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Social Treatment (Stigma) of the Mentally Ill in Bungoma County, Kenya

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Abstract: ***Objective: The objective of the study was to evaluate the social treatment of the mentally ill by the community in Bungoma County, Kenya. Design: The study was a descriptive cross-sectional study and Quantitative methods were adopted. Setting. The study was carried out in Bungoma County. Sample: Five Sub-Counties in Bungoma County were purposively sampled to increase the representation. The household's heads were sampled by stratified sampling; the researcher divided the population into strata and drew a predetermined number using simple random sampling (n = 396). Analysis: Data was analyzed through descriptive statistics, Independent samples' T-test and One-way analysis of variance. Main outcome measures: Social treatment of the mentally ill. Results: Majority of the respondents 248 (62.6%) agreed that even after a person with mental illness has been treated, they would still be afraid to be around them. Majority of the respondents 232(58.6%) disagreed that mental patients should not be treated in the same hospital as other patients. Of the 396 respondents, 280 (70.7%) of the respondents agreed that when a spouse is mentally ill the law should allow for other spouse to file a divorce. Majority 244 (61.6%) of the respondents agreed that mental illness is a punishment for doing some bad things. The ANOVA model showed significant differences in social treatment amongst respondents of different age groups F (3,372) = 9.403, p <0.01 and marital categories F (4,375) = 8.038, p <0.01. Conclusion: It's evident from the findings that there is minimum interaction between the community and mentally ill people in Bungoma County, therefore the study recommends scaling up public awareness campaigns to reach more people by diversifying the approaches so as to make them aware of the impacts of stigmatization on the help seeking behavior of persons with mental illness.***

Keywords: Mental health, Mental illness, Knowledge of mental illness, public knowledge, sensitization, stigma, myths of mental illness

1. Background

Community's perceptions and beliefs play a role in determining help-seeking behavior and successful treatment of the mentally ill. Communities can play a key role in educating their members about mental health and mental illness. However, community surveys on mental health in a variety of countries found that many members of the community lacked knowledge about mental illness, they did not correctly recognize specific disorders, had negative perceptions about treatments, had basic beliefs about causes, and frequently held stigmatizing attitudes (Lauber et al. 2010). The study explained that this lack of mental health literacy and support skills could have had an effect on health seeking and outcomes of people with mental disorders (Gureje et al. 2005). The above author argued that family and friends were seen by the community as the most important sources of help for a person with a mental disorder (Jorm et al. 2008).

Evans-Lacko et al (2014) argues that social beliefs that include lack of knowledge, negative attitudes and perceived stigma about mental illness, may keep those who suffer from mental illness away from treatment. Mental illness stigma is a serious concern, due to its impact on patient's willingness to seek treatment, their quality of life and discrimination that mental illness individuals face (Sartorius, 2011). By activating uniformed and negative responses from members of the society and threatening individual's self-esteem and self-efficacy, stigma thwarts the growth and potential of individuals and families suffering from mental illness (Lacko et al. 2014; Sartorious, 2011) observed that stigma extends to health institutions, health care workers and even mental health specialists who provide treatment. One result is that "stigma makes community and health decision-makers see people with mental illness with low regard, resulting in reluctance to invest resources into mental health care (Adebowale, 2010). Numerous empirical and narrative accounts look at the negative impact of stigma on help-seeking behavior, self-esteem and discrimination (Gikonyo, 2009; Evans-Lacko et al. 2012; Francis, 2008). Specifically, stigma had been found to contribute to discrimination from others and internalized negative self-perceptions in form of self-stigma, both which make people avoid treatment and hide their symptoms. Particular beliefs about the cause of mental illness included the entire family, who may also suffer stigma, prompting them to hide their family member's illness. Also, some investigators have criticized some traditional treatment approaches that are harmful and perpetuate stigma, including chaining, whipping, and burning patients (Deribew & Tamirat, 2011).

Stigma in the form of social distancing had been observed when people are unwilling to associate with a person with mental illness. This might include not allowing the person to provide child care or declining the offer of a date (Livingston & Boyd 2010). Self or internalized stigma is a process in which people with mental health problems turn the stereotype about mental illness adopted by the public towards themselves. They assume they will be rejected socially and so believe they are not valued (Ndetei et al. 2010). Being discriminated against has a huge impact on self-esteem and confidence. This increased isolation from society and reinforced feelings of exclusion and social withdrawal. Mehta et al. (2010) observed that people with mental health problems were frequently the object of ridicule or derision and were depicted within the media as being violent, impulsive and incompetent. The Queensland Alliance for mental health (2010) agree that the myth surrounding violence had not been dispelled, despite evidence to the contrary. In light of this, the department of health (2004) funded a program called shift, which aimed to

reduce the discrimination that those with mental health problems say are the biggest barrier to getting back on their feet is not the symptoms of illness but the perception and attitudes of other people (Gureje et al. 2005). Stigma can be deeply hurtful and isolating and be one of the most significant encounters by people with mental problems (Mehta et al. 2009). Learning to live with mental health problems is made more difficult when someone experiences the prejudice caused by stigma. Gureje et al. (2005) further stated that stigma against people with mental illness can contribute to negative outcomes, as well as perpetuate self-stigmatization and contribute to low self-esteem. Stigma interferes with the rights of people affected and hinders them from participating fully in the community, because they live in difficult situation of rejection and exclusion. Rush et al. (2011) were of the opinion that in many circumstances, people suffering from mental illness have no opportunities of having adequate housing, loans, health insurance, marrying and getting employment or get involved in decision-making.

In addition to the economic burden associated with mental health problems in society, there are significant social and personal costs incurred. People with health problems consistently identify stigma, discrimination and social exclusion as major barriers to their health, well-being and quality of life. Stigma can indeed contribute to limiting access to housing and employment; damaging social relationships and social participation. It has also been suggested by De Vos et al. (2008) that stigma actually reduces self-esteem and dignity. It may also lead to lack of control and influence in how services are designed and delivered, and this resulted in abuse of human rights (De Vos et al. 2008).

Even though previous studies have addressed mental health triggers, early warning systems and mental health management experience, the information on the coping strategies to the same risks has been scanty (Gikonyo, 2009). Lauber (2013) reported that there was an urgent need for support activities for such families at national level in order to curb the huge economic and social burden of care giving and counselling which should be an integral part of rehabilitation for such families.

Amnesty International Ireland recently conducted research in 2011 and 2012 respectively, into the experience of discrimination as reported by people with mental health problems. Nearly everyone who participated in the study (95.4%) reported some level of unfair treatment as a result of a mental health problem. Based on studies conducted in North America and West Europe, (Kabir et al. 2014; Clement et al. 2010). Corrigan, 2011 &Gureje et al. 2005 argued that stigmatization was a major problem in the community. Approximately 40% of the people with mental illness in South Africa had said they did not socialize with other members of the community because negative stereotypes kept them isolated (Norman et al. 2008). Alonso, (2015); Angermeyer, (2009) stated that another common misconception about people with mental illness was that they cannot live independently, let alone make a significant contribution to the community.

Throughout history, however, people with serious mental illness have contributed enormously in terms of politics, culture, academic life, athletics, business, art and science. People with mental illness have been leaders and visionaries, both enriching and expounding our knowledge and understanding in every area (Kabir et al. 2009). Recent studies on mental health literacy in Australia have shown that the public are not well informed about mental illness. It was thus important that the level of mental health literacy in the community be improved, in order for individuals to recognize mental illness and take responsible measures; and informed actions (Cohen &Struening, 2013). Across cultures, knowledge about causes of mental illness varies and has never been very favorable worldwide (Highet et al. 2014; Fisher &Goldway, 2013). This has been acknowledged by the World Health Organization that has called for greater education of the public and greater openness by families of those suffering from mental disorders (Issa et al. 2008). According to Lauber (2003), misconception from a religious perspective about mental illness included that it was caused by sin or the deliberate breaking of Gods commandments indeed resulted in such behaviors that are frightening to others and do not conform with the 'norms' of society. In a survey of 1,596 Japanese it was found that the most frequently cited causes were problems in interpersonal relationships (Stuart, 2008). Similarly, in a survey of South Africa 55%, Afrikaans speaking 83% stated that schizophrenia was caused by psycho-social stress such as difficulties in work or family relationships or life stressful events, whilst only 42.5% thought it was a medical disorder (Hugo et al. 2003).

Writing on mentally/mental illness in Latin America Rush et al. (2011) argued that given their lifestyle and the difficulties in accessing medical services including their inability to pay for such services and malnutrition from their dependence on left-over food from restaurants, food stalls or garbage bins (Thornicroft, 2008). Over the next 50 years, mental illness is likely to become more common or intense in many areas, especially with the unemployment and food inflation rates or in zones currently experiencing drug-abuse infiltration (Patel, 2010). There exists a knowledge gap about the association between mental illness beliefs and stigma on the mentally ill on both facilitation of information and health seeking behavior. The study therefore, sought to assess how the effects of stigma affected the mentally ill in Bungoma County Kenya. It further determined the coping mechanisms towards the mentally ill with an aim of providing sustainable solutions to the out breaks of emergency-induced mental health problems in the area. The objective of the study was to evaluate the social treatment of the mentally ill by the community in Bungoma county.

2. Methods

The study was conducted in Bungoma county and ethics approval was obtained from Masinde Muliro University of Science and Technology ethics board, National commission for science and technology. No further approval was needed since the project did not require access to patients or personal data.

Research Design

The study designs adopted for this study was descriptive cross-sectional and evaluation because they employ quantitative approaches, where self-administered questionnaires were used for data collection. This particular design was ideal since the research entailed collecting and comparing data from the phenomena at the same time of study (Basavanthappa, 2011). A descriptive research design determines and reports the way things are (Mugenda&Mugenda, 2008). Polit&Hungler (2010) observed that a descriptive research design was used when data was collected to describe persons, organizations, settings or phenomena. The purpose of the design was to gather data at a particular point in time with the intention of describing the nature of the existing conditions (Burns and Grove, 2011). Descriptive study design was also ideal as the study was carried out in a limited geographical scope and hence it was logistically easier and simpler to conduct considering the limitations of this study (Mugenda&Mugenda, 2008). It helped make judgments about values or worth of developing mental health campaigns and other rehabilitation programs like half-way home centers for the mentally ill (Wisner *et al*. 2014). Therefore, the descriptive survey was deemed the best strategy to fulfill the objectives of this study.

Study setting

The study was carried out in Bungoma County, Kenya. Bungoma town is the Headquarter of Bungoma County and the third largest County in Western Kenya (Maphill, 2011). It was the Mount Elgon region in the former larger Western Province and it lies 102 kilometers North West from Kisumu City on an altitude of 4,400ft (1,340 m) (Kenya Mpya, 2013). According to the Government of Kenya Census (2012), it has a population of 1,375,063 (1.38m) and the County covers an area of 2,206.9 km ^{2} (852.1 sq mi). There are 67,358 households within the County (Kombo &Delmo, 2015).

Participants

Mugenda and Mugenda (2008) defined population as all elements (individuals, objects and events) that meet the sample criteria for inclusion in a study. In this study the target population was people who resided in Bungoma County and met the criteria of interest to the researcher (Burns & Grove, 2011). The researcher then randomly sampled the units of the study from the accessible population (Polit&Hungler, 2010). The researcher focused on community households heads aged 18 years and above. The research used a sample size of 398.

Bungoma was purposively selected because of the post-election violence in 2008, 2009 and 2013 in Kenya, which caused closure of most factories and industries, thereby increasing violence related mental illnesses and exacerbating existing ones (Inyanji, 2014). It recorded the highest cases of depression and other mental health disorders (Kenya Red Cross, 2015). Like in the Mt Elgon region, there were a lot of animosity resulting in people torching houses and hacking one another to death (UNHCR, 2012). Five Sub-Counties in Bungoma County were purposively sampled to increase the representation (KDHS, 2008/9). The household's heads were sampled by stratified sampling; the researcher divided the population into strata and drew a predetermined number using simple random sampling. The sample size was determined using Cochran equation (1963): a 10% attrition was added to the sample size making it 422.

Questionnaire

Questionnaires were selected as data collection instruments. A questionnaire is a printed self-report from designed to elicit information that can be obtained through the written responses of subjects. The information obtained through a questionnaire is similar to that obtained by an interview, but questions to have less depth (Denzin, 1970). The instrument comprised of the following sections: In section one, the information that was collected was the demographic characteristics and included age, gender , marital status, education level and religion. In section two, eight questions sought to determine social treatment of the mentally ill by the community (Bloom, 1998).this questions were modified from a validated tool used by (Ng & Chan 2004). The questions were ranked on a 2-point likert scale with the anchors being disagree=0 to agree=1. To increase the validity and reliability of the instruments, the questionnaire was evaluated by experts. Then based on the feedback the final questionnaire was prepared for pre-test. The pretest study was conducted in one sub-county hospital.The reliability of the scale of the 8 items was found to be: Internal consistency = (Cronbach's α = 0.87).Deleting selected items would not increase the alpha.

3. Data Analysis

Data analysis was done using the statistical program for social sciences (SPSS) version 23. Inferential and descriptive statistics were used to analyze data. Descriptive analysis of data was done using the mean, frequencies and percentages. In this study association between the study variables was assessed by a two-tailed probability value of $p<0.05$ for significance. Visual inspection of the data illustrated that missing data appeared to be missing at random. After visual inspection, in order to further examine the pattern of missing data, the researcher evaluated whether the data was missing completely at random (MCAR). The researcher utilized Little's MCAR test (Schlomer*et al*., 2010) which employs a chi-square statistical analysis and assumes the null hypothesis, that missing data is missing completely due to randomness. In this case, failing to reject the null hypothesis indicates that the data was most likely not missing in a random way. For this study, Little's MCAR test results showed that stigma (χ^2 [112] = 15.447, p = .630) was not significant indicating that the variables were missing completely at random, the researcher proceeded to address the missing data. To avoid reducing the variances of the scores by replacing missing items using subscale means, the missing data items were instead imputed using the Expectation- Maximization (EM) algorithm within SPSS 23; EM is considered a superior method for conducting missing data imputation when one has MCAR data (Schlomer*et al.*, 2010). Their guidelines were considered when reviewing the missing data for the current research study. Each question was coded and entered in SPSS (Barohn et al, 2012). The findings were entered in the variable view of the Statistical Package for Social Sciences (SPSS) version 20.0 screen,

each questionnaire at a time, starting with first to last questionnaire (Cohen, 2011). The researcher conducted analyses of normality, for the outcome variable, prior to hypothesis testing by examining kurtosis and skewness of the data. In order to test and identify possible outliers in the data, graphical assessment visuals, including scatter and box plots were used. Elimination of observed outliers was based on a case by case basis, dependent on standard deviations, and on normality and homogeneity of variance assessments. Normality was assessed using examination of the histograms by seeing how they related or deviate against a normal bell curve distribution and observing the levels of kurtosis and skewness present.

Univariate analysis was used to describe the distribution of each of the variables in the study objective, appropriate descriptive analysis was used to generate frequency distributions, tables and other illustrations used to analyze the social treatment. Bivariate and multivariate analysis was used to investigate the strength of the association and check differences between the outcome variable and other independent variables. The stigma questions were to be indexed for each household head member and an index score was to be computed and was recorded on a new variable. Alpha level for all the computations was considered $p < 0.05$.

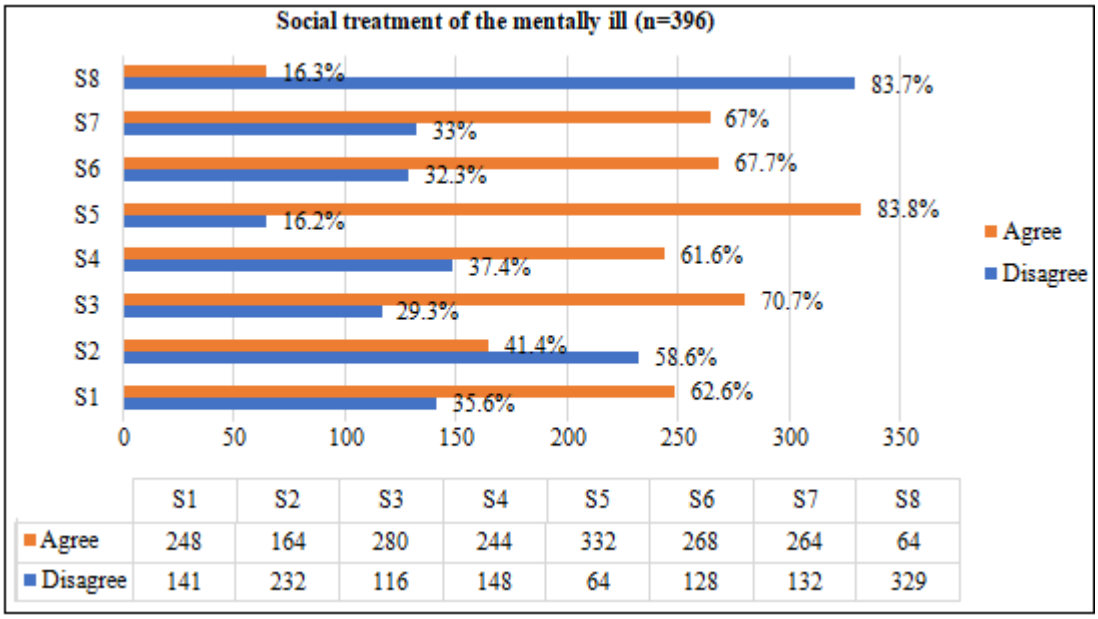
4. Results

Out of the 422 questionnaires distributed, 396 were correctly filled and returned which represented a response rate of 87 percent. According to Mugenda and Mugenda (2003) a response rate of 50 percent is adequate, a response rate of 60 percent is good, and a response rate of 70 percent is very good. Therefore, the 87 percent response rate reported for this study formed an acceptable basis for drawing conclusions. While we should not expect full response in studies where responding is voluntary, scholars utilizing questionnaires should aim for a high response rate (Baruch &Holtom, 2008). Firstly,the study asked the respondents to indicate their background characteristics based on the gender, religion, marital status; age-bracket and education level. The summary of their responses is given in Table 1.

Table 1: Background characteristics of respondents

Demographics		Frequency	Percent
Gender	Male	172	43.4%
	Female	224	56.6%
	Total	**396**	**100.0**
Religion	Christian	220	55.6%
	Muslim	164	41.4%
	Hindu	8	3%
	Total	**396**	**100.0**
Marital Status	Single	148	37.4%
	Married	216	54.5%
	Separated	12	3%
	Divorced	8	2%
	Widowed	12	3%
	Total	**396**	**100.0**
Education level	No education	4	1.0%
	Primary education	220	55.6%
	Secondary education	120	30.3%
	College	28	7.1%
	University	24	6.1%
	Total	**396**	**100.0**
Age Bracket	18-24 years	200	1.0%
	25-34 years	128	55.6%
	35-45 years	48	30.3%
	Over 45 years	16	7.1%
	Total	**396**	**100.0**

Findings in Table 1 revealed that, most 224 (56.6 %) were females while 172 (43.4%) were males. Distribution of age bracket showed that 200 (50.5%) were aged between 18-24 years, 128 (32.3%) were 25-34 years, 48 (12.1%) were 35-45 years, and 16 (4%) were over 45 years. Results on their level of education revealed that 220 (55.6%) had primary school education, 120 (30.3%) had secondary school education, 28 (7.1%) had college education and 4 (1%) had a no education at all. Findings in Table 1 revealed that, majority of the respondents 248 (62.6%) agreed that even after a person with mental illness has been treated, they would still be afraid to be around them. Majority of the respondents 232(58.6%) disagreed that mental patients should not be treated in the same hospital as other patients. Of the 396 respondents, 280 (70.7%) of the respondents agreed that when a spouse is mentally ill the law should allow for other spouse to file a divorce. Of the 396 respondents, 244 (61.6%) of the respondents agreed that mental illness is a punishment for doing some bad things. Results showed that, 244 (61.6%) of the respondents agreed that mental illness is a punishment for doing some bad things. Majority of the respondents 268 (67.7%) agreed that those with mental problems should not tell anyone about their illness. From the results 67% (264) would like mentally ill patients to be isolated. The results also show that 329(83.7%) disagreed that people with mental illness were harmless, this shows that majority of the respondents felt that the mentally ill were harmful. Figure 1 below summarizes the responses on the stigma items.



	S1	S2	S3	S4	S5	S6	S7	S8
Agree	248	164	280	244	332	268	264	64
Disagree	141	232	116	148	64	128	132	329

Figure 1: Social treatment of the mentally ill by the community

Key
S1-Even after a person with mental illness has been treated, I would still be afraid to be around them
S2-Mental patients should not be treated in the same hospital as other patients
S3-When a spouse is mentally ill the law should allow for other spouse to file a divorce
S4-Mental illness is a punishment for doing some bad things
S5-It is easy to identify with those who have mental illness
S6-I suggest that those with mental problem should not tell anyone about their illness
S7-Mentally ill patients should be isolated from the rest of the community
S8-People with mental illness are harmless

Bivariate analysis of social treatment (stigma) and Demographic characteristics
The study also sought to check possible differences in the social treatment amongst the various demographic characteristics. To achieve this one-way ANOVA (more than 3 levels) and independent t-test (two levels) were used, and the results were considered significant at a probability of 0.05.

Differences in social treatment amongst respondents in different age brackets
The ANOVA model showed significant differences amongst the different age groups $F\ (3,372) = 9.403,\ p < 0.05$. The partial eta squared showed that only 7% of the variability in the social treatment could be attributed to the age $\eta^2 = 0.07$.

Differences in social treatment amongst respondents in different religion
The ANOVA model showed no significant differences amongst the different religions $F\ (2,373) = 0.012,\ p = 0.988$. The partial eta squared showed that none of the variability in the social treatment could be attributed to the religion $\eta^2 = 0.00$.

Differences in social treatment amongst respondents with different marital status
The ANOVA model showed significant differences amongst the different marital categories $F\ (4,375) = 8.038,\ p < 0.05$. The partial eta squared showed that only 8% of the variability in the social treatment could be attributed to the marital status $\eta^2 = 0.08$.

Differences in social treatment amongst respondents with different education levels
The ANOVA model showed no significant differences amongst the different education levels $F\ (4,375) = 1.860,\ p > 0.05$. The partial eta squared showed that only 2% of the variability in the social treatment could be attributed to the education levels $\eta^2 = 0.02$.

Differences in social treatment amongst respondents with different gender
The Independent t-test results showed no significant differences between males (M=5.05, SD=1.129) and females (M=4.87, SD=.174) with regards to social treatment of people with mental illness $t\ (378) = 1.492,\ p = 0.137$. The results are as shown in the table below.

Table 2: Summary of bivariate analysis of demographic characteristics and social treatment

Variable	F	Sig	Partial Eta Squared
Age bracket	9.403	0.00	.070
Religion	0.012	0.988	0.00
Marital Status	8.038	0.00	0.79
Education level	1.860	0.117	0.02

5. Discussion

The objective of the study was to find out the social treatment of the mentally ill by the community in Bungoma county. The findings also showed that248 (62.6%) agreed that even after a person with mental illness has been treated, they would still be afraid to be around them. The findings are consistent with findings from a study done by (Watson & Corrigan, 2002) where respondents did not want to

associate with mentally ill patients regardless of treatment. They believed that psychiatric illness was not a disease, but a curse that was caused by witchcraft and evil spirits. Sadok & Sadok, (2007) agreed that communities believed that mental illnesses are caused by spirits and curses, with influences by the moon, or that it is a divine punishment.

Results showed that majority of the respondents 232(58.6%) disagreed that mental patients should not be treated in the same hospital as other patients. The above findings could be attributed to the negative perceptions of the community. A study done by Evans-Lacko *et al.* (2012) established that self or internalized stigma was a process in which people with mental health problems turned the stereotype about mental illness adopted by the public towards themselves.

From the findings 280 (70.7%) of the respondents agreed that when a spouse is mentally ill the law should allow for other spouse to file a divorce. This indicates that the community stigmatizes mentally ill people. A previous study done by (Sangeeta & Mathew, 2017) majority of respondents in all groups considered family burden to be the main effect of mental illness on a family, followed by psychological disturbances. Possible explanations could be due to the fact that there were many superstitious and religious explanations for the causes of mental illness (Girma&Tesfaye, 2011;Kate, Grover, Kulhara& Nehra, 2012).

The findings also revealed that 244 (61.6%) of the respondents agreed that mental illness is a punishment for doing some bad things. The study findings are in agreement with a research carried out by Muga& Jenkins, (2012), Gikonyo, (2009) and Adebowale, (2013). Which revealed that most communities and families perceive it as a punishment from gods for a wrong act committed by a family member. In addition, 332 (83.8%) agreed that it was easy to identify with those who have mental illness. Consistent with a study done by(Sangeeta & Mathew, 2017) where the relatives of an individual with mental illness are more concerned about the associated social stigma. They feel that the illness should remain a private matter for the sake of the family. Often, an individual will not wish to be identified as a relative of a family member with mental illness.This significantly affects treatment and help-seeking behavior.

From the results, 268 (67.7%) agreed that those with mental problems should not tell anyone about their illness. This may increase the fear in the mentally ill patients, especially the young ones still attending school. As noted by Kessler, (2011), stigma and discriminatory attitudes can be worse than the disease itself. Shefer*et al.*, (2012) stated that cognitive and communication impairment may pose a challenge among the mentally ill but not being open about the disease affects them more due to lack of access to assistance. From the results 67% (264) would like mentally ill patients to be isolated. A previous study in Malaysia found that the public believed that psychiatric patients were supernatural cases that were associated with great use of traditional healers and poor compliance with modern medication (Jorm, 2010). Other studies done showed that people fear mentally ill people because the assume that they are drug and alcohol addicts (Benedicto *et al.*, 2016). Inarguably, ignorance and stigma prevent the mentally ill from seeking appropriate help (Kabir*et al.*, 2009). Researchers have often assessed stigma, associated with mental illness, by surveying the community's attitudes and perceptions towards "mental patients", or "persons with mental illness", and in using these terms, evoking images of chronic psychopathology (Corrigan *et al.*, 2011).

Findings also revealed that 329(83.7%) disagreed that people with mental illness were harmless, this shows that majority of the respondents felt that the mentally ill were harmful. Possible explanations could be due to the way media portrays people with mental illness. Trainer & Pierre (2014) stated that movies and television often portray the individual suffering from mental illness as unpredictable and violent. Again, media scripts showed that people with mental illness should be feared, because they have been seen as homicidal maniacs (Trainor & Pierre, 2014).

6. Limitations

Findings from this study are also based on a small, geographical sample and thus, may not represent other populations. Last, due to the nonrandomization of the sample, response bias may also be a limitation. Moreover, there may be selectivity bias such that only those nurses who were interested in the topic of antenatal physical activity agreed to participate in the study.

7. Conclusion& Recommendation

The findings of the study established that there is minimal interaction between the community and people suffering from mental illness. The fact that 67% of the respondents thought that it was shameful to be associated with those with mental illness and that they should be isolated showed how the members of the community want minimal to no contact health with mental problems. 41.4% felt that mental patients should be treated in separate hospitals with other patients while 67% expressed their fear of being around people who have been treated of mental illness. Bivariate analysis showed that there were significant differences in social treatment amongst people of different age brackets. However, there were no significant differences in social treatment amongst people of different education levels. It's evident from the findings that there is minimum interaction between the community and mentally ill people in Bungoma County. The study recommends that sensitization of the community/ public on mental illnesses is important in Bungoma County. Scaling up public awareness campaigns to reach more people by diversifying the approaches targeting specific group of family members having mentally ill persons.

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