

## Determinant Factors of Community Attitude Towards Mental Illness in Northern Ethiopia: Mixed Method

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### Abstract

**Background:** About 76% and 85% of people in low and middle-income countries with severe mental illness did not receive treatment due to fear of expected discrimination and stigma against diagnosed people with mental illness. There are no published works on the attitude of the community to mental illness in this study area.

**Aim:** This study aimed to assess the attitude and its' associated factors towards mental illness among residents of Mertule Mariam town.

**Methods:** A Community-based cross-sectional study was conducted from May to June 2019. Descriptive and binary logistic regression analyses were employed to identify the determinant factors for community attitude.

**Result:** The response rate was 98.2% with the sex distribution of 58.5% (554) males. The attitudes of the community were more authoritarian (52.8%), less benevolent (52.3%), more socially restrictive (38.8%), and positive to mental health services (59.2%). Age between (35-44) [AOR=2.50, CI 1.56-4.23, P-value= 0.001] and (18-24) [AOR=3.08(1.5-6.3) p-value=0.002], have been significantly associated with authoritarianism and the benevolence subscale respectively. Getting information about mental illness [AOR=0.02, CI 0.05-0.75, P-value <0.05], and involved in caring for the mentally ill [1.85(1.28-2.65)\*\*] were significant variables for social restrictiveness and community mental health ideology subscale respectively.

**Conclusion and Recommendation:** The attitude of the participant was more affected by getting information about mental illness and involved in caring mentally ill. Using mass media and health institutions to disseminate information about mental health and involving the community to care mentally ill is essential to improve their attitude.

**Keywords:** Attitude, Mental Illness, Ethiopia

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## Background

Mental illness is a condition that affects the cognition, emotion, and behavior of an individual. It also affects the individual's ability to realize his own potential, cope with normal life stressors, act productively and contribute to his own community [1, 2]. It is one of the major contributors to disability-adjusted life of years (DALYs) and the global burden of disease (GBD) [3, 4]. In Ethiopia, mental illness is the leading contributor of disease burden out of non-communicable diseases (NCD) in which it comprises of 11% exceeding HIV/AIDS [5]. Even though mental illnesses are highly prevalent and incapacitating to the community of this world, no more help are sought from modern health facilities [6]. The community's attitude hinders the help-seeking intention of the community to mental illness [7].

Larger proportions of people with mental illness never receive treatment from mental health care staffs globally. Similarly, more than three-fourths of people with mental illness in low and middle income countries never receive treatment. This is because people with mental illness fears stigma and discrimination from the community [1, 8].

Nigerian community has widely held a bad attitude believing that mentally ill patients are dangerous due to their violent behaviors including avoiding basic social contacts; the majority will be afraid to have conversations with people with mental illness and only a few segments of the community will consider having marriage consideration with them [9].

Community based studies illustrated that the community rejects marriage with people with mental illness, isolated and put in a separate place under supervision. Most of the respondents afraid to be a neighbor, feel ashamed to talk about someone who have mental illness that lives in the home together with them and refused to maintain friendship. The community associated mental illness with difficulty at work and lack of will power and discipline [10-13].

Most of Ethiopian communities believe that mental illnesses are to be caused by "punishing hands of God" for disobeying the principles, doctrines and social taboos [14]. For instance, in Borana semi-nomadic population, the majority of the community believes supernatural influences cause mental illness. Bewitchment, witchcraft, and possession by an evil spirit were the central causes not only for "madness" but also for property loss. People left someone who has mental illness alone if he/she did not respond with treatment, and based on patient condition, he/she may choose to live with the family getting his/her basic needs or wander around the street naked [15].

Studies done in Nigeria state that being male and literate are the factors associated with a positive attitude to mental illness. Literates have 7 times more positive attitude to mental illness than their counters [10]. Based on a study done in Ghana, females are more authoritarian than men are and social restrictiveness decreases with age. More educated people are less authoritarian and less socially restrictive than persons with only basic education are. They also expressed more benevolent than less educated [16]. Females have a bad attitude to marital prospects to

mentally ill and illiterates have a more negative attitude to live with people who have mental illness than literates for those even who are living in one home [17].

In southwest Ethiopia, the study showed that higher educational status and exposure to mental illness information decreases stigma [14]. Community based cross-sectional Study done in Worebe town showed that illiterates have a more socially restrictive and less humanistic attitudes. Having mental health information is highly associated with a less socially restrictive and less authoritarian attitudes towards people with mental illness [18].

Even though there are few studies in Ethiopia assessing the attitude of the community to mental illness but they are limited to the southern and western region and there are no published data in the northern Ethiopia [12, 14, 15, 17, 18-21]. Therefore, this study has importance on determining the determinants of the community attitude for mental illness in the Northern Ethiopia, Ethiopia.

## Methods

### *Study Design and Setting*

Community based cross-sectional study designs using mixed (both qualitative and quantitative) methods were conducted in East Gojam Zone, Northern Ethiopia, from May to June 2019.

### *Study Population*

All residents of the town aged 18 years or more and who reside 6 months and more were included. Those who were severely ill and unable to communicate verbally were excluded from the study.

### *Sampling Procedure and Technique*

Multi stage sampling procedure was applied. The proportionally allocated households in the two kebelles were selected with a systematic random sampling method considering that they are homogenous. The first household, and when there was more than one adult in each selected household, was selected lottery method. Using Single population proportion formula, the sample size was 334 and when we estimates sample size for associated factors we got 964 with 10% non-response rate. Therefore, the final sample size was taken 964.

### *Data Collection Tools*

Data were collected by interview using semi-structured questionnaire by 6 clinical nurses with 2 supervisors. Community Attitude to Mental Illness Inventory (CAMI) was used to assess attitudes of the community. CAMI has four subscales which are authoritarianism, benevolence, social restrictiveness, and community mental health ideology. The tool has been used in different countries of Africa including Ethiopia [16, 19]. Four focus group discussions were held which included religious leaders, health workers, and community participants who were selected purposely.

### *Data Processing and Analysis*

The collected data were entered using Epi info 7th version and exported to SPSS version 20 for analysis. Descriptive statistics and binary logistic regression were used. P-value less than 0.2

was taken to identify factors associated with the outcome variables on bivariate regression and p-value less than 0.05 on multivariate logistic regression were taken as statistically significant presented by OR with 95% confidence interval. Qualitative data were translated from Amharic to English and triangulated with quantitative data.

### Ethical Consideration

Ethical clearance was obtained from the institutional review board of University of Gondar and the ethical review committee of Amanuel mental specialized hospital. Permission paper from the town administration was requested and distributed to the two kebele administrations. Data collectors were explaining about the aim of the study and were asking consent before they started data collection. The right to ask questions about the study and to terminate the interview whenever they want to stop was offered

for the study participants. The information gathered from the participants were kept confidential. The name of the participant was not included or asked during data collection to keep the information anonymous. The data collectors were signed for the consent they gained from their participants.

## Result

### Socio-Demographic Characteristics

Among the 964 study participants, 947 responded the interview completely, which made 98.23% response rate. out of the respondents, 58.5% (554) were males while 393 (41.5%) were females table 1. Amhara ethnicity (99.7%) and orthodox religion (98.7%) took the greater proportion of the respondents. Only 18.2% (178) of respondents have a degree and above educational level while 12.2% of respondents cannot read and write (table 1).

**Table 1: Socio-Demographic Distribution of Participants Among Residents of Northern Ethiopia, Ethiopia, 2019**

Variables	Category	Frequency	Percent
Age	18-24	241	25.4
	25-34	463	48.9
	35-44	193	20.4
	>44	50	5.3
Sex	male	554	58.5
	female	393	41.5
Marital status	single	426	45.0
	married	417	44.0
	divorced	85	9.0
	widowed	19	2.0
Ethnicity	Amhara	944	99.7
	other	3	.3
Religion	orthodox	935	98.7
	other(Muslim and protestant)	12	1.3
Educational Status	unable to read and write	116	12.2
	elementary school	126	13.3
	secondary school	260	27.5
	college diploma	267	28.2
	degree and above	178	18.8
Occupational Status	government employee	387	40.9
	housewife	70	7.4
	farmer	59	6.2
	NGO employee	45	4.8
	merchant	168	17.7
	student	152	16.1
	other	66	7.0
Estimated monthly family Income	under extreme poverty(<750)	290	30.6
	Under poverty (751-1200)	113	11.9
	Above poverty level (>1201)	544	57.4

## Respondent Social Support

Among participants, only 17.2% have strong social support while 39.6% (375) have poor social support and the rest covers moderate level of social support.

## Mental Health Information

About 575 (60.72%) of 947 participants have ever got information about mental illness during the last one year and 39.7% (376) of participants got information from people other than media or health institutions while 11.6% got mental health information from health institutions. Mass media gives information to 6.5% of participants while 4.4% of participants got the information from magazines. About 37.8% of participants got information about mental illness from schools, and religious institutions.

## Contacts with Someone Who Has Mental Illness

About 69.4% of participants know someone who has mental illness and only 6.9% of them have relatives who have mental illness. Around 70% of respondents had never involved in caring someone who have mental illness. Thirty-three percent of participants have been hurt and 72.5 % of participants have witnessed hurt by people who have mental illness.

## Illness Perception to Mental Illness

Around 58.1% of participants graded mental illness as very severe, and 81.6% of them believes that mental illness requires treatment. Most (71.5%) of believe different psychosocial factors as major causes for mental illness, while 6.5% and 7.5% of the participant believe evil spirit possession and God's punishment as a cause of mental illness respectively.

**Table 2: Perception to Mental Illness Among Residents of northern Ethiopia, Ethiopia, 2019**

Variables	Category	Frequency	Percent
Perceived severity of mental illness	mild	24	2.5
	moderate	66	7.0
	sever	307	32.4
	very sever	550	58.1
Perceived cause of mental illness	psychosocial factor	677	71.5
	nerve damage	13	1.4
	poverty	22	2.3
	substance use	102	10.8
	evil spirit possession	59	6.2
	God's punishment	71	7.5
Perceived need of treatment for mental illness	yes	773	81.6
	no	174	18.4
Perceived good place for help	holywater	207	21.9
	holywater and hospital	101	10.7
	hospital	614	64.7
	sorcerer	24	2.5

## Community Attitude to Mental Illness

Respondents were more authoritarian (52.8%), less benevolent (52.3%), more socially restrictive (38.8%), and positive to the mental health services (59.2%). Those aged greater than 44 years old show that they are more authoritarian and more socially restrictive than the other age groups (66%). Females are more authoritarian than males with a negative attitude to mental health services and care (55%, 44%). Peoples who are married are more authoritarian than singles and less authoritarian than widowed ones (58.5%). Peoples who had information about mental illness are less socially restrictive than their counters (63.9% Vs 51.7%).

## Determinant Factors for the Community Attitude Toward Mental Illness

Factors which have p-value less than 0.2 on bivariate regression were taken into multivariate logistic regression and those that have p-value less than 0.05 were taken as statistically significant.

## Authoritarianism

The odds of being more authoritarian among those aged between 35-44 years old were 2.5 times more compared to the age group 18-24 years old [CI= 1.56-4.23, p-value=0.001]. The odds of being authoritarian among those who have elementary education was decreased by 60% compared to illiterates [0.4 (0.19-0.77) p-value=0.007]. The odds of being authoritarian decreased by 67% among degree holders compared to illiterates.

## Benevolence

The odds of being more benevolent among peoples aged  $\geq$  44 years old were 3 times more compared to the reference age (18-24) [AOR=3.08(1.5-6.3) p-value=0.002]. The probability of being benevolent decreased by 83% among Peoples who perceive mental illness mild as compared with those who perceive very severe, [AOR=0.17 (0.06-0.5) p-value=0.001].

## Social Restrictiveness

People aged between 35-44 years old are 2.7 times more likely to stigmatize people who have mental illness compared to those

aged between 18-24 years old [CI (1.7-4.33), p-value=0.001]. Widowed peoples are prone to stigmatize mentally ill people 4 times compared to single ones [CI (1.17-13.7), p-value]. Poor Knowledge of mental illness exposes to social restrictiveness by 1.75[CI (1.31-2.34), p-value=0.001] times compared to having good knowledge.

### Community Mental Health Ideology

The odds of having a favourable attitude to mental health service integration among married people were 1.65 [(1.16 - 2.36), p-value=0.005] times more compared to single people while widowed were[6.2(1.56 - 24.8), p-value=0.01 times] more favourable than singles. The odds of having a favourable attitude among people who perceive mental illness need treatment were 2.17((1.47-3.2)p-value <0.001) times more compared to their counters.

**Table 3: Binary Logistic Regression Analysis of Respondents' Selected Socio-Demographic Characteristics and Other Factors Associated with Attitudes Towards Mental Illness Among Residents of Northern Ethiopia, Ethiopia, 2019**

Variables	Category	Authoritarianism		Benevolence	
		C O R	A O R	C O R	A O R
Age	18-24	Ref	Ref	Ref	Ref
	25-34	1.82(1.32-2.49)	1.70 (1.2-2.5)**	1.08(0.79-1.48)	1.10(0.80-1.52)
	35-44	3.06(2.06-4.54)	2.5 (1.56-4.2)**	1.39 (0.95-2.04)	1.38(0.93-2.05)
	>44	3.10(1.63-586)	2.6 (1.16-5.70)*	2.26 (1.2-4.25)	2.09(1.08-4.06)*
Educational status	Illiterate	Ref	Ref	Ref	Ref
	elementary school	1.82(1.12-2.94)	0.4(0.2-0.7)**	0.71(0.43-1.18)	0.39(0.20-0.76)**
	secondary school	0.72(0.45-1.13)	0.88(0.54-1.44)	0.75(0.48-1.16)	0.93(0.58-1.47)
	Diploma	1.09(0.75-1.60)	0.4(0.21-0.86)*	0.551(0.35-0.85)	0.46(0.23-0.91)*
	degree and above	1.05(0.7-1.54)	0.3(0.15-0.7)**	0.95(0.59-1.52)	0.36(0.17-0.75)**
Getting information	yes	0.82(0.63-1.07)	4.18(1.1-16.2)*	0.83 (0.63-1.07)	0.22(0.06-0.81)*
	no	Ref	Ref	Ref	Ref
Knowing mentally ill	yes	1.37(1.04-1.81)	0.64 (0.45-0.9)*	0.89 (0.67-1.18)	0.95(0.71-1.28)
	no	Ref	Ref	Ref	Ref
hurt by mentally ill	yes	1.39 (1.06-1.82)	0.67(0.48-0.93)*	1.26 (0.96-1.66)	0.71(0.5-0.9)*
	no	Ref	Ref	Ref	Ref
Perceived severity of mental illness	Mild	1.69(0.71-4.01)	0.2(0.06-0.57)**	4.46(1.64-12.1)	0.17(0.06-0.50)**
	Moderate	0.42(0.24-0.72)	0.4(0.17-1.15)	0.71(0.42-1.21)	0.37(0.15-1.01)
	Sever	0.97(0.73-1.28)	0.4(0.50-1.04)	1.19(0.90-1.58)	0.41(0.16-1.03)
	Very sever	Ref	Ref	Ref	Ref

\*p<0.05\*\*p<0.01 ref= reference. \*other=on street, other people's home, \*\*other people= informed by somewhere, \*\*\*other= jobless, retired and daily laborer

**Table 4: Binary Logistic Regression Analysis of Respondents' Selected Socio-Demographic Characteristics and Other Factors Associated with Attitudes Towards Mental Illness Among Residents of Northern Ethiopia, Ethiopia, 2019**

Variables	Category	Social Restrictiveness		Community Mental Health Ideology	
		Crude Odd Ratio	Adjusted OR	Crude Odd Ratio	Adjusted OR
Age	18-24	Ref	Ref	Ref	Ref
	25-34	0.77 (0.56-1.07)	1.7(1.2-2.42)**	0.77(0.56-1.05)	0.74(0.51-1.08)
	35-44	0.92 (0.63-1.36)	2.7(1.7-4.33)**	0.89 (0.6-1.31)	0.91(0.55-1.48)
	>44	2.83 (1.49-5.36)	2.3(1.1-4.76)*	1.72 (0.87-3.42)	0.95(0.42-2.17)
Marital Status	Single	Ref	Ref	Ref	Ref
	Married	1.38 (1.05-1.83)	1.28(0.92-1.77)	1.53 (1.15-2.01)	1.65(1.16-2.36)**
	Divorced	0.87 (0.53-1.44)	0.81(0.47-1.41)	0.53 (0.33-0.85)	0.69(0.40-1.19)
	Widowed	7.04 (2.29-21.6)	3.75(1.1-12.67)*	4.25 (1.22-14.8)	6.2(1.56-24.8)*
Occupational status	Gov't employee	Ref	Ref	Ref	Ref
	Housewife	1.45(0.86-2.4)	1.45(0.82-2.56)	0.41 (0.24-0.69)	0.45(0.21-0.95)*
	Farmer	1.5(0.88-2.67)	1.12(0.61-2.07)	0.45(0.25-0.78)	0.30(0.13-0.71)**



	NGO employee	1.1 (0.58-2.1)	0.92(0.46-1.83)	0.48(0.26-0.90)	0.31(0.15-0.67)**
	Merchant	1.37 (0.94-1.98)	1.34(0.90-2.01)	0.53 (0.37-0.77)	0.41(0.25-0.69)**
	Student	0.94 (0.64-1.40)	0.91(0.58-1.43)	0.52(0.35-0.76)	0.46(0.26-0.83)*
	Other***	1.61 (0.95-2.73)	1.16(0.63-2.14)	0.81 (0.47-1.40)	0.62(0.33-1.17)
Getting information	yes	0.75(0.57-0.98)	0.02(0.05-0.75)*	0.58 (0.44-0.76)	0.47(0.14-1.61)
	no	Ref	Ref	Ref	Ref
Source of information	mass media	Ref	Ref	Ref	Ref
	magazine	1.5 (0.67-3.34)	1.43(0.18-11.55)	1.4 (0.61-3.23)	1.43(0.17-11.55)
	health institution	0.5 (0.25-1.01)	0.44(0.20-0.90)*	0.36 (0.19-0.68)	1.94(0.23-16.36)
	other people**	1.20(0.69-2.11)	1.72(0.23-13.11)	0.84 (0.48-1.46)	0.75(0.09-5.88)
	Religious place and school	1.34 (0.77-2.36)	1.59(0.15-16.98)	1.28 (0.73-2.23)	1.72(0.23-13.10)
Mental illness history	yes	1.03 (0.66-1.61)	0.99(0.62-1.62)	0.62 (0.38-0.98)	1.78(1.05-3.0)*
	no	Ref	Ref	Ref	Ref
Relationship with PWMI	relatives	1.09(0.64-1.85)	1.12(0.61-2.04)	1.12 (0.67-1.88)	0.91(0.62-1.35)
	neighbour	1.19 (0.81-1.75)	1.11(0.73-1.67)	1.84 (1.23-2.74)	1.54(0.92-2.58)
	friend	1.56 (1.08-2.26)	1.54(1.04-2.28)*	2.37 (1.58-3.55)	2.75(1.70-4.45)**
	Other*	Ref	Ref	Ref	Ref
Caring mentally ill	yes	1.68 (1.27-2.23)	1.71(1.25-2.3)**	0.45 (0.34-0.62)	1.85(1.28-2.65)**
	no	Ref		Ref	Ref

PWMI- people with mental illness, \*p<0.05\*\*p<0.01 ref= reference. \*other=on street, other people's home, \*\*other people= informed by somewhere, \*\*\*other= jobless, retired and daily laborer

## Discussion

This study assessed the community attitude to mental illness through four subscales. The four subscales of attitude measurement were authoritarianism, benevolence, social restrictiveness, and community mental health ideology.

The community has an avoidant attitude revealing that they cannot go back to work, care themselves; they are dangerous and should be treated far from the communities' residential area. This is supported by a community study done in Nigeria and Singapore. The community believes that mentally ill peoples are mentally retarded, public nuisance, and dangerous (10, 33). Many participants of the focus group discussion also support this 'mentally ill peoples cannot control themselves and choose what is good for them rather act in contradictory. They shout, wander around the street, and bite people. Another participant said that mentally ill peoples act as 'brainless more than animals. These ideas collectively describe how mentally ill people are stigmatized and discriminated by their own community. The other side of this stigma was lack of knowledge, meaning that they call mentally ill only those who are aggressive, violent, including those who wander on the street. Due to the name given to the violent, all mentally ill patients are considered also violent and aggressive.

Age was a significant associated factor for authoritarianism, benevolence, and social restrictiveness but not for mental health ideology, with all positive effects that show that older peoples are more authoritarian, benevolent, and socially restrictive compared to the youngsters. This is supported by a study finding in Malawi such that older peoples are more authoritarian and socially restrictive (35). Age was not associated with attitude on

a study done in worabe town, silte zone, Ethiopia (31), a study done in Hawassa town (23), and a community study done in Nigeria (10). The difference may be due to model difference, instrument, and method differences. Elders were more authoritarian who forced the other to accept their ideas, more benevolent who strove to help mentally ill peoples, and more socially restrictive affecting the social relationship of the patients. These authoritarian and social restrictors are affecting people who have mental illness negatively because they do not allow them to take their choice and to interact socially.

When people's educational status upgrades from elementary school to diploma and degree, their attitude of authoritarianism and benevolence decrease. This might be due to the fragmented information they could get from schooling and they are going to be less controlling and more negligent for the care of the mentally ill. Findings in Ghana show; when the educational status of the participants increases, their authoritarianism and social restrictiveness decrease (14). This study shows that when people learn more, their attitude toward mental illness gets more positive. This difference might be due the population difference (all urban and mentally ill patients) and the way of using the tool (CAMI). The Ghanaian researcher used the tool as a yes /no questionnaire and assessed the community attitude.

Farmers had negative mental health ideology compared to government employees. This idea is similar to one focus group discussion participant's idea that states as follows: (F-9 is 26 years old, married who is a merchant and knows the mentally ill on the street) 'I don't have any information about mental illness but I know they are called mad (ebid). It is not helpful to take them to anywhere because it is caused by God's punishment and evil spirit possession. Mostly they are left on streets.'

People who ever had information about mental illness were 4.18(1.07-16.26) times more authoritarian and their attitude of benevolent decreased by 78% compared to those who did not. When people get more information, they are going to be more undermining peoples who have mental illness and to be more unhumanistic. These types of people are more likely to keep mentally ill peoples behind a locked door.

Getting information from a health institution has a significant association with social restrictiveness [0.44 CI (0.2-0.4) p-value=0.03] so that people were more supportive for peoples who have mental illness compared to those who get information from mass media. This is supported by a study done in Hawasa town, Ethiopia: People who were informed by the health worker were more comfortable to give a job and responsibility to people who have mental illness (23).

Peoples who have ever been hurt by the mentally ill were less benevolent than those who are not [AOR =0.71(0.52-0.95) p-value=0.02]. This is typical of the focus group discussion participant's idea and other researches done in Nigeria (10). People who have mental illness are thought to be more violent, nuisance, and dangerous, which directly affects the negative attitudes positively. Female (F-1): I have been bitten by one mad man and after that I always afraid of them. They shall be left on a street because of their dangerous behavior. They less likely show improvement with treatment so that investing on people with mental illness is just wasting money. They are left on a street and their basic needs will not be met (15). This could expose mentally ill people to be prone to another medical problem because they are forced to live without human basic needs.

People who have friends with mental illness and people who have ever involved in caring people with mental illness were more likely to accept mental health services and allow the establishment of mental health facilities in the local area of residency. This is about twice as likely as their counters and these ideas are interrelated with each other. Someone whose friend has mental illness is more likely to involve in caring for the victims and in turn is more likely to demand mental health facilities around their residency area. They are also less likely to fear to think about establishing mental health facilities in their area. These variables did not show association in a study done in worabe town, Ethiopia (19).

### Conclusions and Recommendations

The findings of this study indicated that more than half of the community was more authoritarian, less benevolent, less socially restrictive, and have a positive attitude to mental healthcare services. People with mental illness were viewed as inferior and seen as who need supervision as Children. The community denied them empathic and humanistic care. They were also denied to have a job and responsibilities at all in the community. Getting information from a health institution has brought a positive attitude towards someone who has mental illness. Public mental health awareness creating programs, rehabilitation centers for people with mental illness, and public group, like school clubs, which help people with mental illness, are major areas of tackling the bad attitude of the community. Using health institutions as a means of delivering mental health information is also important.

The limitation of this study might be the name mental illness is broad and lacks specificity. The method by itself, cross-sectional study is not the right measure to know the community belief and attitude towards mental illness and mentally ill.

### Acronyms and Abbreviations

AMSH: Amanuel Mental Specialized Hospital  
AU: Authoritarianism  
BE: Benevolence  
CAMI: Community Attitude to Mental Illness Inventory  
CMHI: Community Mental Health Ideology  
Epi info: Epidemiological Information  
GHSQ: General Help Seeking Questionnaire  
MOH: Ministry of Health  
SPSS: Statistical Package for Social Science  
SR: Social Restrictiveness  
UOG: University of Gondar  
WHO: World Health Organization

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