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ICON

GENERAL OBJECTIVES:

The students will be able to gain knowledge regarding “CMH” and develop desirable skills and attitude towards the care of client with “CMH” at various settings.

SPECIFIC OBJECTIVES

At the end of the class, student will be able to

- meaning of CMH
- discuss the epidemiological determinants of CMH
- explain the transmission of CMH
- enlist the high risk patients
- describe the criteria for clinical diagnosis
- describe the clinical features and prevention of CMH

- explain the clinical management of CMH
- enumerate the outbreak control measures and nursing care for CMH

S.NO	SPECIFIC OBJECTIVE	TIME	CONTENT	TEACHERS ACTIVITY	LEARNERS ACTIVITY	AV AIDS	EVALUATION
1	meaning of CMH	2	**INTRODUCTION:** There are large number of people with psychiatric problems in the community unidentified or not-acknowledged as mentally ill. The mental health and illness problem in India is such that on one hand. There are large number of patients who are in state mental hospitals not mainly for treatment but for the sake of the rest of the 'sane' population. **DEFINITION:** "The application of knowledge of psychiatric nursing in preventing, promoting and maintaining mental health of the people to help in early diagnosis and care and to rehabilitate the clients after mental illness" - **BimlaKappoor, 2002.** "The process of involving raising the level of mental health among people in	Explaining	Listening	Roller board	What is the meaning of CMH?

2	discuss the	2	community and reducing the number of cases suffering with mental illness." **HISTORICAL DEVELOPMENT OF COMMUNITY MENTAL HEALTH:** The long the mentally ill were considered to be possessed by devils patients were looked up in tall fail-like buildings, for removed from the center's of population, alienated began to make scientific advance the publications of Sigmond Freud led to new concepts in the treatment of the mentally ill. The late 1930s show the introduction of two empirical treatment insulin come therapy and electric shock treatment. Then came the tranquilizers, they made is possible to admit and treat all types of mental illness in the general hospital. The idea that the mental patients can be admitted and treated in a general hospital developed. The current trend is complete integration of the mentally ill patient into the normal pattern of medical care with continuity of care from his family doctor, utilization of the general hospital and community resources.	Explaining	Listening	Bulleti	

	epidemiological determinants of CMH		**CHANGING FOCUS OF CARE:** Before **1840**, there was no known treatment for individuals who were mentally ill because mental illness was perceived as incurable, the only intervention was thought to be removing these ill persons from the community to a place where they would do no harm to themselves or others. In **1841,** Dorothea Dix, a former school teacher, began a personal crusade across the land on behalf of institutionalized mentally ill clients the efforts of this self appointed "inspector" resulted in more humane treatment of the mentally ill and the establishment of a number of hospitals for the mentally ill. After the movement initiated by Dix, the number of hospitals demand soon outgrew the supply, and hospitals become overcrowded and understaffed. The community mental health movement gained impetus in the 1940s with establishment of the National Mental Health			n board	What are all the epidemiological determinants?
3		2	Act of 1946, the U.S government awarded grants to the states to develop mental health	Explaining	Listening	Black board	Explain the transmission of

	explain the transmission of CMH		programs outside of state hospital. Outpatient clinics and psychiatric units in general hospitals were inaugurated then, in 1949, as an outgrowth of the National mental health Act, the National Institute of mental health (NIMH) was established. In **1955**, the Joint commission on mental health and illness was established by congress to identify the nations mental health needs and to made recommendations for improvement in psychiatric care. In 1961, the Joint commission published a report, Action for mental health, in which recommendations were made for treatment of clients with mental illness, training for care givers, and improvements in education and research of mental illness with considerations given to these recommendation congress passed the mental retardation facilities and community mental health centers construction act(often called the community mental health centers act) of 1963.This act called for the construction of comprehensive community health centers the cost of which would be shared by federal and state governments. The				CMH?

			deinstitutionalization movement (the closing of state mental hospitals and discharging of individuals with mental illness) had begin. In **1980** the community mental health system act, which was to have played a major role in renovation of mental health care as established . Funding was authorized for community mental health centers, identification and services to high-rich population and or rape research and services. Approval was also granted for the appointment of an associate director for minority concerns at NIMH. Budget cut reduced the number of mandated services, and ferula funding for community mental health centers was terminated in 1984. In **1983** the systems of delivery of health care was interrupted in 1983 with the advent of prospective payment- the Reagan administration's proposal of cost containment. It was directed at control of Medicare costs by setting forth pre established amounts that would be reimbursed for specific diagnoses, or				

4	enlist the high risk patients	2	diagnostically related groups (DRGs). Since that time, prospective payment has also been integrated by the states (Medicaid) and by some private insurance companies, drastically affecting the amount of reimbursement for health care services. Mental health services have been influenced by prospective payment. General hospital services to psychiatric clients have been severely resented clients who present with acute symptoms such as acute psychosis, suicidal ideations or attempts, or manic exacerbations, constitute the largest segment of the psychiatric hospital census clients with less serious illness[e.g., moderate depression or adjustment disorders] may be hospitalized, but length of stay has been shortened considerably by the reimbursement guidelines. Clients are being discharged from the hospital with a greater need for after care than in the past, when hospital stays were longer. Provision of outpatient mental health services not only is the wave of the future but also has become a necessity today. We must serve the consumer by providing the	Explaining	Listening	Handout	What are the high risk group for CMH

5	describe the criteria for clinical diagnosis	4	essential services rehabilitation or prevention of long-term disability. **PREDOMINANT CHARACTERISTICS OF COMMUNITY PSYCHIATRY:** 1. Responsibility to a population for mental health care delivery. 2. Treatment close to the patient in community based centers. 3. Provision of comprehensive services. 4. Multi-disciplinary team approach. 5. Providing community care. 6. Emphasis on prevention as well as treatment. 7. Avoidance of unnecessary hospitalization. **NATIONAL MENTAL HEALTH PROGRAMME(1982):** Indian is a signatory state to the Alma-Ata declaration, envisaged health for all by the year, 2000 AD. For the provision of mental health care to total population, at a reasonable cost to enhance hereby psychosocial development of the people, mental health services her to results nearly	Explaining	Listening	Power point	What is the clinical manifestation of CMH

			group and to the total population. **Objectives:** ❖ To ensure availability and accessibility of minimum mental health care for all the population, specific to the most of all the population, specific to the most vulnerable and under privileged sections of population in all the geographic areas. ❖ Apply mental health knowledge in general health care and as measure to social development. ❖ To promote community participation. ❖ To stimulate efforts towards self help in the community. ❖ To prevent and to treat psychiatric disorders. ❖ To utilize appropriate mental health technology to improve general health services. ❖ To apply mental health principles for improving				

			quality of life for entire population. **Aims:** ➢ National coordination group will be formed, comprises of representatives from all states, senior health administrators, professionals from relative fields like psychiatry, education, social welfare. ➢ Curriculum of mental health for the health workers. ➢ Non medical professional's physicians at PHC will have a 2 week training program in mental health care. ➢ Creation of a post for psychiatrist at districts he will be visiting PHC settings regularly, supervise and organize mental health training programs and continuing education programs. ➢ Appointment of a programs officer for teaching and supervision. ➢ Provision of additional support for infusion of community mental health components in teaching institutions.				

			➢ Psychotropic drugs will be included in the list of essential drugs in India. **Approaches:** ➢ Integration of mental health care services to the existing general health services. This mental health cadre starts at gross root level. ➢ Specified tasks have to be provided at all levels by providing appropriate task oriented training to the existing health staff. ➢ Equitable distribution of resources to strengthen mental health care. ➢ Integration of basic mental health care into general health services. Induction of basic mental health care is one of the essential functions of primary health care. ➢ Linkage of mental health services with the existing community development program. ➢ Mental health care induces treatment, rehabilitation and prevention. ➢ Mental health training.				

			Components: **1. Workshops:** Workshops were organized to sensitize and motivate the health care professional to implement NMHP as considering the local priorities and resources. **2. Treatment:** Specified treatment plans and diagnostic work will be implemented by personal at all level. The health professionals have been trained up in following areas. Management of psychiatric emergencies through medicines and crisis intervention strategies. Treatment for catatonic psychiatric disorders. Diagnosis and management of grandmal epilepsy, specially in children, treatment of functional psychosis. Liasion with the school teachers and parents in the management of children with mental				

			retardation and behavioral problem. Counseling of addicts,supervision of MPHW's performance of specified mental health tasks. Management of uncomplicated psychosocial problems without use of drug. Epidemiological surveillance of mental morbidity. **3. District hospital:** Medical consultation to the health center's medical officer with regard to management of difficult cases of psychiatric disorders. One psychiatrist will be posted into each district hospital as an integral part of the district health services 30-50 psychiatric beds will be available in district hospital, psychiatrist will provide clinical cadre, training and supervision of non-specialist health workers. **Mental hospital and teaching psychiatric units:** They do the following: • Care of difficult cases. • Teaching. • Specialized facilities like				

6	diagnosis describe the clinical features and prevention of CMH	3	occupational therapy, counseling, psychotherapy and behavioral therapy. **4. Rehabilitation:** * Development of rehabilitation centers both at district level and the high referral centre. * Treatment of epileptics and psychotics at community level. **5. Prevention:** Community based services with limited involvement of health care professionals, medical officers, community leaders and the people will be involved. **6. Mental Retardation:** Counseling of parents, referring the cases utilizing welfare agencies in rehabilitation of services. **7. Research:**	Explaining	Listening	Power point	CMH diagnosis?

			Evaluative research programs will be conducted to determine the outcome of service deliveries and different levels of functioning and on outcome of training programs. After in depth situation analysis and extensive consultations with state authorities. The NMHP underwent radical restructuring to have a balance between various components of mental health cadre delivery system and clearly specified budget allocations. **FIVE YEAR PLANS*:*** **1. Tenth Five year plan (2002-2007):** • DMHP was extended to 200 districts across the country. • Infrastructure support has to be provided psychiatry departments in the hospitals and strengthening of medical college hospitals. • Streamlining and modernization of mental hospitals to reduce chronicity				

			by intensive therapeutic intervention. • Usage of outreach services, promoting care of chronically ill. At their doorsteps by ensuring qualitative mental health services. • Ensure effective co-ordination in all areas of activity. • Sponsoring community based research projects. • Innovative IEC strategies [Information Education and Communication] will be generated through multi disciplinary collaboration. 2. **Eleventh five year Plan [2007-2012]:** • DMHP will be extended to another 200 districts. • Reinforcement of upgrading psychiatric departments with adequate infrastructure. • Construction of modern building with good				

			infrastructure. • Provision of adequate man power for all psychiatry units. Research, training programs have to be organized for qualitative and quantitative improvement. • IEC training programs has to be conducted. **3. Twelth five year plan [2012-2019]:** • DMHP will be extended to remaining 193 districts. • 20 mental hospitals will be taken up for reconstruction. • Non-viable mental hospitals will be closed or merged with general hospitals (GHPU). • Long term community based research projects will be initiated. • IEC activities will be planned to cover all sections of population. **REVISED NATIONAL MENTAL HEALTH PROGRAMME [2003]:**				

			• Redesigning DMHP around a modal institution, a zonal medical college. • Strengthening medical colleges to improve psychiatric treatment facilities with adequate man power. • Stream lining and modernization of mental hospital. • Research and development programs in the field of community mental health and promotes intersectoral collaboration and linkages with other national programs. • Plan for cost effective intervention models. • Health and policy planning. • Provision of comprehensive community based mental health services will be cost effective and respects human rights. • Promotion of referral services. • Provision of essential psychotropic drugs family support. • Home cadre support by provision of sufficient man power. • Crisis interventions, sheltered				

7	explain the clinical	3	employment provision of community care facilities. • Develops self help groups and provision of funds and space for their activities. • Human resource development-short terms training courses will be conducted for professionals and paraprofessionals. • Public mental health education organizations in provision of mental health cadre services at community Government has to support with funds to NGOs and voluntary organizations for provision of services. • Social skills training program, life skill education programs has to be conducted to focus groups like school children's. • At district level, mental health teams has to be posted (one at district hospital level and other at district medical office), to render clinical care and the integration of mental health at	Explaining	Listening	Pamp-hlet	What are the clinical management of CMH?

	management of CMH		peripheral institutions. • Services are focused to special sections of high risk population prone for stressful disorders. **Special Issues in NMHP-2003:** The NMHP will focus special attention on psychiatric problems specific to certain vulnerable sections of the population who are often marginalized and neglected owing to lack of effective advocacy. a) Senior citizen suffering from severely disabling diseases such as Alzheimer's and other types of Dementia, Parkinson's disease, depressions of late onset and other psycho geriatric disorders. b) Victims of child sexual abuse, marital domestic violence, dowry relegated ill treatment and rape. c) Children and adolescents affected by problem of maladjustment or other scholastic problems, depression/psychosis of early onset, attention default hyperactivity disorders and suicidal behaviors resulting from failure in examination				

			or other environmental stressors. d) Victims of poverty, destitution and abandonment such as women thrown out of the marital home or old and infirm parents left alone to seek help for themselves. e) Victims of natural or manmade disasters such as cyclones, earthquakes, famines, war, terrorism and communal/ethnic strike, with special attention to the specific needs of children orphaned by such disasters. The national Mental health policy is aimed at doing the greatest good to the largest number thoughts, fire independent and mutually synergistic strategies, to be implemented in a phased manner over the next two decades. a) Extension of basic mental health care facilities to the primary level. b) Strengthening of psychiatric training in medical colleges at the under graduate as well as postgraduate level. c) Modernization and rationalization of				

			mental hospitals to develop them into tertiary care centers of excellence. d) Empowerment of central and state mental health authorities for effective monitoring, regulation and planning of mental health care delivery systems. e) Promoting research in frontier areas to evolve better and more cost-effective therapeutic interventions as well as to generate seminal inputs for future planning. **COMMUNITY MENTAL HEALTH PROGRAMME:** The community mental health program is faced with the following needs: 1. Heath education of the public related to mental health and mental illness, prevention and care etc. 2. Help in time of crisis and emergences that have a negative influence on mental health, if not helped on time. 3. Identification of potential problems and marked symptoms of mental illness, guidance to go to the				

			appropriate facilities for help when needed. 4. guidance and supervision for those who are being cared at home. 5. Support and guidance to families of the mentally ill. 6. Continuity of care from mental hospitals and psychiatric institutions 7. Rehabilitation of patients who are discharged from mental hospital 8. Timely guidance of children, adolescents, premarital couple, newly married coupled, parents, aged, handicapped and/or physically ill. 9. Continues research to identify the mental health problems in the community, the factors that have negative and positive influence on mental health and possible ways and methods to help people at various stages of mental illness, to meet the above mentioned needs. **MENTAL HEALTH SERVICES IN INDIA:**				

			The current status of mental health services in India can be best understood by reviewing the development of the service in the last few decades. History Before independence, the approach for the care of the mentally ill persons was largely concentrated to build asylums. i. **Bhore committee,[1946]:** In 1946, the Bhore committee presented the situation in regard mental health services as even if the proportion of mental patients be taken as 2 per thousand population in India, hospital accommodation should be available for at least 8lakhs patients as against the existing provision for a little over 10,000 beds for the country as a whole. In India, the existing number of mental hospital beds is in the ration one bed about 40,000 of the population while in England, ii. **Mudaliar health Committee[1962]:** In suggests that "arranging such that ultimately each region, if not each state, becomes self-sufficient in the				

			matter of training it total requirements of mental health personnel. But till now, there are no mental hospitals in Haryana, Himachal Pradesh, Manipur, Meghalaya, Chandigarh, Pondicherry, Lakhshadeep. Andaman and Nicobar Islands, Arunachal Pradesh, Maharashtra has nearly one third of the mental hospital beds. iii. **General Hospital Psychiatric Units [GHPU]:** Though such units for mentally ill persons were started as early as 1933 major spurts came in the1960s. This period also coincides with the building of the last mental hospital in the country. There units provide a big support for the greater acceptance of psychiatric services by the public without fear of social stigma. As of now, there are about 3500 beds under this facility in different parts of the country an extension of these units has been the upcoming of District Hospital Psychiatric Units [DHPU] in at least two states Kerala and Tamil Nadu. About box of the medical colleges at				

8	enumerate the outbreak control measures and nursing care for CMH	2	present have the departments of psychiatry this lag has contributed to the poor undergraduate training in psychiatry. Training of existing personnel for mental health care delivery, with no additional staff. Development of a state level mental health advisory committee and identification of a stage level program officer [preferably a psychiatrist], establishment of regional centers of community mental health [at least 1 during the plan period], formation of national advisory group on mental health. Development of a task force for mental hospitals, prevention and promotion of mental health. Mental health training of atleast 1 doctor at every district hospital during the next 5 years. Establishment of a department of psychiatry in all medical colleges and strengthening the existing ones. Provision of at least 3 to 4 essential psychotropic drugs in adequate quantity at the PHC level. An important example of the district mental health program is at	Explaining	Listening		

			Bellary district Karnataka (about 320 km from Bangalore) **V. Mental Health Manpower and Training facilities;** • **Psychiatrist:** In 1955, Diploma in psychological mendicant (DPM) was started. At present about 35 centers provided training for DPM and MD courses. It is estimated that over 150 psychiatrist quality annually and currents there are about 2,500 to 3,000 psychiatrists in the country. • **Clinical psychologists:** Training of clinical psychologists in available at Rachi, Bihar, Bangalore. The annual capacity training is about a dozen. About 400 – 500 clinical psychologists are working in the country. • **Psychiatric social workers:** Training a psychiatric social workers is currently going on only at Bangalore and annually a doze processionals are trained.				

			• **Psychiatric Nurses:** Training is available both at Bangalore and Ranchi which offer a diploma course of 10 months. Both at Chandigarh and Delhi a two year course in psychiatric Nursing is available the total number of psychiatric nurses in the country is estimated to be 500. • **PHC Personnel:** These are trained at Bangalore, Chandigarh, Baroda,Calcutta, Hyderabad, Lucknow, Jaipur, Partiala, Delhi and Vellore. • **General Duty Medical officers (GDMO):** The psychiatrists are trained at Bangalore, to farther train the GDMO. **THE PUBLIC HEALTH MODEL:** Though public health has traditionally focussed on physical health, the public health model is well suited to address the broad concepts of mental health and mental illness. Public health is distinguished from				

			medical care in that is does not focus on diagnosis and treatment of the individual the field is primarily interested in the health of the population as a whole. The surgeon general describes the public health model as "characterized by concern from the health of a population in its entirety and by awareness of the linkage between health and physical and psychosocial environment." The model's Foci include epidemiologic surveillance of the whole populations health. Health promotion, disease prevention, and evaluation of the availability and quality of health services. The World Health Organization(WHO) describes the public health model as one that works through the organized efforts of society, which means public health interventions tend to be population based rather than targeted at specific individuals. Public health policy often relies on the social ecological model as a frame work for a multi level approach. This model recognizes complex links between individual health and the health of a population. An				

			intervention aimed at changing behavior or health outcomes for the individual only is less likely to be successful than an intervention that changes the family, community, and society to support individual change. **Social ecological model:** The social ecological model is often depicted as five levels that can be addressed to influence the health of individuals and their communities. The five levels are individual, interpersonal, organizational, community, and society. An intervention works on an individual level when it works to change the beliefs, attitudes, or behaviors of individual. It works on an interpersonal level when it works to change beliefs, attitudes, and behaviors interpersonal groups, such as families, groups of friends, and dubs. It operates on an organizational level when it influences organizations by changing the cultures or practices at schools, places of employment, places of worship, community groups, or sports teams. It works on a community level when				

			is works to change health policy of local government or improve the space, facilities, food supply or other community elements relevant to the target of the intervention. Intervention works at the society level when it changes public policy on a level larger than a community level, this may induce introducing new legislation or changing school policies statewide. As society level intervention could also be a large media campaign or other large scale program. Simultaneously addressing all levels of the model is important because individual change is much more possible and more likely to be sustainable if many levels of society change to support individual **The Social – Ecological mode:** Pointing out that a public health model could be applied to mental health does not necessarily mean that public health agencies should spearhead the work spending for public health agencies has declined been as public health has been presented with a growing number of challenges.				

			Public health agencies are also involved in general public health activities, such as conducting community health assessments, that have implications for mental health (assessment tools like the healthy youth survey cited below can be used to identify community risk and protective factors). One intervention for young children that will be discussed later is nurse home visiting programs for families. In many counties, local public health already provides this service, and local public health officials ranked this kind of program high on the list of services they would like to provide if public health received additional state funding. **CASE MANAGEMENT:** Case management is the co-ordination of community services for mental health patents by allocating a professional to be responsible for the assessment of need and implementation of care plans. It is usually most appropriate for people who, as a result of a serious mental illness, have ongoing support needs in areas such as housing,				

			employment, social relationships and community participation. In particular service were with a major psychotic disorder are most often suited to receiving services with this model. The underlying tasks of case management induced: ❖ Assessment of need ❖ Care planning ❖ Implementation ❖ Regular view The case management model developed in the USA in response to the closure of large psychiatric hospitals [known as deinstitutionalization] and initially following a brokage model, where processionals arranged for the provisions of services, without the need for direct patient care or contact clinical or therapeutic care management then developed as the need for the mental professional to establish a therapeutic relationship and be actively involved in clinical care was recognized. A more intensive form of case management [assertive community treatment or intensive care management] was also developed for				

			patients with more severe illness who needed a more assertive approach. **Managed care:** Managed care is concept designed to control the balance between cost and quality of client care. In a managed care program individuals receive health care based on need, as assessed by coordinates of the provider manage care exists in many settings, inducing (but not limited to) ❖ Insurance-based programs ❖ Employer –based medical provider programs ❖ Social service programs ❖ The public health sector Managed care may exist in virtually any setting in which health care provision is a part of the services that is in any setting in which an organization [whether to be private or government based] is responsible for payment of health care services for a group of people. Examples of managed care are health maintenance organizations [HMOS] and preferred provider organizations [PPOS]. Case management is the method used				

			to achieve managed care. It is the co-ordination of services required to meet the needs of the client. The case management society of America [CMSA] defines care management as "a collaborative process which assesses plans, implements, coordinates, monitors and evaluates options and services to meet and individual's health need through communication and available resources to promote quality cost-effective out comer" (CMSA, 2002). Types of clients who benefit from case management include [but are not limited to]: ❖ The frail elderly ❖ Those who are developmentally disabled ❖ Those who are physically handicapped ❖ Those who are mentally handicapped ❖ Individuals with long-term medically complex problems that require multifaceted costly care [e.g., high risk infants, persons with human immunodeficiency virus or AIDS, and transplant patients].				

			❖ Individuals who are severely compromised by an acute episode of illness or an acute exacerbation of a chronic illness [e.g. Schizophrenia]. The case manger is responsible for negotiating with multiple health care providers to obtain a variety of services for the client. The very nature of nursing that incorporates knowledge about the biological, psychological, and socio cultural aspects related to human functioning makes nurses highly appropriate as care manages. The American Nurses credentialing center [ANCC] now offers national certification by exam for nursing care management. The applicant must hold a current license as a registered nurse with a baccalaureate degree, associate degree, or diploma in nursing. In addition he or she meet have functioned as a nursing care manager for a minimum 2,000 hours of practice within the last 2 years some cadre management programs prefer populations for who the care management service will be rendered. Case management is becoming a recommended method of treatment for				

			infinitudes with a chronic mental illness. This type of care enhances functioning by increasing the individuals ability to solve problems, improving work and socialization skills, promoting leisure time activities, and endeavoring to diminish dependency on others. **THE COMMUNITY AS CLIENT:** **1. Primary Prevention** Primary prevention targets both individuals and the environment emphasis is twofold: • Assisting individuals to increase their ability to cope effectively with stress • Targeting and diminishing harmful forces (stressors) within the environment Nursing in primary prevention is forced on the targeting of groups at risks and the provision of educational programs examples include: 1. Teaching parenting skills and child development to prospective new parents. 2. Teaching physical and				

			psychosocial effects of alcohol/drugs to elementary, school students. 3. Teaching techniques of stress management to virtually anyone who desires learn. 4. Teaching groups of individuals ways to cope with the changes associated with various maturational stages. 5. Teaching concepts of mental health to various groups within the community. 6. Providing education and support to unemployed or homeless individuals. 7. Providing education and support to other individuals in various transitional periods [e.g., widows and widower, new retires and women entering the work force in middle life] There are only a few examples of the types of services nurses provide in primary prevention. These services can be offered in a variety of settings that are convenient of				

			the public [e.g., churches, schools, colleges, community centers, YMCAs and YMCAs, work place of employee organization, meetings of women's groups, or civic or social organizations such as PTAs, health fairs, and community shelters]nurses provide in primary prevention. **Populations at risk:** One way to view populations at risk is to focus on types of crises that individuals experience in their lives two broad categories are maturational crisis and situational crisis. **a)Maturational crisis:** Maturational crises are crucial experiences that are associated with various stages of growth and development. Erickson [1963] described eight stages of the life cycle during which individuals struggle with developmental "tasks" crisis can occur during any of these stages, although several developments periods and life cycle events have been recognized as having increased crisis potential. ➢ Adolescence				

			➢ Marriage ➢ Parenthood ➢ Midlife ➢ Retirement • **Adolescence** The task for adolescence according to Erikson (1963) is identity versus role confusion. This is the when individuals ask questions such as "who am I ? " where can I going"? and " what is life all about?" Nursing interventions with adolescents at the primary level of prevention focus on providing adolescents with support and accurate information to care the difficult transition they are undergoing. Educational offerings can be presented in schools, churches, youth centers, or any location in which groups of teenagers gather. **Types of programs may include:** ❖ Alateen groups for adolescents with alcoholic parents ❖ Other support groups for teenagers				

			who are in need of assistance to cope with stressful situations. ❖ Educational programs that inform about and validate bodily changes and emotional feelings about which there may be some concerns. ❖ Educational programs that informs about the use and abuse of alcohol and other drugs. • **Marriage** The "American Dream" of the 1950s especially that of the American woman was to marry have two or three children, buy a house in the suburbs, ad drive a station wagon to not be at least betrothed by their mid 20s caused many women to ear becoming an "old mailed". Nursing interventions at the primary level of prevention with individuals in this stage of development involve education regarding what to expect at various stages in the marriage many high schools now offer courses in marriage and family situations nurses should offer these kind of classes within				

			the community to individuals considering marriage. Too many people enter marriage with the nation that, as sure as the depth of their love, their soon to be husband or wife will discontinue his or her "undesirable" traits and change into the perceived ideal spouse primary prevention with these individuals involves: i. Encouraging honest communication ii. Determining what each person expects from the relationship iii. Ascertaining whether or not each individual can accept compromise This type of intervention can be effective individual or couples therapy and in support or educational groups of couples experiencing similar circlets stances. • **Parenthood** There is probably no development stage that creates an upheaval equal to that of the arrival of a child. Even when the child is desperately wanted and pleasurable anticipated his or her arrival				

			usually results in some degree of ciaos within the family system. Nursing intervention at the primary level of prevention with the developmental stage of parenthood must begin long before the child is even born how do we prepare individuals for parenthood. Anticipatory guidance is the term used to describe the interventions used to help new parents know what they might expect volumes have been written on the subject but is also important for expect client parents to have a support person or network with whom they can talk, express feelings, excitement, and fears nurse can provide the following type of information help. Care the transition into parenthood. 1. Prepared childhood classes:what most likely will happen but with additional information about possible variations from that which is expected. 2. information about what to expect after the baby arrives a) parent- infant bonding: Expectant parents should know that it is not				

			unusual for parent infant bonding not to occur immediately. The strong attachment will occur as parent and infant get to know each other. b) Changing husband-wife relationships: The couple should be encouraged to engage in open honest communication and role playing of typical situations that are likely to arise after the baby becomes a part of the family. c) Clothing and equipment : Expectant parents need to know what is required to care for a new born child. Family economics, space available and lifestyle should be considered. d) Feeding : Advantages and disadvantages of breast feeding and formula feeding should be presented. The couple should be supported whatever method is chosen. Anticipatory guidance related to technique should be provided or one or both methods,				

			as the expectant parents request. e) Other expectations:It is important for expectant parents to receive anticipatory guidance about the infants sleeping and crying patterns, bathing the infant, care of circumcision and cord, toys that provide stimulation of the newborn senses, aspects of providing a safe environment, and when to call the physician. 3. Stages of growth and development. It is very important for parents to understand what behaviors should be expected at what behaviors should be expected at what stage of development. It is also important to know that their child may not necessarily follow the age guidelines associated with there stages. However, a substantial deviation from these guidelines should be reported to their physician. • **Midlife:** Midlife crises are not defined by a specific number various sources in the				

			literature identify these conflicts as occurring anytime between age 35 and 65. What is a midlife crisis? This too is very individual, but a number of patterns have been identified within three broad categories. **1. An alteration in perception of the self:** One's perception of self may occur slowly one may suddenly become aware of being "old" or "middle aged". Other biological changes that occur naturally with the aging process may also impact on the crises that occur at this time. In women, a gradual decrease in the production of estrogen initiates the menopause, which results in a variety of physical and emotional symptoms. Some physical symptoms include: hot flasher, vaginal dryness, cessation of menstruation, loss of reproductive ability, night sweats, insomnia, headaches and minor memory disturbances, emotional symptoms				

			include anxiety, depression, crying for no reason and temper outbursts. Although the menopausal period in men is not as evident as it is in women, most clinicians subscribe to the belief that men undergo a climacteric experience redetect to the gradual descries in production of testosterone. Although sperm production diminishes with advancing age, there is usually no complete cessation, as there is of ovum production in women at menopause some men experience hot flashes, sweating chills, dizziness and heart palpitation, where others may experience severs depression and an overall decline in physical vigor. An alteration in sexual functioning is not uncommon. **2. An alteration in perception of others:** A change in relationship with adult children requires is sensitive shift in caring. There experiences are				

			particularly difficult when parents values conflict with the relationship and types of lifestyles their children choose. An alteration in perception of one's parents also begins to occur during this time having always looked to parents for support and comfort, the middle – aged individual may suddenly find that the roles are beginning to reverse. Aging parents any look to their children for assistance with making decisions regarding their everyday lives and or assistance with chores that they have previously accomplished independently when parents due, middle aged individuals must come to terms with their own mortality. The process of recognition and resolution of one's own finitude begins in earnest at this time. **3. An alteration in perception of time** Middle age has been defined as the end of youth and the beginning of old age individuals often				

			experience a sense that time is running out " in haven 't'" don't all I went to do or accomplished all I intended to accomplish depression and a sense of loss may occur as individuals realize that some of the goals established in their youth may go unmet. The "empty nest syndrome" has been identified as the adjustment period parents experience when the last child leaves home to establish an independent residence. The crisis is often more profound for the mother who has devoted her life no nurturing her family. As the last child leaves, she may perceive her future as uncertain and meaningless. Nursing intervention as the primary level of prevention with the developmental stage of midlife involves providing accurate information regarding changes that occur during this time of life and support for adapting to these changes effectively these interventions might include:				

			1. Nutrition classes to inform individuals in this age group about the essentials of client and exercise. Educational materials on how to avoid obesity or reduce weight can be included along with the importance of good nation. 2. Assistance with ways to improve health[e.g., quit smoking, cease or reduce alcohol consumption, reduce for intake] 3. Dispersions of the importance of having regular physical examinations, including pap and breast examinations or women and prostate examinations or men monthly breast self examinations should be taught and yearly mammograms encouraged. 4. Classes on menopause should be given provide information about what to expect my this that bound regarding this topic should be expelled support groups for women (and men) undergoing the menopausal experience should be				

			formed. 5. Support and information related to physical changes occurring in the body during this time of life. Assist with the grief response that some individuals will experience in relation to loss of youth "empty nest" and sense of identity. 6. Support and information related to care of aging parents should be given Individuals should be referred to community resources for respite and assistance before strain of the caregiver role threatens to disrupt the family system. • **Retirement** Retirement, which is often anticipated as an achievement in principle, may be met with a great deal of ambivalence when it actually occurs. Nursing intervention at the primary level of prevention with the development task of retirement involves providing information and support to individuals who have retired				

			orconsidering retirement support can be on a one to one basis. These individuals to short out their feelings regarding retirement support can also be provided in a group environment support groups of individuals undergoing the same types of experiences can be extremely helpful nurses can form and lead these types of groups ;to assist retiring individuals through this critical period. These groups can also serve to provide information about available resources that offer assistance to individuals in or nearing retirement, such as information concerning Medicare, social security and Medicaid, information related to organizations that specialize in hiring retires, and information regarding ways to use newly acquired free time constructively. **b) Situational crisis:** Situational crises are acute responses that occur as a result of an externalcircumstantial stressor. The number and types of situational				

			stressorsare limitless and may be real or exist only in the perception of the individual. Some types of situational crises that put individuals at risk for mental illness include the following. ➢ Poverty ➢ High rate of life change events ➢ Environmental conditions ➢ Trauma • **Poverty:** A number of studies have identified poverty as a direct correlation to emotional illness. This may have to do with the direct consequences of poverty such as inadequate and crowded living conditions, nutritional deficiencies, medical neglect, unemployment, or being homeless. • **High rate of life change events:** Miller andRahe (1997) found that frequent changes in life patterns due to a large number of significant events occurring in close proximity tend to decrease a person's ability to deal with stress, and physical or emotional illness may be the result. These include life				

			change events such as death of a loved one, divorce, fired from a job, change in living conditions, change in place of employment or residence, physical illness or change in body image as a result of loss of a body part or function. • **Environmental conditions:** Environmental conditions can create situational crises. Tornados, foods, hurricanes and earthquakes have wreaked devastation on thousands of individuals and families in recent years. • **Trauma:** Individuals who have encountered traumatic experiences must be considered at risk or emotional illness. These include traumatic experiences usually considered outside the range of usual human experience, such as participating in military combat, being a victim of violent personal assault, undergoing torture being taken hostage or kidnapped, or begin the victim of a natural or manmade disaster [APA, 2000]. **Interventions for nursing of clients**				

			in crisis include the following: 1. Use a reality – oriented approach. The focus of the problem is on the here and now. 2. Remain with the individual who is experiencing panic anxiety. 3. Establish a rapid working relationship by showing unconditional acceptance, by active listening, and by attending to immediate needs. 4. Discourage lengthy explanations or rationalizations of the situation, promote an atmosphere for verbalization of true feelings. 5. Set – firm limits on aggressive, destructivebehaviors. At height level of anxiety, behavior is likely to be impulsive and regressive establish at the outset what is acceptable and what is acceptable and what is not, and maintain consistency.				

			6. Clarify the problem that the individual is fours. 7. Help the individual determine what he or she believes predicated the crisis. 8. Acknowledge feelings of anger guilt helplessness, and powerlessness, while taking care not to provide positive feedback for these feelings. 9. Guide the individual through a problem solving process 10. Identify external support systems and new social net works fromwhom the individual may seek assistance in times of stress. **2. Secondary Prevention:** Secondary prevention is accomplished through early identification of problems and prompt initiation of effective treatment nursing in secondary prevention focuses on recognition of symptoms and provision of, or referral or treatment. **Population at Risk:**				

			➢ Maturational crisis ➢ Situational crisis **a)Maturational Crisis:** *** Adolescence:** Nursing intervention with the adolescent at the secondary level of prevention may occur in the community setting at community mental health centers, physicians officer, schools, public health departments and crisis intervention centers nurses may work with the families to problem solve and improve coping and communication skills, or they any work one to one basis with the adolescent in an attempt to modify behavior patterns marriage. Nursing intervention at the secondary level of prevention with individuals encountering marriage problems may include on or more of the following:				

			1. Counseling with the couple or with one of the spouses one one-to-one basis 2. Referral to a couples support group 3. Identification of the problem and possible solutions, support and guidance as changes are undertaken. 4. Referral to a sex therapist 5. Referral to a financial advisor 6. Referral to parent effectiveness training • **Parenthood:** Intervention at the secondary level of prevention with parents can be required for a number of reasons. A few of these include: 1. Physical, emotional, or sexual abuse of a child. 2. Physical or emotional neglect				

			of a child 3. Birth of a child with special needs 4. Diagnosis of a terminal illness in a child 5. Death of a child Nursing intervention with parents may include teaching effective methods of disciplining children, aside from physical punishment methods the emphasize the importance of positive reinforcement for acceptable behavior can be very effective family members must be committed to consistent use of this behavior modification technique for it to be successful. • **Midlife:** Nursing care at the secondary level of prevention during midlife becomes necessary when the individual's unable to integrate all of the changes that are occurring during this period. An inability to accept the physical and biological changes, the changes in relationships between				

			them sales and their adult children and aging parents, and the loss of the perception of youth may result in depression for which the individual may require help to resolve. • **Retirement:** Nursing intervention at the secondary level of prevention with depressed individuals takes place in both inpatient and outpatient settings severely depressed clients with suicidal ideations will need close observation in the hospital setting, whereas the with mild to moderate depression may be treated in the community a nursing care plan for the client with depression. These concepts apply to the secondary level of prevention and may be used in all nursing care settings. **b)Situational crisis:** Nursing care at the secondary level of prevention with clients undergoing situational crisis occurs only if crisis intervention at the primary level failed and the individual is unable to function socially				

			or occupationally exacerbation of mental illness symptoms requires intervention at the secondary level of prevention. **3.Tertiary Prevention:** Nursing in tertiary prevention focuses on helping clients learn or relearns, socially appropriate behaviors so that they may achieve a satisfying role within the community. **The Chronically mentally ill:** **Historical and Epidemiological Aspects:** In 1955, more than half a million individual resided in public mental hospitals more recent statistics indicate that approximately 100,000 mentally ill persons inhabit these institutions on a long-term basis. Deinstitutionalization of persons with chronic mental illness began in the 1060s as national policy change and with a strong belief in the individuals right to freedom other considerations included the deplorable conditions of some asylums the introduction of neuroleptic medications, and the cost				

			effectiveness of caring for these individuals in the community setting. **Treatment Alternatives:** **Community mental Health centers:** The goal of community mental health centers in caring for the chronically mentally ill is to improve coping ability and prevent exacerbation of acute symptoms. A major obstacle in meeting this goal has been the lack of advocacy or sponsorship for clients who require services from a variety of sources. This has placed responsibility for health care on a mentally ill individual who is often barely able to cope with everyday life care management has become a recommended method of treatment with a chronic mental illness. Bower (1992) identified five core components and nursing role functions that blend with the steps of the nursing process to form a frame work for nursing case management. The care components include: • **Interaction**: The nurse must develop a trusting relationship with the client, family members and other service providers.				

			• **Assessment:** **Establishment of a Database:** The nurse conducts a comprehensive assessment of the client's physical health states functional capacity, mental status personal and community support systems, financial resources and environmental conditions. • **Planning:** A service care plan is devised with client participation. The plan should include mutually agreed on goals, specific actions directed toward goal achievement and selection of essential resources and services through collaboration among health care professional, the client and the family or significant others. • **Implementation:** In this phase, the client requires the needed services from the appropriate providers. In some instances the nursing care manager is also a provider if care, whereas in others, he or she is only the co-coordinator of care.				

			• **Evaluation:** The case manager continuously monitors and evaluates the clients responses to interventions and protocols toward pre-established goals. **Assertive community Treatment (ACT)** NAMI (2003) identifies the primary goals of ACT as follows: ❖ To lessen or eliminate the debilitating symptoms of mental illness each individual client experiences. ❖ To minimize or prevent recurrent acute episodes of the illness. ❖ To meet basic needs and enhance quality of life. ❖ To improve functioning in adult social and employment roles. ❖ To enhance an individual's ability to live independently in his or her own community. ❖ To lessen the family's burden of providing care. **Day/Evening Treatment/Partial**				

			hospitalization programs: Day or evening treatment programs (also called partial hospitalization) are designed to prevent institution or to care the transition from inpatient hospitalization to community living various types of treatment are offered many include therapeutic community (milieu) activities and occupational therapy many programs offer medication administration and monitoring as part of their care. Some programs have established medication clinics for individuals on long –term psychopharmacological therapy. These clinics may include educational classes and support groups for individuals with similar conditions and treatments. Partial hospitalization programs generally offer a comprehensive treatment plan formulated by an interdisciplinary team of psychiatrists, psychologists, nurses, occupational and recreational therapists and social workers nurses take a leading role in the administration of partial hospitalization programs. **Community Residential facilities:**				

			Community residential facilities for persons with chronic mental illness are know by many names group homes, halfway houses, foster homes, boarding homes, sheltered care facilities, transitional having independent living programs, social-rehabilitation residences and others. These facilities defer by the purpose for which they exist and the activities that they offer. Some of these facilities provide food shelter, housekeeping and minimal supervision and assistance with activities of daily living others may also include a variety of therapies **The Homeless Population:** **Historical and Epidemiological Aspects:** In 1992, Dr. Richard lamb, a recognized expert in the field of severe and persistent mental illness wrote. **Mental illness wrote:** Alec Guinners, in his memorable role as a British Army colonel in Bridge on the River Kwai, exclaims at the end of the film when be finally realizes he has been working to help the enemy ‘what have I done? As a vocal advocate and spokesman for				

			deinstitutionalization and community treatment of severely mentally ill patients foe well over two decades I often find myself asking that same question. Two methods of counting the homeless are commonly used. The point-in time method attempts to count all the people who are literally homeless on a given day or during a given week. The second method (called period prevalence) counts examines the number of people who are homeless over a given period of time. This second method may result in a more accurate count because the pretended time period would allow for inducing the people who are homeless on day (or week) but find employment and affordable housing later, removing them from the homeless count. At the same time during this extended period others would lose housing and become homeless.. **Mobile outreach units:** Mobile outreach units provide assistance to homeless individuals who are in need by physical or psychological care. The emphasis of outreach programs is to accommodate the homeless who refuse to				

			seek treatment statement elsewhere most target the mentally ill segment of the population. **Community Based Rehabilitation:** "A strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities." "CBR is a strategy for enhancing the quality of life of disabled people by improving services delivery, by providing more equitable opportunities and by promoting and protecting their human right." [**E –Helander**] **ROLE OF NURSE IN COMMUNITY MENTAL HEALTH:** The Nursing practice standard reflects the values of nursing professionals, prescribes the responsibilities of nurse, provides direction for implementation of services related to care or clinical practice. Based on state laver, the standards or clinical nursing practice varies.				

			a. Liasion Role: Nurses will be connecting links, bridges the gaps between clients and family members, with family health care professionals, between community welfare agencies or resources, and families, thus acts as a supporting system for clients and their families. **b. Consultant role:** Advises family and other community resources about the level of support and care required for a specific group. **c. Practitioner or clinician role:** Renders direct nursing care to the clients within community nurses has to accept the clients as they assists the client to develop coping abilities that promote psychological functioning nurses will identify that client with behavioral deviations, refer then immediately assist for therapeutic care, follow up care and continuity of services nurses should not give any false reassurance and false promises to the clients. They should not criticize or hurt inner feelings, of the client, nurses have to direct the clients and their family members.				

			The ways to attack the problems or dealing with the problems case management, counseling, psychobiological interventions, milieus therapy, enhancement of quality of life modification of life style, etc are components in nurse practitioner role. Adopts nursing process to solve the client's problems and meet their needs in order to obtain positive outcomes. 1. Students enrichment programs with the help of teaches will be conducted, where the study habits tips for success. The way of communication and writing exams, answering viva and role of emotional factors in study measures to raise students self-esteem etc, will be discussed. 2. Arranges vocational training for chronically mentally at clients with the help of voluntary agencies and self help groups. 3. Anganwadi workers and teachers were trained, to provide basic mental health care to the children and to identify the children with behavioraldeviation				

			4. Educates parents about the importance of good child rearing practices [psychosocial aspects] for enhancing. Childs growth and development 5. Training of primary care workers (from local community) in provision of basic mental health care. **d. Counselor role:** Counsels the family members and help them in meeting the client's needs at home and reduces the social stigma assonated with the motivates the community to provide support to the families, mobilizes the community agencies and its resources for welfare of mentally ill and provision of needed services. **e. Nurse educator role:** Organizes community awareness campaigns specific focus to vulnerable groups on health promotion and health maintenance and community action teaching the community on the manifestations of illness, importance of early diagnosis, so that they will be able to observe and refer the cases immediately.				

			f. Coordinator Role: Psychiatric care is based on multidisciplinary team approach and the nurse has to coordinate between all team members, follows the therapeutic team members, advices and implements necessary care related activities informs to the team members whatever observations made, which may help for planning the therapeutic activities care findings, screening, follow-up, continuity of services and referral, etc **g. Therapeutic Role:** Plan and assists psychotherapeutic activities for improvement in the clients condition, encourages family members to utilize outdoor services in OPDs. **h. Domiciliary care:** Community mental health nurses visits the houses and assess the health status, coping strategies utilized by the family members psychological functioning of individuals supportive systems, family coping index, etc and plans, implements necessary care at their doorsteps. Treating minor complaints, physiotherapeutic sessions, counseling activities to improve the				

			services within the community. **i.Social skills Training:** To develop effective interaction and communication abilities social skills training will be given, e.g., withdrawal cafes in dead diction centers for recovering addicts, e.g., coping skills, interpersonal skills etc. Teachers relaxation exercise to the community. **j. Other Services :** • Assertiveness training will be given to improve self-confidence • Provision of care for the people in all age groups carry out community outreach services • Provide crisis intervention services **THE PSYCHIATRIC/ MENTAL HEALTH NURSE:**				

			Definition: A registered Nurse (RN) who is educationally prepared in nursing and licensed to practice in his or her individual state (ANA,2000). **Education:** Baccalaureate degree in Nursing (BSN), has worked in the field of psychiatric / mental health nursing for a minimum of 2 years, and demonstrates competency in the skills of psychiatric mental health nursing (ANA,2000) **Additional credentialing:** In addition to professional licensure by the state, psychiatric/mental health RNs may apply to sit for ANA examinations that certify their as basic level psychiatric / mental health nurse. **Employment setting:** Inpatient psychiatric hospital unit, day treatment and partial hospitalization programs, community health centers, home health care, long – term care centers. **Processional responsibilities:** Health promotion and health maintenance, intake screening and				

			evaluation, care management, provision of a therapeutic environment [e.g., milieu therapy], promotion of self care activities administering and monitoring psychobiological treatment regiment [including prescribed psychopharmacological agents and their effects], health teaching, crisis intervention, counseling complementary interventions, and psychiatric rehabilitation [ANA, 2000]. **THE PSYCHIATRIC/ MENTAL HEALTH ADVANCED PRACTICE REGISTERED NURSE:** **Definition:** A licensed RN who is educationally prepared either as a clinical nurse specialist or a nurse practitioner at least at the master's degree level in the specialty of psychiatric/ mental health nursing (ANA, 2000). **Education:** Minimum of a master's degree in psychiatric and mental health nursing. This preparation is distinguished by a depth of				

			knowledge of theory and practice, validated experience in clinical practice, validated experience in clinical practice, and competence in advance clinical nursing stall (ANA, 2000) **Additional credentialing:** Master's or doctorate-prepared nurse may sit for ANA examinations that certify them as a psychiatric/mental health clinical nurse specialist or nurse practitioner. In addition some states have special licensure that may be granted to nurses with advanced education that permits them to practice at a more independent level [Advanced practice Registered Nurse APRN] and that make them eligible for prescriptive authority, in patient admission privileges, third-partly reimbursement, and other specific privileges (ANA, 2000) **Employment settings:** In patient psychiatric hospital units, day treatment and partial hospitalization programs, community mental health centers, private mental health facilities, individual private practices, crisis intervention services, or in the capacity of mental health				

			consultant, supervisor, educator, administrator, or researcher. **Professional responsibilities:** In addition to those required at the basic RN level, the RN in advanced psychiatric/mental health nursing practice must demonstrate knowledge and expertise related to psychopharmacological intervention, complementary interventions, complementary intervention, varicose forms of psychotherapy, community interventions various forms of psychotherapy, community interventions, care management, consultation liaison, clinical supervision, and expanded advocacy activities (ANA, 2000). **JOURNAL ABSTRACT:** Three models of community mental health services in low economic countries. The three programs discussed here all began operations in the period 2004-2006 when CBM piloted a number of community mental health programs in order to assess their feasibility and effectiveness when carried out as components of community				

			based rehabilitation projects in LIC. A non-governmental organization with a focus on care for persons with mental disorders. **CONCLUSION:** Community mental health psychiatric nursing is the application of specialized knowledge to populations and communities to promote and maintain mental health, and to rehabilitate populations at risk that continue to have residual effects of mental illness.				

BIBLIOGRAPY:

BIBLIOGRAPHY

- Park. K Preventive and social medicine,4th edition ,Branarsidarbanot,Jobalpur, 1995, pg. 135-148
- Basavanthappa B.T(2001) Community health nursing , 1st edition Jaypee, Newdelhi,pg351-357
- Potter. Perry. (2000) "Basic Nursing Essentials for Practice". Mosby Elsevier publication, fifth edition, volume 1st. southasia.
- NanjundaGowda S.N. (2011) "Basic principles and Practice of Nursing" J.N publication, 1st edition. (India)
- Neelamkumari. (2011) Community health nursing II 1st edition Vikas and company Jalandhar city, 3rd edition. pg 360
- S.kamalam, essentials in community health nursing practice, 2nd edition, jaypee brothers publication, india, pg no:418- 421

NET REFERENCE:

- www. Slideshare . com
- https://du.ac.in>sol
- https://www. Scribed. Com
- Server, firefighters. org
- https://www.tnmcnair.com