in the state of Andhra Pradesh (by about 145g), followed by West Bengal (99g), Odisha (87g) and Madhya Pradesh (81g). Kerala, on the other hand, witnessed an increase of about 24 g. A borderline drop of about 04- 09 g was observed in the overall input of other foods like green lush vegetables (09g), other vegetables (06g) and sugar/ jaggery (04g).

- **The Food Input by Ethnical Mothers:** Food input by ethnical mothers is shy not only in terms of protein and calories, but in iron, calcium and vitamins as well. Only about 25 pregnant and lactating women had acceptable inputs of both protein and calories. This leads to undernourished mothers and children and threat-prone gravidity. This is further complicated by the practice of hard labour till the time of delivery, the input of alcohol by ethnical woman, and certain traditional beliefs. For case, in many communities, the food input of the pregnant woman is in fact reduced due to the fear of intermittent vomiting and to reduce the size of the baby for easier delivery.
- **Malnutrition:** While the NNMB checks enable us to get a picture of malnutrition as the ethnical child grows. There is huge difference between the nutritive status of ethnical children and those belonging to non-tribals, except in the north- eastern countries. This can be attributed to socio-profitable determinants similar as livelihoods and income knowledge, family size, presence of concurrent morbidity. still, compared to other social groups, ethnical children continue to be the most glutted. The frequency of underweight is nearly one and half times in ethnical children than in the' other' gentries. The same trend is noticed in NFHS 4, where chance of under 5 children being light has been reduced to 41.93 against 54.5 in NFHS 3.

 Mental Health and Addictions:

In the absence of knowledge about the detriment caused by alcohol and tobacco, compounded by the easy vacuity due to tradition as well as the legalized or illegal trade, ethnical people world- over are known to be easy prey to these addicting substances. In addition, ethnical people during the ultramodern time have been exposed to several empirical pitfalls and the internal stress. A large member of the ethnical population lives in areas that are mired in conflicts. The Naxalite movement is grounded generally in ethnical areas. Also, numerous insurrectionary groups operate in the north-eastern countries which are primarily inhabited by the ethnical communities. The preceding violence has redounded in instability,

severe stress and accordingly internal health problems in the ethnical population. Relegation and migration due to environmental disasters, mining, land accession and loss of livelihoods also takes its risk on the internal health of ethnical people. The medicine corridor passes through the north-eastern countries and there's a high prevalence of medicine abuse among ethnical communities in these countries. Yet there are no methodical studies that validate the extent of internal health problems among the ethnical community and their causes. Further, in utmost of these areas no help or comforting is available for the victims.

- **Tobacco:** The 9 state NNMB check 2008-09 showed that about 36 of ethnical men and 6 of women were smoking tobacco; the proportion of smokers in both relations was advanced among the 50-70 times age group as compared to the 20-30 times age group. About 27 men and 6 women had been smoking for further than 10 times. About 11-52 were biting tobacco, while about 3 men and 5 women were smelling the same.

- **Alcohol:** According to NNMB 2008-09, the consumption of alcohol was significantly advanced among ethnical men compared to women. diurnal consumption of alcohol was reported by about 5-11 among adult men and 1-3 in women. These figures are analogous to the NFHS 3 which showed that slightly below half of ST men consume some form of alcohol at the public position. formerly again this is much advanced than the consumption among non-ST men (30 percent). The estimated consumption among STs is set up to be advanced in the eastern countries like Assam, West Bengal, Odisha, Chhattisgarh, Jharkhand followed by Arunachal Pradesh and Andhra Pradesh.

- **Health Infrastructure and Human Resources for Tribal Health:**

India has 0.7 croakers per, 1000 people and utmost Indians travel about 20 kilometres to reach a sanatorium. Thedata from the Rural Health statistics reveals huge gaps in the health structure and coffers across the country. This gap is particularly huge in ethnical areas due to serious geographical and socio- profitable challenges. Access to health services becomes delicate as the roads are poor or defined. There's lack of public or private transport and] ambulance services are weak or missing. frequently indeed telephone networks don't reach these areas. Poor vacuity of health labour force, lack of acceptable outfit, language and social walls, staying time at health centres and poverty also add to problems of access.

- **Burdens of Tribal Health**

The Burdens of Tribal Health live within their own ethnical health systems, which they would like to retain as follows:

- ✓ Transmissible conditions, motherly and child health problems and malnutrition continue to prevail;
- ✓ Non-communicable conditions including internal stress and dependence are fleetly adding;
- ✓ Injuries due to accidents, snake and beast mouthfuls and violence in conflict situations;
- ✓ Delicate natural conditions arising due to geographic terrain, distances and harsh surroundings;
- ✓ Worse social-profitable determinants, especially in education, income, casing, connectivity water and sanitation;
- ✓ Poor quality and unhappy health care services with low access and content, low labours and issues;
- ✓ Severe constrains in health mortal resource at all situations; the professionals from outside are unintentional to serve in ethnical areas, and the original implicit mortal resource isn't trained and employed by the health system.
- ✓ The licit and required fiscal share for ethnical health isn't allocated or used in utmost of the countries. There's lack of transparent account of the factual expenditure on ethnical health.
- ✓ Lack of data, monitoring and evaluation that masks the below- mentioned problems;
- ✓ Political disempowerments of ethnical people- from the individual to the public position that exacerbates these problems. There's little addition of ethnical people in the planning, precedence setting and in prosecution.

- **Challenges and Recommendations:**

It's important to insure timely access to quality healthcare for ethnical people at a position closer to them. This entails that at least 70 of the focus on ethnical health should be

on primary health care. At the same time the compass of health care services available to ethnical population needs to be expanded to include important demanded gynaecological and surgical care, eye care, dental care, internal health among others. For this, we suggest to reorganization of Service Delivery Mechanisms in ethnical areas.

* **Ethnical ASHA's:** In the ethnical areas where townlets are frequently scattered, ASHAs should be appointed at the position of each habitation- going down to one for every 50 homes (about 250 population). townlets which are lower than 50 homes have to be added up together for a minimal critical size. Though the ASHA was introduced as a health activist, utmost of her work presently focusses on provision of health services. It's important to ensure that the ASHA pays equal attention to the part of social activation. For this, fifty per cent of their remuneration should be fixed and the rest should be performance grounded, linked to service delivery. Further, ASHA training class and capabilities in ethnical areas need to be kindly different, and designed to make her multi-skilled to manage all preventative and promotive exertion, acute simple ails, follow up care on all habitual ails and to maintain records. Being from the ethnical community, the ASHA will be conscious of the original culture and traditional belief systems. still, she needs to be acquainted of the morbidity profile of the habitation and the factors that impact it. The current ASHA is a starting point and a process of instrument can reiterate towards the asked skill set. These ASHAs should be handed with medical accoutrements for treatment of minor affections.

* **Ethnical Health:** Levies Original ethnical youth- 5 boys and 5 girls per village should be linked, motivated and trained as Arogya Mitras or health levies to spread information on good health practices. (further details in section on Road chart to primary health care in ethnical areas) These youth will be named by the Gram Sabha and work under it.

* **Village Health Sanitation and Nutrition panels:** There's a need for precisely named village position VHSNCs. presently, VHSNCs are formed at the position of profit townlets. This is inadequate as townlets are frequently piecemeal and fairly independent. Under the PESA Act, each village is an independent Gram Sabha. The VHSNC should follow an analogous pattern.

* **Tribal Health and Wellness Centres:** At the present norm of one PHC per, 1000 population in ethnical areas, each PHC caters to 50- 100 townlets, with large distances.

Hence, if not the primary health centre, the primary health care must move closer to the people. The Government proposes to convert present health sub-centres, across the country, into health and heartiness centres over the coming 5-10 times, depending on the capacity of countries. Given the situation of health among the ethnical people and the disproportionate burden of morbidity and mortality amongst them, this commission proposes that this centre in ethnical areas be called Tribal Health and Wellness Centres (THWC), originally at a population rate of 13000 but over a period to reach 12000. This rollout of Health and Wellness centre should begin in the ethnical areas and should, over a period of 3 times, cover all ethnical sub-centres (including those in listed areas, ITDP and MADA pockets), beginning with places with further than 50 ethnical population.

- **Conclusion**

The Ministry of Health declares that there are about 6 to6.5 lakh croakers available in India. But India would need to double that number by 2020 to maintain the needed rate of 1 croaker per, 1000 people. Therefore, it can be concluded that ethnical health in India suffers from ten burdens Together these ten burdens have redounded in poorer health issues among the ethnical people, in comparison with the rest of the population. Yet over the decades, significant advancements have taken place. This can be seen by comparing the fertility rates, IMR and CMR, and malnutrition in children in the NFHS II, Ill, IV and R-SoC, or the series of nutritive checks of ethnical population by the NNMB. This means two effects. One, that the health situation of the ethnical population can be bettered and two, that as effects stand moment, a lot of work needs to be done. There's need for critical action. A broader handbasket of main types of services should be offered at these ethnical health and heartiness centres will include:

- Health education and Adolescent health care services Care during gestation and parturition (at all centres for ethnical areas),
- Family planning, contraceptive services and other Reproductive Health Care services,
- Neonatal and child health care services including immunization and operation of sick child.
- Operation of common transmissible conditions and general out-case care for acute simple ails and minor affections operation of transmissible conditions

- Programmes National Health Screening and operation of non-communicable conditions
- Counselling, particularly with respect to substance abuse and nutrition and Webbing and introductory operation of Mental health affections
- Care for Common Ophthalmic and ENT problems Basic Dental health care senior and palliative health care services
- Training for health workers in these centres should include original language and sociological skill development, in addition to multi-skilling as paramedics.
- Trauma Care (that can be managed at this position) and Emergency Medical services withReferral Service and installations

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Role of social worker in Indian health system: Special context in mental health issues

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Abstract

Mental health is defined globally by both academic scholars and professional practitioners. There appears to be some difference regarding its definition in psychology and psychiatry. Year 2017 published in the prestigious Lancet journal show that the overall prevalence of mental disorders in India has increased significantly since 1990. According to the data of the year 2017, out of every 1 lakh people in India, 2443 people suffer from some mental health problem. The World Health Organization says that the Government of India is spending Rs 4 per person for their treatment. Talking about human resources regarding mental health, a total of 25,312 professionals, both government and non-government, are working in this field.

Aim of Study: In the present article, an attempt has been made to clarify the role of social work in field of mental health on the basis of facts related to the prevalence of mental health problems in India and the staff available to deal with them.

Methodology: The present article is completely based on secondary sources. Paper mainly based on facts related to mental health problems in India and the human resource available to deal with them. The analysis of the obtained facts has been completed through interpretive process.

Conclusion: Social workers help patients and their families make difficult personal decisions, facilitate communication between health care team members, raise policy issues that need to be addressed by the hospital, nursing home or rehabilitation center.

Key word: Social Work, Mental Health, Psychiatry, Psychiatric Social Work

Introduction

Mental health is defined globally by both academic scholars and professional practitioners. There appears to be some difference regarding its definition in psychology and psychiatry. On the other hand, even in physical science, mental health has been defined on physical grounds by some scholars. After the arrival of Sigmund Freud in psychology, human behavior started being studied in different branches of psychopathology and abnormal psychology. As a result, psychiatry began to be determined through the alliance of medical science and psychology.

On one hand, psychologists like Mary Jahoda define mental health on the basis of positive aspects of a person under positive psychology, while on the other hand, institutions like American Psychiatric Association, which has scholars related to physiology at its core and today is a global institute of psychiatrists, Under this, the symptoms of mental illness are being determined. That is, psychology and psychiatry are already seen defining mental health within their own academic scope. Apart from this, after the rise of the mental hygiene movement, the activities that were carried out for the betterment of mentally ill patients reach the slogan of the World Health Organization 'Mental Health for All'. The World Health Organization's 1948 definition of mental health is considered to be a result of this. In which it is written-

Mental health is “a state of well-being in which a person realizes his or her own abilities, can cope with the normal stresses of life, can work productively and productively, and is able to contribute to his or her society.” "

Even before the advent of this definition, integration of body-mind-soul was being talked about in India from the very beginning. Therefore, a holistic approach to mental health is already present in the culture here. Evidence of this is found in texts like Ayurveda, Charak Samhita. Despite this, the process of thinking separately about mental health and physical health in India after independence would be called blind imitation of the principles of the West. Colonial influence is visible on almost the policies made after independence. Mental health is also one of these. Overall, mental health at a global level now appears to include factors that were previously isolated. Yoga is an example of this. Till a few years ago, it was considered unnecessary or associated with faith, but today its usefulness in managing common mental problems like stress and depression has increased significantly globally. This changed concept of mental health and the organizations that determine it have made changes from time to time, therefore, it appears that even today the concept of mental health has not been completely determined by medical science. The same situation can also be seen in the mental health policies made in India.

India’s mental health status

As there is currently a lot of turmoil going on in India regarding mental health. The recent survey and formulation of advanced acts in this regard are all indications of India's attitude

towards it. The following figures will help in analyzing the recently enacted Mental Health Act.

The above table can be used to understand the prevalence of mental health in India. Data for the year 2017 published in the prestigious Lancet journal show that the overall prevalence of mental disorders in India has increased significantly since 1990. Its percentage in men and women is 17.3. Apart from this, if compared with the global statistics of mental disorders, the population suffering from global idiopathic developmental intellectual disability (IDID) disorder is seen to be higher in India i.e. 4.5 percent. Apart from this, disorders related to depression and anxieties are being seen at 3.3 percent. On the other hand, it is also being seen that like global figures, in India too, women have been found to be suffering from disorders in large numbers. As can be seen in the data, integrated mental disorders are more common in women than in men. Almost the same situation has been seen in depression and anxiety.

After looking at the global and Indian data related to mental disorders, it is clear that its burden is almost the same. On the other hand, while substance abuse related disorders are at their peak globally, Idiopathic Developmental Intellectual Disability (IDID) disorder is found to be prevalent in India. Despite this, the status of women appears to be almost the same at both the levels.

Mental Health Human Resources and Workforce in India Year-2017

It can be seen in the data that what is the human resources and workforce related to mental health in India and what is the per capita expenditure. According to the data of the year 2017, out of every 1 lakh people in India, 2443 people suffer from some mental health problem. The World Health Organization says that the Government of India is spending Rs 4 per person for their treatment. Talking about human resources regarding mental health, a total of 25,312 professionals, both government and non-government, are working in this field. This is 1.93 i.e. around 2 professionals per 1 lakh population. Apart from this, if we talk about the workforce, the number of psychiatrists, other specialists, mental health nurses, psychologists, social workers, occupational therapists, speech therapists and other paid workers is less than 1 per 1 lakh. There are hardly any child psychiatrists in this.

Role of social work

Social work is a modern knowledge discipline working from a humanistic perspective. It is recognized in the society due to the addition of professional ethics. Social workers trained in this discipline generally work as part of an interdisciplinary team, which includes physicians, nurses, nutritionists, rehabilitation staff, etc. The shortage of health workers that is being seen in the health sector can be met immediately by the use of social workers. Social workers provide counseling, information about needed resources, and referrals to patients and their families. For example, home health care, financial assistance, etc. Social workers are also skilled in organizing and facilitating groups of people dealing with various health-related problems, such as providing support to cancer patients, rape victims and parents of severely

handicapped infants. They provide support to increase the availability of community-based resources. Social workers advocate on behalf of patients who need services. Social workers help patients and their families make difficult personal decisions, facilitate communication between health care team members, raise policy issues that need to be addressed by the hospital, nursing home or rehabilitation center. Social workers performing all these roles can potentially be used as an alternative once they are adjusted to the Indian health system.

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Fostering Universal Access to Health Care in India: Forging a shared path?

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1. INTRODUCTION

1.1 The advent of the concept of Universal Health Care (UHC)

The notion that governments should bear the responsibility for health care of its citizen emerged in 19th century Europe amid the rise of industrial capitalism. A more expansive organization of healthcare materialized after World War II and with the creation of the United Nations (UN) in 1945 and World Health Organization (WHO) in 1948 (Kumar & Birn, 2023). The Alma Ata Declaration of 1978 with the goal of "Health for All", broadened the concept of health beyond medical systems, and emphasized the need to address social determinants of health and social justice through primary health care (PHC). Universal access to health care got further recognition with the formulation of Millennium Development Goals (MDGs) in 2000 and Sustainable Development Goals (SDGs) in 2015. As a concept, Universal Health Coverage (UHC) is based on equity and social justice. According to WHO, UHC implies that all people have access to full range of quality health services they need, covering full continuum of essential health services, without financial hardship (WHO, 2010). A critical feature of UHC is its universality and improving access to health care is an important step in that direction. India being a signatory to all these international covenants, reflect the willingness of the Indian government to deliver on its commitment to meet the human rights obligations related to health and well being.

Universal health coverage vis-à-vis Universal access to health care**:** Universal health coverage is ensured when ***all*** people actually obtain the quality health services they need through financial risk protection. However, it cannot be obtained unless good health services

and financial protection measures are accessible and acceptable to people. In literature the term universal health care is mostly associated in describing health care systems of high-income countries, while the word "care" is replaced by "coverage" in describing health policies of low and middle-income countries, thus overlooking the right to guaranteed spectrum of health care services for a large proportion of population of these countries (Abiiro & De Allegri, 2015; Bump, 2015). This difference in terminology arise as a recognition of the fact that low and middle-income countries do not have required capacity to effectively provide comprehensive quality health care to all its population, thus just ending up with 'basic coverage' (Stuckler, et al 2010), while universal health care in most of the high-income countries evolved as an outcome of political discourse and commitment.

1.2 Policy context of universal health care in India

The World Health Report of 2008 had maintained that primary health care provisioning should be the foundation of an effective and resilient health system, and so primary health care (PHC) should be accepted as the appropriate approach towards achieving Universal Health Coverage (UHC) and as a essential way to achieve Goal 3 of SDG (Ugargol, et al 2023). The concept of universal health care through primary health care provisioning in India is not new. Derived from the recommendations of the Bhore Committee in 1946, India's first National Health Policy (NHP) of 1983 emphasized comprehensive primary health care services and committed itself to the Alma Ata 'Health for All' goal by 2000. Thereafter there have been several programs and policies that have shaped the primary health care landscape in India and National Health Mission being one of them. The 2017 NHP, has reinforced importance of public health provisioning through Ayushman Bharat Programme (ABP) by establishing Health and Wellness centres, as well as providing financial coverage for hospitalisation as part of the Ayushman Bharat Pradhan Mantri Jan Aarogya Yojna (AB-PMJAY) (Basu 2020). The progress towards UHC in India should be relooked in the context that India's health care system faces a multitude of challenge of accessibility and affordability. The harsh reality of these issues became glaringly evident during the unprecedented outbreak of COVID-19 pandemic and the more recent news of infant deaths in Nanded district of Maharashtra, exposing the fragmented Indian health care system. According to 2018 World Bank data, out-of pocket (OUP) health expenditure in India was as high as 65 percent of total current health expenditure, highlighting the financial burden faced

by the poor to access health care, and thereby pushing them to further poverty. A lopsided distribution of health care facilities mostly catering to urban rich population, overcrowded public hospitals, and persistent shortage of skilled healthcare workforce are long-standing issues which will be challenging the implementation of universal access to health care in India through ABP.

1.3 Objective

In this paper, we review the present status of access to health care of vulnerable groups by analyzing key indicators of the recently conducted National Family Health Survey (NFHS-5) in the context of the Ayushman Bharat program.

2. Methodology

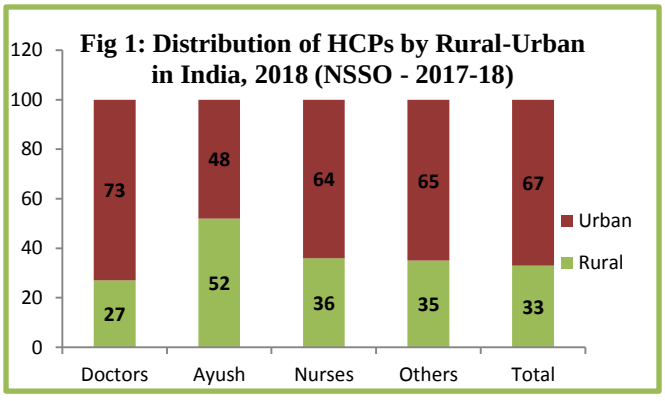
Data from the last round of NFHS – 5 (2019-21) survey was used to highlight the issue of inaccessibility of health services of vulnerable groups in the country. Data of select health indicators was used for analyses. The review would examine the health care system (supply-side dimensions of access) and abilities of people (demand-side dimensions of access) of UHC.

Following this, Thailand which has a successful UHC system was analyzed to understand the factors necessary for its implementation. Literature was accessed from peer reviewed journals and reports, without any hard inclusion and exclusion criteria using Google search.

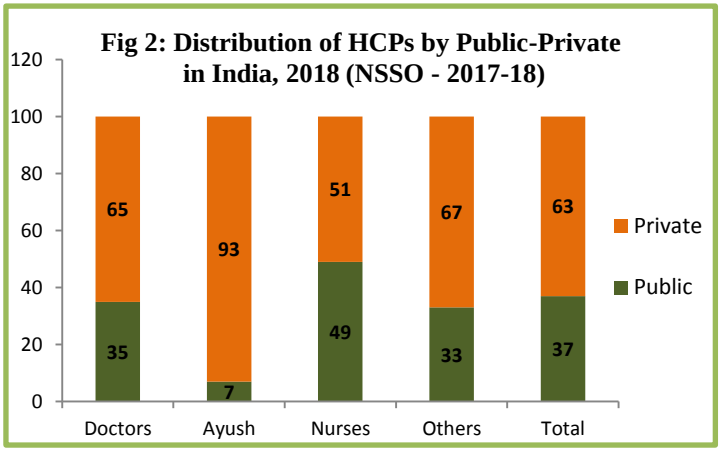
3. Findings

3.1 Supply side barriers to access to health care

Geographic accessibility: India has a huge population of 1.4 billion, and it is definitely a challenge to provide adequate healthcare to all. As per the NSSO report of 2018 (Fig 1), 67 percent of health care providers (HCPs) in India are based in urban areas, where only 34 percent of the population resides (GoI,



2019). This urban concentration of health care facilities denies the large proportion of population in India who lives in rural areas with access to adequate health care.



Availability of skilled public healthcare providers: Availability of trained human resources for health (HRH) needs to be ensured to provide quality health care to all and to achieve the WHO norm of at least 23 health workers (doctors, nurses, ANMs) per 10,000 population. According to the NSSO report of 2018 (Fig 2), 63 percent of HCPs are working in the for-profit, unregulated private sector, leaving large proportions of under-privileged population like tribals, poor without proper health care. This high concentration of HCPs serving the private health sector, leaves the government funded public hospitals overwhelmed with large amount of poor patients, resulting in poor quality of health care service delivery and poor health outcomes of rural, poor and tribal population are a direct reflection of their poor access to health care. Sixty percent women in India reported that they had atleast one significant problem in accessing medical treatment. (Table 1).

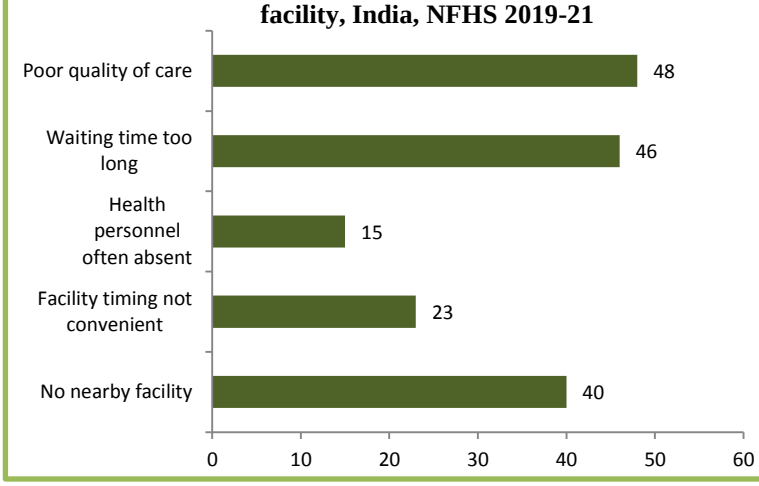
Table 1: Health Related Indicators and Outcomes in India, NFHS, 2019-21

Indicators/ Outcomes	Rural	SC	ST	Lowest wealth quintile index	India
Infant Mortality Rate	38	41	42	48	35
% Children (under-5 years) who are stunted	37	39	41	46	35
%Children (12-23 mths) received all basic vaccines	77	77	77	71	77
% of deliveries in health facilities	87	87	82	76	87
% pregnancies registered in first trimester	84	85	86	80	85
% pregnancies with ANC from skilled provider	83	83	82	72	85
% pregnancies with PNC in the first 2 days after birth	61	61	62	57	61
%women reporting atleast	65	61	71	76	60

one significant reason for
not accessing health care

Affordability to access health care services: The government health care facilities offers healthcare at low or no cost yet it is not the first choice of more than 50 percent of the population in India, and is perceived as being unreliable, with indifferent quality of services (Fig 3) (IIPS & ICF, 2021). A study in Rajasthan found that around 80 percent of rural people seeking in-patient services had to travel more than 100 kms (Iyengar & Dholakia, 2012). Public health care facilities were accessed only when one cannot afford private care. In India, private health care is largely unregulated and exploitative, yet in the absence of a sensitive public healthcare system, people are forced to access them.

Fig 3: Reasons for not accessing Government health facility, India, NFHS 2019-21



An important component of UHC is financial protection of households seeking health care and Government of India launched Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) in September 2018, aiming to provide publicly financed health insurance to 500 million individuals comprising the poorest 40 percent of the population (Mohanty, et al. 2023). However, with only 36 percent of poor and 42 percent of rural population being covered by health insurance in India (IIPS & ICF, 2021), many families are forced to finance their own health care costs through out-of-pocket expenditure[1] (OOPE), pushing them into poverty and impoverishment. According to the Economic Survey 2022-23, OOPE as a percentage of total health expenditure has decreased to 48.2 percent in 2018-19 from 64.2% in 2013-14 due to increase in government health expenditure, yet PM-JAY has only able to benefit less than 50 percent of the originally targeted under the scheme (GoI, 2023).

3.2 Demand side barriers to access to health care

[1] OOPE is the money paid directly by households at the point of receiving health care.

Availability of transport and cost: People from rural areas have to travel long distances for availing healthcare services which besides imposing cost, also takes a lot of valuable time, which many times become cause of mortality. According NFHS-5 data, 17 percent of women cited long distance and no transportation facility as the reason for not accessing a facility during delivery. Studies have consistently indicated that there is a strong correlation between distance and direct maternal mortality (Gabrysch & Campbell 2009), with half to one-third of maternal deaths in India occurring at home during delivery or on the way to a health care facility (Iyengar, et al 2009; Singh, et al 2015). This persuaded families to often use the services of nearby unqualified private healthcare practitioners for their health needs, with a potential to cause a negative outcome.

Information about health care facilities: Studies in India has shown that nonutilization of primary health centres (PHCs) as first point of contact is a major factor for overcrowding at district hospitals, affecting quality health services (Sivanandan, et al 2020), as well as increasing cost of care (Gautham, et al 2011), causing impediments in seeking access to healthcare. People many times are not aware about services they may be able to access in sub-centres or PHCs.

3.3 Health care delivery in Thailand – A successful model of UHC

Since 2002, Thailand achieved UHC through the implementation of the Universal Coverage Scheme (UCS). The national health insurance is overseen by three different schemes: (i) the civil servants' medical benefit scheme under the finance ministry; (ii) the social security scheme under the labour ministry; and (iii) the universal coverage scheme under the public health ministry. The scheme comprises of essential healthcare services for all age groups Limwattananon, et al. 2015).

Impact of UHC (cited heavily from Sumriddetchkajorn, et al. 2019):

- Financial protection for patients – The scheme includes coverage to high-cost medical treatments, such as renal replacement therapy, cancer therapy, stem-cell transplants, etc reducing OOPE of people in case of medical emergency and increasing household savings (Hongdilokkul, 2017).

- Increased utilization - Healthcare service utilization has increased contributing to a low prevalence of unmet needs for both outpatient and inpatient services.
- Improving physical accessibility and reducing transportation – Well coordinated health systems enabled individuals to seek care or referral at health facilities close to residence.
- Better health outcomes – Since the implementation of UHC, Thailand has experienced better health outcomes like increased life expectancy, decline in IMR.
- Economic growth – Expenditure on medicines and medical supplies stimulated the chemical, trade, electricity and transport sectors in Thailand (Evan, et al. 2012).

Reasons for success of UHC:

- Health financing: Thailand's financing for UHC is predominantly non-contributory, financed by general government taxation, exploring different revenue sources to expand UHC, including explicit earmarking in government budget.
- Human resource in health: Proper distribution of health care providers through effective recruitment policy, medical education curriculum and labour market regulation.
- Effective primary health care and inter-sectoral approach: Establishing people-centered primary health care along with addressing various determinants of health resulted in reducing morbidity in the population.
- Effective referral and utilization of tertiary care: Proper referrals by family physicians ensured that tertiary hospitals are not overcrowded ensuring appropriate utilization of specialty care and human resources
- Political will: Strong social support gave the policy resilience against political and economic challenges.

4. Access To Uhc In India – Path Forward

Political commitment for health as a 'right': For a successful implementation of UHC, strong political commitment is fundamental, which would then lead to increase in government investment in health and subsequent policy reforms.

Increased government financing on health: Reducing out-of-pocket expenditure on health is an essential part of achieving UHC and to eradicate poverty, another target of SDG. In the

present 2023-24 union budget, expenditure on the health sector stood at around 1.98 percent of the GDP (GoI, 2023), and the budgeted increase does not seem to enough to cater to the current challenges of up-gradation of infrastructure as proposed in NHP. Therefore, the government should increase budget allocation on health to 2.5 percent of GDP and must undertake health sector reform emphasizing on comprehensive primary health care as outlined in NHP 2017.

Access to comprehensive healthcare: Health care services in India traditionally have been about 'selective' health care, mostly focusing on narrow set of cost-effective curative interventions such as the GOBI program (Cueto, 2004) . The concept of UHC should be based on providing comprehensive health care, and besides addressing financial and supply side issues of health care, it should also address the demand side issues like social barriers impending access to health care using multi-sectoral approach. Transformation in approaches to UHC is urgently needed to move away from current paradigm of UHC's implicit insurance-based financing mode.

Proper allocation of human resources and skill-mix: As per the Rural Health Statistics 2020-21, there is about 80 percent shortfall of specialists at the CHC[2] level, highlighting the lopsided urban bias. As per Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), aimed at addressing the shortfall of human resources and educational capacity in the tertiary care system, many medical and nursing colleges are proposed. However, producing HRH is not going to help achieve UHC, unless vacancies in public health sector serving the rural and under-served areas are addressed through proper recruitment procedure, instilling proper ethos and values.

Regulation of private health sector: More than 70 percent of health sector is under unregulated, fragmented private sector, and does not view health care as a 'right'. All the reforms undertaken to implement UHC in India, such as 'access to essential medicines', should have a right-based approach.

[2] Community Health Centres (CHCs) are the first tier of the public healthcare system at block level in which patients have access to specialists, which include surgeons, physicians, pediatricians, obstetricians and gynecologists.

Information about available health services: Lack of information on health services and about their own entitlements is a demand-side barrier to UHC. There is a need to create awareness about the newly established wellness centres and upgradated PHCs under the new Ayushman Bharat Program.

Better health systems governance: Accountability and transparency are keys to achieving UHC, because lack of it will limit its success. Health system corruption has been identified as a global public health problem (Koller, et al. 2020). Under NRHM, community-based accountability mechanisms were created, however down the years it got diluted, mostly in practice. Thus in order to achieve total UHC, there is a need to strengthen institutional mechanisms for community engagement and accountability in order to make planning, implementation and review more responsive to the needs of the communities.

Multi-stakeholder engagement: Collaboration between healthcare providers, policymakers, technology developers, and community stakeholders is essential to ensure equitable implementation of UHC.

5. Conclusion

With the formulation of NHP 2017, and India being a signatory to SDG, the policy environment in India is primed for an all-out progress towards UHC. Nevertheless, perennial supply-side barriers to access to healthcare, coupled with demand-side barriers pose a serious threat to the timely realization of UHC goals. Therefore, context-specific strategies need to be incorporated for achieving access to healthcare for all in India, and it cannot happen in isolation, there is need for shared collaboration among policy makers, academicians, health care providers and community to forge the path of access to universal health care.

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Uncovering the Silent Struggle: Occupational Stress and Burnout Dynamics among Working Women

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Introduction

"An enlightened woman is the source of infinite energy."

– Swami Vivekananda

Job stress has become one of the most important elements in diminishing productivity and losing human resources, which can have physical and psychological consequences for employees. Teaching experience, workload, previous year's performance, student conduct, household work, an imbalance between household work and job, and lack of proper social support for female faculties. Female faculty members experience burnout as a result of job-related stress. Burnout is the result of prolongedoccupational stress. Stress is the psychological strain or distress caused by unusual or difficult events known as stressors. Occupational stress (OS) is the reaction to organizational pressures in the workplace that provide a "perceived threat to an individual's well-being or safety." Individual-level elements and organizational issues have been implicated in stress outcomes, both as contributing factors and as stress moderators. (Cullen, 1985). According to Kyriacou (1978), stress can be generated by persistent demands and can be controlled by the individual's coping strategies. Thus, persistent problems cause stress in anyone's life, and this tension causes a slew of disruptions in the individual's life. The individual coping mechanism has control over this. In general, stress is not limited to the workplace, and distinguishing between occupational and personal life difficulties is sometimes difficult, if not impossible. A family member's illness, children starting school, or a breakup will likelyimpact an employee's ability to work. Even if such conditions are not the employer's duty for the employee's health, a good employer may consider assisting the employee in such circumstances, reducing the inevitable transition of problems in the workplace (Quick & Henderson, 2016). Occupational stress affects all countries, professions, andworker categories (ILO, 1993). World Labour Report (1993)

highlighted occupational stress as one of the most important health crises of the twentieth century, and the World Health Organization (WHO) labeled it a "World Wide Epidemic" a few years later. Cultural constraints were the principal barriers to female employment; nevertheless, with a shortage of jobs in every industry, the country currently has more unemployed women. Even if the woman is employed, she may not have authority over the money she earns,even though it is frequently used to support the home. Women in Indian culture is expected to spend almost all their time, energy, and money on their families. The underlying architecture of society has not improved even though the role of women within the same framework is in transition. Even in her economically independent status, she is naturally subject to exploitation. Though males increasingly contribute to family obligations, women continue to performdomestic caregiving. As a result, efforts should be made to reframe work and family concerns. There is an urgent need for study on working women, particularly the impact and prevalence of job stress on children's mental health. Longitudinal data on young childbearing families is required to investigate the complicated work-family concerns surrounding the family in today's environment (Islahi, F., 2017). Burnout is not common among married female academic staff, but it is common among divorced and widowed female academic staff, which has an impact on the depersonalization dimension. Female academic staff absenteeism was positively associated with the burnout parameters. Female academic staff's physiological and psychological health symptoms are linked favourably with all burnout factors(Maha Abdul-Moniem Mohammed El-Amin 2015). High targets and concentrations were the main sources of stress for the women, but canteen, refreshment, transportation, noise pollution, leadership, time, lack of participatory management, physical stress, and so on were also issues. More of them had selected yoga as a stress-reduction approach. She proposed that the corporation focus on the well-being of its employees, primarily affected by stress (Hemamalini. R, 2014). Working women in their forties and fifties endure more stress than other age groups. Household responsibilities, employment demands, a lack of support, a lack of facilities and infrastructure, having too much duty, inability to provide time to family, inability to learn enough to take on larger tasks, having a heavier workload, and confusing and unclear directions are all factors of stress (Kumar & Yadav, 2014). Occupational stress is linked to the following health problems in humans, i.e., cardiovascular problems, anxiety, sadness, and post-traumatic stress syndrome, Gastric ulcers, Metabolism issues, Skeletal and muscle problems. A person under stress

frequently exhibits the following risk behaviours: Smoking, Excessive alcohol consumption, Drug use, a sedentary lifestyle with little movement, unhealthy diet **(**Harris and Hartman, 2002**)**.

Objectives of the Study

The study's objective is to find the coping techniques adhered to by the female faculty members of Visva-Bharati.

Research Design

Exploratory research design adopted to carry out the research.

Universe& Sampling

The universe of the study is the female faculty members of Visva-Bharati. The researcher has taken all the Bhavanas / Vibhagas of the university to fulfil the requirement of the research as the universe. Different Bhavanas / Vibhagashave female faculties working in various roles; hence, the researcher wishes to bring the multiple analysis under one frame. The researcher has taken 3 cases with the help of purposiveto fulfil the research objective.

Methods of Data Collection

Case Study: In the present study, the researcher has approached the faculty members directly to collect relevant data. Three cases are considered for the fulfillment of the research objective.

Ethical Considerations

In research, ethical considerations are crucial. In this study, the researcher considered the following ethics:

- Prior to data collection, all respondents were informed, and the researcher collected data with their permission.
- The researcher promised the respondents that their data would be kept private and used exclusively for academic research.
- The researcher attempted to prevent personal bias while collecting data.

Results

The researcher conducted an in-depth case study to determine the causes and coping mechanisms for the stress and burnout experienced by female faculty members at Visva-

Bharati. The researcher purposively chose three respondents from his sample for the case study.

Respondent 1 argues that stress occurs for various causes in life, but when it comes to the workplace, she has never experienced severe stress that caused him to leave. She also mentioned that when working, she had tension occasionally, but it never hindered her productivity. She stated that regular noises made by machinery are the primary source of stress at the workplace. However, it is not severe enough to pose a threat to her health or have an impact on the effectiveness of her activities.

She states that she has never experienced stress as a result of physical issues, family issues, or financial issues. She also manages stress by focusing on the positive, better organizing her time, and communicating her emotions with close friends and family. According to herresponse, she insisted that the institute provide employees with safe and healthy working conditions and an effective approach for fostering harmonious relationships between employers and employees. These outcomes result in willing employees all around the world. She also revealed that providing holidays as a stress-reduction approach is an effective mechanism for lowering stress levels.

Suggestion: She advised the other staff members to focus on yoga and meditation to relieve stress.

Respondent 2 believes that stress can manifest in various ways during working hours. She thinks that stress is more prevalent when there are a lot of tasks to complete in a short time. As a stressful component, it is sometimes necessary to undertake parallel work, such as failing to complete some documents from prior works that need to be examined while also completing a set of new tasks. It might be stressful since there is too much to accomplish and the physical environment becomes crowded. She stated that it had never occurred to her to a greater extent during her job performance to lose focus or concentration or to endanger her health.In contrast, it really aided her in increasing her productivity at work, such as managing her time effectively and efficiently for each assignment. She was the only respondent who stated that stress boosted her productivity in both her professional and personal lives. It enables her to do a huge number of tasks in a short period of time. In terms of coping with and managing stress, respondent 2 stated that she employs effective techniques to execute her

job well while also reducing her stress level. As an internal activity, she highlighted time management as a useful factor in completing the assignment efficiently while also reducing stress levels during working hours.However, she believes that visiting friends, going to picnics or parties, sipping coffee or tea with each other, speaking and sharing ideas are effective stress relievers. She stated that Visva-Bharati assists employees in having easy access to firm services so that they can work freely and comfortably.

Suggestions: Be disciplined in your life so that you can fulfil your obligations and responsibilities on time.

Respondent 3 argues that stress is a phenomenon that occurs in all situations in life, although she did not feel stressed throughout her occupational activity. She believes she has always worked in a difficult environment and is practically accustomed to it. However, she does become anxious when there is a great amount of work to do and it becomes more stressful to handle many things in a short period of time, such as when the department receives additional work and must do it on time. In terms of managing and coping with stress, respondent 3 stated that she employs an effective technique and regards time management as an important factor for keeping stress at bay.She stated that she feels liberated and at ease when she manages her time effectively. For example, during working hours, she sequences the tasks, prioritises the activities one through ten, and arranges them one by one. In the event of an unclear circumstance, she indicated that she looks exclusively at the bright side and shares her emotions with close friends, co-workers, family members, or relatives. Finally, she stated that management places a high priority on stress and does everything in its power to keep employees' stress levels to a minimum.They offer several services and facilities to help female faculty members and reduce their stress levels, such as indoor psychological doctors, medical sections, and salary payment in the event of employee absence due to illness or treatment. Finally, she stated that providing vacation and holidays is quite beneficial in managing and reducing stress levels.

Suggestion: Managing your time and adapting to your surroundings can help you avoid stress.

Findings

Coping Strategies

Sharing the stress with someone close to you might sometimes be the most effective stress reliever. The process of talking it out and receiving support and sympathy—especially face-to-face—can be a highly effective technique of releasing tension and recovering control. The other person does not need to "fix" your problems; they simply need to listen. The researcher discovered many forms of coping mechanisms used by female faculty members in the current study. However, an important feature is that practically all female faculty members used the same coping strategy.

The following are the coping mechanisms used by female faculty members at Visva-Bharati, according to the researcher.

- The majority of responders utilise yoga and meditation to cope with stressful situations.
- Make a balanced schedule, which entails balancing job and family life, social engagements and solitary pastimes, daily tasks and downtime.
- For many people, a good place to start is to stop using artificial stress relievers like alcoholism or smoking, which are harmful to our health and appearance and only temporarily relieve our stress symptoms without addressing the underlying problem.
- More vacation time can help them reduce stress.
- Consume a well-balanced diet rich in nutrients, as well as foods high in complex carbs. A healthy diet should include moderate levels of protein while keeping low in fat.
- Avoid excessive caffeine use (coffee, black/red tea, caffeine-containing soft drinks, etc.), which can exacerbate anxiety and even trigger palpitations.
- Exercise is one of the most effective methods for eliminating stress and improving overall quality of life. Take a walk or do whatever exercise you enjoy.
- Time management is the most effective strategy to reduce stress in a stressful existence.
- Visiting friends, attending picnics or parties, and sipping coffee or tea.
- Determine the activity's priority.
- Feelings are expressed to intimate friends, coworkers, family members, or relatives.

- When possible, spend time outside. A little sunshine and activity can do you a lot of good and improve your overall outlook on life.
- Think positively. Try to counteract each negative idea with something positive. Always look for the bright side.
- Set attainable goals for yourself. Set unreasonable goals to avoid setting yourself up for failure. Allow enough time to achieve your objectives and accept that setbacks will occur.
- Learn to manage your time effectively. When you have to juggle multiple projects or roles, time management is critical. Always allow yourself enough time to complete your responsibilities.
- Set aside time for yourself. You must be at the top of your priority list. Prioritise your own wants. When they are met, you may discover that you have more time for others.
- Adopt healthy sleeping habits. Make an effort to go to bed and wake up at roughly the same time every day.
- Taking a deliberate break or pause can have a calming impact and give you extra time to review the issue before acting on impulse and perhaps unpleasant acts.
- Laughter is the most effective medicine. Many faculty members admitted to watching comedic shows to relieve stress.

Eliminating the major sources of stress and learning to handle the remainder can help you have a good attitude on life, which will rub off on your family and friends. Things that appear overpowering will quickly become trivial with improved stress management strategies.

Discussion and Conclusion

Some work-related stress is natural, excessive stress can negatively affect your productivity and performance, as well as your physical and mental health, relationships, and home life. It can even determine employment success or failure. You may not be able to control everything at your workplace, but it does not imply you are helpless, especially if you are in a terrible circumstance. Whatever your goals or job responsibilities, there are steps you can take to protect yourself from the negative impacts of stress, increase job satisfaction, and improve your overall well-being in and out of the workplace.This study basically aims at understanding the causing factors of the stress and the coping mechanisms adopted by the

female faculty members in order to have a stress-free life.Our lives are full with stressful occurrences, and sometimes stress improves our professional skills, allowing us to produce better results. Stress cannot be considered as a negative influence in our lives. Sometimes a little tension helps us stay focused, energetic, and execute our tasks more effectively. Being aware genuinely helps to prevent accidents or blunders. However, in today's hurried environment, the office often appears to be an emotional roller coaster. Working long hours, meeting tight deadlines, and dealing with ever-increasing demands can leave you feeling concerned, fatigued, and overwhelmed. When stress exceeds your ability to deal, it begins to harm your mind and body, as well as your job happiness.Many factors influence university faculty members' stress levels. Work overload can result in tremendous pressure, resulting in physical and emotional tiredness. One of the respondentsdescribed growing student numbers as a source of stress, owing to the need to accommodate the needs of various students. Furthermore, a lack of university support, such as resources, financing, and recognition, contributes to occupational stress. Employees with low job satisfaction experience higher stress and are more likely to leave colleges. Too many administrative matters have taken up too much teaching and research time, making faculty members stressed. There is a link between work-life imbalance and occupational stress. Furthermore, a poor coping technique might lead to occupational stress.

Way Forward

Based on the study's findings, the author would like to propose the following ways to alleviate the stress

- Steps should be taken to lessen female faculty members' burden. Measures could include minimizing non-teaching activity.
- More female faculties should be recruited.
- Theemphasis should be given in building culture of team work in professional space.
- Launch programs to educate pupils about acceptable behaviour.
- Gender friendly environment should be promoted.
- Interventions such as relaxation technique training and increased social engagement at university activities may be beneficial. These measures must be accompanied by

regular health checks for female faculty members in order to diagnose stress-related disorders.

- Counselling and stress management programs should be available within the campus premises so as to encounter the occupational stressors.

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A Journey From Community Development To Mental Health In Social Work : Opportunities And Challenges -A Self Study Approach

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Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people.Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance well being."(IFSW,2014).Community development and mental health forms two important areas of specialization in social work.Community development and social work have never made comfortable bedfellows. On the one hand, community development is acknowledged as a professional practice in social work education and is one of the specialization utilized by social workers in community contexts. However, community development is also a distinct discipline with its own set of principles, theory, and practice history. Moreover, it is linked to other disciplines that cover a wide range of topics, including geography, sociology, citizen science, and health settings.Community development has a holistic approach in it.It is mix of social work,sociology and other subject areas.It is a planned approach to improving the standard of living and well-being of disadvantaged populations across the globe and help them to deal with their problems on their own.These problems will be mostly social in nature including substance use,access to education,health..etc.Though it forms a specialization in the the social work field both of it have certain differences.The way in which the discursive stances of social work and community development differ primarily is in how they approach power dynamics and the role of experts. The field of social work has evolved in the neo-liberal and potentially post-neo-liberal era to assert its expert role through legislative powers, required degree and

qualification pathways, and registration in certain locations. In contrast, community development typically emphasizes power transfer to the community and the utilization of existing expertise to create and address local needs.Mental health on the other hand forms the other major specialization of mental health dealing with the mental well being of individuals and community as a whole.Mental health is a complex concept of state of emotional and mental well being in which the individual is able to cope with stress of daily life in a positive and daily manner(WHO,2022).Our ability to make decisions, form connections, and influence the environment around us as individuals and as a society is largely dependent on our mental health. Mental health forms basic right of humanity. Furthermore, it is essential for socioeconomic, community-wide, and personal development.The major characteristics of mentally healthy person includes :positive self concept,sense of responsibility,better relationship with other people,adaptability to change ,ability to face shortcomings and disappointment,ability to face problem squarely,ability to accept criticism.According to Canadian Association of Social Workers ,mental health is is the capacity of the individual ,the group and the environment to interact with one another in ways that promote subjective well being,the optimal development and use of mental abilities(cognitive,affective and relational).So in order to maintain the mental health it is important to ensure the collective mental well being of the individual.

Methodology

Social work is an emerging profession which comprises of different specialization Research on specific specialization is a carried out in a wide spread manner.But the differences and similarities between different specialization are still an untouched area.The study on these will provide insights on multidimensional aspect of social work and the characteristics and limitations of different specialization.This study focuses on analyzing the opportunities and challenges of each specialization- and the differentiation between the specialization and the role and working pattern of social worker in each specialization.

Research Context

The research was conductedin the context of the researcher’s shift from community development specialization to mental health settings after the post graduation for the M.Phil programme.The research was carried out during the time period of April 2023 to October

2023.The researcher completed Master of social work from Pondicherry University in the time period of 2021-2023 in Community Development specialization.During this time period when the researcher done internship in various NGOs and government organizations from which the researcher comes to know about the need for practice in mental health for providing psycho-social support in the community as well. This results in joining for Mphil cousre providing clinical training in psychiatric set up in CIP Ranchi.The study thus aims to understand the structural as well as psychological changes happens to the researcher after the shift.

Methodology and Evaluation

A mixed method of research was used in the research where the qualitative method was used to evaluate the experience of the research over this period of time and also quantitative method has been used to understand in specific about the stress,well being and professionalism after choosing the specialization.The details of the methodology described in the table below:

Table No: 1 Technical Sheet Of The Study

Object	A Journey From Community Development To Mental Health In Social Work
Methodology	Mixed,Quantitative And Qualitative Evaluative Research With Self Study Approach
Key Informant	Researcher
Data Collection	From April 2023 To October 2023

This combination is at the basis of processes oriented toward the generation of knowledge in social work that harmonize scientific rigor with the intention to be useful in decision-making for management and planning (Grinnell & Unrau, 2005). Likewise, it connects with recommendations in research on health that agree on advocating quantitative and qualitative strategies simultaneously as a means of triangulation or of completing perspectives on the same object of study (Amezcua & Carricondo Guirao, 2000).

Result

The qualitative data is collected directly from the daily experience of the researcher and the quantitative data is collected and analyzed by applying three scales such as Perceived Stress Scale(PSS),Perceived Wellness Survey(PWS),Hall's Professionalism scale.The qualitative process generated a set of three thematic categories.The first thematic category analyses the need for the shift for the change,the second and third category analyses the changes in the new environment and the challenges faced respectively.

Thematic categories

The need for the shift

The changes reflected while shifting

The challenges faced during the shift

The need for the shift

The field work experiences during the post graduation time of the researcher help her in understanding about communities,the felt needs and the further intervention procedures.While working with different NGOs the researcher come across different types of social problems which is social and psychological in nature.As a community development specialist the researcher on that context able to deal it socially only.Like if a person with problems in their household approaches the researcher she could able to solve it socially by providing solution to the problem but the mental health of that particular person remains unaddressed.This created a thought in researcher to train in such way to provide psycho-social support to the community.Also while working in a shelter home during the same time period the researcher felt the same feeling.Generally,the community development specialization helps the trainees to deal with problems in community socially,in order to provide holistic and sustainable solution psycho-social support is need.The society is now heading to the state of community based rehabilitation.According to WHO(2023) In recent years, there has been increasing acknowledgement of the important role mental health plays in achieving global development goals, as illustrated by the inclusion of mental health in the

Sustainable Development Goals. Depression is one of the leading causes of disability. Suicide is the fourth leading cause of death among 15-29-year-olds. People with severe mental health conditions die prematurely – as much as two decades early – due to preventable physical conditions,which reflects the need for focus on mental health in the communities.The researcher mainly aims to train on both specialization as social work is a multidisciplinary approach.

The changes reflected while shifting

The researcher consider the shift from community development to mental health setting brings certain drastic changes in the total working pattern of the researcher,which she divided into particular domains.Such as:

- **Working profile:**The major function of mental health social worker includes interviewing the individuals and the family for history taking,attending case conferences,sharing the social history to the medical team,assisting the team for proper diagnosis,guidance to family,promoting treatment adherence,dealing with discharge planning and discharge issues,mental health education,sensitizing community for community based rehabilitation,followup of the patient,counselling and supportive therapies,family assessment and intervention,addiction counselling and therapies..etc
- **Working time:** The first major change reflected was that with regard to the working environment.Earlier when the researcher was working in community development specialization the researcher mostly engaged in 24 *7 basis.But when comes to mental health settings especially psychiatric settings the working time is fixed.While providing therapies and counselling sessions it is important to maintain proper timing.
- **Session Duration**:The sessions provided to the client should in a perfect time frame.Ideally,the session should be completed within 45 minutes and also no continuous two session for the same client in the same day.Sometimes this vary according to the nature of the problem but generally following this time pattern.Otherwise it will affect the efficiency of both client and the social worker.
- **Working amenities**:In case of community development specialization a social worker is dealing with the different kinds of social problems including violence, offenses against

women, children and minorities, unemployment, poverty, drug addiction, communalism, youth unrest, corruption, migration and displacement, environmental degradation, population explosion, prostitution, HIV/AIDS, etc.Most of the time the social worker will be in the field engaging with different people and this kind of problems.Thus it is difficult to get basic amenities such as washrooms,waiting facilities,working area…etc.Most of the time meeting will be held in public areas or buildings that is accessible to the community people.But in case of mental health field it is associated with hospital or psycho-social unit in which there will 'space' for the social workers especially in the psychiatric social work setting where the researcher is working now.It also have the basic amenities such as proper washrooms,counselling areas..etc

- **Multidisciplinary approach:**The decline of big psychiatric facilities has coincided with the development of interdisciplinary teams providing mental health treatment and care. Community-based care has replaced inpatient mental health facilities since the 1950s. Improvements in pharmaceutical therapies as well as significant social, political, and economic developments led to this movement. Increasing focus on human rights, knowledge of the negative consequences of institutionalization, the participation of family and service user associations, value for money, and the impact of the therapeutic community movement were a few of these.Though the community development specialization is also deals with different sectors of the society but the multidisciplinary approach is effectively seen in the mental health settings.The determinants of the mental health comprises of psychological aspects (ability to manage one's thought,emotions,behaviour and interaction with others) as well as social aspects such as social,cultural,economic,political and environmental factors.So working in a mental health setting includes a collaboration with psychiatrist,nurses,other mental health professionals as well as community level workers.This need the additional skill to deal with the team.
- **The spectrum of mental health problems**: Mental health is a field that primarily focuses on the well being of individual and community as a whole.With physical health the individual some days feel stronger and energetic than others.But sometimes things will be opposite.Similar in case of mental health also.This will in turn affect the normal functioning of the individual.So it is important to identify the mental health problems and intervene at the right time.The mental health problem can be of different types ranging

from mild issues to severe mental illness including depression,mania ..etc.Each type need specific kind of interventions which need specific skills and techniques for the social worker to deal with.

- **The family as major area of intervention**: Mental health is a field that require in-depth analyses of the individuals problem.Most of the time while providing interventions to the individuals the social worker needs to focus on their family dynamics.Any dysfunctions in the family dynamic such as family structure,composition,cohesiveness…etc can results n formation of stressors for a mental health issue in the family member.Families play a significant role in identifying the mental health problems in their members and also can act as a bridge between the worker and the organization in facilitating mental health care. The family members play key roles in providing significant support and care to persons suffering from serious mental illness/psychological distress. So as a mental health professional the social worker needs to deal with family effectively.

The challenges faced during the shift

- **Knowledge barrier:** The first and foremost problem faced by the researcher during the shift from community development to mental health was that of knowledge barrier especially with regard to dealing with mental illness and subsequent interventions.Though the social work in general needs sepcific skills and technique to deal with the problems the mental health in specific needs skills such as understanding of mental illneess,dealing with family,psycho-education,therapy sessions,teaching skills,critical thinking.etc
- **Dealing with families:**Family is a major component in the treatment process of person with mental illness.Making family understand about the condition of the patient or the client and involving them in mental illness require time as well as patience.Inorder to carry out family assessment and interventions the trust of the family is important.Building trust forms the major challenge here.
- **Challenges in working with multi disciplinary team:** The mental health service is end the result of collaboration of multidisciplinary team.So for the social work who is focusing on providing holistic and sustainable solutions for the problems of the

individuals and family with mental illness, it is important to deal with all the members of the treating team from the attender to the consultants.

- **Dealing with people with severe mental illness:**Individuals with mental illness especially with severe mental illness is difficult.The most important problem is with their insight on their problems.They are unable to understand about their problem and finding solutions to it.
- **Stigma of the public :** Stigma is major concern especially with regard to the mental health.People with mental illness are usually seen with a stereotypical mindset by the public and this in-turn results in the discrimination of the individuals from main stream of the society.This stigma results in the hindrance for providing services to the individuals in problems and also results in the development of perceived stigma in the individuals.
- **Lack of psycho-social support for the social workers**:Unlike the community development specialization the social workers in mental health field is dealing with the mental health problems which mental affect the mental health of the professionals also.Till date there is proper mechanism anywhere in the mental health settings to deals with the issues of the professionals which form a major challenge faced by the social worker during the initial days of the shit.

Quantitaive Data Analysis

Test Administered	Result
Perceived Stress Scale(PSS)	Total Test Score:23 Moderate Stress
Perceived Wellness Survey(PWS)	Five Domains: 1. Mental Health:20 2. Emotional Health:23 3. Social Health:25 4. Physical Health:20 5. Spiritual Health:30 6. Intellectual Health:23
Hall's Professionalism Scale	● Sense Of Calling To The Field ● Autonomy ● Using The Professional Organization As Major Referent ● Belief In Self-Regulation ● Belief In Public Service

The quantitative data analysis shows the facts that the researcher has been experienced with moderate stress after the shifting from community development to mental health and the perceived wellness scale suggests issues with regard to mental health and physical health after the shift.The Hal's professionalism scale shows heightened understanding in all the five domains depicting increased professionalism in the researcher.

Discussion and Summary

The research undertaken has allowed evidence to understand about the challenges and opportunities while shifting from one specialization to the other.Here in this study it majorly focused on analyses the factors associated with shifting from community development to mental health.Though these two are two specialization in social work the shift results in drastic change in the working pattern of the social worker.The review of literature reveals the fact that in order to effectively meet the needs of vulnerable groups and promote mental health, community development is essential (Francis, 2014). In order to integrate formal and informal treatment for mental health patients, social workers play a critical role in enhancing the notion of community care (Yip, 2000). Taking into account the person's surroundings and social life, they also play a big part in enhancing mental health (Segal, 1981). With an emphasis on proactive care management and transdisciplinary interaction, the necessity of integrated functioning between health and social care is highlighted (Gibb, 2002).According to B.Jenne et.al(2005)Social workers in mental health services report on practitioners' descriptions of what they do as they perform their occupational roles.Gibb et al (2002)pointed out that The path to achieving integrated working between health and social care appears to be littered with as many failures of teamworking as successes.These all literature highlighliting the importance of each specialization.So at this point of time it is important to understand specifically about each specialization and also the way to change from one specialization to other.Ultimately all the specialization in social work is interconnected and interdependent and working with the prime motto of helping people to help themselves.

The study reveals the fact that the shift from community development to mental heath results in the confrontation of certain challenges and opportunities in the researcher majorly in the domains of professionalism,recognition of the profession,dealing with people with mental illness,their family,addressing the stigma associated with mental illness..etc.But ultimately

the shift results in the attainment multidisciplinary approach by the researcher applying the learning from the both the specialization to each of the field.

Conclusion

Mental health and community development are two branches of social work.A shift from one specialization to other results in adjustmental problems as well as evaluation of the competency.These opportunities and challenges can be considered as the pathway to attain multi-talented approach in social work,which is a necessary quality in the profession.Inorder to attain such a state it is important for both the professional and the external environment to facilitate that change.

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Social Work Practices within Public Health Care: A Situational Analysis of Maharashtra State

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The public sector of a country like India plays a crucial role where a majority of its people rely on it to fulfil their needs. It is equally true when it comes to healthcare provisioning, in the face of growing costs for healthcare facilities. Social work is a professional and academic discipline which makes efforts to improve the quality and well-being of individuals, families and society. Professional social workers in healthcare settings play an important role by offering support services to patients and their relatives. The public healthcare system of Maharashtra state offers such professional spaces for employed social workers and has launched a massive recruitment process this year 2023. In this context, this paper is an attempt to review of existing nature of social work practices in the state.

The Study Method

The present article is an inquiry into the role of social work professionals and their recruitment within the public sector of Maharashtra state's healthcare system. It is accomplished by analysing data about already recruited professionals and the recent recruitment process for social work professionals in the health system of the state. The data is triangulated with the official records available on the government web portals and results of analysis are presented as findings of the study. In the context of the three-tier governance system, social work professionals are recruited in various healthcare facilities established and governed by the central government, municipalities and other social sector institutions in the state. However, the scope of this article is limited to the study of social work professionals recruited through the state government of Maharashtra.

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Background

The Indian healthcare system is one of the largest, most complex and diverse systems comprising the public, private and social/ philanthropic sectors. In the context of the rising cost of healthcare services offered through the private sector, the role of the public sector is very crucial. It becomes further noteworthy when a majority of the Indian population depends on the public sector to fulfil their healthcare needs. The government makes efforts towards fulfilling these healthcare needs of the masses either by directly providing services through the public sector or supporting treatment costs through social insurance schemes.

Social work: Practice and profession

As defined by Friedlander (1964), "Social work seeks to assist individuals, groups and communities to reach the highest possible degree of social, mental, and psychological wellbeing. Its function requires awareness of the dynamic interplay of personal, biological, and psychological elements within the socio-economic forces of the environment of human beings." Social work in general deals with mass problems such as poverty, unemployment, illiteracy, deprivation, destitution, ill-health, malnutrition, child labour, neglected elderly, caste discrimination, gender discrimination, women's exploitation and abuse, elderly neglect and abuse, ethnic conflicts, communal riots, corruption and so on (Singh 2020).

Over a period, social work evolved from philanthropy to a profession (Simon 2021). However, when it comes to social recognition, social work is a less-recognised profession (Kumar 2019; Singh 2020). The professional concept of social work got recognition in the 19^{th} century and so, it is a relatively newer and emerging profession in India. Christian missionaries introduced professional social work education and practice in India around 1930. They started it with the establishment of schools, orphanages, and hospitals with the social work approach. Since the beginning major emphasis of professional social work education has remained on providing training to students to gain employment in remedial and service-oriented social work.

The introduction of various national programmes of social welfare and development created employment opportunities for trained social workers in diverse positions in both the

volunteer and government sectors. Further, only full-time experts who have received their social work training at recognized higher educational institutions and have qualified themselves through examinations can be termed as 'Professional Social Worker' (Simon 2021). As remarked by Jacob (2016), professional social work is focused on problem-solving and change. Initially, social work methods were mostly utilised in the field of social welfare and healthcare; however, over time, it extended to working in a variety of fields, such as rural development, child development, social development, and so on. However, the scope and need for social work services in the healthcare sector have remained persistently high.

Social work within the healthcare delivery system

The application of social work methods and philosophy in healthcare settings like clinics, nursing homes and hospitals is generally referred to as "Medical Social work". The professional social worker serving healthcare establishments is referred to as a "Medical Social Worker" who is a psychological well-being proficient (Dev & Eljo 2021) and helps families and people in a medical service setting. As noted by Kumar (2019), they perform multifaceted roles and a variety of activities with respect to direct patient services, administration, teaching, training, supervision, and research. Within the clinical setting, they even work as therapists, educators and facilitators in assisting institutions (Dev & Eljo 2021). They further play an important role as "patient advocate" and serve as a bridge between the hospital, community, and family Mitrowski (1983). This member of the healthcare team is responsible for helping the patient comprehend and get used to hospital processes, interpreting and explaining medical plans, giving the patient a safe place to express their emotions, and helping the patient's family with financial preparation. The special role of the medical social worker is to identify the strengths found in the family system and to support the use of these resources for facilitating the treatment process.

Healthcare system of Maharashtra

Following the national trend, the healthcare needs of the masses are fulfilled by the public, private and social sectors in Maharashtra state. The responsibility of offering healthcare services through the public sector lies with two departments of the Maharashtra government i.e. Department of Public Health and the Department of Medical Education and Drugs (MEDD). These two departments under the leadership of separate Ministers, and

further administrative structures work towards providing healthcare services in the state through the public sector.

The former department, administered through the Directorate of Health Services (DHS) has a huge infrastructure for purely healthcare delivery, implementation of national health programmes and family welfare. As depicted by the government of Maharashtra, public health department (2023), it has a huge health infrastructure in the form of 10780 sub-centres, 1906 primary health centres (PHC), 37 Ashram schools, 25 sub-district hospitals, district hospitals and 387 rural hospitals.

The latter, MEDD of the Government of Maharashtra, has an administrative responsibility of medical education, research and training towards producing human resources for health. The administrative function is carried out through the Directorate of Medical Education and Research (DMER). It looks after the administration of medical education through Government Medical, Dental, Nursing, Ayurvedic and Homeopathic colleges and also provides general, speciality, and super-speciality healthcare services through attached teaching hospitals.

Engagement of Social Workers with Maharashtra State Health Services

Probably Maharashtra state is a pioneer in recruiting trained social workers in the healthcare delivery system, as the social work education in India started in Bombay state. It is said that following the beginning of social work education in Mumbai, a full-time social worker was employed in this Child Guidance Centre clinic in 1938 followed by appointing a medical social worker at J J Hospital in 1946. With the effects of requirements of minimum standards for medical colleges and operational guidelines of various national health programmes recruitments of professional social workers happened in hospitals and medical colleges (Kumar 2019). Thus, there has been continuous growth in the number of professional social workers recruited in the state.

Table 1

Distribution of Social work professionals in Maharashtra Health Services

Department	**Male**	**Female**	**Total**
Directorate of Medical Education and Research (DMER)	111	16	**127**
Directorate of Health Services (DHS)	51	20	**71**
Total	172	36	**198**

Source: data from seniority lists of Social Service Superintendents published by DHS (2023b) and DMER (2023b) as of 1st Jan 2023

As depicted in Table 1, currently there are 198 total social workers engaged full-time in the public sector on a permanent basis. The seats filled by female candidates are pointedly less and contribute not even 20 per cent of the total. The medical education and drugs department has a major share of $3/5^{th}$ of the total recruited social work professionals. The total vacancies of medical social workers at MEDD are 184 posts of which 127 posts are filled on a permanent basis (DMER 2023a).

With the effect of the Maharashtra government resolution dated 7^{th} December 2011 the prior designation of medical social worker changed to "Social Service Superintendent" throughout the whole state and is followed for further recruitment processes.

Recent Recruitment of 2023

The year 2023 observed a massive recruitment process for filling vacant posts of social work professionals within the Maharashtra government health system. The recruitment is offered for **Group C Technical cadre** with the basic level of 7^{th} Pay Matrix level of S-14: 38600-122800. The required educational qualification for the DHS is a two-year full-time Master of Social Work (MSW) with Medical and Psychiatric Social work specialization or a degree in Master of Social work. However, in the case of DMER, it was set to a Master's degree in Social Science with preference for the candidate having specialisation in Medical and Psychiatric or Family and Child Welfare or both (DMER 2023c).

Table 2: Maharashtra State Recruitment of Social Service Superintendents 2023

	DMER	**DHS**	**Total**
Social Service Superintendents (Medical)	83	14	**97**
Social Service Superintendents (Psychiatric)	0	09	**09**
Total number of Vacancies	**83**	**23**	**106**
Source for data: 2023 recruitment notification of DMER (2023a) and DHS (2023a)			

As shown in Table 2, around 3/4th of recruitment opportunities are offered by the MEDD department and the remaining by the public health department of the state. Further 91 per cent of recruitment of social work is happening for the medical division and the remaining for the psychiatric division of the social work cadre combining both the department of government of Maharashtra state. Further, the effect of a 30 per cent reservation for female candidates adopted in this recruitment process will enhance female participation in the social work workforce within the public healthcare system of the state.

DISCUSSION

If we look at the history of professional social work in India, Maharashtra became the pioneer in providing professional training in social work with the establishment of Sir Dorabji Tata Graduate School of Social Work in 1936 in Mumbai. Probably, it is similarly true for employing trained social work professionals in the public healthcare system, as the first medical social worker was appointed in 1946 in J.J. Hospital, Mumbai. As of today, there are around 200 social work professionals are employed in the Maharashtra state government healthcare system. These trained social work professionals provide close support to patients and family members whose medical condition is causing them or a loved one to experience financial, family, emotional, or mental stress. Their primary focus is on supporting patients and their families in hospitals and other healthcare settings by coordinating and facilitating the treatment process. So, they play an essential role in professional support services in patient care, providing psycho-social and financial help. They also work for networking and resource mobilisation for the betterment and infrastructure development of the institute.

It must be pointed out here that social work is different from other professions like medicine, engineering, law, teaching, nursing, etc. It focuses on raising people's general quality of life, particularly for those who are the most vulnerable and weaker groups in society. It adopts a multidimensional approach to guarantee that individuals can live dignified lives, utilise their potential and make meaningful contributions to society. Towards achieving that, social work professionals need to work in collaboration with a wide range of other professions and stakeholders as per the demands of the situation. Like any other profession that wishes to grow its value in society, social work must demonstrate its worth to the public,

especially to its clients. To do this, it must enhance the effectiveness of the services provided by its professionals, especially by providing them with up-to-date knowledge about methods and techniques.

The Medical Education and Drugs Department of the Maharashtra Government has a major share in terms of recruiting social work professionals with medical specialisation. It is similarly applicable to the recent 2023 recruitment for the post of Social Service Superintendent (Medical). The overall recruitment process of 2023 will add another one-third to the existing number of professionals already working in the public healthcare services of the state. Further with the effect of 30% reservation for female candidates their share in the total social work workforce in public sector health services. Thus, it seems a promising step and a good career opportunity for social work professionals in the state.

Conclusion

The social work profession has a very promising role to play in the Indian healthcare services system. Maharashtra state has a pioneering and supportive role in providing social work education, practices and professional engagement with the health system. The recent recruitment process, adding another one-third to the Maharashtra state's existing social work workforce is an auspicious step supporting this claim. For any profession to prosper investment and support of the government is a prerequisite, and so for social work. Thus, the paper advocates the necessity for social work to be valued and acknowledged on a professional level.

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New Education Policy (2020): An Analytical Study

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Recently, a new National Education Policy was brought by Government of India under the able leadership of Prime Minister Narendra Modi, which has been prepared in consultation with the eminent scholars of various sections of the society as well as after extensive discussions with educational institutions across the country. With its introduction, a wide discussion has started on education in the country. In relation to education, Gandhiji means the all-round and best development of body, mind and soul of child and man. Similarly, Swami Vivekananda said that education is the expression of the inherent perfection of man.[1] In the midst of all these discussions, we will see what were the shortcomings left in the education policy of 1986, for which government felt a need to introduce a new National Education Policy. Also, will this new National Education Policy be able to fulfill the objectives that Mahatma Gandhi and Swami Vivekananda had dreamed of?[2]

First of all it is necessary to consider what is 'education'. The literal meaning of education is the act of learning and teaching, but if we look at its broad meaning, then education is a continuous social process in any society, which has a purpose and by which the development of human inner powers and behavior is refined. Man is made a capable citizen by increasing knowledge and skills through education.[3]

Significantly, with the announcement of the New Education Policy 2020, the name of the 'Ministry of Human Resource Development' has been changed to the 'Ministry of Education'. This policy has expected transformational reforms in schools and higher education in the country. Its objectives include achieving 100% GER (Gross Enrolment Ratio) in school education by the year 2030 as well as universalization of education from pre-school to secondary level.[4]

Important Features of New Education Policy 2020

- The last National Education Policy was formulated in 1986 which was amended in the year 1992.
- Current Policy came into existence based on the report of the committee headed by renowned Space Scientist K.Kasturirangan.
- Under the New Education Policy 2020, a target has been set to bring the Gross Enrolment Ratio (GER) to 100% by the year 2030.

- Under the New Education Policy, a target of 6% of GDP has been set for public expenditure on the education sector with the cooperation of the central and state governments which is currently 4.43%.
- With the announcement of New Education Policy, the name of Ministry of Human Resource Development has been changed to Ministry of Education.[5]

Key points of New Education Policy 2020

Provision of School Education

- The New Education Policy has proposed a 5+3+3+4 format educational structure that covers children in the age group of 3 to 18 years.
- Five-year Foundational Stage - 3 years of pre-primary school and Grades 1, 2
- Preparatory Stage of three years
- Three-year middle (or upper primary) stage – Grades 6, 7, 8 and
- 4 years high (or secondary) stage - grades 9, 10, 11, 12
- Under NEP 2020, HHRO has proposed to set up a 'National Mission on Foundational Literacy and Numeracy'. By this, by the year 2025, basic skills will be ensured for children up to class-3 level.[6]

Protection of linguistic diversity of the Country

- In NEP-2020, emphasis has been laid on adopting mother tongue/local or regional language as the medium of instruction in education up to Class-5. Along with this, it has been suggested to give priority to mother tongue for Class-8 and further education.
- The option of Sanskrit and other ancient Indian languages will be available for students in school and higher education, but there will be no compulsion on any student to choose the language.[7]

Physical Education

Efforts will be made to provide horticulture, regular sports, yoga, dance, martial arts to students at all levels in schools as per local availability so that children can participate in physical activities and exercise etc. These will be included in the main curriculum instead of secondary courses or additional courses.

Curriculum and Assessment Reforms

- According to the reforms proposed in this policy, there will not be much distinction between arts and science, vocational and academic subjects and curricular and extra-curricular activities.
- Vocational education will be included in the educational curriculum from class-6 onwards and internship will also be arranged in it.
- National Curricular Framework for School Education will be prepared by the National Council of Educational Research and Training (NCERT).

- Changes will be made in Class-10 and Class-12 examinations keeping in mind the goal of overall development of the students. It may include reforms like semester or multiple-choice questions etc. in future.
- A new 'National Assessment Center' called 'Parakh' will be set up as a standard-setting body for evaluating the progress of students.
- Use of 'Artificial Intelligence' (AI) based software to evaluate student's progress and help students take decisions related to their future.[8]

Reforms related to Education System

- Adherence to effective and transparent process in appointment of teachers and promotion on the basis of performance assessment done from time to time.
- National Professional Standards for Teachers (NPST) will be developed by the year 2022 by the National Council for Teacher Education (NCTE).
- On the basis of consultation with NCERT, National Curriculum Framework for Teacher Education (NCFTE) will be developed by the National Council for Teacher Education.
- By the year 2030, the minimum degree qualification for teaching will be 4-year integrated B.Ed. Possession of degree will be mandatory.[9]

Provisions related to Higher Education

- Under NEP-2020, a target has been set to increase the 'Gross Enrolment Ratio' in higher educational institutions from 26.3% (year2018) to 50%, along with this, in 3.5 crore higher educational institutions of the country new seats will be added.
- Under NEP-2020, multiple entry and exit system has been adopted in undergraduate courses, under this, students in 3 or 4year undergraduate program will be able to leave the course at multiple levels and will be awarded degree or certificate accordingly (Certificate after 1 year, Advanced Diploma after 2 years, Bachelor's degree after 3 years and Bachelor's degree with research after 4 years).
- An 'Academic Bank of Credit' will be given to digitally secure the marks or credits obtained from various higher educational institutions, so that degrees can be awarded to students based on their performance in different institutions.
- Under the New Education Policy, M.Philprogram has been abolished.[10]

Higher Education Commission of India

The New Education Policy (NEP) envisages a single regulator for higher education institutions across the country i.e. Higher Education Commission of India (HECI), which will have multiple verticals to fulfil different roles. The Higher Education Commission of India will act as a single umbrella body for the entire higher education sector except medical and legal education.

Four bodies for effective execution of HECI's functions-

- National Higher Education Regulatory Council (NHERC): It will act as a regulator for higher education sector including teacher education.
- General Education Council (GEC): It will frame the expected learning outcomes for higher education programs, i.e. they will work for their standard setting.
- National Assessment and Accreditation Council (NAAC): It will undertake accreditation of institutions which will be primarily based on core criteria, public self-disclosure, good governance and outcomes.
- Higher Education Grants Council (HEGC): This body will do the work of funding for colleges and universities.[11]

Note: It may be noted that currently higher education bodies are regulated through bodies like University Grants Commission (UGC), All India Council for Technical Education (AICTE) and National Council for Teacher Education (NCTE).

Multidisciplinary Education and Research Universities (MERU) of global standards equivalent to IITs and IIMs will be established in the country.

Provision for children with disabilities

- In this new policy, cross-disability training, resource centre, accommodation, assistive devices, above-mentioned technology-based equipment, full support of teachers and ensuring regular participation in the school education process from elementary to higher education, etc. for children with disabilities will be implemented.

Provisions related to Digital Education

- "National Educational Technology Forum" will be formed as an autonomous body through which ideas can be exchanged for enhancement in teaching, evaluation, planning and administration.
- A separate technology unit will be developed to develop digital education resources, which will coordinate for digital infrastructure, content and capacity building.

Provision of Traditional Knowledge

Indian knowledge systems, which will include tribal and indigenous knowledge, will be included in the curriculum in a precise and scientific manner.

Feature points:

- Areas such as aspirational districts where large numbers of students facing economic, social or caste barriers, will be designated as 'Special Educational Zones'.
- To build capacity in the country, the Centre will set up a 'Gender Inclusion Fund' to provide equal quality education to all girl and transgender students.

- It may be noted that a National Curriculum and Pedagogical Framework for Early Childhood Care and Education for children up to the age of 8 will be developed by the NCRTE.[12]

Financial Help

Financial assistance will be provided as incentive to meritorious students belonging to SC, ST, OBC and other socially and economically disadvantaged groups.

National Policy on Education, 1986

- The policy was aimed at removing inequalities with special emphasis on equalizing educational opportunity for Indian women, Scheduled Tribes and Scheduled Caste communities.
- This policy launched "Operation Blackboard" to improve primary schools.
- This policy expanded the 'Open University' system with the Indira Gandhi National Open University.
- The policy called for the creation of a "rural university" model based on the philosophy of Mahatma Gandhi to promote economic and social development at the grassroots level in rural India.[13]

Why the need for change in the previous Education Policy?

- In the changing global scenario, there was a need for change in the existing education system to meet the requirements of knowledge-based economy.
- New Education Policy was needed to enhance the quality of education, promote innovation and research.
- To ensure the global reach of the Indian education system, there was a need to change the education policy to adopt global standards of education.

Challenges related to New Education Policy

- Cooperation of States: Since education is a concurrent subject, most of the states have their own school boards, so the state governments will have to come forward for the actual implementation of this decision. Also, the idea of bringing in a National Higher Education Regulatory Council as the apex controlling body may be opposed by the states.
- Expensive Education: The New Education Policy has paved the way for admission in foreign universities. Various educationists believe that admission in foreign universities is expected to cost the Indian education system dearly. As a result, it can be challenging for lower class students to get higher education.
- Sanskritization of education: South Indian states allege that the government is trying to Sanskritize education with the 'three-language' formula.

- Inadequate Funding Checks: Fee regulation is still in place in some states, but these regulatory processes are unable to curb profiteering in the form of unlimited donations.
- Funding: Securing funding will depend on the will to spend the proposed 6% of GDP on education as public expenditure.
- Lack of Human Resources: At present, there is a lack of skilled teachers in the field of elementary education, so there are practical problems in the implementation of the arrangements made for elementary education under the New Education Policy, 2020.[14]

Conclusion

The New Education Policy 2020, which has been approved by the Union Cabinet to change the Indian education system to meet the needs of 21st century India, if it is implemented successfully, then this new system will make India one of the leading countries of the world andwill bring equivalent to most of the developed countries. Under the New Education Policy, 2020, children from 3 years to 18 years have been kept under the Right to Education Act, 2009. The aim of this New Education Policy, which came after 34 years, is to provide higher education to all the students. It also aims to universalize pre-primary education (3-6 years age group) by 2025. The inclusion of areas such as Artificial Intelligence, 3-D machines, data-analysis, Bio-technology etc. in graduate education will create skilled professionals in cutting-edge fields and increase the employability of the youth.

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Caregiving Beyond Boundary: Roadblocks In The Practice Of Psychiatric Social Work (Psw) In Tertiary Care Mental Health Institutions

Khushboo Shah [4]

Introduction

Family as a '***caring-agent***' mediatesthe treatment of impaired functioning (loss of old skills and failure to learn new skills) of the person with mental illness. Hartfield (1992) expresses the challenges concerningpersons with severe mental illness and their families which revolve around the issue of ***independence/dependence***. The person with severe and persistent mental illness often finds themselves compelled to rely on others ('***continued dependence on others')***for support. This ongoing need for***continued dependence***frequentlygenerates significant tension in family dynamics. The severity of mental illness is further associated with ***family burden*** and ***family stigma*** (Lefley 1989). Lefley (1989, p. 556) noted the transition of ***familial experience of mental illness*** from '*family as a causative role in illness'* to being perceived as a '*potential precipitant of the relapse'*. Both viewpoints contribute to the existing stigma experienced by the family. Marsh and Colleagues (1996) while reviewing comments regarding ***family burden***, linked burden with the description of being '*suffering*', '*very sad*', '*draining*', and '*lonely*'. The burden intertwined with socioeconomic status is reflected in the responses caregivers have toward the patient. ***Response-reaction*** of caregivers and guardians during the illness is contingent upon the ***family-support system*** and ***family experiences of the mental health condition*** of their family member. ***Aftermath experienced*** by them as a consequence of severe mental illness or chronic mental health conditions at times results in ***extreme emotional responses*** which has a ***traumatic impact*** on the caregivers. The impact is mediated by the ***support provided*** *vis-à-vis* ***received*** and the cohesiveness of the familial-patient relationship. The caregiver's vulnerability to mental health issues during the process of caregiving for a person with a mental disability cannot be overlooked.

Overview Of Existing Literature

People with mental illness rely on their caregivers for basic sustenance of living as they are incapable of performing their basic socio-occupational and family responsibilities. It is

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therefore they are primarily dependent on their caregivers (most often who are relatives). ***Intersectionality*** of the burden of mental illness incurred by self (causing self-harm to self and others or suicide), family (hostility, abandonment, or even homicide), neighborhood & community (stigma, prejudices, or even murder)at times becomes threatening tothe people suffering from mental illness. As a result of their relative's mental illness, all members of the family share in the ***subjective*** and ***objective burden*** (Cook, Lefley, Pickett, & Cohler, 1994; Lefley, 1996; Reinhard, 1994). The ***subjective burden*** refers to the personal suffering experienced by family members in response to the mental illness of their relative (Greenberg, Greenley, McKee, Brown, & Griffin-Francell, 1993). The burden transacts with psychological distress borne by family members which is engendered by theirrelative's illness.In addition to their subjective burden, family members are also challenged with an ***objective burden***: the daily problems and challenges that accompany mental illness. It deals with specifically identifiable, observable problems associated with people with mental illness. Families encountering severe mental illness and ***familial deficits*** are more vulnerable to ***bio-psycho-socio-economic distress***. The findings of previous inquiries into mental health and the process of caregiving the primary carer reported experiencing various ***emotional reactions*** when caring for relatives with serious mental illness including feelings of ***shame, stigmatized, sadness, distress, frustration, tiredness, worries, confusion, resentment, anger, gratefulness,*** and ***compassion*** for the service users (H. Susanti et, al. 2019). At times delay in help-seeking behavior and preoccupation with alternative methods of treatment further worsen the current symptomatology of the index patient suffering from a chronic mental health condition (as depicted in Figure 01).

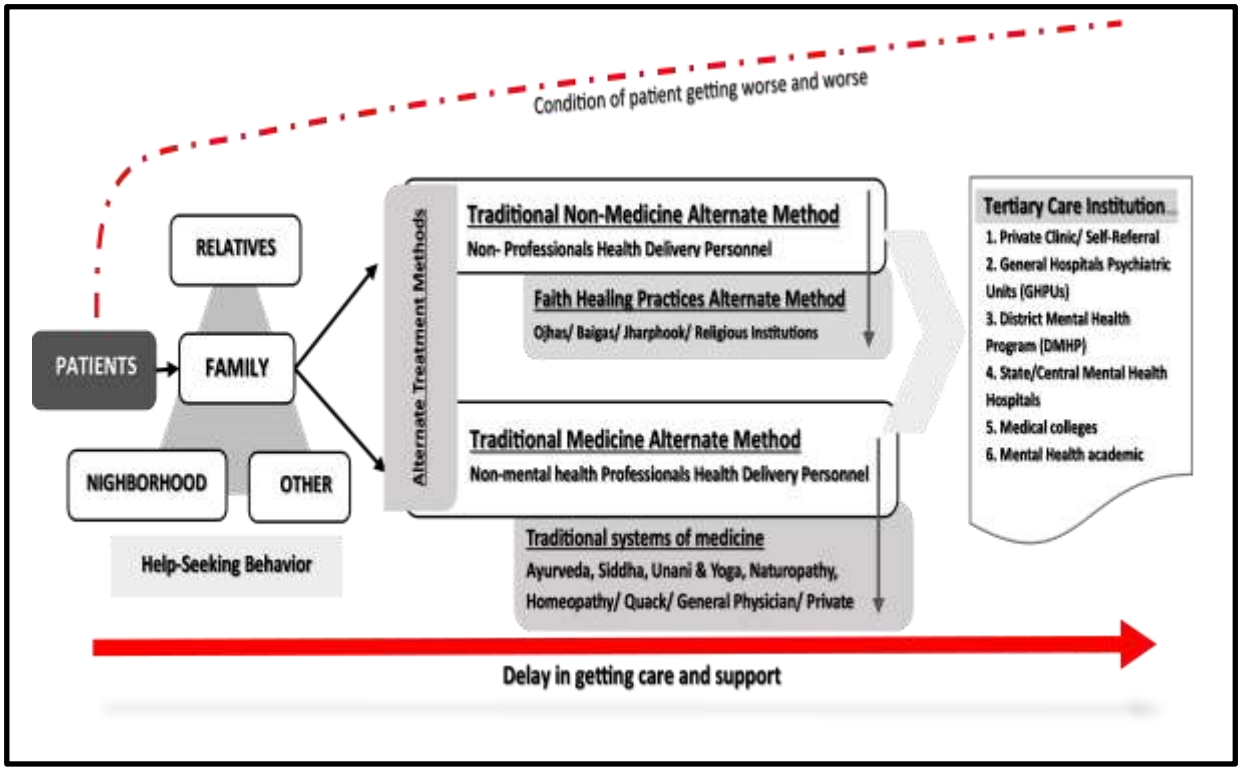
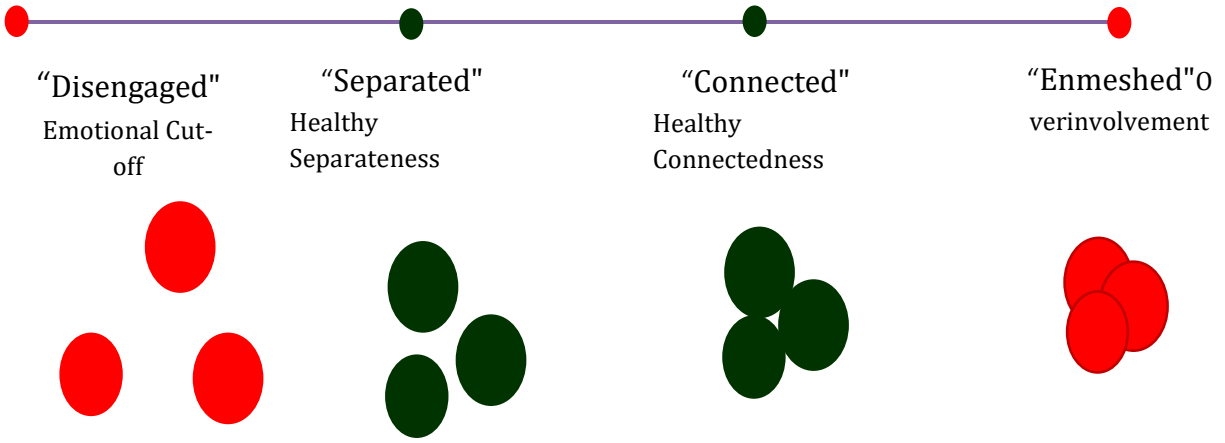


Figure 01: Help-seeking and Alternate treatment method

Caregivers and their patients reach out to tertiary care treatment modality as the last resort, until then maximum damage is caused to the patient's ***bio-psycho-socio-adaptive functioning***. The patient till then has had maximum deterioration in his/her mental health condition, and huge financial expenditure on treatment- at times significant financial debts adding to the family's financial burden. The family is the safe space, and the caregiver is the ***change agent*** bringing about safety, love, and belongingness. ***Cohesion*** is ***family togetherness***, satisfaction received from inside the family vs outside the family, and acceptance of family members. As presented in Figure 2, the ***cohesion*** in a family range from "***disengaged***" (very low) to "***separated***" (low to moderate) to "***connected***" (moderate to high) to "***enmeshed***" (very high). (Circumplex Model Oslon 1986).

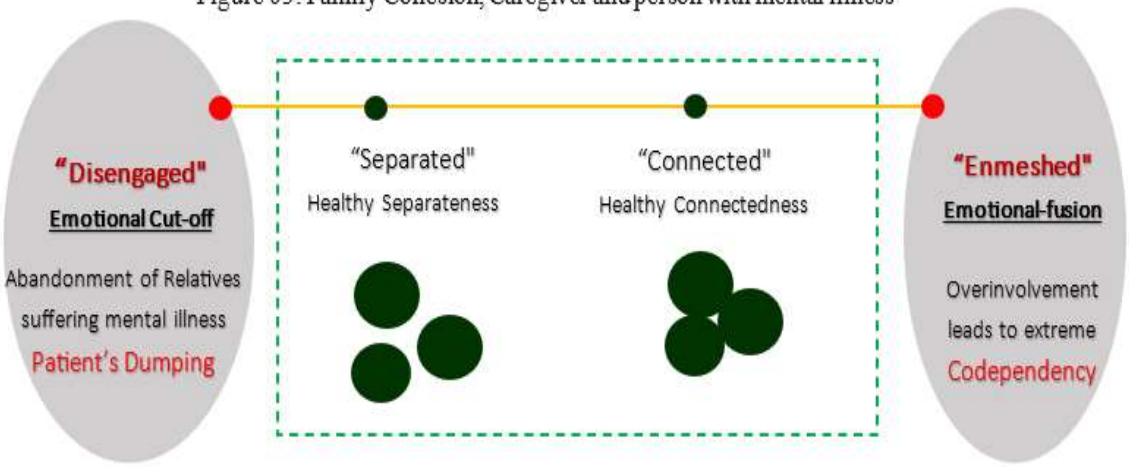
Figure 02: Family Cohesion



The extremes (disengaged or enmeshed) are considered to be problematic. Families falling in the middle of the dimension (separated or connected) are healthy because family members can be both independent of and connected to, their families.***Family cohesion***affects the process of caregiving in the long run and increases the ***burden of care***& *attitude towards relatives suffering from mental illness (Figure 03).* On one spectrum '***disengagement'*** or *partial or complete emotional cutoff* is seen in a mental health institution in the forms of ***patient dumping*** (whereby the caregivers abandon the patient after admission and leave the relative suffering from mental illness in a tertiary care setting which often is government-based care in the Indian context). Whereas on the other spectrum lies the '***enmeshment***' or Fusion experienced as *"togetherness"* or *"connection"* but costs the person an authentic

'sense of self' seen in mental health institutions in the form of***familial intrusion***,***lack of boundaries***, ***emotional autonomy***,***codependency*** on their family members (where patient become ***placaters*** or ***underfunctioners*** to another family members, who become the over-functioner, and prevent socio-adaptive functioning of relative's suffering from illness due to the mental health condition, ***accommodating*** the illness). As Yalom (2012) said: **"***Fusion eradicates anxiety in radical fashion- by eliminating self-awareness… Thus, one sheds anxiety, but, loses oneself*".Both disengagement and enmeshment contribute to aggravatingthe family burden of care.

Figure 03: Family Cohesion, Caregiver and person with mental illness



Boundary is a metaphor for rules and limits leading to a ***sense of safety*** (Goldstein 1999). ***Sense of safety*** evolves from having appropriate closeness or distance in a relationship and also the extent to which people are involved in the relationship having dual roles (family member and patient). Boundaries in relationships based on informal ties and union, where multiple roles are being performed at once by family members, tend to be more open and flexible. This happens as boundaries between roles are not clearly defined. Ambiguity in ***family boundaries*** ranges from being ***rigid and closed*** to ***open and flexible*** to ***diffused***(figure 04).

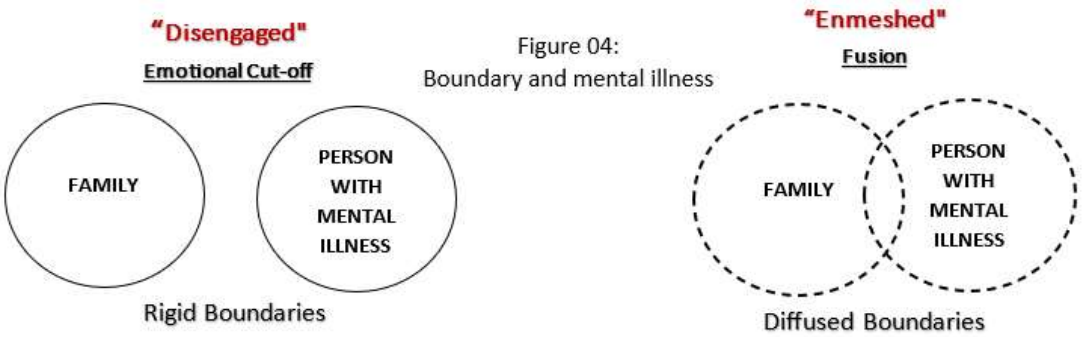
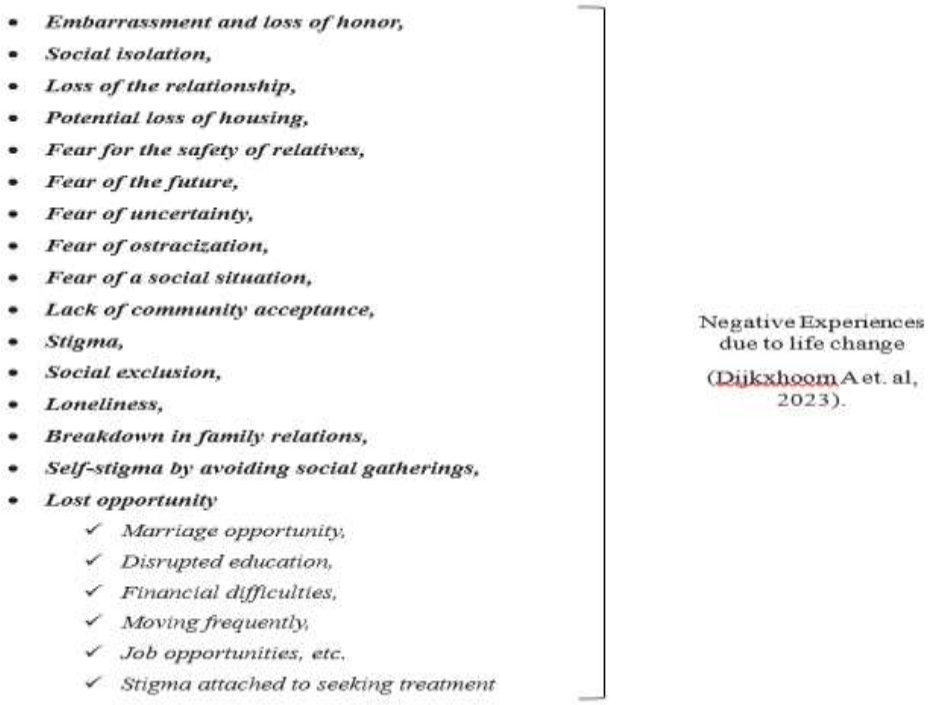


Figure 04:
Boundary and mental illness

In the case of ***disengagement***, an ***emotional cut-off*** is seen from the side of the family towards a relative with mental illness who later is abandoned by their families. Similarly, ***enmeshment*** gives rise to the diffused sense of self with other family members precipitating a lack of boundaries between family members. Due to laid down fusion in the family caregiver becomes more stressed, and more accommodating towards a relative's illness.

This raises a question as to why caregivers continue to care for a relative with mental illness. The main reason why caregivers took care of and did not abandon the relative was that they ***felt love and affection***, had ***a sense of familial responsibility of care***, and saw ***providing care as natural and expected*** as a part of ***familial duties***(Dijkxhoorn A et. al, 2023). They identify with strong and positive experiences for and before the period of a relative's mental illness. On the other hand, negative and difficult experiences bring about a ***life change*** affecting the relationship between the family members and the relative with mental illness (Dijkxhoorn A et. al, 2023). The negative experiences are fueled by the following



The experience of the caregiver leads to evolving certain attitudes further confounding the rights of a person suffering from mental illness. Mental Healthcare Act 2017 is a relevant legislation in India that outlines the rights of persons with mental illness. It provides the safety net that strengthens their human rights as a person. Under the Right to Community Living, it is stated in the MHCA Act 2017 that: *'Every person with mental illness shall, (19. (1) (a) have a* ***right to live****in, be part of, and not be segregated from society; …'* (MHCA 2017). Individuals have the ***right to live with dignity****in the community*, and to not be segregated or isolated from the community. The ***right to live*** is, therefore, prima-facia important, but generally violated (MHCA 2017). ***Violence*** at times is perpetuated by family or neighborhood in the absence of family members. Since people with mental illness are at times not in the state to act upon consciously, they are subjected to violence. Therefore, there is a need to understand why and how caregiving as a care agent can prevent or perpetuate violence against people with mental illness.

Framework For The Study

The current study is an attempt to understand the difficulty faced by a psychiatric social worker in a mental health institution with the caregiver, the process of caregiving, and the ***violation of the right to live with dignity of people*** with mental illness. A ***mixed-method***

approach was used in the study. ***Observation-based experience approach*** helped in understanding the challenges faced by psychiatric social workers or mental health professionals in a tertiary care institution. Whereas ***quantitative data*** wasfocused on analyzing ***NCRB: Crime in India Report****spanning from 1999-2016. Specifically, within the section on* ***Incidence and Rate of Violent crimes****,attention is directed toward cases categorized under****motives/causes of murder 'lunacy'****. This selection aims to draw inferencesand assessthe state of violent crime against people with mental illness. The objective of the study is to draw inferences from the distribution of murders caused due to 'lunacy' in India and the practical challenges faced by a psychiatric social worker in a tertiary care institution.*

Clinical Observations As A Psychiatric Social Worker

The psychiatric social worker*(PSW)* provides intensive and holistic support to people suffering from mental health and behavioral challenges. The PSWs primary goal is to stabilize and support people experiencing socio-occupational impediments due to mental and behavioral problems. So who are **PSWs** or ***Psychiatric Social Workers?***

The ***Mental Healthcare Act*****of 2017**defines'***Psychiatric Social Worker***... ***Mental health professional***…a person having a ***post-graduate degree in Social Work (MSW)*** and ***a Master of Philosophy in Psychiatric Social Work (MPhil PSW)*** … qualification … obtained after completion of a full-time course of two years which includes supervised clinical training from any University recognized by the University Grants Commission established under the University Grants Commission Act, 1956 (3 of 1956) or such recognized qualification'(MHCA 2017). *The psychiatric social worker is an eminent part of an* ***interdisciplinary mental health team*** *acting as a bridge between people with mental illness, their families, and mental health facilities in a tertiary care institution. Psychiatric social workers as '****service agents****' guard against the violation of the rights of people with mental illness. From intake to discharge and beyond till psycho-social and vocational rehabilitation PSWs face ample challenges in navigating complex ethical and practical dilemmas in approachingpatientswith* ***patient-centered facilities****in mental health care institutions. As per MHCA 2017, People with mental illness have the following rights:*

Right to access mental healthcare.	MENTAL HEALTH CARE ACT (MHCA) 2017
Right to community living.	
Right to protection from cruel, inhuman, and degrading treatment.	
Right to equality and non-discrimination.	
Right to information.	
Right to confidentiality.	
Restriction on release of information in respect of mental illness.	
Right to access medical records.	
Right to personal contacts and communication.	
Right to legal aid.	
Right to make complaints about deficiencies in the provision of services.	

Internationally, the Universal Declaration of Human Rights (UDHR, 1948) adopted the United ***Nations' inherent dignity and equal rights of all individuals*** *as proposed in Article 1 "All human beings are born free and equal in dignity and rights": recognizing and respecting the dignity of people with mental illness. The legal framework related to mental health in India safeguards the dignity and rights of people with mental illness as shown in the above table. People with mental illness have a unique challenge in exercising the right to live with dignity, which is a basic human right. It becomes difficult for people with mental illness to fully enjoy their rights as a person due toBarriers to treatment,Delay in help-seeking behavior, Associated stigma and discrimination, Loss of autonomy with institutionalization, Breakdown of social and intimate relationships, Sense of alienation, Difficulty in self-care, and Socio-adaptive impaired functioning due to illness Loss of old skills Acquisition of new skills (Failure to learn new skills)*

Right to dignity and to live *as a person is shielded at the same time violated by Family (the secure base) for relatives with mental illness.* Caring for a family member with a chronic illness could be both a rewarding and challenging experience for caregivers. In an overview of the family burden of psychiatric patients, it was noted that the ***Indian family*** often tolerates considerable burden without complaint. They experience ***subjective distress*** concerning the ***patient's symptoms, role dysfunction,*** and the ***adverse effect of the patient's illness*** on their own and other family's lives, ***interpersonal familial and extra-familial***

relationships, work, and leisure time.The ***degree of burden*** experienced will be greatest in relatives who believe that the patient is able to control his/her patient illness- related behavior and in those relatives who are fully aware of the seriousness and prognosis of the illness. Perceiving the patient's illness symptoms under his or her control has been associated with a ***higher level of expressed emotion –critical comments, perceiving as helplessness or rage, contributing to the experience of the burden***. *But at times* ***family boundaries*** *and* ***familial expression of feelings*** *can violate the basic human rights of people with mental illness as illustrated in Figure 05.*An increase in the severity of mental illness with an increase in the magnitude of family ***negative expressed emotions***, ***stigma & prejudices***, the ***burden of care*** (financial and caregiver), disruption in the ***family's recreational activity***, ***and family interaction*** predisposed people suffering from mental illness to ***violence***, ***abandonment***, ***dumping in tertiary care hospitals***& at times costs their ***life*** as well.***Family care*** is associated with a full-time job, often necessitating abandonment of one's own life, career, and physical, mental, and social well-being.*In the case of abandonment (as a consequence of the breakdown of familial relationships), it is widely noticed that abandoned people with mental illness become voiceless, identity-less, homeless, untreated, and unmanaged.*

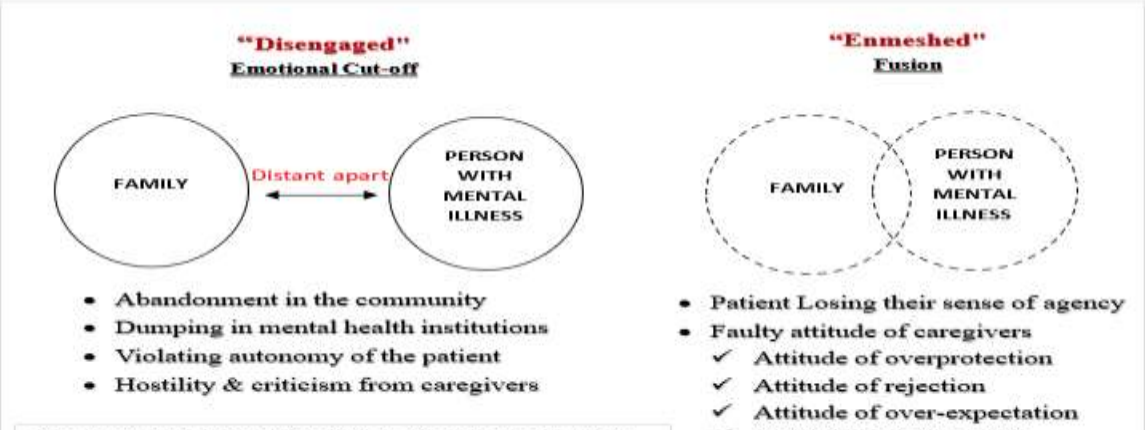


Figure 05: Violation of the right to life and dignity of the people with mental illness due to family boundary

With time they are subjected to violence and assault as well by the wider community and society. Highly distressed families experience traumatic ***life stressors*** due to their patients' illnesses. It creates extreme emotional responses in situations as mentioned below while approaching tertiary care treatment:

- ***Repeated hospitalization***,
- ***Increased cost of care***,
- ***Weakening support system***,
- ***Loss of inter-familial and intra-financial assets***,
- ***Adverse patient reaction to caregiving***,
- ***Poor socio-economic sustenance & adaptability***

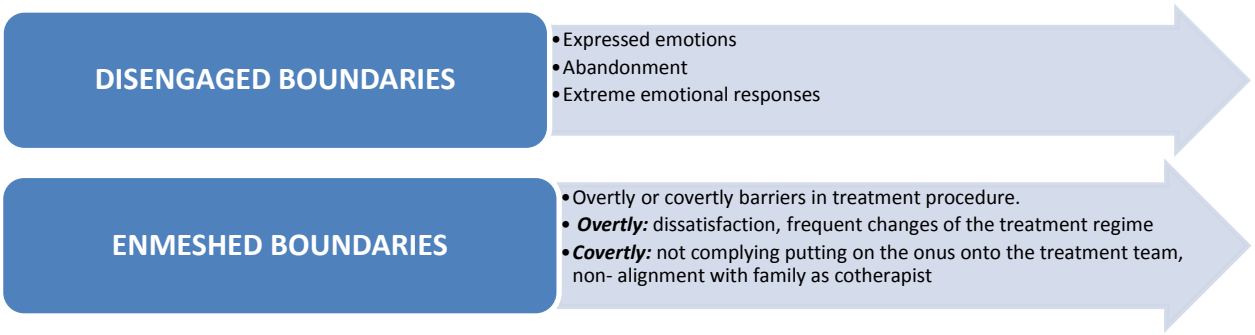
People with mental illness are at higher risk of experiencing violence and victimization which is further challenging the ***right to live free from harm and with dignity****. Increased vulnerability to violence is very well depicted from NCRB data of the last 20 years for* ***Incidence and Rate of Violent crimes****, directed toward people with mental illness categorized under* ***motives/causes of murder 'lunacy'****. 'Lunatic' is a pejorative used for people with mental illness, underlying stigma, and faulty wider perception in society. The data showcases a total of* ***939 murders*** *that happened between 1999-2016, and 'lunatics' being the cause of murder specified (see Appendix I). Initially, the baseline for crime against people with mental illness in the Mental Health Act, of 1987, was recorded as 292 murders (see Appendix 2). The escalation is nearly three times the baseline crime held against people with mental illness. It raises a question how safe are people with mental illness in our society? One important thing to note here is that this is the reported crime against people with mental illness. The number of unreported crimes is going unnoticed and unrecognized which further builds on the tension. Crime against people with mental illness is sometimes committed by the family as well. The reason for such crime is unknown and needs further research but, it surely puts a question on how much the assumed safe space is safe and secure for someone who does not even have a sense of self, behavior, and actions.*

Incidence And Rate of Violence 2000-2016, Cases Registered Under Motives/Causes of Murder 'Lunacy' State with maximum registered cases			
States	**2000-2016**	**% Share out of 939 reported murders**	
• Andhra Pradesh	55	5.86	
• Assam	21	2.23	
• Bihar	27	2.87	
• Chhattisgarh	160	17.04	**L**
• Gujarat	142	15.12	**U**
• Jharkhand	74	7.88	**N**
• Kerala	40	4.25	**A**
• Madhya Pradesh	108	11.5	**C**
• Maharashtra	105	11.18	**Y**
• Tamil Nadu	23	2.44	
• Uttar Pradesh	59	6.28	

Before the enactment of MHCA 2017 the reported number of cases of murder registered under lunacy (for people with mental illness) was found to be 939 from 1999-2016. Notably, Chhattisgarh (17.04%), Gujarat (15.12%), Madhya Pradesh (11.50), and Maharashtra (11.18) emerged as states with the highest proportion of such crimes in India (as shown in the above figure). In 2017 Mental Healthcare Act (MHCA) came into force which warranted the protection of the rights of people with mental illness. The inherent right to live with dignity still poses a question for people with mental illness as a crime against them still persists even costing their life at a certain point in time. MHCA 2017 has expanded the scope of criminal acts committed against people with mental illness resulting in a subsequent increase in registered the number of cases against people with mental illness as shown below.

SLL Crimes (Special & Local Laws)	**SLL Crimes (Crime Head-wise) - 2018-2020**		
	2018	**2019**	**2020**
Under section Food, Drug & Essential Commodities Acts	**Cases**	**Cases**	**Cases**
• The Mental Health Act (Table 1.3 page 3 of 3, NCRB 2020)	504	487	292

The ***right to live with dignity*** is, therefore, prima-facia important, but generally violated. One important question to consider: who are these people perpetrating the crime against people with mental illness? It's not necessarily always that extra-familial community members, strangers, and neighborhoods will commit crimes against people with mental illness. Often, intra-familial members also indulge in crimes against people with mental illness violating boundaries, agency, sense of self, life, and rights as a family member. Even when it comes to the right to live free and with dignity family members with disengaged boundariestend to more violate their rights in terms of expressed emotions, abandonment, extreme emotional response, etc. But what about the enmeshed boundary family? The Family members here will be overly involved in the treatment of relatives with mental illness. At times the overinvolvement acts as a barrier to re-wiring the loss of skills in relatives with mental illness.Overinvolvement*overtly* or *covertly* impacts the treatment regime and hampers the prognosis of illness.



Conclusion

The ***right to live with dignity and life*** is a basic human right, and people with mental illness are no exception to it. Crime against people with mental illness is continuing, and offenders at times are intra-familial members. There is limited data available on the murders of people with mental illness especially when the offenders are intrafamilial members leveraging as the ***care-agent*** and important ***significant others***. Even when the crime is committed what about the mental health of the family members? Under what circumstances do intrafamilial members opt for ending the life oftheir patient?*Why and what factors contribute to it? I would like to close my trail of statements and would like to put forward these questions for future researchers.*

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Psychosocial Intervention in Person with severe depression: A case study

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Abstract

Background: Adolescence is a crucial period in human development that requires extra care and guidance. Erikson's psychosocial theory states that identity formation is a central task during the adolescent stage. Childhood and adolescent depression are linked in multifaceted and complex, common risk factors can be puberty and hormonal changes, parenting style and exposure to family stressors. Effective prevention and intervention depend on understanding these interconnections.

Aim and Objectives: To assess the psychosocial factors influencing the course and progression of the illness and to provide psychosocial intervention to the individual and family.

Methodology: This case study was a single-subject case study done in the inpatient department of CIP, Ranchi. A case diagnosed with severe depression according to ICD-10 criteria was selected. Psychiatric social work assessment was done using various assessment scales and semi-structured clinical interviews. Based on the assessment, interventions were provided.

Results: Significant improvement was seen in the post-assessmentlike family functioning, and significant deterioration in suicide ideation and depression.

Conclusion: Psychosocial assessment and intervention help the individual with depression to improve their individual, familial and social functioning.

Keywords: Adolescence, depression, psychosocial intervention, family environment.

Introduction

According to the World Health Organization, depression is the second leading cause of disability for people ages 15–44 (World Health Organization 2009). Adolescent depression has finally been recognized as a serious mood disorder that affects the functioning of millions of adolescents (Koplewicz, 2002). Research shows various factors related to the onset of adolescent depression. Environmental risk factors such as poverty, deprivation and violence

(Fleming and Offord, 1990; Simons and Miller, 1987), as well as systemic familial issues (Allen et al. 1994). The aetiology of adolescent depression can be referred to as a truly biopsychosocial phenomenon (Lewis and Lewis, 1985). Current brain research shows that teenagers may be particularly vulnerable to mood disorders because of the overproduction of synapses and the subsequent pruning that is occurring in their brains. To determine the efficacy of psychosocial intervention in adolescents with severe depression and family, the current study has been initiated.

Methodology

This case study was a single-subject case study done in the inpatient department of CIP, Ranchi. A case diagnosed with severe depression according to ICD-10 criteria was selected. Psychiatric social work assessment was done using various assessment scales and semi-structured clinical interviews. Based on the assessment interventions were provided.

Assessment scales used in the study:

1. **McMasterFamily Assessment Device (FAD):** It is a 60-item self-report questionnaire designed to measure the family functioning of an individual. Cronbach alpha was found to range from 0.79 to 0.81 (Epstein et al. 1983).
2. **Beck Depression Inventory (BDI):** It Contains 21 items that assess cognitive, behavioural, affective, and somatic components of depression. Higher scores represent more reported depression. Cronbach alpha was found to range 0.86 (Beck et al. 1988)
3. **Beck Scale for Suicide ideation (BSS):** It contains 21 statements, BSS score can range from 0 to 38, with higher values indicating a greater risk of suicide. Cronbach alpha was found to >0.8. (Esfahaniet al. 2015).
4. **Katz Index of Independence in Activities of Daily Living (Katz ADL):** To assess functional status as a measurement of the client's ability to perform activities of daily living independently. Cronbach alpha was found to 0.838 (Arik et al. 2015).

Case Introduction

Mr. X, is 13 years old, male, unmarried, Hindu, studying in 7th STD, hailing from middle socio-economic status (MSES)belonging from the suburban area of West Bengal. The adolescent came to the outpatient department of the Central Institute of Psychiatry (CIP), Kanke with the chief complaint of guilt feeling, fearfulness, reduced social interaction, and death wishes for 4 months. Hearing voices for 3 months. Crying spells, self-harm behaviour, absconding tendency and irritability for 1 month. In the past history of illness, when the adolescent was 10 years old he had two dissociative episodes.The mode of onset was insidious, continuous course and deteriorating progress of illness. The adolescent's parentswere the primary caregivers, who reported that the client always preferred to stay aloof , and even his academic performance and activities of daily living deteriorated. He was

diagnosed with F32.3(Severe depressive episode with psychotic symptoms), according to the International Classification of Diseases-10(ICD-version 10).

Family History

The adolescent's eldersisterhada depressive episode, dissociative episode, and query of borderline personality disorder, with ongoing treatment from CIP, Ranchi.

Family Dynamics

Based on assessment scales, and semi-structured clinical and psychosocial interviews, it was found that the internal boundary wasenmeshed, and the external boundary was open and flexible. The couple subsystemwasformed, and a need-based relationship was identified, the parent-child subsystem wasformed, and over-involvement was identified from the mother towardsthe adolescent. The father-child dyad was not functioning adequately, switchboard communication was found, critical comments were present from the father side toward adolescent. Positive reinforcement from the father was minimal.The sibling subsystem was formed and functioning adequately. Sisters and mother meet the emotional and recreational needs. Frequent verbal and physical altercationshave been found between parents, and noise level was high in the family environment. The family follows an autocratic decision-making style carried out by the father. High expectationswere present from the parents towards the adolescent. Adaptive pattern found to be dysfunctional.

Strength and weakness of the family

Strengths	Weakness
1. The Adolescent was interested in education 2. Family is financially stable 3. The adolescent and family had an insight of the problem and were positive towards taking treatment.	1. Psychiatric illness in the family 2. Poor resilience in the adolescent as well as in the family. 3. Dysfunctional family dynamics 4. Uninvolved parenting from the father 5. Poor affective involvement 6. High expectations from parents toward adolescent 7. Presence of expressed emotions 8. Non-congenial home atmosphere

Psychosocial Diagnosis

Z62.4 Emotional neglect of the child
Z62.5 Other problems related to neglect inupbringing
Z63.8 Other specified problems related to the primary support group

Psychiatric Social Work Intervention

Psychosocial assessment and intervention were provided to the client and the family in the Centre of Erna Hoch Centre for Child and Adolescent and OPD of CIP, Ranchi. Altogether 21 sessions (08 individual sessions, 09familysessions (primary caregiver) and 04follow-upswere provided. No suicidal contract wasmade.

At Individual Level

1. ***Establishing rapport and therapeutic alliance (Session 1, duration 40min.):*** In the introductory session the objective was to establish a therapeutic alliance, the adolescent explained the purpose of the visit, the intervention's process, goal, expected outcome and nature of the treatment. He received an assurance ofconfidentiality.

2. ***Psychoeducation (Session 2, duration 40 min):***The objective was psychoeducation regarding the onset of illness and drug adherence. The informative modelwas used in simple, clear, and concrete terms according to adolescent age and developmental level.

3. ***Supportive psychotherapy (Session 3, duration 45 min):***The objective was to provide emotional support. Major components of the session were reassurance, encouragement, and guidance.

4. ***Cognitive Behaviour Therapy (CBT)(Session 4-5, duration 40min):***Cognitive structuring was done to reduce cognitive overload and negative orientation such as negative thinking, ruminating or emotional dysregulation. Behaviour modification using activity scheduling was also initiated.Initially started with unstructured and later levelled up to structured activities. Both pleasure and mastery principleswere used. The token economy strategy was used to promote desirable behaviour. Motivational interviewing was also done to actively participate in ward duties.

5. ***Feedback and follow-up (Session 6, duration 45min):***The objective wasto take feedback on the previous sessions and the current state of functioning.He opened up that he was angry after hearing about the discharge plan.Later,while answering open-ended questions, he talked about the conflicts between his parents and the fights that were happening in the family in front of him.

6. ***Coping skill training (Session 7, duration 45min):***The objective was to initiate a coping strategy to regulate emotions. The adolescent was using emotion-focused coping strategy, so the therapist through motivation interviewing, skill training, emotional regulation tried to make him shift to problem focus coping .It included mindfulness, breathing techniques, and distracting activities.

7.***Pre-dischargecounselling (Session 8, duration 45min):***The objective was to revise previous sessions and to conclude it.The adolescent recalled previous sessions. The

adolescent was encouraged for treatment follow up and focus has been given to medication adherence. Experiencing sharing through story has also been shared on family dysfunctions to make him understand that all family has problems.

8 ***Follow-up(Session1-2, duration 30min):***Two sessions were at an interval of two months. The objective was to assess the current state of functioning. Significant improvement was observed, in his daily activities, academic performance, inter-personal relationships.

At Family Level

1.***Safety Ensure (Session 1, duration 35min):*** The objective was to discuss removing any means of self-harm or lethal objects from the person's environment.

2.***Family Psychoeducation (Session 2, duration 50min):*** The objective was to build a therapeutic alliance and psychoeducation tothe mother and father about the nature of illness like onset, course, causal factors, and treatment rationale of illness by using the diathesis-stress model.

3.***Supportive Psychotherapy (Session 3, Duration 45 min):***The objective was to provide emotional support to the mother, and acknowledgement was given to her emotions. Components like reassurance and validation were used.Catharsis was also carried out.

4.***Parent Management Training and Feedback (Sessions4-5, duration 40-45min):*** The objective was to introduce reinforcement techniques and modelling. Explained the importance of reinforcing positive behaviours in the adolescent by providing rewards or praise. While using social learning theory parents were explained that children often learn by observing and imitating their parents, so maintain a congenial environment in th family is important. Inter-personal conflicts were also addressed in the present and subsequent sessions.

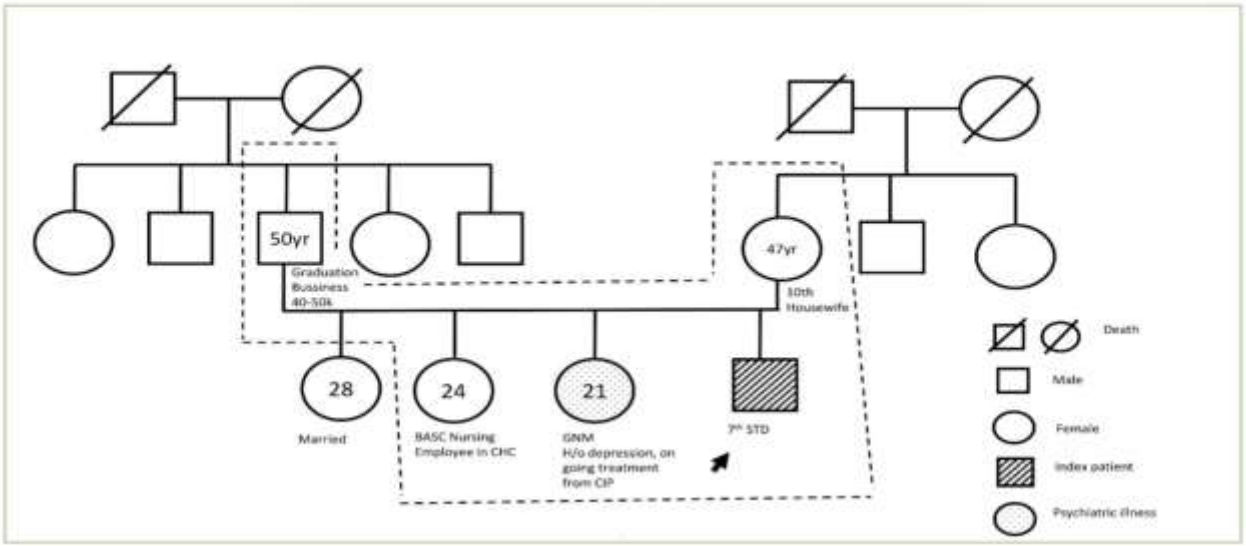
5.***Family Dynamics Modification (Session 6-7, duration):*** Objectives were to discuss on boundaries, address the dysfunction of the couple subsystem, and to work on the parent-child dyad. Strategies such as clear communication, definingroles and responsibilities where the father was encouraged to participate in household activities and parenting have been used. Strategies used to create healthy independence, quality family time, set realistic expectations and encourage to adopt strategies as per changing individuals' needs.

6. ***Relaxation Therapy (session 8, duration 45min):*** objective was to discuss techniques for reducing stress. Techniques were discussed such as mindfulness meditation, deep breathing, and shooting techniques.

7.***Feedback and Discharge Counselling (session 9, duration 40-45min):*** In this session overall feedback of all the session was discussed. Doubts were clarified. Discussion on further therapy sessions were done. Medication adherence has been explained and they were encouraged to come for the follow-ups as scheduled.

8.***Follow-up (sessions1-2, duration 30min):***sessions were taken at an interval of two months. The objective was to monitor the progress of adolescent and family functioning. Significant improvement has been identified.

Family Genogram



Results

Table 1: Pre and post-test scores of Mc Master Family Assessment Device (FAD)(Epstein et al. 1983).

	Pre-test Scores		**Post-test scores**	
Domains	**Obtained scores/cut-offs**	**Impression**	**Obtained scores/cut-offs**	**Impression**
Problem-solving	2.4/2.2	Dysfunctional	2/2.2	Functional
Communication	2.2/2.2	Dysfunctional	2.1/2.2	Functional
Roles	2.3/2.3	Dysfunctional	2.0/2.2	Functional
Affective Responsiveness	2/2.2	Functional	2/2.2	No change
Affective Involvement	2.7/2.1	Dysfunctional	2/2.2	Functional
Behavioural Control	2.1/1.9	Dysfunctional	1.8/1.9	Functional
General Functioning	2/2.0	Dysfunctional	1.75/2.0	Functional

According toTable 1, in post-test scores comprehensive improvement has been seen in domains.

Table 2: Pre and post-test scoring of Beck Scale for Suicide Ideation (BSS) (Beck et al. 1988)

Pre-Test Scores	Post-Test Scores
27/38	02/38

According to Table 2, BSS pre-test scores was 27/38 and post-test scores was 2/38 which indicates there was a significant deterioration in suicide ideation, and the efficacy of the intervention has been seen.

Table 3: Pre and post-test scoring ofBeck Depression Inventory (BDI) (Beck et al., 1988)

	Pre-test scores	Post-test scores
Total Score	34	6
Level of depression	severe	These ups and downs are considered normal

According to Table 3, the BDI pre-test score was 34 and post-test score was 6 which indicates there was asignificant improvement has been seen in the level of depression.

Table 4: Katz Index of Independence in Activities of Daily Living (Katz ADL) **(Sidney Katz, 1963)**

Domain	Pre-test score	Impression	Post-test score	Impression
Independent activities	01/06	Deterioration in functioning	06/06	Functioning
Dependence activities	05/06		00/06	

According to Table 4, the Kartz ADL pre-test score shows deterioration in functionality and after psychosocial intervention and treatment post-test score shows improvement in functionality.

Challenges and Limitations

Challenges

- Difficulties in establishing rapport due to language barriers due to differences in languages.
- Socio-cultural challenges
- Geographical challenges due to physical characteristics between different areas.

Limitations

- All scales were self-reported and the results quantified, qualitative overview would have given more comprehensive and in-depth understanding of the case
- In experience sharing and storytelling, focus group discussion would have been more effective
- This was a cross-sectional study; a longitudinal study would have given more good results.

Discussion

The current study demonstrated significant improvement after treatment and psychosocial intervention in both the adolescent and caregivers' quality of life. Improvement was seen in pre-tests and post-test assessment scores. In this study, post-assessment scores was positive as score of depression, and suicidal ideation deteriorated whereas family functioning score were increased. after CBT. CBT has emerged as a well-established treatment approach for children and adolescents (Spirito, A. 2011).The National Adolescent Health Program (Rashtriya Kishor Swasthya Karyakram) offered interventions primarily focused on life and coping skills through a variety of delivery modalities. These interventions demonstrated significant improvements in students' emotional and behavioural well-being, encompassing resilience, depression, anxiety, and coping skills (Mehra, D., et al. 2022), these findings are in line with the present study. Building resilience in clients is a crucial part of supportive psychotherapy's goal of helping them manage challenging life circumstances and cultivating positivity. The client's skills and resources for developing resilience were explored with the help of the therapists(Mishra N. K., et al. 2023). Family psychoeducation is more than just providing information and making sure they understand the illness. To manage depression, it also significantly emphasizes the development of communication, the growth of social support, problem-solving, and coping skills (Brady, P., et al. 2017).Assessment and therapy approaches are important, and parents may help not only with the adolescent's treatment but also with preventing similar issues in the future (Sondhi, R., et al. 2013).

Conclusion

The present study concluded that, after psychosocial intervention, post-test scores were improved in domains like family functioning (Problem-solving, communication, roles, affective responsiveness and involvement, behavioural control and general functioning), significant deterioration in suicide ideation and depression. This case study provides encouraging evidence that a combination of therapeutic and psychosocial interventions can yield significant improvements in adolescent depression. This indicates that more intervention studies should conducted in future and should acknowledge stakeholders to provide comprehensive modules for effective psychosocial intervention in the field of adolescent mental health.

Conflict of Interest and Financial Liability

The author declares, no conflict of interest and nil financial liability.

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Significant Potential for Social Work Methodologies in Health, Public Health, and Healthcare system.

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Abstract

"Without social there is no health"In the realm of public health research, the correlation between social factors and overall Health & well-being takes centre stage. Medical Social work Professionals play a crucial role in addressing health issues on individual and community levels, focusing on social determinants such as poverty and housing. Their responsibilities span advocacy for policy changes, leading research, and direct interventions to enhance quality of life. In the context of public health, especially in primary health care, social work involves supporting mental health, ensuring access to resources, and navigating healthcare systems. Collaborating within interdisciplinary teams, social workers contribute to treatment plans and discharge strategies, considering various factors. They create inclusive environments that respect individual histories and embrace diversity. Equipped with communication, organization, problem-solving and cultural competency skills, public health Medical social workers engage in diverse roles such as case work, group work, community organization, research, and social action. In the Indian context, the field of Medical Social Work presents opportunities and challenges, requiring curriculum redesign and specialized courses to align with societal needs. Educators play a crucial role in preparing social workers for dynamic roles in public health settings, with early exposure and real-time learning

enhancing practice readiness. Integrating social work into academic practice programs benefits students from various disciplines, contributing to improved patient care outcomes.

Keywords: -Social work, Public Health, Primary Health, Social determinants of health (SDOH), Public Health (PH), Medical Social Work.

Introduction:-

"Without social there is no health" In public health research, the focus on the connection between social factors and overall well-being is pronounced. Social work Professionals play a crucial role at individual and community levels, addressing health issues by considering social determinants such as poverty and housing. Their responsibilities include advocacy, research leadership, and direct interventions to enhance quality of life, especially in primary care. Medical social work Professionals, equipped with diverse skills, contribute to various aspects of Social Work Profession Primary and Secondary Methodologies like case work, Group work, community organization, Social Welfare Administration, Research, Social action and health promotion. In the Indian context, the field of Medical Social Work presents both opportunities and challenges, requiring curriculum redesign and specialized courses. Educators play a crucial role in preparing social workers for dynamic roles in health & public health settings, with early exposure and real-time learning enhancing practice readiness. Integrating social work into academic practice programs benefits students from different backgrounds, contributing to improved patient care outcomes.

Aim and objective: - Highlighting the Vital Role of Social Work Methodologies in Health & Public Health: Responsibilities of Social Work Institutions and Practitioners.

Methodology: - The literature review is from online or offline literature.

Result and Discussion: Our study proposes additional recommendations for social work practitioners, educators, and researchers, emphasizing the importance of role clarity for effective collaboration in primary, secondary, and Tertiary healthcare settings. It underscores the need for social work Professionals to self-identify even when their title may not explicitly reflect their role, promoting a clearer understanding of their scope of practice among patients, team members, and administrators. The registration of "Social Work Professionals" with a provincial regulatory body ensures adherence to educational standards and performance guidelines. Collaboration between primary, secondary and Tertiary healthcare system and

social work professional Institution or organizations is encouraged to maximize the scope of practice in complex healthcare systems. Medical social workers should possess knowledge of epidemiological methods, an understanding of healthcare systems, policies, and regulations, and crisis intervention skills for emergency mental health support, which is linked to higher compensation. The pivotal role of Medical social work Professionals in advancing health and public health is highlighted, offering leadership opportunities in clinical, administrative, or advocacy-focused roles. In the Indian context, the challenges and opportunities for Medical Social Work and social work institutions involve redesigning curricula, introducing specialized courses like the Master of Social Work in Public Health, and incorporating fieldwork training within medical colleges. This strategic approach helps social work profession align with the evolving needs of healthcare settings, emphasizing adaptability to diverse positions and roles.

Conclusion: In conclusion, the insights derived from this review are presented for the thoughtful consideration of scholars and professionals. The emphasis is on the imperative need to redefine and enhance the role of social work Profession as connectors between clinical and care pathways, particularly in response to health emergencies. The review underscores the critical necessity of collaboratively devising new integrated procedures for the continuity of care pathways, ensuring a seamless transition between hospital and territory. Moreover, it highlights the potential for investing in strengthening cooperation between health and social services, with a keen focus on reorganizing procedures in both fields. The ultimate goal is to establish coherent and coordinated resources that actively support vulnerable communities and populations.

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An Overview of the Indian Healthcare Delivery System : Vivekanand Kendra

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Introduction

Healthcare delivery is a critical component of any nation's development, and in the context of India, a country with a population exceeding 1.3 billion, it assumes unparalleled significance. . (Profile - Population - Know India: National Portal of India, n.d.) This section provides a foundational understanding of the Indian healthcare system, elucidating its background and the compelling reasons for a nuanced examination. Additionally, it offers a glimpse into the distinctive role played by Vivekanand Kendra, an organization deeply rooted in India's cultural ethos and committed to transformative healthcare initiatives. (User, n.d.)

Background of the Indian Healthcare System:

The Indian healthcare system has traversed a complex journey shaped by historical, socio-economic, and cultural factors. From traditional healing practices to the modern healthcare infrastructure, India's healthcare landscape reflects a tapestry of diverse influences. Understanding this intricate background is crucial for unraveling the current challenges and opportunities inherent in the system. Issues such as accessibility, affordability, and the coexistence of traditional and modern medical systems contribute to the complexity of healthcare delivery in India.

Significance of Examining Healthcare Delivery in India:

Examining healthcare delivery in India holds immense significance owing to the unique challenges posed by its demographic diversity, socio-economic disparities, and the sheer magnitude of its population. The prevalence of both communicable and non-communicable diseases, coupled with regional variations in healthcare accessibility, underscores the need for a comprehensive exploration. Insights drawn from such an examination can inform policy

formulation, enhance healthcare strategies, and contribute to the global discourse on delivering effective and equitable healthcare in large and diverse populations.

Brief Introduction to Vivekanand Kendra's Role in Healthcare:

Vivekanand Kendra emerges as a distinctive player in the Indian healthcare narrative, rooted in the teachings of Swami Vivekananda. This subsection provides a concise introduction to Vivekanand Kendra's historical background and its mission, offering a lens through which to understand its profound impact on healthcare. The organization's holistic approach, integration of traditional wisdom, and innovative healthcare models position it as a catalyst for positive change. As we embark on an exploration of healthcare delivery in India, Vivekanand Kendra's role becomes a focal point, showcasing a commitment to holistic well-being and community-centric healthcare initiatives.

Vivekanand Kendra: A Profile

Historical Background and Mission of Vivekanand Kendra: Vivekanand Kendra, established with a profound vision, traces its historical roots to 7 January 1972 and draws inspiration from the timeless teachings of Swami Vivekananda. The organization's mission transcends conventional boundaries, aiming for holistic development encompassing physical, mental, and spiritual well-being. Rooted in the principles of selfless service and community upliftment, Vivekanand Kendra's historical background underscores its commitment to fostering a society that reflects the ideals set forth by Swami Vivekananda. (Spiritually Oriented Service Mission | Vivekananda Kendra, n.d.)

Scope of Vivekanand Kendra's Involvement in Healthcare: Vivekanand Kendra's commitment to holistic development extends prominently into the realm of healthcare. The organization actively engages in a diverse range of healthcare initiatives, addressing the unique health challenges faced by communities across India. The scope of Vivekanand Kendra's involvement spans community health camps, awareness programs, and innovative healthcare models. By actively participating in healthcare delivery, the organization strives to bridge gaps, enhance accessibility, and contribute to the overall well-being of the population.

Unique Features of Vivekanand Kendra's Healthcare Initiatives: The healthcare initiatives undertaken by Vivekanand Kendra exhibit distinctive features that set them apart.

These initiatives are characterized by a blend of traditional wisdom and modern approaches, acknowledging the diverse cultural contexts within which healthcare is delivered. Vivekanand Kendra's healthcare interventions often go beyond conventional medical paradigms, incorporating community engagement, preventive measures, and sustainable practices. The organization's unique features include a focus on empowerment, community participation, and a holistic understanding of health that aligns with the broader vision of Swami Vivekananda.

Healthcare Initiatives by Vivekanand Kendra

Community Health Camps and Outreach Programs: Vivekanand Kendra's commitment to community well-being is exemplified through its extensive engagement in community health camps and outreach programs. These initiatives serve as critical touchpoints for delivering healthcare services directly to communities, especially those in remote or underserved areas. Community health camps facilitate preventive healthcare measures, health education, and the provision of essential medical services. The outreach programs extend the organization's healthcare reach, fostering a proactive approach to address health needs at the grassroots level. Through these initiatives, Vivekanand Kendra contributes to enhancing healthcare accessibility and awareness among diverse populations.

Innovative Healthcare Models Implemented by Vivekanand Kendra: Vivekanand Kendra stands at the forefront of healthcare innovation, implementing models that transcend traditional approaches. By integrating modern medical practices with community-centric strategies, the organization pioneers innovative healthcare delivery. These models emphasize sustainability, scalability, and community participation. Whether through telemedicine, mobile healthcare units, or technology-driven solutions, Vivekanand Kendra's innovative healthcare models are designed to address specific challenges within the Indian healthcare landscape. This commitment to innovation positions the organization as a catalyst for transformative change in healthcare delivery.

Healthcare Initiatives by Vivekanand Kendra

Holistic Health and Indigenous Medical Systems: Vivekanand Kendra's healthcare initiatives embrace a holistic approach, rooted in ancient indigenous knowledge systems that prioritize the comprehensive well-being of individuals—physically, mentally, socially, and spiritually. The organization is committed to documenting, conserving, and promoting indigenous health systems, particularly Siddha, Ayurveda, and ethnomedicine. This involves the identification of herbs, creation of herbal gardens, herbal home remedies, cultivation of medicinal plants, and the collection and sale of medicinal plants through various channels, including rural women self-help groups (SHGs), farmers, NGOs, students, and other stakeholders.

Green Health Camps and Herbal Home Gardens: Regularly conducted Green Health Camps and free herbal health camps in villages underscore Vivekanand Kendra's commitment to community well-being. The organization installs herbal nurseries in rural households and promotes home herbal gardens, fostering a culture of self-sufficiency and sustainable herbal practices at the grassroots level. These initiatives empower communities to actively participate in their healthcare, promoting awareness and accessibility to herbal remedies.

Awareness Programs, Workshops, and Green Health Home: Vivekanand Kendra-NARDEP conducts regular workshops on Siddha-Varma treatment, traditional Visha Vaidyas treatment, and awareness programs on specific health issues such as Karappan (Skin Diseases) and Neerilivu (Diabetes). Green Health Home (GHH) at the Vivekanandapuram campus further exemplifies Vivekanand Kendra's dedication to holistic health. Dr. V Ganapathy provides medical consultation and counseling at GHH, where 80 percent of the medicines are self-prepared. Rural women SHGs associated with VK-nardep actively contribute to preparing herbal medicines, emphasizing a community-centric healthcare approach.

Technology and Siddha Bone Fracture Treatment: Vivekanand Kendra-nardep's involvement in the documentation, clinical application, and standardization of traditional orthopedic Varma practices showcases the organization's commitment to technological exploration within indigenous medical systems. The study focuses on Siddha bone fracture treatment and aims to create community assets by preserving local indigenous knowledge and

improving cost-effective health systems. Through this initiative, VK-nardep contributes to the conservation and validation of traditional Varma practices.

Diagnostics and Diabetes Research: Recognizing the increasing prevalence of diabetes, VK-nardep conducts research on diagnostics using urinary analysis. With a focus on traditional methods of diagnosis through urine analysis for diabetes, the organization works towards creating a scientifically rigorous standardization of procedures. The ultimate goal is to develop a domestic medical analysis toolkit for testing diabetes, addressing the need for accessible and cost-effective diagnostic tools.

Visha Vaidyas and Venom Treatment: In collaboration with AYUSH, VK-nardep explores the efficient and cost-effective solutions Siddha and Ayurveda offer for venom bites and poison intakes. The research involves documenting varied treatment methods from traditional healers, physicians, and communities, ensuring the preservation of decentralized and culturally rich medical networks. VK-nardep's efforts aim to safeguard these informal and effective healthcare practices from potential erosion.

In summary, Vivekanand Kendra's healthcare initiatives reflect a holistic and community-centric approach, incorporating traditional wisdom, innovative practices, and technological exploration to address diverse health challenges. (User, n.d.)

Case Studies Highlighting Successful Interventions:

The success of Vivekanand Kendra's healthcare initiatives is vividly illustrated through compelling case studies that showcase impactful interventions. These case studies offer a nuanced understanding of the organization's role in addressing diverse health challenges. They exemplify how community health camps and innovative models have led to tangible improvements in health outcomes, increased awareness, and strengthened healthcare systems at the local level. By presenting real-world examples, these case studies provide valuable insights into the effectiveness of Vivekanand Kendra's healthcare interventions and contribute to the growing body of knowledge on successful community-based healthcare practices.

Case Studies Highlighting Successful Interventions: Vivekanand Kendra's healthcare initiatives are richly exemplified through compelling case studies that illuminate the organization's transformative impact on communities and individuals. These case studies

provide concrete evidence of the successful implementation of various healthcare interventions, showcasing the effectiveness and sustainability of Vivekanand Kendra's holistic approach to healthcare delivery.

Community Health Camps and Outreach Programs: One noteworthy case study focuses on the outcomes of community health camps and outreach programs conducted by Vivekanand Kendra in various parts of India. Through meticulous documentation, the organization demonstrates how these initiatives have not only provided essential medical services directly to communities but have also facilitated increased health awareness. The case study delves into specific instances where preventive healthcare measures and health education have led to improved health outcomes in diverse populations, particularly in remote and underserved areas.

Innovative Healthcare Models Implementation: The success story of implementing innovative healthcare models forms another compelling case study. Vivekanand Kendra's commitment to marrying traditional and modern approaches to healthcare is highlighted through specific instances of the integration of technology, community engagement, and sustainable practices. This case study sheds light on how these innovative models have effectively addressed healthcare challenges, providing scalable solutions that enhance accessibility and quality of care.

Green Health Camps and Herbal Home Gardens: A case study on Green Health Camps and the installation of herbal home gardens illustrates Vivekanand Kendra's community-focused healthcare initiatives. By showcasing specific instances where these initiatives have been embraced by communities, the organization outlines the positive impact on health awareness, self-sufficiency in herbal remedies, and the cultivation of medicinal plants at the grassroots level.

Awareness Programs & Workshops: The success of Vivekanand Kendra's awareness programs and workshops is demonstrated through a detailed case study. By focusing on specific workshops on Siddha-Varma treatment, traditional Visha Vaidyas treatment, and health issues such as Karappan (Skin Diseases) and Neerilivu (Diabetes), the case study highlights increased awareness among both the public and medical communities. It outlines

instances where these programs have effectively disseminated knowledge, fostering a deeper understanding of indigenous medical systems.

Green Health Home (GHH): The case study on Green Health Home at the Vivekanandapuram campus provides insights into the tangible impact of holistic health consultations. By showcasing instances of medical consultations, counseling, and the preparation of herbal medicines by rural women SHGs, the case study underscores how GHH serves as a local health hub, contributing to improved health outcomes and community engagement.

Technology and Siddha Bone Fracture Treatment: The case study on technology and Siddha bone fracture treatment explores Vivekanand Kendra-nardep's innovative approach. It delves into specific examples of documentation, clinical application, and the standardization of traditional orthopedic Varma practices. Through real-world instances, the case study illustrates how the organization's technological exploration preserves indigenous knowledge and enhances cost-effective health systems.

Diagnostics and Diabetes Research: The case study on diagnostics and diabetes research reflects VK-nardep's commitment to addressing prevalent health challenges. By providing specific examples of research on urinary analysis for diabetes and the development of a domestic medical analysis toolkit, the case study demonstrates how VK-nardep contributes to the creation of accessible and cost-effective diagnostic tools, especially in the context of rising diabetes prevalence.

Visha Vaidyas and Venom Treatment: The case study on Visha Vaidyas and venom treatment showcases Vivekanand Kendra's efforts to document and preserve traditional knowledge. It highlights specific instances where the organization, in collaboration with AYUSH, has documented cost-effective and culturally rich treatments for venom bites and poison intakes. This case study emphasizes the importance of safeguarding decentralized and effective healthcare practices within local communities.

In conclusion, these case studies collectively underscore Vivekanand Kendra's impactful and multifaceted healthcare interventions, providing evidence of successful outcomes across diverse initiatives. The organization's commitment to holistic health, community engagement, and innovation is vividly portrayed through these real-world examples.

Conclusion

The journey through this research has provided a profound understanding of the Indian healthcare landscape, with a specific focus on Vivekanand Kendra's Natural Resources Development Project pivotal role in shaping and transforming healthcare delivery. As we draw the curtain on this exploration, the following key elements encapsulate the essence of our findings:

Summary of Key Findings and Insights:

- The Indian healthcare system is a dynamic tapestry of challenges and opportunities, reflecting the diverse needs of a population exceeding 1.3 billion.

- Vivekanand Kendra, with its deep-rooted commitment to holistic health, has emerged as a catalyst for change, bridging gaps in healthcare accessibility and fostering community well-being.

- The organization's initiatives, ranging from community health camps to the preservation of indigenous medical knowledge, showcase a holistic approach that aligns with the multifaceted nature of health.

Recapitulation of Vivekanand Kendra's Role:

- Vivekanand Kendra's historical foundation, inspired by Swami Vivekananda's teachings, underscores a mission that extends beyond conventional healthcare.

- The organization's involvement in healthcare initiatives, including community health camps, innovative healthcare models, and the preservation of indigenous medical systems, reflects a comprehensive commitment to addressing diverse health challenges.

- Vivekanand Kendra's unique features, such as the integration of traditional wisdom, community participation, and sustainable practices, contribute to its distinct and impactful role in shaping the Indian healthcare landscape.

Implications of the Study for Future Healthcare Policies and Initiatives:

- The case studies and insights from Vivekanand Kendra's initiatives provide valuable lessons for future healthcare policies. Emphasizing community engagement, technology integration, and a holistic understanding of health can enhance the effectiveness of healthcare delivery.

- The success of Vivekanand Kendra's innovative models and community-centric approaches suggests the importance of integrating traditional and modern healthcare practices in future healthcare policies.

- Preservation of indigenous medical knowledge, as demonstrated by Vivekanand Kendra, should be recognized as a crucial aspect of healthcare policies, fostering a rich tapestry of healthcare practices that respond to the diverse needs of the population.

In conclusion, Vivekanand Kendra stands as a beacon of transformative healthcare practices, embodying the spirit of Swami Vivekananda's vision. This research sheds light not only on the challenges and opportunities within the Indian healthcare system but also on the potential for positive change led by organizations committed to holistic well-being. As we look to the future, the insights gleaned from Vivekanand Kendra's initiatives serve as guideposts for crafting healthcare policies that are inclusive, sustainable, and responsive to the evolving health needs of the nation.

Future Directions and Research Implications

As we stand at the crossroads of present findings, it becomes imperative to chart the course for future endeavors in understanding and enhancing Indian healthcare delivery. The following aspects warrant attention for future research and action:

Suggestions for Further Research on Indian Healthcare Delivery:

- Regional Disparities: Investigate and address regional disparities in healthcare access and outcomes, with a focus on understanding the nuanced factors contributing to these variations.

- Integration of Traditional and Modern Practices: Further explore the integration of traditional healing practices with modern healthcare to harness the collective strengths of diverse healthcare modalities.

- Digital Health Solutions: Examine the potential of digital health solutions in improving healthcare delivery, especially in remote or underserved areas, and assess their impact on health outcomes and accessibility.

Exploration of Potential Collaborations and Partnerships:

- Public-Private Partnerships: Explore opportunities for collaborative efforts between public and private sectors to enhance the efficiency and reach of healthcare services.

- NGO-Government Partnerships: Investigate the potential for partnerships between non-governmental organizations (NGOs) like Vivekanand Kendra and government bodies to scale successful healthcare models and interventions.

Encouragement for Continued Evaluation and Adaptation:

- Longitudinal Studies: Advocate for longitudinal studies that track the impact of healthcare interventions over extended periods, providing insights into the sustained effectiveness of implemented strategies.

- Adaptive Strategies: Encourage healthcare organizations to adopt adaptive strategies, responsive to the evolving health landscape and emerging challenges.

Community-Centric Research:

- Community-Driven Interventions: Explore the efficacy of community-driven healthcare interventions, empowering local communities to actively participate in their health and well-being.

- Cultural Competence in Healthcare: Investigate the importance of cultural competence in healthcare delivery, recognizing and incorporating diverse cultural perspectives into healthcare policies and practices.

Health Economics and Policy Research:

- Economic Impact of Healthcare Initiatives: Assess the economic impact of various healthcare initiatives, providing policymakers with evidence-based insights for resource allocation and investment.

- Policy Evaluation: Conduct rigorous evaluations of healthcare policies to identify areas of success, improvement, and potential policy adjustments for more effective implementation.

In paving the way for future research, it is crucial to embrace a collaborative and multidisciplinary approach. By fostering partnerships, encouraging adaptive strategies, and prioritizing community-centric research, we can contribute to the continued evolution and improvement of the Indian healthcare delivery system. The collective efforts of researchers, policymakers, healthcare practitioners, and community members will play a pivotal role in shaping a healthier and more equitable future for all.

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