

**Mental Health**  
**An Indian Perspective**  
**1946-2003**



# **Mental Health**

## **An Indian Perspective**

### **1946–2003**

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## Preface

**M**ental disorders have profound implications on the health and well-being not only of individuals but also of families and entire communities. The resultant emotional distress affects the ability to cope with stress as well as productivity. Other negative implications include alcohol and substance abuse, delinquent behaviour and impaired quality of life. Inappropriate risk-taking behaviour patterns contribute to major public health problems such as HIV/AIDS and road accidents. In this context, the projected rise in the proportion of the global burden of disease attributable to mental/neurological disorders and substance abuse from 11.5% in 1998 to 15.5% by the year 2020 is a cause for concern. Increasing suicide/attempted suicide rates, comprising 1.6% of the global burden in 1998, add yet another disturbing dimension to this somber scenario. What causes even greater worry is the high incidence of suicide in Kerala, the most literate state in the country with a high quality of life rating. This highlights the complexity of the problem. The need for renewed vigour in the provision of community-based mental healthcare services is thus self-evident.

India was perhaps the first country in the world, and certainly the first among developing countries to recognise the need to integrate mental health services with general health services at the primary care level. The National Mental Health Programme (NMHP), launched in 1982, aimed at the treatment of mental disorders within the community, using the existing primary health centre and community health centre staff who were given special training for this purpose. Unfortunately, however, the subsequent progress in the implementation of this programme was not satisfactory. In May 2001, several months before the tragedy at Erwady, a small town in the Ramanathapuram district of Tamil Nadu, where 26 mental patients who had been kept chained in a religious asylum were burnt to death, drew national attention to the plight of the mentally ill, a small group was constituted in the Directorate General of Health Services to analyse the causes of this under-performance and to suggest corrective measures. In order to generate baseline data in respect of mental health laws and services, detailed questionnaires were sent to all state governments, but the response was poor. Later, consequent upon the directions issued by the Hon'ble Supreme Court in CWP 334 of 2001, the same format was used to collect the required information. In the meanwhile the NMHP underwent a complete review and reorientation. From a one-dimensional programme, virtually synonymous with the district mental health programme, the restructured NMHP became a comprehensive mental healthcare delivery system, with an outlay of Rs 190 crore (US \$ 42 million) for the 10<sup>th</sup> Five Year Plan. This represents a quantum jump over the 9<sup>th</sup> Plan allocation of Rs 28 crore (US \$ 6 million). Formally launched on 22 Oct 2003, the programme is expected to cover nearly two hundred districts across the country. Medical college departments of psychiatry will be strengthened to improve undergraduate as well as postgraduate training. Mental hospitals are to be modernised and streamlined to provide community oriented tertiary care of a high standard. Destigmatisation of mental illness through information, education and communication activities will be a major thrust area in this national programme. Relevant research to study the demographic and longitudinal profile of mental morbidity is expected to

provide the necessary inputs for refining the system and for future planning. The availability of psychotropic drugs at reasonable cost has been ensured by our robust and innovative pharmaceutical industry and we hope to weather the fallout of globalisation and the new trade environment without any major hardships to our people.

As we embark on this ambitious journey, it might do well to pause, introspect and take stock. The present book is a sincere attempt in this regard. It aims to provide a platform for a wide spectrum of views on various aspects of the subject, primarily from a public health perspective. The authors have been accorded full freedom in this regard and the views expressed herein do not reflect government policy. In an area as complex as this, there are bound to be differences in opinion. This does not, however, dilute our commitment to the common aim: doing the greatest good to the largest number. I have no doubt that this book will constitute a landmark in the chronicles of mental health in India.

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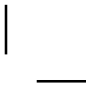
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**Section I**  
**An Overview**

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# Chapter 1

## Mental Health 2003: The Indian Scene

*D. S. Goel • S. P. Agarwal • R. L. Ichhpujani • S. Shrivastava*

“It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the seasons of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to Heaven, we were all going direct the other way—in short, the period was so far like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only”.

*Charles Dickens: A Tale of Two Cities*

**I**t all began with a fire. Given the context of the tragedy at Erwady, one is tempted to use this rather melodramatic beginning. The rhetoric could be, in fact, carried further. The asylum fire in the Ramanathapuram district of Tamil Nadu was a ‘disaster waiting to happen’. Such vacuous platitudes mean little in a scenario where every cinema hall, every public building and every wedding *shamiana* is a potential fire-trap and where any public gathering could culminate in panic, stampede and mass fatalities. The knee-jerk reaction to these almost routine incidents is an administrative or judicial inquisition, which nearly always comes out with predictable prescriptions. Improved infrastructure, built-in safeguards and penal action against the violators of the law are ritually recommended. Erwady has been no different and the judicial enquiry commission appointed by the Tamil Nadu Government to probe the tragedy has, among other things, recommended the setting up of five mental hospitals in the state, including one ‘exclusively for women’. Earlier, in its order dated 12 April 2002 in CWP No. 334 of 2001 (Appendix H), the Hon’ble Supreme Court had, interalia, directed the central government thus:

4. (a) To frame a Policy and initiate steps for establishment of at least one Central Government run Mental Health Hospital in each state (As provided under Section 5 of the Act);
5. All State Governments are also directed to frame Policy and initiate steps for establishment of at least one State Government run Mental Health Hospital in each State. It is clarified that a Mental Health Hospital as stated above means a full-fledged Hospital catering only to mentally challenged persons and does not include a separate psychiatric ward in a Medical College or Government Hospital.

In this context, three salient facts need to be highlighted. A psychiatrist was posted at the Ramanathapuram District Hospital when the fire at Erwady killed 26 mental patients. The *dargah* asylum was not a charitable or free facility: families of patients were paying a monthly charge of Rs 1,500 or more. Also, most of the inmates of the asylum were not intractable psychotics: a majority of the survivors subsequently recovered rapidly after undergoing suitable psychiatric treatment at the Institute of Mental Health, Chennai. Of these, two were ex-servicemen, in receipt of defence pensions, who could have obtained free out-patient treatment at the nearby military psychiatric centres. It follows, therefore, that the non-availability of mental health services or penury is not the main driver of such atrocious forms of alternative care. Stigma and superstition associated with mental disorders, coupled with the unwillingness or inability of families to care for their mentally ill relatives, appear to be the main contributory factors. Support for this view accrues from an analysis of the demographic profile of India's mental hospital population wherein nearly half are long-stay patients. Most of these patients continue to vegetate in a dehumanised asylum environment, not on account of clinical considerations, but because they have been abandoned by their families, many of whom had given fictitious addresses at the time of the initial admission, thereby betraying their intentions *ab initio*. Yet, we continue to prescribe the creation of new mental hospitals as the panacea for all ills. This pernicious philosophy will result in the culpable waste of scarce resources, which can be better utilised to create therapeutically rational as well as more cost-effective community-based mental healthcare services. While it costs Rs 500 per day to keep a patient in a mental hospital, the per capita national expenditure on health is only Rs 200 per year. Gujarat spends more (Rs 37.2 million) on its four mental hospitals (total bed strength = 680) than on the five government medical colleges (Rs 34.6 million) which cater to the health needs of a much larger population. Considerable damage has been already done. The impoverished state of Bihar, which had neither implemented the Mental Health Act (MHA) Rules till the Hon'ble Supreme Court passed the order dated 12 April 2002 nor implemented a single District Mental Health Programme (DMHP), suddenly designated a defunct/derelict leprosy sanatorium as a mental hospital in the manner prescribed by the apex court. Given the past track record, there is little doubt about the eventual product: a centre not of excellence but of maladministration, maltreatment of patients and human rights abuse, yet another convenient dumping ground for unwanted mental patients. We are rushing in where the angels fear to tread. According to the World Health Report 2001:

“The failures of asylums are evidenced by repeated cases of ill-treatment to patients, geographical and professional isolation of the institutions and their staff, weak reporting and accounting procedures, bad management, ineffective administration, poorly targeted financial resources, lack of staff training, inadequate inspection and quality assurance procedures. Also, the living conditions in psychiatric hospitals throughout the world are poor, leading to human rights violations and chronicity. In terms of absolute standards, it could be argued that conditions in hospitals in developed countries are better than living standards in many developing countries. However, in terms of relative standards – comparing hospital standards with general community standards in a particular country – it is fair to say that the conditions in all psychiatric hospitals are poor. Some examples have been documented of human rights abuse in psychiatric hospitals.

In contrast, community care is about the empowerment of people with mental and behavioural disorders. In practice, community care implies the development of a wide range

of services within local settings. This process, which has not yet begun in many regions and countries, aims to ensure that some of the protective functions of the asylums are fully provided in the community, and the negative aspects of the institutions are not perpetuated. Care in the community, as an approach, means:

- services which are close to home, including general hospital care for acute admissions, and long-term residential facilities in the community;
- interventions related to disabilities as well as symptoms;
- treatment and care specific to the diagnosis and needs of each individual;
- a wide range of services which address the needs of people with mental and behavioural disorders;
- services which are coordinated between mental health professionals and community agencies;
- ambulatory rather than static services, including those which can offer home treatment;
- partnership with carers and meeting their needs;
- legislation to support the above aspects of care.

The accumulating evidence of the inadequacies of the psychiatric hospital, coupled with the appearance of “institutionalism” – the development of disabilities as a consequence of social isolation and institutional care in remote asylums – led to the de-institutionalisation movement. While de-institutionalisation is an important part of mental healthcare reform, it is not synonymous with de-hospitalisation. De-institutionalisation is a complex process leading to the implementation of a solid network of community alternatives. Closing mental hospitals without community alternatives is as dangerous as creating community alternatives without closing mental hospitals. Both have to occur at the same time, in a well-coordinated incremental way. A sound de-institutionalisation process has three essential components:

- prevention of inappropriate mental hospital admissions through the provision of community facilities;
- discharge to the community of long-term institutional patients who have received adequate preparation;
- establishment and maintenance of community support systems for non-institutionalised patients.

Reflecting the paradigm shift from hospital to community, far-reaching policy changes have been introduced in a number of countries. For example, Law 180, enacted in Italy in 1978, closing down all mental hospitals, formalised and accelerated a pre-existing trend in the care of the mentally ill. The major provisions of the Italian law state that no new patients are to be admitted to the large state hospitals nor should there be any readmissions. No new psychiatric hospitals are to be built. Psychiatric wards in general hospitals are not to exceed 15 beds and must be affiliated to community mental healthcare centres. Community-based facilities, staffed by existing mental health personnel, are responsible for a specified catchment area. Law 180 has had an impact far beyond Italian Jurisdiction”.

## The Base Line

For these reasons, all over the world, mental hospitals are being closed down and the focus has decisively shifted to community-based care, which was also the basis of the National Mental Health Programme (NMHP) that was launched in India in 1982 with high expectations. For various reasons, however, the subsequent progress was rather tardy and at present, DMHP is under implementation in only 25 districts, spread across 20 states/Union Territories (UTs) (Table 1.1).

**Table 1.1: Implementation of District Mental Health Programme**

State	District	Nodal Institution
Andhra Pradesh	Medak	Institute of Mental Health, Hyderabad
	Vizianagaram	Government Hospital for Mental Care, Vizianagaram
Assam	Nagaon & Goalpara	Guwahati Medical College
Rajasthan	Sikar	SMS Medical College, Jaipur
Arunachal Pradesh	Naharlagun	Government Hospital, Naharlagun
Haryana	Kurukshetra	Pt. B.D. Sharma PGIMS, Rohtak
Himachal Pradesh	Bilaspur	I.G. Medical College, Shimla
Punjab	Mukstar	Medical College, Amritsar
Madhya Pradesh	Shivpuri	Manasik Arogyashala, Gwalior
Maharashtra	Raigad	Institute of Mental Health, Pune
Uttar Pradesh	Kanpur	King George's Medical College, Lucknow
Kerala	Thiruvananthapuram	Mental Health Centre, Thiruvananthapuram
	Thrissur (1999-2000)	Mental Health Centre, Thrissur
West Bengal	Bankura	State Mental Health Authority
Gujarat	Navsari (Kutch & Surendranagar yet to be funded)	Civil Hospital, Navsari
Goa	South Goa	Director of Health Services
Daman & Diu (UT)	Daman & Diu	Chief Medical Officer
Mizoram	Aizawl	District Hospital, Aizawl
Chandigarh	-	District Hospital
Manipur	Imphal East	State Mental Health Authority
Tamil Nadu	Trichy, Ramanathapuram and Madurai	Institute of Mental Health, Chennai
Delhi	Chhattarpur	Institute of Human Behaviour & Allied Sciences, Delhi

It was in the above context that a small group was constituted in the Directorate General of Health Services in May 2001, to undertake a Current Situation Analysis (CSA) and to evolve a comprehensive plan of action (PoA) to energise the NMHP. An exhaustive questionnaire to elicit the relevant information with regard to the current state of mental health-related activities (including conditions in the 37 state-run mental hospitals) in all states/UTs was prepared and presented at the meeting of the Central Mental Health Authority (CMHA) held in June 2001. This questionnaire was subsequently sent to all state/UT governments but, unfortunately, their response was poor. These efforts received a massive boost in the wake of the Hon'ble Supreme Court orders dated 15 October 2002, which empowered the central government to obtain the necessary information from the states. The same procedure was followed again and the questionnaire was forwarded to all the states/UTs. This was supplemented by on-the-spot inspections carried out between November 2001 and January 2002, by specially constituted teams under the authority of the Government of India Order dated 5 November 2001.

Thus, for the first time, a massive database was built up in respect of mental health laws and services across the country. The picture which emerges is not a happy one. The 1987 Act and the State Mental Health Rules 1990 appear to have made little impact on the ground realities. None of the parties involved can be absolved of having abdicated their responsibilities in this regard. The disinterest/apathy of mental health professionals is equalled by the torpor of the executive, which appears content to abdicate its responsibility to the judiciary. The intervention of the Hon'ble Supreme Court in CWP No. 334 of 2001, virtually forcing the state governments to enforce strictly the licensing and regulatory provisions relating to private psychiatric clinics and nursing homes, led to a panic reaction from private sector psychiatrists, who protested strongly against being at the receiving end of what they termed as a reincarnation of the 'license-permit raj'. The factual position in early 2002 is depicted in Table 1.2.

**Table 1.2: The State of the Nation: Mental Health Laws and Services**

State/UT	Status of the Mental Health Act 1987	Status of the State Mental Health Authority	Status of State Mental Health Rules	Number of District Mental Health Programmes under implementation	Whether visitors appointed and inspections conducted	Any adverse comments from the National Human Rights Commission
i	ii	iii	iv	v	vi	vii
Andaman & Nicobar Islands	Implemented	Constituted (vide order dated 7 May 1993)	Not framed	Nil	Yes	Nil
Andhra Pradesh	Implemented w.e.f. 1 April 1993	Constituted (vide order dated 14 May 1996)	Not known	Two districts	Yes	Nil
Arunachal Pradesh	Not implemented	Not constituted	Not framed	Nil	No	Nil
Chhattisgarh	Not implemented	Not constituted	Not framed	Nil	No	Nil

*To be Continued...*



Table 1.2 Continued...

i	ii	iii	iv	v	vi	vii
Goa	Implemented w.e.f. 1 July 1995	Constituted w.e.f. 1 July 1995	Rules framed	One district	Yes	Nil
Karnataka	Implemented w.e.f. 24 May 1994	Constituted (vide Order dated 24 May 1994)	Not known	One district	Yes	Nil
Maharashtra	Implemented w.e.f. 11 September 1995	Constituted (vide Order dated 11 September 1995)	Not known	Six districts	Yes	Yes
Meghalaya	Implemented w.e.f. 13 March 1993	Constituted w.e.f. 13 March 1993	Not known	Nil	Yes	Nil
Manipur	Implemented w.e.f. 6 June 1996	Constituted w.e.f. 6 June 1996	Rules framed	One (Imphal East) district	Yes	Nil
Nagaland	Implemented w.e.f. 13 June 1994	Constituted w.e.f. 10 March 1999	Not known	Nil	No	Nil
Orissa	Not implemented	Not constituted	Not framed	Nil	No	Nil
Rajasthan	Implemented w.e.f. February 1995	Constituted (vide Order dated 18 February 1999)	Not known	One district	Yes	Nil
Sikkim	Implemented w.e.f. April 1993	Constituted (vide notification dated 5 August 1999)	State is in the process of framing the rules	One district	No	Nil
Tripura	Implemented w.e.f. 20 November 1993	Constituted 26 November 1993	Not known	Nil	No	Nil
Uttaranchal	Not implemented	Not constituted	Not framed	Nil	No	Nil
Assam	Implemented w.e.f. 1 April 1993	Constituted w.e.f. 18 October 1994	Rules framed	Two districts (Nagaon & Goalpara)	Yes	Nil
Bihar	Not implemented	Not constituted	Not framed	Nil	No	Nil
Chandigarh	Implemented w.e.f. 22 April 1997	Constituted w.e.f. 21 August 2001	Rules framed	Nil	No	Nil
Delhi	Implemented w.e.f. 3 June 1994	Constituted w.e.f. 26 October 1995	Rules framed	One district	Yes	Nil

To be Continued...

Table 1.2 Continued...

i	ii	iii	iv	v	vi	vii
Gujarat	Implemented w.e.f. 12 May 1993	Constituted w.e.f. 12 May 1993	Rules framed	Two districts	Yes	Nil
Haryana	Implemented w.e.f. 1 April 1993	Constituted w.e.f. 20 May 1994	Not framed	One district	No	Nil
Himachal Pradesh	Implemented w.e.f. 22 May 1996	Constituted w.e.f. 22 May 1996	Not framed	One district	Yes	Nil
Jharkhand	Implemented	Constituted w.e.f. 22 December 2001	Not framed	Nil	No	Yes
Kerala	Implemented w.e.f. 1 November 1993	Constituted w.e.f. 1 November 1993	Not framed	Two districts	Yes	Yes
Madhya Pradesh	Implemented w.e.f. 1 April 1994	Constituted	Rules framed	One district	Yes	Yes
Mizoram	Implemented w.e.f. 1998	Constituted w.e.f. 14 June 1999	Rules framed	One district	No	Nil
Punjab	Implemented w.e.f. 9 August 1994	Constituted w.e.f. 1 December 1999	Not framed	One district	Yes	Not known
Tamil Nadu	Implemented w.e.f. 1994	Constituted w.e.f. 1 August 1994	Rules framed	One district	Yes	Yes
Uttar Pradesh	Implemented w.e.f. 15 March 1996	Constituted w.e.f. 15 March 1996	Not framed	One district	Nil	Not known
West Bengal	Implemented w.e.f. 17 March 1993	Constituted w.e.f. 17 March 1993	Not framed	One district	Yes	Nil

The survey of 37 mental hospitals conducted between November 2001 and January 2002 revealed an even more dismal picture, despite the monumental National Human Rights Commission (NHRC) initiative in the preceding decade (Table 1.3). Aside from poor infrastructure, the most glaring deficiencies are in the area of qualified staff. Some mental hospitals do not have even a single psychiatrist on their permanent roster. The level of motivation is generally unsatisfactory, and becomes worse as one goes lower down in the hierarchy. The 'warder' mindset and nomenclature still prevails and the approach continues to be custodial. There are, however, islands of hope in this sea of despair. The small district town of Ratnagiri, situated on the picturesque Konkan coast, is a shining example of what a sense of commitment and missionary zeal on the part of a young psychiatrist can achieve in a traditional mental hospital located in buildings over a hundred years old. The patient-friendly environment and harmonious integration into the community are examples worth emulating. Ratnagiri should become a place of pilgrimage for all mental health professionals, particularly those working in mental hospitals.

**Table 1.3: Mental Hospitals: Still a Long Way to Go**

S. No.	Facility evaluated	Adequate		Inadequate	
		Number	Percentage	Number	Percentage
1.	Infrastructure	12	32.4	25	67.6
2.	Staff	10	27.0	27	73
3.	Clinical services including investigations	16	43.2	21	56.8
4.	Availability of drugs and other treatment modalities	28	75.7	9	24.3
5.	Quality of food/ kitchen facility	23	62.2	14	37.8
6.	Availability of linen/ patient clothing	15	40.5	22	59.5
7.	Recreational facilities	18	48.6	19	51.4
8.	Vocational/ rehabilitation facilities	14	37.8	23	62.2

The qualitative inferences drawn from the survey merit equal, if not greater, attention. While the details are covered elsewhere, three aspects need to be highlighted here. Conventional antipsychotics should be phased out and replaced with new generation drugs, such as risperidone, which are not only more patient-friendly but are also more cost-effective. Great scope for improvement exists in the quality of food – the way it is served, the availability of even basic linen and the pitiable condition of sanitary annexes in many places. The third and probably the most important area of darkness is the lingering custodial atmosphere in most mental hospitals. This can be traced directly to one common malady: the high proportion (up to 50% or more) of long-stay patients. The most unfortunate aspect of this problem, as highlighted earlier, is that these patients have been in hospital for years, not because of treatment-related reasons, but because their families have abandoned them. Prolonged hospitalisation has further impaired their socio-vocational skills and rendered them virtually non-persons. A possible strategy to address this mega problem is outlined below.

### ***Primary prevention***

The advent of newer antipsychotic drugs has rendered hospitalisation virtually redundant, in all except a few cases. A vast majority of patients, including those suffering from acute psychotic illness or severe depression, can be safely and swiftly treated at home with oral medication. In fact, admission to hospital is counterproductive, as it tends to alienate the patient from his or her family and impair his or her social skills. On the other hand, involvement of the family in acute care at home reinforces intra-family bonding and improves morale/motivation, as relations see the rapid and often dramatic improvement in the patient's condition. It is, therefore, recommended that:

- Hospitalisation of the mentally ill should be avoided as far as possible, and where it becomes inevitable, the patient should be admitted to a General Hospital Psychiatric Unit (GHPU) rather than to a mental hospital, where de-socialisation is an almost inescapable hazard.

- If owing to unavoidable circumstances the patient has to be admitted to a mental hospital, the family should be asked to stay on to look after the patient. This can be done by reorganising some of the hospital wards as family stay wards, as has been done in the Institute of Mental Health, Chennai. The hospital stay should not exceed 30 days, which is more than adequate to treat the acute phase. Follow-up treatment can be continued as out-patients within the community.
- In order to operationalise the above strategy, it is essential that no new mental hospitals or exclusive psychiatric institutes should be established, as these involve huge expenditure without any commensurate benefits to the community. A more rational and cost-effective utilisation of our limited resources will be to establish GHPUs in all medical colleges/district hospitals, and to implement the DMHP in a progressively increasing number of districts in order to take psychiatric out-patient care to the community at its doorstep. This will automatically address the twin/interrelated problems of chronicity and abandonment by the families.

### ***Secondary prevention***

Addressing the problem of existing long-stay patients in state mental hospitals will involve the intensive treatment of such patients to render them fit for discharge, returning them to their families wherever possible and exploring other options for their relocation within the community where family support is not available. In this context, the following are recommended:

- Intensive therapeutic efforts, using newer antipsychotic drugs such as risperidone and olanzapine to relieve chronic psychotic patients and make them fit for rehabilitation within the community through appropriate psychological interventions. Such patients could return to the community under the proposed 'supervised domiciliary aftercare programme.
- Concurrent efforts to contact the relatives of long-stay patients with the help of the district administration of the patients' home-district and persuading them to accept their patient back into the family in view of his/her improved condition, and the assurance of continued domiciliary aftercare as outlined above. The possibility of reimbursing the family for the time/effort spent in caregiving in case of partially recovered cases may be considered.
- Pending the return of such patients to their families, or where the families are not immediately willing to accept them, they can be transferred to the district/sub-divisional hospital near their home-town and maintenance therapy can be continued under the supervision of the Physician/Medical Officer (MO). The district administration/hospital authorities will also make efforts to ensure that the patients' families visit them in hospital to see for themselves their current condition and help them to re-establish family bonds. A social worker may be designated to work with the family and motivate them to re-integrate the patient within the family. Where this fails, alternative options may be explored, including the 'adoption' of such patients by suitable Non-Governmental Organisations (NGOs) whose credentials have been verified.

### ***Tertiary prevention***

As a last resort, when all efforts to rehabilitate the patient within the family/community have failed, the option of transferring such abandoned patients to half-way/quarter-way homes may

be considered. A detailed scheme in this regard (including budgeting) has been prepared by the Ministry of Social Justice and Empowerment under their Umbrella Scheme, and the Planning Commission has accepted the same. It is recommended that this scheme may be considered for implementation initially on a trial basis, at ten selected sites across the country through suitable (NGOs). It is the authors' view that governmental agencies should not get involved in actual day-to-day running of such half-way/quarter-way homes, though technical supervision and monitoring of the project may be entrusted jointly to field officers of the Ministry of Social Justice and Empowerment and the Ministry of Health and Family Welfare. This programme can be integrated with the DMHP.

The proposed supervised domiciliary aftercare programme referred to earlier is briefly outlined below.

### ***Supervised domiciliary aftercare programme***

#### *Target population*

Patients relocated to their families after treatment at mental hospitals/GHPUs.

#### *Aim*

To treat patients as in-patients/out-patients in hospital during the acute phase of their illness and thereafter to ensure variable term follow-up/maintenance treatment at home under supervision.

#### *Methodology*

The patient will be registered at the nearest out-patient psychiatric facility and will receive medicines for a fortnight/month/three months at a time during out-patient visits. In the interim period, the patient will be visited at home once a week/fortnight by a social worker who will confirm that medication is being taken as prescribed and will also offer basic counselling to the patient/family. In the event of the social worker finding that the patient is not taking the medication regularly or that there has been a deterioration in the individual's condition, then she/he will arrange for the patient to visit the psychiatric OPD at the earliest.

#### *Personnel required*

Social workers with orientation training in psychiatry or psychiatric social workers, if available. Each social worker can be assigned a case load of up to 100-150 patients and visits will be planned as per a formal roster.

#### *Intersectoral linkages*

The programme can be integrated with the DMHP where operational, or with other health programmes. The social worker will be supervised by the programme officer concerned.

#### *Incentives*

For those living below the poverty line, suitable financial incentives can be provided to compensate the family for the loss of the earning capacity of the patient and/or for the time spent by the family caregivers in looking after the patient. This benefit could be extended to lower middle-income level families also, subject to the availability of resources.

#### *Advantages*

1. Simple programme without a complex/expensive infrastructure.

2. Economical: no capital costs or recurring expenditure.
3. No dislocation of the patient from his family/societal context, strengthening of intra-family bonding.
4. Can be integrated with other national programmes such as the district components (DMHP) of the NMHP.
5. Will not result in creating yet another form of institutionalisation, from which it may be difficult to relocate the patient back into his/her family.

### ***Mapping of mental health resources***

Armed with the authority of the Hon'ble Supreme Court's Order dated 12 April 2002, detailed information relating to mental health resources on the ground was elicited from all states/UTs between May and July 2002. The analysed data (Table 1.4) indicate severe manpower shortages in all categories of mental health personnel, but are more pronounced among clinical psychologists, psychiatric social workers and psychiatric nurses. Equally glaring is the uneven distribution of these scarce resources, with over 90% of the districts in Arunachal Pradesh being without any psychiatric services, while each of the 30 districts in Tamil Nadu has a government psychiatrist. Yet, Erwady incident took place in Tamil Nadu!

These data highlight not only major deficiencies, but also fundamental flaws in perception and planning. The enormous asymmetry between different domains of the mental healthcare delivery system and among various geographical regions illustrates the need for serious introspection and radical reordering of priorities. Prescriptions might vary, but the need for therapeutic intervention is undeniable. State-wise inferences at Appendix C attempt to address some of the issues involved. However, one vital point needs to be highlighted in this regard. The mere allocation of resources, however abundant, is not going to solve our problems. This could, in fact, prove to be counterproductive in the absence of pragmatic, down-to-earth planning, shorn of grandiose dreams of replicating prestigious institutions such as National Institute of Mental Health and Neuro Sciences (NIMHANS). More than anything else, we must locate the faculty before embarking upon seductive schemes of creating 'centres of excellence'. Government jobs are no longer attractive for the young professionals and even prestigious institutions like All India Institute of Medical Sciences (AIIMS) are haemorrhaging faculty. There should be no hesitation in winding up obsolescent/dysfunctional/money-draining institutions which are no longer viable, and disinvesting their fixed assets to raise resources for creating more relevant healthcare delivery systems. The Andhra Pradesh government has made a good beginning in this regard (Appendix D). A tentative, hypothetical prototype plan, based on sound principles of health economics, is reproduced below.

## **Proposed Mental Health Plan for the State of Jharkhand**

### ***Introduction***

The newly created state of Jharkhand with a population of 26,909,428 (population density =338/sq km) presents a curious paradox in many respects. Rich in natural resources and home to most of the major industries in the former state of Bihar, it remains relatively backward with regard to infrastructure and communications. Unemployment is high, fuelling agitations for a greater number of reservations for the 'sons of the soil'. Overall, health facilities are inadequate

Table 1.4: Mental Health Resource Map of India

S.No.	State (1)	Population (2)	Density/sq km (3)	Estimated case load (4)		Existing facilities Hospital beds (5)		Manpower resources (6)												Dist. wise distribution of psychiatric facilities	
				Major mental disorders	Minor mental disorders	Govt. sector	Pvt. sector	Psychiatrists		Clinical psychologists		Psychiatric social workers		Psychiatric nurses							
				v	vi	vii	viii	ix	x	xi	xii	xiii	xiv	xv	xvi	xvii	xviii	xix	xx	xxi	xxii
	i	ii	iv	v	vi	vii	viii	ix	x	xi	xii	xiii	xiv	xv	xvi	xvii	xviii	xix	xx	xxi	xxii
1.	A & N	356265	43	3562	18810	10	-	1	4	3	-	6	6	-	8	8	-	3	3	1	1
2.	Andhra Pradesh	75727541	275	757275	3766375	1020	210	180	757	577	8	865	857	3	1154	1151	NH	123	123	NA	NA
3.	Arumahal Pradesh	1091117	13	10911	54555	10	-	1	10	9	-	15	15	-	20	20	-	1	1	1	12
4.	Assam	26638407	340	266384	1331720	500	-	29	266	237	5	450	445	1	564	563	1	50	49	23	17
5.	Bihar	82878796	880	828787	4143935	-	-	28	828	800	13	1214	1201	NA	1656	**	NA	**	**	NA	NA
6.	Chandigarh	900914	7903	9009	45045	57	-	31	9	+22	14	14	-	10	18	8	1	6	5	1	-
7.	Chhattisgarh	20795956	154	207959	1049795	10	3	15	207	192	1	304	303	2	414	412	-	2	2	1	15
8.	Daman & Diu, Dadra & Nagar Haveli	158059, 220451	1411, 449	3785	18925	10	-	1	4	3	-	6	6	1	8	7	4	1	+3	1	3
9.	Delhi	13782976	9294	137829	689145	329	113	155	137	+18	43	207	164	13	274	261	172	32	+140	7	7
10.	Goa	1343998	363	13439	77195	210	-	26	14	+12	2	21	19	3	28	25	2	21	19	2	-
11.	Gujarat	50596992	258	505969	2529845	853	326	97	505	408	12	753	741	12	1010	998	-	118	118	20	5
12.	Haryana	21082989	477	210829	1054145	89	98	39	210	171	2	315	313	-	420	420	1	19	18	9	10
13.	Himachal Pradesh	6077248	109	60772	303860	14	3	8	61	53	2	90	88	-	122	122	-	6	6	3	9
14.	Jharkhand	26909428	338	269094	1345470	1173	145	50	270	220	15	405	390	10	540	530	NA	135	**	3	15
15.	J & K	10069917	99	100699	503495	120	-	4	100	96	1	150	149	1	200	199	-	12	12	2	12
16.	Karnataka	52733958	275	527339	2636695	1341	1113	198	527	329	69	762	693	56	1052	996	175	245	70	18	9
17.	Kerala	31838619	819	318386	1591930	1937	1539	238	318	80	42	477	435	40	636	596	14	348	334	13	-
18.	Lakshadweep	60595	1894	605	3025	-	-	-	1	1	-	2	2	-	4	4	-	1	1	-	-
19.	MP	60388118	196	603881	3019405	592	NA	12	603	591	-	905	905	-	1206	1206	1	60	59	6	39
20.	Maharashtra	96752247	314	967522	4837610	6073	652	486	967	481	33	484	451	44	1934	1890	117	672	555	17	18
21.	Manipur	2388634	107	23886	119430	10	-	6	24	18	1	36	35	2	48	46	-	1	1	2	6
22.	Meghalaya	2306069	103	23060	115300	70	-	5	23	18	-	35	35	-	46	46	2	7	5	1	6
23.	Mizoram	891058	93	8910	44550	14	-	4	9	5	1	13	12	1	18	17	2	2	-	2	6
24.	Nagaland	1988636	120	19886	99430	25	-	5	20	15	-	30	30	-	40	40	1	3	2	3	5
25.	Orissa	36706920	236	367069	1835345	118	-	19	367	348	5	550	545	1	734	733	-	11	11	4	26
26.	Pondicherry	973829	2029	9738	48690	44	20	15	10	+5	1	5	14	13	20	7	20	7	-(+13)	4	-

To be continued...

Table 1.4 Continued...

i	ii	iii	iv	v	vi	vii	viii	ix	x	xi	xii	xiii	xiv	xv	xvi	xvii	xviii	xix	xx	xxi	xxii
27.	Punjab	24289296	482	242892	1114460	580	267	89	242	153	18	363	345	21	484	463	10	85	75	11	6
28.	Rajasthan	56473122	165	564731	2823655	627	110	75	565	490	12	798	786	4	1130	1126	-	74	74	16	16
29.	Sikkim	540493	78	5404	27020	20	12	2	5	3	-	7	7	-	10	10	-	3	3	2	2
30.	Tamil Nadu	62110839	478	621108	3105540	1800	NA	262	621	359	7	910	903	21	1242	1221	-	180	180	30	-
31.	Tripura	3191168	304	31911	159555	16	-	9	31	22	-	45	45	-	62	62	-	2	2	1	3
32.	Uttaranchal	8479562	159	84795	423975	-	-	6	84	78	-	126	126	-	168	168	-	-	-	1	12
33.	Uttar Pradesh	166052859	689	1660528	8302640	1750	275	115	1660	1545	20	2490	2470	35	3320	3285	-	202	202	10	60
34.	West Bengal	80221171	904	802211	4011055	1471	210	83	802	719	28	1204	1176	-	1604	1604	4400*	1604	+4258	20	-
	<b>Grand Total</b>			<b>10270165</b>	<b>51251625</b>	<b>20893</b>	<b>5096</b>	<b>2219</b>	<b>9696</b>	<b>7477</b>	<b>343</b>	<b>13259</b>	<b>12926</b>	<b>290</b>	<b>19064</b>	<b>17118</b>	<b>** (6527)</b>	<b>4036</b>	<b>**</b>	<b>219</b>	<b>311</b>

**Notes**

\* Figures unreliable: Nurses with some psychiatric training but without a Diploma in Psychiatric Nursing (DPN) appear to have been included.

\*\* Figures unreliable

**Column 2.** The population figures have been taken from the Census of India-2001 as published in **Provisional Population Totals (Registrar General Census Commissioner, India)**.

**Column 3.** Population density per square kilometre together with geographical terrain is a useful input in planning deployment of mental health resources.

**Column 4.** Case-load in respect to major mental disorders has been calculated at the rate of 1% of the population and that of minor mental disorders at the rate of 5% of population.

**Column 6.** (a) While the exact requirements of mental health personnel have not been definitively prescribed, the ideal required number of mental health professionals has been calculated as under:

Psychiatrists: 1.0 per 100,000 population	Clinical Psychologists: 1.5 per 100,000 population
Psychiatric Social Workers: 2.0 per 100,000 population	Psychiatric Nurses: 1.0 per 10 psychiatric beds

(b) District-wise data in respect of psychiatric facilities are not available for the states of Andhra Pradesh (total districts – 23 ) and Bihar (total districts – 40).

Total number of psychiatrists trained in the country during 2000–2001

Qualification	Male	Female	Total
MD	36	9	45
DPM	15	6	21
<b>Grand Total</b>			<b>66</b>

**Source:** National Survey of Mental Health Resources carried out by the Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, during May and July 2002.



but the state capital, Ranchi boasts of three major psychiatric hospitals, two in the government sector (Central Institute of Psychiatry [CIP] and the Ranchi Institute of Psychiatry and Allied Neurosciences [RINPAS] and the privately owned Dennis Institute of Neuropsychiatry, founded by an eminent British-Indian psychiatrist. Yet, 15 out of the 18 districts in the state have no mental healthcare services at all. This glaring imbalance needs to be addressed on a priority basis. The core issue in formulating a mental health plan for the state, therefore, is correction of this asymmetry in the distribution of mental health resources, rather than the creation of yet another glamorous but dysfunctional 'centre of excellence' at enormous cost.

### ***Resources***

It is customary to bemoan the lack of resources for inadequacies in healthcare, including mental healthcare delivery systems. The basic problem, however, often lies in unwise allocation, rather than actual paucity of resources, as is the case with Janjatikhanda. The state has a large 500-bed mental hospital turned institute, RINPAS, located close to the even larger CIP, a federal government undertaking. Spread over nearly 350 acres, RINPAS has an annual budget of approximately Rs 95.4 million with an average bed occupancy of around 50%, which works out to over Rs 1,000 per day per patient. Most of these 250-odd patients are in RINPAS not because they require psychiatric hospitalisation but because their families have abandoned them and refuse to accept them. The phenomenon of alienation from families and eventual abandonment itself is a direct consequence of incarceration in mental institutions such as RINPAS, which promote vegetative regression among their patients. For this reason, all over the world, mental hospitals are being closed down and the focus has decisively shifted to community-based care, which is also the basis of the Federal National Mental Health Programme.

### ***The proposal***

It is proposed that RINPAS may be reorganised into a compact psychiatric centre, integrated into either the existing government medical college at Ranchi or into the multi-specialty referral hospital envisaged along the lines of the Dr Rajendra Prasad Centre for Ophthalmic Sciences at AIIMS, New Delhi. The resources saved will be more than adequate to fund DMHPs in all 18 districts of Jharkhand, as detailed below:

- (a) Present annual budget of RINPAS = Rs 95.4 million.
- (b) Anticipated annual budget of the proposed psychiatric centre = Rs 25 million.  
(General duty MOs and other paramedical staff rendered surplus may be absorbed in the DMHPs).
- (c) Amount saved annually = Rs 70.4 million.
- (d) Annual expenditure on DMHPs in 18 districts = 20.5 lakh x 18 = Rs 36.9 million.  
(for detailed budget, see page 116).
- (e) Net annual savings = Rs 33.5 million.
- (f) Annual expenditure on keeping 100 patients on payment in FIP = Rs 18 million.
- (g) Actual annual savings to Jharkhand government = Rs 15.5 million.

### ***Operational strategy***

As highlighted above, most of the 250-odd patients in RINPAS have been in hospital, often for five years or more, not because they require active psychiatric intervention, but because their families refuse to accept them back into the family fold. This problem can be addressed effectively if a focused time-bound operation, using the Management By Objectives (MBO) technique, is undertaken to relocate such long-stay patients into the community. Implemented sincerely, such an operation can de-institutionalise all but a few refractory patients, who can be admitted to CIP, Ranchi as paid patients. Legal steps under the provisions of the MHA, Sections 79 and 80, may be taken to recover the cost of maintenance of such patients from the estate of the individual/person legally bound to bear such maintenance. The Government of Jharkhand may request the federal government to earmark 100 paid beds for the state for patients requiring prolonged hospitalisation. With community-based mental healthcare facilities in place through the DMHPs, early identification and treatment of those suffering from mental disorders will become possible and the interrelated problems of chronicity/abandonment by families will automatically be resolved.

### ***GHPUs***

The proposed psychiatric centre at Ranchi will become the prototype for such centres at other medical college hospitals in the state. The in-patient component at this centre should not exceed 100 beds, distributed in four wards: the acute male ward, the acute female ward, the alcohol treatment ward and the drug de-addiction ward. An active OPD with specialised clinics for child and adolescent mental health problems, mental retardation, tobacco-cessation, etc., will form a major component of the comprehensive mental healthcare facilities available at this centre. In the second phase, such GHPUs can be created in other state medical colleges and in larger general hospitals.

### ***Half-way homes/day-care centres***

Recovered mental patients who do not require hospitalisation but who still need partial supervision, or who do not have adequate family/social support, can also benefit from such centres. The federal Ministry of Social Justice and Empowerment has formulated a pragmatic scheme for funding such homes and the Jharkhand government can actively promote NGOs willing to run these institutions.

### ***Disinvestment of fixed assets***

Most of the old mental hospitals/successor institutions such as RINPAS and CIP, Ranchi, are located on hundreds of acres of land which has now become extremely valuable and therefore vulnerable to encroachment by the land mafia. This phenomenon has already resulted in loss to the state to the tune of billions of rupees. These large campuses are now impossible to maintain and have become a liability. The feasibility of disinvesting such high-value fixed assets therefore needs to be considered seriously. The resources generated from the sale of such surplus land can yield enough money to fund the construction of modern, state-of-art institutions. This concept is already under implementation in the progressive state of Andhra Pradesh, after having survived legal challenge through a Public Interest Litigation filed in the High Court of Andhra Pradesh. The details of this scheme are set out in AP Govt. Order No. 336, dated 29 August 2001 (Appendix D).

### ***Conclusion***

It is submitted that the major hurdle in the path of providing mental healthcare to the community lies not in the purse but in our minds. If we can rid ourselves of the obsolete notions of the inevitability

of institutionalised psychiatric treatment and think innovatively, it is possible to create an effective community-based mental healthcare delivery system with our existing resources. Grandiose visions of cloning AIIMS or NIMHANS are destined to fail, at immense cost in financial terms. Incomplete, half-built shells of several such institutions dot the countryside, particularly in relatively under-developed states. Even if a grand building could be constructed and state-of-art medical equipment procured, the requisite faculty with the necessary skills/eminence will be hard to come by. In the meanwhile, costly equipment would rust/become obsolescent. This aspect had been highlighted by a high level group of experts who visited Ranchi in July 2002, at the invitation of the Jharkhand government to advise them on setting up a modern 'super-specialty referral hospital on the lines of AIIMS'. The World Health Organisation (WHO) Mental Health Policy Project (Policy and Service Guidance Package) document articulates this philosophy in clear and unequivocal terms:

“Large and centralised psychiatric institutions should be discontinued. Existing financial and human resources should be diverted to the general health system and the community”.

### **The Restrategised NMHP**

As stated earlier, an extensive review of the NMHP was initiated in May 2001, and the reasons for non-performance were analysed. The most striking feature of the existing programme was its one-dimensional nature. The NMHP was virtually synonymous with the DMHP. In actual practice, it was the DMHP and both terms were used interchangeably, often leading to a great deal of confusion. A uni-modal mental health delivery system is neither conceptually sound nor functionally viable. Mutually synergistic integration of community-based services with other existing modalities of care, such as medical college psychiatric units and mental hospitals, is essential for creating a holistic, multi-tier mental healthcare delivery system, with dynamic inter-level linkages and flow of patients. Therefore, five key domains were identified and incorporated into the restrategised NMHP: the DMHP; medical college departments of psychiatry; mental hospitals (State Mental Health Authorities—SMHAs); and Information, Education and Communication (IEC) and training; and research. Clearly demarcated budgetary support for each of these domains (except in the case of the SMHAs where only technical/administrative support is envisaged) has been incorporated in the Tenth Five Year Plan NMHP estimates:

DMHP	Rs 775 million
Medical college departments of psychiatry	Rs 375 million
Mental hospitals	Rs 600 million
IEC and training	Rs 100 million
Research	Rs 50 million
	<hr/>
	Rs 1,900 million

In monetary terms, this reflects a quantum jump from the Ninth Five Year Plan allocation of Rs 280 million for the NMHP. It is proposed to implement the DMHP in 200 districts across the country, along with strengthening the departments of psychiatry in an equal number of medical colleges and modernisation of 37 government mental hospitals. Innovative IEC strategies and promotion of relevant research are the other significant thrust areas.

## **Mental Health Needs in Disaster Situations**

Disasters, natural as well as man-made, are endemic in India. Over the years, a number of studies have been conducted to assess the mental health needs of the victims of disasters and to suggest targeted interventions. These sporadic efforts have not, however, resulted in a coherent, institutionalised system for responding to such situations. Following the devastating earthquake in Gujarat in January 2001, NIMHANS, Bangalore and the Institute of Human Behaviour and Allied Sciences (IHBAS), Delhi sent in their teams to provide support to relief agencies in some of the worst affected areas. The inferences drawn by the NIMHANS team merit attention:

“Based on its field visit discussions with administrators, professionals, voluntary organisation coordinators and relief camp coordinators, the team infers that there is a need for sensitisation of varied groups of persons involved in disaster management work with specific reference to psychological issues of the earthquake disaster survivors. Sensitisation programme need to include the administrators, mental health professionals, healthcare functionaries, education development sector personnel and the NGOs and the volunteers”.

Drawing upon various inputs mentioned above a plan to constitute crisis intervention units in various states/UTs has been formulated as under:

### ***Crisis Intervention Units***

1. Crisis intervention units may be constituted initially in at least one medical college in each state at the discretion of the state government. Preferably, this medical college should be situated in the state capital to facilitate coordination with the central disaster management machinery at the state government level, and to ensure fiscal as well as logistic support at short notice. The unit will consist of:
  - Psychiatrist—One (if a psychiatrist is available in the affected district, he may be co-opted as an additional team member).
  - Psychiatric social worker—One (or a medical social worker if the psychiatric social worker is not available).
  - Psychiatric nurse—One (or a general duty nurse who has some training in psychiatric nursing, if a psychiatric nurse is not available).
  - Psychiatric nursing orderly—One (or a general nursing orderly who has some experience in psychiatric nursing).
2. The aforesaid personnel will be designated by name, by the principal of the concerned medical college, who will also be responsible for arranging or mobilising the necessary fiscal and logistic support for the unit by liaising with the relevant state departments. The team will then move to the disaster affected district in the shortest possible time and will liaise on arrival with the District Collector and Civil Surgeon or Chief Medical Officer for planning their deployment, as well as for the necessary logistic/administrative support through the local district administration. The psychiatrist in charge of the team will be responsible for discipline/internal administration of the team, and for establishing linkages with other relief agencies in the area. The team will carry the following drugs which being relatively cheap, will be provisioned from the relevant head of the medical college/state government budget:

- Tranquilisers                      Tab. Alprazolam 0.5 mg—750 tablets.  
   Tab. Diazepam 10 mg—500 tablets.
- Antidepressants                    Cap. Fluoxetine 20 mg—500 caps.  
   Tab. Imipramine 25 mg—1,000 tablets.
- Antipsychotics                    Tab. Risperidone 2 mg—250 tablets.  
   Tab. Trifluoperazine 5 mg—750 tablets.  
   Tab. Trihexyphenidyl HCl 2 mg—250 tablets.
- Parenteral                         Inj. Diazepam 10 mg—50 ampoules.  
   Disposable syringes 2 ml—50 syringes.

It is visualised that the inputs required for organising such crisis intervention units will be mainly conceptual/skill acquisitive and that very little additional financial support will be needed. The latter can be comfortably met from the financial resources of the state concerned.

## **Mental Health and the Media**

Ignorance and prejudice surrounding mental illness, deprioritisation of mental health plans/programmes amidst 'basic' health concerns, such as the provision of clean/safe drinking water and the prevailing climate of cynicism with regard to any (especially government) initiatives are major barriers in implementation. The media, particularly the electronic media, with its phenomenal instant reach can play a vital role in this endeavour. In a highly competitive environment, however, the temptation to sensationalise and even doctor facts in order to score on viewership ratings may be too difficult to resist. It is said that war is too serious a business to be left to the generals alone. Mental health is far too important to be left only to psychiatrists or bureaucrats. It concerns everyone. As the WHO Director General notes in her evocative Foreword to the World Health Report 2001: "Rare is the family that will be free from an encounter with mental disorders". It is not 'my' or 'their' war. It is *our* war. Despite the immense odds, in spite of many inadequacies and hurdles, the battle must be fought unitedly, abjuring the 'us and them' mindset.

## **Towards a National Mental Health Policy: Vision 2020**

The first draft of the National Mental Health Policy (NMHP-2001) was prepared in late 2001. It has since been discussed at various levels. According to critics, there are several good reasons why we do not need such a policy. The National Health Policy-2002 (NHP-2002) covers mental health as well. A policy by itself achieves little; in the absence of politico-administrative will it remains just what it is, a piece of paper. The restrategised NMHP provides the necessary conceptual framework for achieving our goals. More importantly, it is now being energetically implemented, with adequate budgetary support during the Tenth Five Year Plan. These are valid issues which merit extensive debate. The case for the defense is best articulated by the WHO Mental Health Policy Project document:

"Mental health policies describe the values, objectives and strategies of the government to reduce the mental health burden and to improve mental health. They define a vision for the future that helps to establish a blueprint for the prevention and treatment of mental illness, the rehabilitation of people with mental disorders, and the promotion of mental health in the community. Policies specify the standards that need to be applied across all programmes and services, linking them all with a common vision, objectives and purpose. Without this overall coordination, programmes and services are likely to be inefficient and fragmented".

*Mental Health Policy Project*  
Policy and Service Guidance Package WHO, Geneva 2001:8

The essential elements of the draft of the aforesaid National Mental Health Policy-2001 (revised) are reproduced below to provide a framework for focused discussions:

“It is sobering to realize that more than half a century after the Bhole Committee had focused attention on the need to revitalise mental health services in the country and over two decades into the National Mental Health Programme, its basic component, the District Mental Health Programme covers only 25 out of 593 districts across India. The available psychiatric services, including those in the private sector, are unevenly distributed and vast sections of the population/ large geographical areas in many states lack even rudimentary mental healthcare. Within the organised sector also there are major distortions. Most of our mental hospitals are physically dilapidated and conceptually obsolete, still custodial rather than therapeutic in their orientation. Nearly half of their patients have been in hospital for two years or more and many for over five years. The teaching of psychiatry at the undergraduate level remains grossly inadequate and the average doctor is ill-equipped to deal with mental illness. Postgraduate training in medicine and allied specialities has virtually no psychiatric component even though it is generally accepted that 40% of those attending medical OPD suffer from emotional rather than physical problems. Many medical colleges are without independent departments of psychiatry or special wards for psychiatric patients. Worthwhile research, especially in the field of community psychiatry is limited to a few institutions such as NIMHANS, AIIMS, etc. This dismal scenario calls for an urgent, time-bound remedial action plan which would ensure:

- (a) **Accessibility** of at least basic psychiatric facilities within the community to as large a section of the population as possible in all parts of the country.
- (b) **Affordability** of the services with regard to the initial capital cost as well as recurring expenditure (including that on essential drugs) to accord with our limited resources and low-income levels of the consumer population.
- (c) **Adaptability** to the widely varying geographical, socio-cultural and economic mosaic of our vast country.
- (d) **Acceptability** of mental healthcare by the target population in the context of low levels of literacy, ignorance, superstition, economic backwardness and lack of empowerment of women, adolescents and children.
- (e) **Assessment** of performance at the ground level through continuous monitoring, online audit by an independent agency and periodic review at the national level in order to identify areas of non-performance/reasons for the same at an early stage and introduce necessary corrective measures as well as relevant feedback for future planning.

### **Policy Objectives**

The proposed National Mental Health Policy outlines the prioritised agenda for extending within a pragmatic time-frame basic mental healthcare facilities to all sections of the population across the country by the year 2020. The tactical vehicle for implementing the said policy will be the refocused NMHP, initially formulated in 1982, with five key thrust areas:

- (a) This DMHP redesigned around a nodal institution which in most instances will be the zonal medical college. School mental health programmes and dementia care services may be gradually integrated with the DMHP.

- (b) Strengthening the medical college psychiatry departments with a view to develop psychiatric manpower, improve psychiatric treatment facilities at the secondary level and to promote the development of general hospital psychiatry in order to reduce and eventually to eliminate to a large extent the need for big mental hospitals with all their attendant infirmities.
- (c) Streamlining and modernisation of mental hospitals to transform them from the present mainly custodial mode to tertiary care centres of excellence with a dynamic social orientation for providing leadership to research and development (R&D) in the field of community mental health.
- (d) Strengthening of Central and State Mental Health Authorities in order that they may effectively fulfil their role of monitoring ongoing mental health programmes, determining priorities at the central/state level and promoting intersectoral collaboration and linkages with other national programmes.
- (e) Research and training aimed at building up an extensive database of epidemiological information relating to mental disorders and their course/outcome, therapeutic needs of the community, development of better and more cost-effective intervention models, promotion of intersectoral research and providing the necessary inputs/conceptual framework for health and policy planning. Focused IEC activities with the active collaboration of professional agencies such as the Indian Institute of Mass Communication and directed towards enhancing public awareness and eradicating the stigma/discrimination related to mental illness, will form an important component of this policy objective.

### **Prioritised Goals**

Subject to availability of resources the following time-frame is visualised for attainment in a phased manner the policy objectives outlined above:

- (a) **Tenth Five Year Plan (2002-2007)**
  - (i) DMHP will be extended to one district attached to each of the 100 medical colleges in the country, thereby covering 100 districts in the first phase, and thereafter expanding it to 100 districts more in the second phase, thus making a total of 200 districts across the country.
  - (ii) Strengthening of medical colleges with allocation of Rs 50 lakhs each to 100 medical colleges, preferably located in backward areas, for upgrading the departments of psychiatry with the aim of instituting postgraduate training courses leading to MD (Psychiatry). Infrastructural support to psychiatry departments in all medical colleges will be provided as part of the DMHP over the plan period.
  - (iii) Streamlining and modernisation of mental hospitals with the aim of reduction in chronicity through intensive therapeutic intervention using non-conventional antipsychotic medication, promoting care of chronically mentally ill patients in the community using outreach maintenance modalities and reduction of load/rational downsizing to ensure quality mental healthcare to a manageable number of patients. The feasibility of disinvesting fixed assets such as surplus land in order to mobilise additional resources for creating state-of-art institutions may be considered.

- (iv) Strengthening of Central and State Mental Health Authorities by facilitating the establishment of permanent secretariats and related machinery and networking of the state authorities with that at the national level to ensure effective coordination in all areas of activity.
  - (v) IEC, research and training by sponsoring relevant community-based research projects and building up an extensive database which will form the basis for development of intervention models and policy planning. Innovative IEC strategies will be generated through multidisciplinary collaboration and an effective 3-tier monitoring/audit/review machinery will be created to ensure continuous online assessment/course correction.
- (b) **Eleventh Five Year Plan (2007–2012)**

The DMHP will be extended to another lot of 200 districts while consolidating the same in the 200 districts covered at the end of the Tenth Plan. Psychiatry departments of the remaining medical colleges will be upgraded and the infrastructure created during the previous plan will be reinforced. Based on the results of the pilot disinvestment plan the process will be extended to 10 more mental hospitals with the aim of constructing modern buildings and providing state-of-art equipment as well as adequate staff. The activities of the Central and State Mental Health Authorities will be augmented. Qualitative as well as quantitative improvements will be introduced in the areas of research, training and IEC, with more focused attention on epidemiological catchment area surveys on a larger scale.

- (c) **Twelfth Five Year Plan (2012–2019)**

The DMHP will be extended to the remaining 193 districts and the gains made in the previous plans will be consolidated, further upgradation of the medical college psychiatry departments will be undertaken and 20 mental hospitals will be taken up for disinvestment/reconstruction. Non-viable mental hospitals will be closed down or merged with general hospitals to create GHPUs. Central and State Mental Health Authorities will be further reinforced and technologically more sophisticated long-term research projects will be initiated in selected institutions while continuing support to community-based research. IEC activities will be augmented to cover all sections of the population across the whole country. A comprehensive, holistic assessment and review of programme performance in the preceding two decades will be undertaken at the national and state levels by an independent agency to identify achievements, areas of non- or poor-performance, remedial measures, current needs and future requirements.

### **Special Issues**

The NMHP will focus special attention on psychiatric problems specific to certain vulnerable sections of the population who are often marginalised and neglected owing to lack of effective advocacy.

- (a) Senior citizens suffering from severely disabling diseases such as Alzheimer's and other types of dementias, Parkinson's disease, depressions of late onset and other psycho-geriatric disorders.
- (b) Victims of child sexual abuse, marital/domestic violence, dowry-related ill-treatment, rape and incest.



- (c) Children and adolescents affected by problems of maladjustment or other scholastic problems, depressions/psychosis of early onset, attention deficit hyperactivity disorders and suicidal behaviour 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 to fend for themselves.
- (e) Victims of natural or man-made disasters such as cyclones, earthquakes, famines, war, terrorism and communal/ethnic strife, with special attention to the specific needs of children orphaned by such disasters.

### **Conclusion**

The National Mental Health Policy is aimed at doing “the greatest good to the largest number” through five interdependent and mutually synergistic strategies, to be implemented in a phased manner over the next two decades:

- (a) Extension of basic mental healthcare facilities to the primary level.
- (b) Strengthening of psychiatric training in medical colleges at the undergraduate as well as postgraduate level.
- (c) Modernisation and rationalisation of mental hospitals to develop them into tertiary care centres of excellence.
- (d) Empowerment of Central and State Mental Health Authorities for effective monitoring, regulation and planning of mental healthcare 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.

### **Epilogue**

The mental health scene in India at the dawn of the twenty-first century is a bewildering mosaic of immense impoverishment, asymmetrical distribution of scarce resources, islands of relative prosperity intermixed with vast areas of deprivation, conflicting interests and the apparent apathy of governments and the governed alike. In the context of the huge and perhaps unsustainable levels of over-population, the problems appear to be insoluble. Yet, a solution must be found if we are to survive. This calls for courage, vision and a vibrant spirit of innovation, unburdened with the obsolescent shibboleths of psychiatric mythology. We will have to get off the beaten track, and embark upon this journey without a road map to help us along. We will have to invent solutions. We have the technical skills required to achieve this goal. Do we have the wisdom to choose the right path?

## Chapter 2

# Mental Health: The Pre-independence Scenario

*S. D. Sharma*

In India, mental hospitals as they exist today, were entirely a British conception. However, there is some evidence that modern medicine and hospitals were first brought to India by the Portuguese during the seventeenth century in Goa, but their impact was limited. Naturally, the early institutions for the mentally ill in the Indian subcontinent were greatly influenced by the ideas and concepts as prevalent in England and Europe at that time. Primarily, mental asylums were built to protect the community from the insane and not to treat them as normal individuals. Accordingly, these asylums were constructed away from towns with high enclosures, in dilapidated buildings like the barracks left by the military. Their function was more custodial and less curative.

To understand the development of mental hospitals, it is relevant to relate the political developments in India during that time. The eighteenth century was a very unstable period in Indian history. With the decline and fall of the mighty Moghul powers in Delhi, there was a consequent rise of Marathas in most of Central and South India, and of Sikhs in the North. At the same time, there were fights for supremacy between the French and the English in south India. These events gave rise to political instability, and also contributed to psychological and social turmoil in the Indian subcontinent.<sup>1</sup> It is notable that the development of lunatic asylums in Calcutta (Kolkata), Madras (Chennai) and Bombay (Mumbai) were almost parallel to the political events taking place in each region. Initially, these centres developed largely as British enterprises and the need to establish hospitals there became more acute, mainly to treat the Englishmen and the Indian sepoy employed by the British East India Company. It is worth mentioning here that there was a close relationship between political developments and the establishment of mental hospitals. The East India Company won the first decisive battle in India at Plassey near Calcutta in 1757 and a few years later, the battle of Buxar was won in Bihar in 1764 against Nawab Sirajudaula, under the leadership of Lord Clive.

### **Establishment of Lunatic Asylums (1784-1857)**

After Lord Clive, it was during Hasting's regime in 1784 when the Pitt's India Bill was introduced and the activities of the government of the East India Company came under a Board of Control. Systematic reforms and welfare measures were undertaken during Lord Cornwallis' rule from 1786 to 1793.<sup>1</sup> It was during his rule that reference to the first mental hospital at Calcutta was

recorded in the proceedings of the Calcutta Medical Board of 3 April 1787. It suggests that the need for a hospital was felt much earlier. The credit for the establishment of this hospital goes to Surgeon George M. Kenderline. However, this asylum could not be recognised by the Medical Board as he had been dismissed from service for neglect of duty in 1777. Later, a private lunatic asylum was constructed, recognised by the Medical Board under the charge of Surgeon William Dick and rented out to the East India Company at a rent of Rs 400 per month. Almost at the same time, another lunatic asylum was opened on 17 April 1795 at Monghyr in Bihar, about 400 miles north of Calcutta. This hospital was specially meant for insane soldiers. The remnants of this building are still to be found at Shyamal Das Chakravarty Road and is known as the 'Paghla Ghar building' (house of lunatics).<sup>2</sup>

Madras was another seat of British rule. Here, the East India Company was fighting Tipu Sultan, the ruler of Mysore. After Tipu's defeat in 1792, the British began gaining power in South India. One of the earliest mental hospitals in India was set up in Bombay in 1745, and a beginning was made to construct a small lunatic asylum in Colaba in 1806.<sup>3</sup> The city of Bombay was transferred from the Portuguese to the British in 1662 as part of the dowry given to Charles II of England when he married Catherine Braganza of Portugal. It may be added that the Britishers first tried to concentrate their efforts in Madras, Calcutta and Bombay. As mentioned earlier, the beginning to establish mental hospitals was made in Calcutta in 1787 by Surgeon G.M. Kenderline. In 1817, a Surgeon 'Breadmore' tried to improve the conditions of the hospital at another site behind the Presidency General Hospital. It appears that this hospital had between 50 and 60 European patients, with clean surroundings and a garden. During this period, overexcited patients were treated with morphia and opium, and were given hot baths. Sometimes leeches were applied to suck their blood as it was believed the blisters were useful for chronic patients and were also helpful in controlling their periodic excitement. In 1855, in Dacca, now part of Bangladesh, another lunatic asylum was opened in Murli Bazar. Music as a form of treatment to calm down excited patients was also experimented with, for the first time during that period at the Dacca hospital.<sup>2</sup> There is also some evidence on the use of cannabis to treat anxiety and stress disorders.

In the state of Bihar, which was also under the British, two hospitals were opened: one in 1795 at Monghyr for insane soldiers and the other in 1821 at Lower Road, Patna. At Kilpauk in Madras, the first mental hospital was started in 1794 for 20 patients by Surgeon Vallentine Conolly, who was the first superintendent as well as the owner of the hospital. A few years later, in 1799, the government obtained the lease of premises and another surgeon, Morris Fitzgerald, was appointed as the medical superintendent. Later, in 1807, the hospital was expanded to house 54 Europeans and 15 housekeepers under the charge of Surgeon James Dalton.

Until the early part of the nineteenth century, mental asylums were located only at the major cities of that period like Madras, Bombay and Calcutta. These asylums were primarily custodial in nature and mostly catered to the British and the Indian sepoy employed by the British. It appeared that the East India Company's administration concerned itself only with its own countrymen and their Indian employees. The large masses of the local population were mostly left unattended and uncared for. The mentally ill from the general population were taken care of by the local communities and by traditional Indian medicine doctors, qualified in *ayurveda* and *unani* medicine.

### **Growth of Mental Asylums (1858-1904)**

After Lord Cornwallis' rule (1786-1793), there was no further development in the growth of lunatic asylums in other parts of India until 1857, except in the major cities of Calcutta, Bombay

and Madras. Later, the suppression of the '1857 Freedom Movement' brought about some interesting changes and the powers of the East India Company were directly taken over by the British Crown on 1 November 1858.

The year 1858 is significant, also because the first Lunacy Act, known as Act No. 36, was enacted by the British Parliament during December of that year. The 1858 Act not only laid down guidelines for the establishment of mental asylums, but also set the procedures for admitting mental patients. This Act was later modified by a committee appointed in Bengal in 1888, which gave elaborate instructions and guidelines for admission and treatment of criminal lunatics. Asylums for the insane were originally built in India, as in other countries, primarily to protect the society from those who by reasons of insanity were troublesome and dangerous to their neighbours. Therefore, the asylums constructed at that time were simply places of detention. As medical supervision of some sort was considered necessary in the event of an illness amongst the inmates, the institutions, for the sake of expediency were given over to token medical management. After 1858, there was a more systematic expansion of the British empire when the British Monarch took control of the Indian Government from the East India Company. This also brought many changes in the administration and healthcare system, which later resulted in the establishment of more lunatic asylums during the next 20 years in the eastern part of India, which included Bengal, Bihar and Orissa. By 1874, there were at least six such asylums at Bhowanipore in Calcutta, Patna, Dacca, Berhampur, Dulanda (in Calcutta) and at Cuttack (Orissa). The year 1874 is also important in Indian history as Assam was separated from Bengal, and by 1876 a new asylum was opened at Tezpur to cater to the needs of the mental patients of Assam.

In the South, in Madras Presidency, new hospitals were opened at Waltair and Trichinopoly in 1871. In May 1871, a new hospital was also opened for 145 European and Indian patients in the city of Madras. In the Western part of India, in Bombay, a similar expansion was noted and by 1865 five such institutions were opened at Colaba, Poona, Dharwar, Ahmedabad and Ratnagiri. Similarly, new asylums were established in 1866 at Jabalpur and Ellichpur in Berar. A hospital was started at Banaras in 1854, at Agra in 1858 and later at Bareilly in 1862.<sup>2</sup>

In this phase, there was a discernible growth in the number of mental asylums, located away from the major metropolitan cities in the provinces, and the local population was also permitted to avail these facilities. However, most of these asylums were set up primarily near cantonments, where the British army units were stationed.

### **Humanistic Approach and Early Legislation (1905-1919)**

The third phase of development of mental hospitals in India started in the early part of the twentieth century. This was the result of adverse publicity in the press, both in Britain and in India, about the conditions of the hospitals being run by the British Government and the need felt for a more humanistic approach. This period is also significant, for another reason: in 1906, a central supervision system of these hospitals was contemplated. The concern of the Government of India ultimately resulted in a few more changes. In 1905, at the initiative of Lord Morley, the control of mental hospitals was transferred from the Inspector General of Prisons to the Directorate of Health Services and, at the local level, to the Civil Surgeons. It was also acknowledged that specialists in psychiatry and medical doctors should be appointed as full-time officers in these hospitals when available. The third significant development was the intent of the government in 1906 to have a central supervision by legislation of all the lunatic asylums. This resulted in the Indian Lunacy Act 1912. The other associated development at that time was the growing concern of the public about the poor and unhygienic conditions of mental hospitals. This resulted in not only the

improvement of existing conditions of hospitals at that time, but also in the opening of many more new hospitals.

The year 1912 is also significant, as it was during this year that the capital of India was shifted from Calcutta to Delhi. Under the Indian Lunacy Act 1912, a central lunatic asylum was established in Berhampur for European patients, which later closed down after the establishment of the Central European Hospital at Ranchi in 1918. It was the far-sightedness, the hard work and the persistence of the then superintendent of the European Hospital (now known as the Central Institute of Psychiatry), Col (Dr) Owen Berkeley Hill, that made the institution at Ranchi the foremost in India at that time and attracted many European patients for treatment.

Dr Berkeley Hill was deeply concerned about the improvement of mental hospitals in those days.<sup>4</sup> His concern is reflected in one of his articles, which he wrote in 1924 after the government brought out a notification in 1920 to change the word asylum to mental hospital.

“There is a Persian saying that there is no greater anguish known among mankind than to have many thoughts at heart and no power of deed. This particular form of anguish must be well-known to most medical superintendents of mental hospitals. For how many of them longed to be able to raise the standard of the work at hospitals whose welfare they have at heart but for some reason or another the power of deed is denied to them. Nevertheless, in spite of many a heart made sick by deferred hopes, every medical superintendent is probably in a position to raise the efficiency of the hospital in his charge provided he can get plenty of good ideas to work with”<sup>4</sup>

The developments of this phase were characterised by a more humane handling of mental health issues, leading to significant legislative, administrative and clinical modifications. In spite of these changes, mental health services were confined to mental hospitals, and these hospitals were managed by physicians assigned to the posts of superintendents. Mental health services till then did not have formally trained manpower and most of the qualified psychiatrists were British living in India.

### **Movement away from Mental Hospitals (1920–1947)**

The sustained efforts of Dr Berkeley Hill and many of his colleagues not only helped to raise the standard of treatment and care at the mental hospital at Ranchi, but also persuaded the government to change the term ‘asylum’ to ‘hospital’ in 1920. There were other significant changes that took place during this period. Occupational therapy was recognised as a part of the treatment given, in addition to other rehabilitative measures, during the third decade of the century. The need of associating social scientists, mainly psychologists in the diagnosis and management of psychiatric patients, was also gradually realised and practised for the first time in 1920–1930 at Ranchi. The first efforts to train psychiatrists and psychiatric nursing personnel were made during this period, also at Ranchi. As a part of the social awareness, initial attempts to establish direct links with the patient’s family were made in the form of family units. In 1930, an Association of the Medical Superintendents of Mental Hospitals was established. The Ranchi European Hospital was one of the first to begin these radical practices and thus became a symbol of excellence. Later in the 1940s, the emphasis was on improving the conditions of existing mental healthcare and the treatment programmes. Systematic efforts for using physical treatment methods like Electro-Convulsive Therapy (ECT), insulin-coma treatment and psychosurgery began in the late thirties. Electroencephalography (EEG) was introduced for diagnosis. For the first time, the emphasis shifted from custodial care to a curative approach in some of these hospitals.

This attitudinal change also led to another significant development. The first psychiatric out-patient service, precursor to the present-day general hospital psychiatric units, was set up at the R.G. Kar Medical College, Calcutta in 1933 by Dr G.S. Bose.

The second such unit was organised by Dr K.R. Masani at the J. J. Hospital, Bombay in 1938. This progressive trend, however, remained confined to the two major metropolitan centres and mental hospitals continued to constitute the backbone of the system.

It was against this background that the Government of India in 1946 appointed a high level Health Survey and Development Committee, headed by Sir Joseph Bhore, to review the entire public health sector in the country, including the 19 mental hospitals which, together, accounted for 10, 181 beds. The monumental report produced by this committee, generally referred to as the Bhore Committee Report,<sup>5</sup> became indispensable for health planners in independent India and merits attention even today (the part of the Report that pertains to Mental Health is reproduced as Appendix A).

## References

1. Sarkar SC. *A Text Book of Indian History*. Calcutta, 1932.
2. Varma LP. History of psychiatry in India and Pakistan. *Indian Journal of Neurology and Psychiatry* 1953; 4(1-2):26-53, 138-164.
3. Weiss M. The treatment of insane patients in India in the lunatic asylums of the nineteenth century. *Indian Journal of Psychiatry* 1983;25(4):312-316.
4. Berkeley Hill. The Ranchi European mental hospital. *Journal of Mental Sciences* 1924;LXX:38-45.
5. Bhore Committee. *Health Survey and Development Committee, Vol. III*. Simla: Government of India Press, 1946.

## Chapter 3

# Mental Health in Independent India: The Early Years

*M. Sarada Menon*

Contemporary understanding of appropriate mental health policies, programmes and service models to deliver optimal mental healthcare to all parts of India has evolved over several decades. These policies suggest the development of health systems, which are primarily community-based, integrated with primary care and linked to overall developmental processes (NMHP 1982).<sup>1</sup> The role of institutions and specialised care has also been defined in the range of health service delivery models required to meet the demands of this diverse and pluralistic society. In the current dispensation, mental health promotive and preventive approaches are accorded importance equal to that of curative services. Finally, increasing attention is being paid to issues ranging from human rights to initiatives, that attempt to demystify mental health through community participation.

It is important to recognise that this comprehensive framework of policies, programmes and service models has not occurred because of any dramatic paradigm shifts, but has been built on a cumulative body of clinical knowledge, research and administrative acumen, technomanagerial capacity-building, and visionary foresight and experience by succeeding generations of mental health professionals, health planners and policy makers.

In this chapter an attempt is made to understand the mental health scene in India during the first 15 years after independence, in the dimensions of mental health policy, practice and implementation. The contribution of policy planners and mental health professionals during this period is critically evaluated, not only in the context of their immediate impact, but their influence on the current conceptualisations of mental health services is also documented.

As a prelude to this analysis, it is important to understand the four background realities that dictated the functioning of the mental health delivery system in the early years and therefore, defined both the priorities and the challenges for mental health professionals working during this period.

1. Indian mental health professionals inherited a mental health system from the British. In keeping with Western models of that era, the mental health infrastructure was exclusively asylum-based and custodial in its outlook, which imposed limits on the number of patients who could receive services.

2. Non-pharmacological management of psychiatric disorders was limited to non-specific psychotherapy and in a few centres, Western models of psychoanalysis were practised. Therapeutic options for the management of psychotic disorders included ineffective preparations like paraldehyde, bromide and treatments like insulin-coma. This situation, however, changed with the advent of chlorpromazine.
3. The research literature focused primarily on in-depth psychological understanding of mental disorders, focusing primarily on the individual, and robust epidemiological data, which is crucial for planning of health services, was practically absent.
4. Trained manpower was negligible.

The background realities therefore dictated the priorities for both policy and practice. These included:

- Enhancing the capacity of the mental health infrastructure to serve a greater number of service seekers.
- Improving the quality of services in custodial institutions and developing innovative approaches in non-custodial settings.
- Initiating research that would provide information on planning and implementing appropriate services.
- Manpower development.

This chapter discusses how these four mental health priorities were tackled. The contribution of professional bodies which functioned during the early years is also highlighted.

## **Enhancing the Capacity of the Mental Health Infrastructure**

### ***Increasing the number of mental institutions***

At the time of independence, India had about 30 institutions for the mentally ill, with 10 of them having been built prior to the twentieth century.

Among the earliest policy recommendations relating to mental health development was the Bhore Committee Report 1946,<sup>2</sup> which cogently argued for the creation of primary care infrastructure to cater to the needs of the vast rural population. The committee also recommended improvement in the existing 17 mental hospitals and a phased increase in the number of mental institutions. Thus, the early years saw the emergence of seven major psychiatric hospitals in the states of Gujarat, Punjab, Jammu and Kashmir, West Bengal and Delhi.<sup>1</sup>

### ***Increasing the service capacity of individual institutions***

Even with an increase in the number of institutions, it became clear that they were extremely overcrowded as discharges were minimal, which imposed limitations on the number of patients who could receive treatment.

In what appeared to be a radical move, especially in an era that equated treatment with in-patient custodial care, mental health administrators began to develop out-patient services in mental institutions. This had a three-fold impact. The gross overcrowding in hospitals began to be reduced. More importantly, larger numbers of service seekers could receive treatment. Also, families of the mentally ill could chart the progress and recovery in their patients which facilitated greater acceptance by their natural caregivers. By the 1960s, traditional custodial institutions like the



Institute of Mental Health, Chennai were offering a range of specialised services, including child and adolescent clinics. Geriatric, epileptic and neuro-psychiatric services were added to complete the range of comprehensive OPDs. Another important innovation in the 1960s was the concept of a day hospital, by which patients resided in the community with their families, yet enjoyed the therapeutic and pharmacological benefits of hospitalisation. Slowly, alternative accommodations were explored for patients who had recovered, but could not return to their families. Social service organisations were persuaded to accept these patients. It was these small yet path-breaking innovations which were to sow the seeds of community care, and break the well-entrenched thinking that care necessarily had to be custodial and institutional.

### ***Integrating mental health with general health***

Among the most visionary and radical steps undertaken to enhance the service capacity of the mental health system was the setting up of GHPUs. Although Dr Girindra Sekhar Bose at the R.G. Kar Medical College Hospital opened the earliest GHPU in 1933, it was the decade of the 1960s, which witnessed a true and phenomenal growth of these units. Many of these early facilities were begun in collaboration with departments of neurology and were often termed as neuro-psychiatric clinics. Subsequently, the out-patient units began functioning as independent psychiatric facilities. In the 20 years that followed independence, 90 general psychiatric units came into existence. Many contemporary practitioners have either worked in or have had training in these units, which appear to blend seamlessly into the service facilities offered by a general hospital. However, it is important to recognise that starting such units 25 years ago was no easy task. There was strong resistance from both the medical personnel and health administrators of general hospitals, many of whom subscribed to the asylum concept for the management of mental health problems. It was a struggle to get a few beds allotted to psychiatric patients in the general medical wards and overcoming these initial hurdles required innovative thinking. As one senior psychiatrist recounts, 'during the morning teaching rounds in medical wards psychotic patients had to be moved to the OPD lest they disturb the rounds, and give an opportunity to the physicians to press for their ejection'. In the future, the obvious advantages of general hospital psychiatry far outweighed such minor problems. Patients found GHPUs more accessible than the custodial institutions. Issues of stigma and loss of contact with the family were easily obviated. Comprehensive medical care to psychiatric patients became easily available. The GHPUs also opened up the new field of consultation-liaison psychiatry. Psychiatrists got an opportunity to demonstrate their knowledge and skills in the management of neurotic and psychosomatic disorders. This resulted in greater acceptance and support from general physicians.

### **Improving the Quality of Service in Custodial Institutions**

Custodial institutions traditionally evoke images of gross overcrowding, poor sanitary conditions, regimentation and loss of individual freedom. All of these issues were the 'real issues' that confronted mental health administrators in the early years. Mental health budgets were extremely limited and often admissions meant lifetime care, as families were reluctant to take back patients who were disruptive. Against this bleak scenario of limited budgets and escalating demands, it appears incongruous to document improvements in the quality of services. However, within the constraints outlined above, mental health administrators did try to change the mental hospitals in structure and function, and thereby improved the living conditions in these institutions. Overcrowding was tackled by the introduction of out-patient services and day hospitals, and during the 1970s, individual institutions witnessed a slow and steady reduction in beds, accompanied by the growth in GHPUs and out-patient services.

Occupational therapy and recreational facilities were introduced in a phased manner in many of the large institutions. Occupational therapy was limited in its focus because the prime objective was to keep patients from being idle. This was achieved by assigning them tasks like weaving of linen and mats, tailoring and carpentry which catered to the needs of the institution.

The Institute of Mental Health, Chennai pioneered the Industrial Therapy Unit (ITU) which was path-breaking on several counts. First, patients began to receive a wage, which helped them to prepare for a life outside the hospital. Second, the unit competed for, and won service contracts for bakery products from non-mental health institutions. The ITU was also awarded service contracts for supplying milled flour and soap for the institution itself. The manufacture of paper covers became a profitable venture with job orders coming from even outside the city. These small and successful experiments were to lay the foundation for many of the modern principles of psycho-social rehabilitation that are practised today.

Custodial institutions also evoke strong images of fear and stigma. Among the earliest attempts to combat these negative perceptions was to encourage social service and religious organisations to organise activities for the residents of the hospitals. Exposure and interaction with patients gradually helped dispel some of the myths concerning mental illness and also provided opportunities for patients to interact with people outside the sphere of mental illness. Combating stigma and widening the social network of patients are regarded by contemporary practitioners as core elements of a successful rehabilitation programme. These initiatives were undertaken more than 25 years before the formal principles of psycho-social rehabilitation were enunciated and therefore can be regarded as pioneering approaches.

For many patients admitted to mental hospitals, the failure to maintain ties with their family prevented an eventual return to the community. This came to be recognised as a major drawback of custodial institutions. The Institute of Mental Health, Chennai overcame this lacuna by appointing non-professional social workers who would maintain contact with the family. These workers were recruited from agencies such as the Indian Red Cross and provided on-the-job training. They can be regarded as the forerunners of the modern day trained social service professional.

An extremely significant innovation that has been extensively validated in recent times was the bold experiments of Dr Vidya Sagar at the Amritsar Mental Hospital<sup>3</sup> and at the Mental Health Centre, Christian Medical College (CMC), Vellore.<sup>4,5</sup> This approach used the comprehensive involvement of families in the care, recovery and aftercare of psychotic patients and facilitated their acceptance and return to their own homes in the community. These efforts continued in the 1960s at NIMHANS and culminated in the opening of the family ward.<sup>6</sup> Today, there is widespread international acceptance of such approaches, which are known under the rubric of 'family interventions'. This is testimony to the foresight that characterised the early days.

Improvements in the quality of treatment and care also occurred by the establishment of facilities and infrastructure that could cater to the physical illness in patients. Institutions began to set up radiology, laboratory, dental and dermatology services within their campuses, and some institutions like the Institute of Mental Health, Chennai, even installed electroencephalography facilities. Thus, the stage was set for a contemporary, holistic approach towards the management of mental illness.

## **Developing Innovative Services in Non-Custodial Settings**

A perusal of the background realities that influenced programme planning and practice revealed that care was predominantly custodial. Therefore, the scope for innovation in non-

custodial settings was limited in the early days. However, mention must be made of Wig's attempts to use yoga as a therapeutic tool and his efforts to develop programmes for university students and school children.<sup>7</sup> This period also witnessed efforts to define the core elements of an Indian approach to psychotherapy in the form of a *guru-chela* relationship.<sup>8</sup>

## **Implementing Research for Planning and Implementing Appropriate Services**

Psychiatric research conducted during the early years has been reviewed by Wig and Akthar and two fairly clear-cut phases have been identified.<sup>9</sup> Articles that were psychoanalytically oriented and theoretical in nature dominated the research literature from 1947 to 1960. The overriding themes were psychological interpretations which focused on individual dysfunction. It is important to note that literature on phenomenology and epidemiology was conspicuous by its absence, and this was a major handicap in planning of services.

During the second phase of psychiatric research (1960–1972), a distinctive trend emerged. Research publications became broader in their orientation and moved from individual psychopathology to the interface between the individual and society and group behaviour. The cross fertilisation of ideas between sociology, psychology and psychiatry was very beneficial from a public health perspective, thus sowing the seeds for community-oriented research and programme planning. Among the major epidemiological studies of the early days included those of Surya, Sethi, Ganguli and Gopinath, which helped to establish the magnitude and nature of mental health problems in the community.<sup>10-13</sup>

The major work of Dubey was significant because it was carried out on both rural and urban populations and covered a much larger population than the earlier studies.<sup>14</sup> A fairly uniform prevalence rate of psychiatric disorders in both rural and urban populations highlighted the urgency to develop mental health services for the unserved rural population. In addition to creating an epidemiological base for programme planning, mental health researchers in this decade were also active in the field of psychological testing, with performance norms being established for the Indian population along with modification of psychometric tools.

## **Manpower Development**

One of the important recommendations of the Bhole Committee was the imperative to develop manpower in the field of mental health. With this in mind, the Government of India established the All India Institute of Mental Health in 1954 at Bangalore (later known as NIMHANS). This became the first Indian training centre for postgraduate training in psychiatry, clinical psychology and psychiatric nursing. The first batch of physicians to be trained in psychological medicine were enrolled in 1955. The Mudaliar Committee also noted the serious shortage of trained mental health manpower and recommended the development of the Ranchi Mental Hospital into a full-fledged training institute and urged that 'ultimately each region, if not each state become self-sufficient in the matter of training its total requirement of mental health personnel'.<sup>15</sup> Subsequently, training centres came up in various places like Chennai, Delhi, Lucknow, Goa, etc.

A formal training programme for clinical psychologists (Diploma in Medical Psychology) also commenced in the year 1955 and was later converted into an M. Phil in Medical and Social Psychology in 1978. In keeping with the recommendations of the Mudaliar Committee, the Hospital for Mental Diseases, Ranchi (now Central Institute of Psychiatry), started training for clinical psychologists in 1961. The B.M. Institute of Mental Health, Ahmedabad began training clinical psychologists in 1972.

The Shanta Vashisht Committee (a subcommittee of the Mental Health Advisory Committee, Ministry of Health, Government of India, 1966) identified the need to offer advanced training for students of social work in settings which were clinical. Based on the recommendations of this committee, training in psychiatric social work was initiated at NIMHANS, Bangalore. In 1970, the Central Institute of Psychiatry, Ranchi also took up this training activity. Subsequently this programme was suspended owing to a combination of scarce resources and official apathy.

A one-year training course in psychiatric nursing commenced at the All India Institute of Mental Health, Bangalore in 1956. One important development was the astute suggestion of the Indian Nursing Council to integrate mental health nursing into the general nursing curriculum. This was undoubtedly a forerunner of the integrated training approaches that are advocated today. Unfortunately, due to lack of adequate trainers only 50% of the schools of nursing adopted this recommendation.

The huge gap between the required trained manpower and the availability of this important resource continues to be a source of major concern for mental health planner and administrators. However, it is important to recognise that 25 years ago, health administrators identified these lacunae and laid the foundation for an exponential growth in manpower, which unfortunately has not matched the growing needs of the population. The lacunae are particularly critical in the allied specialties of psychology, social work and psychiatric nursing.

## **The Role of Professional Bodies in Shaping Policy During the Early Days**

The Indian Psychiatric Society (IPS), among the oldest mental health professional bodies in the country, came into being in 1947, and the first Annual Conference of the society was held in 1948. It is also interesting to note that two of the society's distinguished presidents during the early years were not psychiatrists. Dr Bardhan, President of the IPS in 1960, was a pathologist; in 1962, the presidency of the IPS passed to Dr Saha, who was an eminent physician and who included the teaching of psychological medicine in the undergraduate medical curriculum.

The *Indian Journal of Neurology and Psychiatry* came into being in 1949 and, during the 11th conference of the IPS, the journal assumed its present name *Indian Journal of Psychiatry*. The IPS along with the Indian Association of Clinical Psychologists, which came into existence in 1968, and the Indian Association of Professional Psychiatric Social Workers have played an important role in influencing mental health policy. Superintendents of mental hospitals convened a conference in 1960, in which a draft mental health bill was discussed. In 1964 the IPS's standing committee on public education in mental health highlighted the inadequate professional manpower and urged that mental health be viewed from a public health perspective. These suggestions were undoubtedly the forerunners of the modern principles of community psychiatry. In a far-sighted recommendation, the committee also stressed the importance of dispelling myths and superstitions, which even in contemporary practice, continue to influence utilisation of mental health services.

In conclusion, the last two decades have seen an explosion in the knowledge base of the neurosciences, epidemiology and therapeutics. There has also been a parallel growth in interdisciplinary linkages, which support integrated, socially and culturally appropriate approaches to mental health interventions. Against this background, it is sometimes difficult for contemporary practitioners to fully comprehend the wide ranging challenges that confronted mental health professionals in the period following India's independence. However, it is important to remember that the foundations for the current knowledge base were laid during those early years.

## References

1. National Mental Health Programme for India. Directorate General of Health Services, Ministry of Health Government of India and Family Welfare, New Delhi, 1982.
2. Bhore J. *Health Survey and Development Committee*. Government of India, 1946.
3. Vidya Sagar. Innovations in psychiatric treatment at Amritsar hospital. *Report in a Seminar on the Organization and Future Needs of Mental Health Services*. New Delhi: World Health House, 1971.
4. Chacko. Family participation in the treatment and rehabilitation of the mentally ill. *Indian Journal of Psychiatry* 1967; 9:328-333.
5. Verghese A. Involvement of families in mental healthcare. *Journal of Christian Medical Association of India* 1971; 46:24.
6. Narayanan HS, Reddy GNN. Review of treatment in family ward. *Indian Journal of Psychiatry* 1968; 14:123.
7. Wig NN. Psychiatric problems in university students. *Indian Journal of Psychiatry* 1969; 11:35.
8. Neki JS. Psychotherapy in India. *Indian Journal of Psychiatry* 1977; 19:1.
9. Wig NN, Akthar S. Twenty-five years of psychiatric research in India. *Indian Journal of Psychiatry* 1975; 16(1):48-64.
10. Surya NC, Datta SP, Gopalkrishna R, Sundaram D, Kutty J. Mental morbidity in Pondicherry (1962-1963). *Transactions of the All India Institute of Mental Health* 1964; 4:50-61.
11. Sethi BB. 300 Urban families: A psychiatric study. *Indian Journal of Psychiatry* 1967; 9(4):280-289.
12. Ganguli HC. Prevalence of psychiatric disorders in an Indian industrial population. *Indian Journal of Medical Research* 1968; 56(5):754-776.
13. Gopinath PS. *Epidemiology of Mental Illness in an Indian Village* (MD thesis). Bangalore; Bangalore University, 1968.
14. Dubey KC. A study of prevalence and biosocial variables in mental illness in a rural and urban community in UP, India. *Acta Psychiatrica Scandinavica* 1970; 46:327-359.
15. Mudaliar AL. *Health Survey and Planning Committee*. Government of India, 1962.

## Chapter 4

# Psychiatric Epidemiology in India: Moving beyond Numbers

G. Gururaj • M. K. Isaac

India with its population of more than 1 billion faces a myriad health problems.<sup>1</sup> The socio-demographic changes, epidemiological transition and media revolution consequent to urbanisation, industrialisation, migration and changing lifestyles of people along with improvements in healthcare, have brought the triple burden of communicable and non-communicable diseases along with injuries, to the forefront. The success in the prevention and control of communicable diseases is slowly changing the health scenario of the country, with a shift towards non-communicable diseases and injuries.<sup>2,3</sup> The reduction in infant and under-5 mortality coupled with the control of nutritional and infectious disorders due to massive commitments by national and international agencies has brought to the fore the new challenge of behaviour-linked, man-made lifestyle-related problems (Table 4.1). The increase in the per capita income of people, along with changing healthcare availability, has also resulted in the greater life expectancy of people. The expansion of healthcare infrastructure in both public and private sectors, along with technological progress in medicine, has brought about improvement in the health of people, even though investment in healthcare expenditure has remained stagnant over a period of time.<sup>4</sup>

In this evolving healthcare scenario, non-communicable diseases pose major problems due to lack of skilled healthcare manpower, inadequate information and the inability of systems to meet this challenge all over the world, including India.<sup>5</sup> The World Health Report 2001 clearly identifies a number of risk factors that pose major threats to the health of the mankind. The aggressive market-oriented, liberalising economies, in combination with an invasive media, have helped in the rapid expansion of hazardous lifestyles. The social, biological and psychological strength of the past are slowly being replaced by a fragile life pattern of people, making them more vulnerable to social, mental and psychological problems at all ages.

Mental health problems have long been recognised in every society. Communities had their own mechanisms of handling these problems, many of which are gradually being replaced by modern science. A greater understanding of mind and behaviour from all dimensions has revolutionised our efforts of managing these problems in today's society. The interaction of man, mind and behaviour is at an exciting phase today, with advances in genetic, molecular, biochemical

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**Table 4.1: The Changing Profile of India 1991-2001**

S. No.	Indicators	Year		Year	
1.	Population	1991	846 million <sup>a</sup>	2001	1027 million <sup>a</sup>
2.	Density (persons/sq km)	1991	267 <sup>a</sup>	2001	324 <sup>c</sup>
3.	<b>Age distribution (%)</b>				
	< 14 Years	1993	36.1 <sup>b</sup>	1998-99	35.7 <sup>c</sup>
	15-59 Years	1993	57.5 <sup>b</sup>	1998-99	46.0 <sup>c</sup>
	60+ Years	1993	6.4 <sup>b</sup>	1998-99	8.0 <sup>c</sup>
4.	<b>Place of residence (%)</b>				
	Urban	1991	25.7 <sup>a</sup>	2001	27.8 <sup>c</sup>
	Rural	1991	74.3 <sup>a</sup>	2001	72.2 <sup>c</sup>
5.	<b>Sex distribution</b>				
	Men	1991	439 million <sup>a</sup>	2001	531 million
	Women	1991	407 million <sup>a</sup>	2001	496 million
6.1	Maternal mortality rate (per 1000 live births)	1992-93	437 <sup>a</sup>	1998	407 <sup>c</sup>
6.2	Infant mortality rate (per 1000 live births)	1991	80 <sup>b</sup>	2000	68 <sup>c</sup>
6.3	Under-5 mortality rate (per 1000 live births)	1995	115 <sup>b</sup>	2000	96 <sup>c</sup>
7.	<b>Health infrastructure</b>				
	Subcentres	1995	132730 <sup>b</sup>	2001	137311
	PHCs	1995	21854 <sup>b</sup>		22842
	Hospital beds	1993	596203 <sup>b</sup>		
	Hospitals (all)	1993	13692 <sup>b</sup>	1999	15501
	Health workers including supervisors (male and female)	1993	230651 <sup>b</sup>	1999	243303 <sup>c</sup>
	Registered medical practitioners	1988	355600 <sup>b</sup>	1997	410800 <sup>c</sup>
8.	<b>Expenditure (as % of GDP)</b>				
	Health	1990-91	1.6 <sup>b</sup>	1992-97	0.9 <sup>c</sup>
	Family welfare	1990-91	1.3 <sup>b</sup>	1992-97	0.8 <sup>c</sup>
	Water and sanitation	1990-91	3.1 <sup>b</sup>	1992-97	2.1 <sup>c</sup>
9.	<b>Life expectancy</b>				
	Male	1991	60.6 <sup>a</sup>	2001-02	63.9 <sup>c</sup>
	Female	1991	61.7 <sup>a</sup>	2001-02	66.9 <sup>c</sup>
10.	<b>Causes of deaths (%)</b>	-	-		
	Communicable diseases	-	-	1998	42 <sup>b</sup>
	Non-communicable diseases	-	-	1998	48 <sup>b</sup>
	Injuries			1998	10 <sup>b</sup>

Source: <sup>a</sup>Census of India 2001; <sup>b</sup>Health Monitor 1999; <sup>c</sup>Park 2002.<sup>6</sup>

and environmental domains based on the agent-host-environment approach. The organisation of services for those with mental health problems has moved from crude, primitive methods, to more sophisticated, technologically driven approaches with a combination of pharmacological and non-pharmacological methods.<sup>5</sup>

Beginning with the Second World War, epidemiology has grown by leaps and bounds all over the world, even though gross disparities are noticed even today, both between and within countries in its development and application. This branch of community and clinical medicine, means literally 'on the people', indicating study of populations. Epidemiology as a branch of public health has also grown in principles, methods and applications over a period of time.<sup>6</sup> While epidemiology has paved the way for control and eradication of some health problems, it has also recognised the emergence of new problems the world over. Epidemiology is defined as 'the study of distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems'.<sup>7</sup> Undoubtedly, it has formed the cornerstone of the healthcare delivery system at global and national levels. Moving from its traditional bastion of infectious diseases, today epidemiology has diverse applications in health, illness and behaviour. Beginning from assessment of individual risks to directing governments for developing need-based programmes, it has inputs from several fields such as social sciences, public health, biostatistics, laboratory medicine and demography, within its own realm of clinical area of interest.

Psychiatric epidemiology is a branch of psychiatry and public health that investigates how mental disorders are distributed in the population. In simple terms, it answers basic questions: (a) how many people are suffering from a given disorder at any point of time; (b) how a disease of interest is distributed in terms of several socio-demographic variables like age, sex, education, occupation, income and residence; (c) what are the causes for a given mental disorder in terms of social, biological, environmental, psychological and cultural factors; (d) the changing patterns of a given disease in a population, (e) the natural history of a given illness in terms of relapse, remission or recovery; (f) the syndrome-wise distribution; (g) the conceptual construction of diagnosis and classification through the development of culture-specific and standardised instruments and approaches; (h) the evaluation of possible interventions in terms of outcome and effect at individual and community levels; and (i) the evaluation of organisation and functioning of mental health services.<sup>8,9</sup> Anthony, et al. observed that at the global level, the first-generation studies applied administrative treatment statistics to study the association of socio-demographic variables with specific mental disorders.<sup>10</sup> The use of census method and surveys of the general population to study the prevalence formed the core in second-generation studies. The third generation combined field survey approaches with a specific focus on individual disorders.<sup>11</sup>

As many strongly believe, psychiatric epidemiology is not just a 'sterile exercise in head counting' and does not stop at 'number games' or 'a survey'.<sup>12</sup> Constant improvements are occurring in epidemiological principles, methods and applications. While psychiatric epidemiology attempts to find out 'what is behind numbers (causation)', numbers *per se* are relevant for mental healthcare delivery in terms of hospital and community services, augmentation of specific services, manpower development, changes in medical curricula, and planning, programming, implementing and evaluating mental health services. Thus, psychiatric epidemiology has academic and administrative applications and directs both policy makers and professionals for further refinement and improvement.<sup>13</sup> It is precisely this understanding that has revolutionised psychiatric epidemiology all over the world to ask new questions and search for practical solutions with refinement in methodology to overcome the classic problems of case



definition, screening, assessment and clarification. If this branch succeeds in identifying causes of mental disorders that are amenable for prevention, it also helps in implementing cost-effective, culture-specific and sustainable interventions. The obvious question at this point of time is “Can the ‘psychosis-pellagra story’ be repeated?” It is not simple to answer this question, given the multi-factorial causation of mental disorders.<sup>8</sup> Definitely, a long way to travel!

Mental and behavioural disorders account for 12% of the global burden of disease. It is estimated that nearly 450 million people suffer from a mental or behavioural disorder in the world. Nearly 10% of total population suffers from these disorders. In 1990, it was estimated that 10% of Disability Adjusted Life Years (DALYs) across all age groups were due to depressive disorders, suicides and alcohol-related problems. A selective examination in 15–44 years and in gender specific terms indicate that depressive disorders, alcohol abuse, suicides, schizophrenia, bipolar disorders and panic disorders rank high among causes. Depression ranks third among men and second among women. Yet, mental health budgets of most countries are less than 1% of their total health expenditure. Further, 40% of the countries have no mental health policy and 30% have no mental health programmes.

*WHO Report 2001<sup>5</sup>*

A major cause for this scenario in India is lack of epidemiological data and absence of policy driven epidemiological data and research driven mental healthcare policies. It is estimated that India alone has about 100 million people in need of mental health services.

*NIMHANS Journal 1999<sup>14</sup>*

## Psychiatric Epidemiology in India

Psychiatric epidemiology has kept pace with the general growth of psychiatric research in India. Psychiatric research itself has grown by leaps and bounds in India since the time of independence. Wig clearly classifies this during the periods 1947–1960 (a slow phase of growth due to the lack of researchers and clarity issues) and 1960–1972 (a period of psychiatric epidemiological surveys and some focused studies).<sup>15</sup> The era after 1975 has shifted to more specific and focused work on several specific disorders, standardisation of methodologies and development of interventions.

While significant global developments have occurred in this field,<sup>16</sup> India has not lagged behind in the growth of psychiatric epidemiology.<sup>17</sup> The period between 1950 and 2000 has seen tremendous growth of this discipline across India with studies getting more and more refined and advancing clearly. This branch was not even heard of at the time of independence and assumptions had to be made on guesstimates. The growth of psychiatric epidemiology can be clearly traced through several distinct phases of development and progress. Sir Joseph Bhore made the first assumption as ‘even if population of mental patients is taken as 2/1,000 population in India, hospital accommodation should be available for 8,00,000 patients as against the existing 10,000 beds’.<sup>18</sup> Dr A.L. Mudaliar mentioned that ‘reliable statistics regarding the incidence of mental morbidity in India are not available’.<sup>19</sup>

Dr M.V. Govindaswamy was the first person to consider psychiatric epidemiology in India.<sup>20</sup> However, it failed to make any significant impact due to methodological errors. The first major survey on psychiatric problems in India was undertaken by Professor K.C. Dube in Agra in 1961.<sup>21</sup> At a time when resources were nil and knowledge was deficient, several unanswered questions confronted the researchers. ‘With a sum of Rs 10,000 given by the Union Health Minister a great

responsibility was thrust upon my shoulders, which I could not evade. As work progressed, myself and my team became more aware of the mistakes, pitfalls and labour that went into the work'.<sup>21</sup> Despite the odds, Professor Dube marched ahead and published his paper in *Acta Psychiatrica Scandinavica* in 1970.<sup>22</sup> Following this pioneering work, several Indian psychiatrists led the way with several studies in different parts of India.

The period between 1960 and 1980 was marked by a series of descriptive population-based studies of psychiatric morbidity in several parts of India. These studies dispelled several myths like 'psychiatric problems are as common in India as in the West'; 'mental disorders are as relevant in rural India as in urban parts' and 'even with limited resources, services can be organised both in hospital and community settings'.<sup>17</sup> A summary of these studies is provided in Table 4.2.

A majority of the classical Indian psychiatric epidemiology studies in the last four decades have been population based, focusing on general psychiatric morbidity in small to medium populations. A review of these studies reveal the wide variation in prevalence rates ranging from 10 to 370 per 1,000 population in different parts of the country.<sup>21</sup> The disparities narrow down when examined specifically for individual problems. A conclusion arrived at from these studies,<sup>22-41</sup> indicates that nearly 1% of the Indian population suffer from serious mental disorders and 5-10% from moderate disorders, requiring psychiatric help. The wide disparities are due to a large number of factors like the selection of study population, urban/rural population, choice of method, case identification methods, different screening instruments, case ascertainment methods, classification without inclusion and exclusion criteria, use of different gold standards and the use of inappropriate statistical procedures. Different tools have been used by different researchers like symptom checklists (with different numbers), questionnaires, interview schedules (both structured and unstructured), and confirmatory tools.

A more recent meta-analysis of 13 epidemiological studies in India, comprising 33,572 individuals, concluded that the prevalence estimate is 58.2 per 1,000 population.<sup>42</sup> Among the various problems, organic psychosis—0.4/1,000; schizophrenia—2.7/1,000; affective disorders—12.3/1,000; mental retardation—6.9/1,000; neurotic disorders—20/1,000 and alcohol-related disorders—6.9/1,000 are the major problems encountered in the community. Mental disorders were found to be higher in urban areas, among women, in the age group of 35-44 years and in the lower socio-economic strata. The study concluded that nearly 1.5 million people suffer from severe mental disorders and 5.7 million persons suffer from various psychiatric disorders requiring immediate help at any given point of time. In a more recent review of mental disorders in India, Ganguli concluded that national prevalence rates are 73/1,000 population, with rural and urban rates of 70.5 and 73/1,000, respectively.<sup>43</sup> The prevalence of schizophrenia was 2.5/1,000, being consistent across time and cultures. The morbidity load in urban India was found to be 3.5% higher compared with rural India. The author highlighted that biological, socio-cultural, psychological and other factors are responsible for the causation of mental illness as the rates are not uniform across cultures.

The late 1980s registered the third wave of psychiatric epidemiological studies and focused upon specific disorders in specific populations and in specific settings. The period also established in brief the incidence, course and outcome of schizophrenia and also some evaluation of interventions in mental healthcare.<sup>35,44,45</sup> Recent years have witnessed large-scale epidemiological studies in large populations on specific problems with methodological advancements that focus on issues of case definition, screening, diagnosis and classification.<sup>46,47</sup> Interestingly, in the last decade, research is also getting linked to service evaluation due to large-scale expansion of mental health services in India.

**Table 4.2: Prevalence of Psychiatric Disorders in Indian Epidemiological Studies**

S. No.	Author	Year	Place	Sample characteristics	Sample size	Prevalence rates/1000 population	Remarks
i	ii	iii	iv	v	vi	vii	viii
1.	Dube K.C. <sup>22</sup>	1970	Agra	Rural	29468	17.9	Three-stage survey
2.	Surya N.C. et al. <sup>23</sup>	1964	Kanchikuppam, Pondicherry	Rural	2731	9.5	Screening questionnaire of 28 items
3.	Sethi B.B. <sup>24</sup>	1967	Alambagh, Lucknow	Urban	1733	72.7	Questionnaire method
4.	Sethi B.B. <sup>25</sup>	1972	Four villages in Lucknow	Rural	500 families	39	Questionnaire method
5.	Sethi B.B. et al. <sup>26</sup>	1974	Lucknow city	Urban	4481	6.7	Questionnaire & clinical classification/DSM
6.	Ganguli H.C. <sup>27</sup>	1968	Delhi	Urban	327 industrial	14	Multiple sources of data (case history, examination & psychological text)
7.	Gopinath P.S. <sup>28</sup>	1968	Bangalore	Rural	423	16.54	28 item screening questionnaire
8.	Elnagar M.N. <sup>29</sup>	1971	Hoogly district	Rural	1383	27	Four sets of schedule & clinical evaluation
9.	Carstairs G.M. & Kapur R.L. <sup>30</sup>	1976	Kota	Rural	1233	369	IPSS with 124 symptoms
10.	Verghese A et al. <sup>31</sup>	1973	Vellore	Semi-urban	539 households	66.5	60 item questionnaire
11.	Thacore V.R. et al. <sup>32</sup>	1975	Lucknow	Rural	497 families	82	Diagnosis by DSM-1968 version
12.	Nandi D.N. et al. <sup>33</sup>	1975	Gambirgachi, West Bengal	Rural	1060	10.3	WHO definition of a case and ICD 1965 version

*To be continued...*

Table Continued...

i	ii	iii	iv	v	vi	vii	viii
13.	Nandi D.N. et al. <sup>49</sup>	1976	Gambirgachi, West Bengal	Rural	1078	17	Incidence study
14.	Nandi D.N. et al. <sup>97</sup>	1978	West Bengal	Rural	3718	207	Higher morbidity in urban areas
15.	Shah A.V. et al. <sup>34</sup>	1980	Ahmedabad	Urban	2712	47	—
16.	Isaac M.K. <sup>41</sup>	1987	Bangalore, Baroda, Calcutta, Patiala	Rural Rural Rural Rural	35548 39655 34582 36595	11.1 4.6 8.3 14.1	Focus on severe mental morbidity
17.	Mehta P. et al. <sup>36</sup>	1985	TamilNadu	Rural	5941	14	IPSS+ Psychiatric evaluation
18.	Sachdeva J.S. et al. <sup>37</sup>	1986	Punjab	Rural	1989	37	Symptoms in others of IPSS and confirmation by psychiatrists
19.	Premarajan K.C. et al. <sup>39</sup>	1993	Pondicherry	Urban	1115	99	Modified form of IPSS + Psychiatric evaluation
20.	Shaji S. et al. <sup>40</sup>	1995	Kerala	Rural	5284	15	IPSS + Psychiatric evaluation + ICD 10
21.	Reddy M.V. & Chandrashekar C.R. <sup>42</sup>	1998	Bangalore from selected studies	Pooled data	33572	58.2	Meta-analysis approach
22.	Ganguli H.C. <sup>43</sup>	2000	Bangalore	Pooled data from 15 selected studies	-	73.0	Pooled data analysis

DSM – Diagnostic and Statistical Manual; IPSS – Indian Psychiatric Survey Schedule; ICD – International Classification of Diseases.

A recent review of psychiatric and neurological disorders by NIMHANS, Bangalore, estimates that nearly 100 million people (10% of the total population) suffer from mental and neurological problems requiring professional help at any point of time.<sup>48</sup>

These pooled observations from a number of studies on 'all psychiatric problems' have the limitation of a combined masking effect on a detailed understanding of individual problems. Hence, the next few sections make an attempt at unravelling the various dimensions of selected psychiatric problems. The time has come to move forward by asking focused questions on both methodological and service need issues in individual disorders.

### ***Schizophrenia***

Schizophrenia was recorded in Indian history nearly 3,300 years ago by Charaka.<sup>44</sup> Beginning with the first epidemiological study by Dr M.V. Govindaswamy in 1957, several researchers have examined the prevalence and socio-demographic correlates of schizophrenia.<sup>22,23,26,27,29-31,45,50,51</sup> These studies were followed by an international pilot study of schizophrenia and determinants of

**Table 4.3: Prevalence of Schizophrenia as Reported in Indian Psychiatric Epidemiological Studies**

Author	Year	Rural/urban	Population size	Prevalence rate/1000
Surya N.C. et al.	1964	Urban	2731	1.5
Sethi B.B. et al.	1967	Urban	1733	2.3
Ganguli H.C.	1968	Urban	327	-
Gopinath P.S.	1968	Rural	423	2.36
Dube K.C.	1970	Rural/urban	29648	2.17
Elnagar M.N.	1971	Rural	1393	4.3
Thacore V.R. et al.	1971	Urban	1977	1.3
Sethi B.B. et al.	1972	Rural	2691	1.1
Carstairs G.M. & Kapur R.L.	1973	Rural	1233	7.2
Verghese A. et al.	1973	Urban	1887	2.6
Sethi B.B. et al.	1974	Urban	4481	2.5
Nandi D.N. et al.	1975	Rural	1060	2.8
Nandi D.N. et al.	1980	Rural/urban	1862	5.3
Isaac M.K. and Kapur R.L.	1980	Rural	4209	0.9
Nandi D.N. et al.	1980	Urban	4035	2.2
ICMR - DST	1987	Rural	46380	2.2
Rajkumar S.	1988	Urban	101229	2.49
ICMR/CAR/CMH	1990	Rural	32645	1.83

*Source: Sekar and Murthy, 1999.<sup>53</sup>*

the outcome of severe mental disorders in India.<sup>52</sup> The first large-scale study on prevalence and service evaluation was undertaken by Indian Council of Medical Research—Department of Science and Technology (ICMR–DST) in four centres of India in 1987. More recently, several longitudinal studies and those to study the course and outcome in India have followed.<sup>47,54,55</sup>

The Indian studies have examined population of varying sizes, ranging from 327 to 1,01,229 (Table 4.3). The reported prevalence rates for schizophrenia vary from 0.9 to 7.2 per 1,000. The Bangalore study, conducted on a population of 32,498 and incorporating significant methodological improvements, found the prevalence to be 3.09/1,000.<sup>46</sup> The largest of these studies was done on a population of 1,01,229 near Chennai, recorded a lower prevalence (2.49/1,000).<sup>47</sup>

A meta-analysis by Reddy and Chandrasekhar estimates the prevalence of schizophrenia to be 2.7 (2.2–3.3)/1,000 population.<sup>42</sup> Ganguli identified the prevalence to be 2.5/1,000 (urban 2.5 and rural 3.6) from a review of 13 studies.<sup>43</sup> Even with a rate of 2.5–2.7/1,000, it is estimated that India has nearly 2.5 million schizophrenics needing care at any point of time.

Studies on the incidence of schizophrenia have also been undertaken by Indian researchers.<sup>33,44,54</sup> The estimates of schizophrenia incidence was 0.38/1,000 in urban and 0.44/1,000 in rural parts of Chandigarh.<sup>54</sup> In West Bengal the incidence was 0.93/1,000 population.<sup>33</sup> The ICMR-SOFPUC study established the incidence to be 0.35/1,000.<sup>54</sup>

The recent longitudinal study of functional psychosis in urban community slums by ICMR, Chennai covered a population of 1,01,229.<sup>54</sup> The Indian Psychiatric Survey Schedule (IPSS) and Present State Examination (PSE) were used for screening purposes and International Classification of Diseases (ICD-9) criteria for diagnostic classification purposes. Incidence rates were arrived from a population of 25,661 and the overall incidence was 0.35/1,000, with an age-adjusted incidence rate of 3.87/1,000. The study also identified that nearly one-third of patients had received no psychiatric care during illness. A ten-year follow-up study revealed that the pattern of the course was favourable and had a short duration of illness (less than six months), indicating better prognosis. Some of the specific observations on schizophrenia in India are: a higher incidence of the condition in India; increasing rates among men compared with women; better course and outcome. The last could be perhaps due to several factors such as low expressed emotions among relatives, greater tolerance, better quality of social support, and lower expectations from patients.

### ***Common mental disorders***

Common Mental Disorders (CMDs) is a term used for a range of conditions, with depression recently gaining importance being the commonest condition studied by Indian researchers. Many CMDs are present in a variety of settings, varying from primary health centres to apex referral institutions. Depending upon the methodology adopted and the setting, the prevalence rates have varied in India. Patel in a recent review of CMDs in India, reports prevalence figures ranging from 2% to 57% (Table 4.4).<sup>56</sup> The prevalence in general/primary healthcare settings varies from 20% to 45%.<sup>57–63</sup> In a review of utilisation pattern of services in extension services of NIMHANS, neurotic and psychiatric disorders constituted 24% of total attenders in the five extension service centres.<sup>64</sup> Ganguli, summarising the findings from 15 studies, observed the prevalence of depression to be 34/1,000 of the population.<sup>43</sup> For psychotic depression and neurotic depression, the rates were found to be 7.8/1,000 and 22.8/1,000, respectively. Reddy and Chandrashekhar noticed the prevalence rates to be 13.9 in rural areas and 35.7/1,000 in urban areas.<sup>43</sup> The factors associated with the occurrence of CMDs were female gender, poverty, unemployment, lower levels of literacy

**Table 4.4: Prevalence of Common Mental Disorders in Indian Studies**

Authors	Setting	State	Sample size (%)	Prevalence
Krishnamurthy S. et al.	GP Urban	Karnataka	300	36
Bagadia V. et al.	GHC Urban	Maharashtra	500	57
Shamasundar C. et al.	GP Urban	Karnataka	882	36
Sen B. et al.	PHC Urban	West Bengal	202	25
Nandi D.N. et al.	Rural/ urban	West Bengal	1424	2.3–4
Channabasavanna S.M. et al.	GHC Urban	Karnataka	1366	24
Patel V. et al.	PHC Urban+rural	Goa	303	46.5
Amin G. et al.	GHC Urban	Gujarat	200 Systematic	21 (depression)

GP—General Practice; GHC—General Health Centre; PHC—Primary Health Centre.

Source: Patel, 1999<sup>56</sup>

and others, which in turn are linked to a wide variety of social, economic and cultural issues as per the review.<sup>56,65</sup>

CMDs are also linked to significant disability and impaired quality of life. It has been observed that work loss due to illness affects the quality of life and that families face an increased financial burden in addition to the disruption of family and leisure activities.<sup>64</sup>

There are no studies in India of the incidence, course, outcome, service needs and utilisation, disability and socio-economic burden of CMD, even though it is the most common disorder seen in the general population, primary care or hospital-based settings. Although about one-third of primary care attenders suffer from various CMDs, both in urban and rural areas, it is well known that less than one-third of these are identified by primary healthcare doctors. Further, even when identified, most of the patients are just treated symptomatically. With prevalence rates ranging from 30 to 35 per 1,000, it can be estimated that nearly 30–35 million people in India require mental health services.

### ***Mental retardation***

The measurement of human intelligence in the beginning of the nineteenth century paved the way for the recognition of mental retardation (MR) across the world. MR can be defined in combination or in isolation with the measurement of intelligence, neurologic functioning, social adaptation, and behavioural competence.<sup>65a</sup> Prevalence of MR in selected Indian states is given in Table 4.5. Most of the Indian epidemiological studies have included MR in their audit. A review of Indian studies on MR by Prabhu et al. revealed that the prevalence rates varied from 0.22 to 32.7 per 1,000 of the population.<sup>67</sup> Madhavan in a collective review, noticed that the rates varied from 3.4/1,000 to 30/1,000 in India.<sup>68</sup> Using a two-step procedure of screening and confirmation by a psychiatrist, Gupta and Sethi from Uttar Pradesh, in a population-based survey of 500 rural and

**Table 4.5: Prevalence of Mental Retardation from Selected Studies in India  
(Rate/1,000 children)**

Author	Place	Sample size	Nature	Rate	Remarks on age group
Surya N.C. et al. <sup>23</sup>	Pondicherry	2731	Urban	0.7	0-15
Dube K.C. <sup>22</sup>	Agra	8035	Mixed	77	5-12
Nandi D.N. et al. <sup>33</sup>	West Bengal	462	Rural	2	0-12
Verghese A. et al. <sup>31</sup>	Vellore	747	Urban	20.1	4-12
Lal N. & Sethi B.B. <sup>70</sup>	Lucknow	272	Urban	29.4	0-12
Narayan H.S. <sup>71</sup>	Bangalore	10700	Rural	3.4	3-15
Subramanya B. <sup>72</sup>	-	1468	Rural	27.4	6-16

1,000 urban households, reported a prevalence of 2.1%.<sup>69</sup> Those with severe MR in this study were observed to be 1.5%. Other studies have documented the prevalence of MR to vary from 8.6 and 8.3/1,000 in Kolkata and Vellore respectively.<sup>31</sup> Specific surveys in school-going children have shown prevalence of 14.0-32.7/1,000. Reddy and Chandrashekar established a weighted prevalence rate of 6.9/1,000 from a meta-analysis-based study, with higher occurrence among males.<sup>42</sup> The urban and rural rates were found to be 8.9 and 6.4/1,000, respectively. Ganguli, in a review of 10 studies observed a prevalence rate of 3.7 and 9/1,000, respectively.<sup>43</sup> Srinath and Girimaji in a recent review of child and adolescent mental health problems in India, concluded that 2% and 0.5% of children in India suffers from mild and severe forms of MR, respectively.<sup>73</sup> Based on this, it can be estimated that nearly 8-10 million children in India require services.

Few studies have examined the causes of MR in the Indian region. Narayan in a study of severe MR in 10,700 individuals identified the possible causes in 47% of MR cases.<sup>71</sup> The major contributors were: obstetric factors—24%, chromosomal disorders—10%, and mutant genes—13%. A variety of factors like obstetric causes, infections, malnutrition and birth damage account for the greater extent of MR in India. In a multi-centre study of MR to identify causes,<sup>74</sup> it was noticed that chromosomal disorders (24%), metabolic factors (5%), genetic syndromes (12%) and prenatal causes (30%) were the commonest causes. It is commonly known that goitre in India is one of the principal causes of MR in the sub-Himalayan region of India. More than a quarter of the incidence of mental retardation in India is due to preventable causes. Childhood MR can be prevented with better obstetric care for pregnant women, better internal and child health services, iodization of salt and improved health education.

### ***Child and adolescent mental health problems***

Several population-based/hospital-based/specific children-based epidemiological studies have been completed in India (excluding MR). As compared to adult epidemiological surveys, studies on children are much more difficult to carry out due to problems in definition of deviance, emotion, and perception, understanding disability by parents, teachers and interviewers and measurement issues. Prabhu in a review of child and adolescent mental health research in India, identified three periods: the past (1950-1965), the eclipse (1965-1980) and the turning point (1980 onwards) of growth in this area.<sup>75</sup> It was identified that the current scenario would change



with the availability of more trained personnel in research, counselling, in school mental health programmes and that there is a need for many more programmes in these areas. The prevalence rates recorded in another study in different populations varied from 7 to 172 per 1,000 children.<sup>76</sup> In a review of studies by Kapur on mental health problems in children, it was observed that community surveys identified only severe problems like enuresis, stuttering, sleep disorders, MR and epilepsy.<sup>77</sup> Further, school-going children have higher psychological disturbances; urban children report more problems compared to rural children; boys have a higher preponderance than girls and scholastic backwardness is a major problem in the Indian region. It was concluded that academic problems of children need to be examined simultaneously with mental health problems.

Srinath and Girimaji in a recent review on childhood psychiatric and emotional problems, reported the prevalence to vary from 25 to 356 per 1,000 in field studies.<sup>73</sup> The wide variation is due to methodological problems discussed earlier. In order to overcome these lacunae, the ICMR undertook a study in Bangalore and Lucknow in 1997.<sup>78</sup> Adopting a two-stage survey and using standardised instruments for different age groups (child behaviour checklists, Rutter's teacher's questionnaires, diagnostic interview schedules for parents and teachers, parents' interview schedules, children's global assessment scales, intelligence assessment, assessment of felt treatment needs; and physical examination), the prevalence of child and adolescent disorders in this study was observed to be 12.8% in 1-16 year-old children.<sup>5</sup> With the recent figures from ICMR to be 128/1,000, nearly five million children (under 15 years) would require mental healthcare in India.

### ***Alcohol-related mental health problems***

The Vedic scriptures have documented the use of *soma sura* (intoxicating beverages) as early as 2000-800 BC in India. Even the ancient Indian texts of Charaka and Shusruta (around 300 AD), make distinctions between normal and excessive drinking. These texts and scriptures also identified the harmful effects of drinking.<sup>79</sup> It has been observed that throughout history, while alcohol was referred to as an evil, it was still glamourised and accepted in certain classes.<sup>80</sup> In recent years, the production, distribution, availability and advertisements of alcohol have increased due to market-oriented policies of governments, resulting in the increased per capita consumption all over India.<sup>80</sup>

In the last two decades, alcohol-related psychiatric problems have been studied through psychiatric morbidity surveys in general population and also through studies in specific populations. Surya et al. reported a prevalence rate of 3.6/1,000 for alcoholism,<sup>23</sup> while Gopinath observed rates of 2.4/1,000 in Bangalore.<sup>28</sup> The prevalence of alcoholism in Vellore,<sup>31</sup> Agra,<sup>81</sup> Hoogly district,<sup>29</sup> was observed to be of 4.8/1,000, 1.4/1,000 and 13/1,000, respectively for alcoholism, habitual use of alcohol and alcohol addiction. More recently, Premarajan et al. reported rates of 34.1/1,000 in Pondicherry for alcohol dependence syndrome.<sup>39</sup> Varma et al., in a survey of adults in urban and rural populations near Chandigarh, observed that 23.7% reported regular use of alcohol.<sup>82</sup> Sethi and Trivedi reported 50% of men above the age of 15 in rural areas were found to consume alcohol.<sup>83</sup> More recently, Ponnudurai et al. in Chennai noticed a prevalence rate of 16.7% among men, using the Michigan Alcoholism Screening Test.<sup>84</sup> Similarly, other studies from Tamil Nadu by Chakravarthy and Mathrubootham observed rates of 17% and 33% among men.<sup>85,86</sup> In an interesting survey by Bang and Bang in 104 villages of the Ghadchiroli district of Maharashtra, it was observed that nearly 1,00,000 men consumed alcohol, of which one-fifth were addicts.<sup>87</sup> From a head of the household survey in New Delhi by Mohan et al. it was noticed that 26% of the residents in urban slums were substance abusers, the majority involving alcohol.<sup>88</sup>

In a recent survey of 32,400 people in and around Bangalore, 1.2% of men were found to suffer from alcohol dependence syndrome.<sup>46</sup> The meta-analysis study by Reddy and Chandrashekar revealed an overall prevalence of 6.9/1,000 (95%, CI 5.7–8.1) for India, with urban and rural rates of 5.8 and 7.3/1000 of the population.<sup>42</sup> The rates among men and women were 11.9 and 1.7, respectively.

Surveys of alcohol use in specific populations have also been carried out in India. These populations include school students, industrial workers and medical personnel. Mohan reported that 10–15% of college students were regular alcohol users.<sup>89</sup> Among medical personnel, the problem was severe, with 40–66% reporting alcohol use.<sup>90,91</sup> Nearly 10–60% of industrial workers were also found to be regular alcohol users as per the data available from Delhi, Punjab and Chennai.<sup>92,93</sup>

In accordance with the growing abuse of alcohol, hospital admission rates in India are also increasing. Several studies indicate that nearly 20–30% of hospital admissions are due to alcohol-related problems in mental care settings.<sup>94</sup>

On the basis of these rough estimates assuming that nearly 30% of men are current alcohol users, with 30% of them being alcohol dependent, it would appear that nearly 30 million people require some form of mental healthcare. Further, long-term alcohol consumption is linked to a wide variety of social (family disruption, marital disharmony, impact on children, deprivation of family, work absenteeism, growing crime and violence, etc.) and health (cirrhosis of liver, road traffic injuries, suicides, etc.) problems. Based on these observations, it is estimated that nearly 9–10 million people would require interventional support for alcoholism and many more need help to overcome the social and health evils of alcohol.

### ***Suicides***

Suicides are one of the acute emergencies resulting in death, depending on the mode of the attempt as decided by nature, intent, lethality and the availability of healthcare. Suicides have been existing since the beginning of mankind and only recently research to unfurl its mysteries have begun in India. Even the ancient Vedic texts of Indian culture highlight, depict and glorify suicides.

Suicides have not been part of many population-based surveys, but have been an area of independent research by psychiatrists. Suicides have recorded an increase from nearly 40,000 in 1980 to 1,10,000 in 1999.<sup>94a</sup> Due to its medico-legal nature, information on suicides is available from national, state and city crime record bureaus in various parts of India. As per the latest reports, nearly 1,00,000 persons committed suicides in India in 1999, with an annual incidence of 11/1,00,000. Several studies undertaken in India have revealed the incidence of suicides to vary from 8 to 43 per 1,00,000 of the population (Table 4.6).<sup>95-104</sup>

It is estimated that attempted suicides are 10–20 times this number and those with suicidal thoughts, 50–100 times this figure.<sup>105</sup> All studies on suicides have been based on police records with very few from hospital records and nil from population settings. Given the inadequacies of police reporting—analysis and misclassification bias (suicides, homicides, accidental deaths)—the numbers may be an under-reporting of the situation. The male to female distribution has varied from 1:1.2 to 1:1.7 in different regions. Significant regional variations have been noticed with Pondicherry, Kerala, West Bengal and Maharashtra registering higher numbers. Interestingly, nearly 60% of suicides occur in the 20–40 years age group all over India.<sup>94a</sup> Further, the majority of suicides took place by hanging and poisoning, with self-immolation occurring more in women. In sharp contrast with the West, a number of social, economic, cultural, mental health and general health conditions have been incriminated in causation of suicides.<sup>105</sup>

Among the various mental health problems, depression, alcoholism, affective disorders and even schizophrenia have been identified for suicides. In a recent case-control study from Chennai,

**Table 4.6: Incidence Rates of Suicide in India**

S.No.	Author	Year	Place	Incidence rate
1.	Shah J.H.	1960	Sourashtra	14.1
2.	Satyavathy & Murthy Rao D.L.N. <sup>95</sup>	1961	Bangalore	8.1
3.	Ganapathy M. N. & Venkoba Rao A. <sup>96</sup>	1966	Madurai	43.0
4.	Nandi D.N. et al. <sup>97</sup>	1978	West Bengal (rural)	26.5
5.	Hegde R.S. <sup>103</sup>	1980	North Karnataka (rural)	9.3
6.	Ponnudurai R. K. Jayakar J. <sup>99</sup>	1979	Chennai	14.1
7.	Banerjee G. et al.	1990	West Bengal	43.4
8.	Shukla G.D. et al. <sup>101</sup>	1990	Jhansi (1986–87)	29.0
9.	Sarma G.P. & Gautam Sawang D.	1993	Rural Andhra Pradesh	22.8
10.	India	1999	National level data	11.0
11.	Gururaj G. & Isaac M. K. <sup>104</sup>	2002	Bangalore	34.0

the presence of depression axis I disorder (OR–19.5), family history of psychopathology (OR–12.8) and stressful life events (OR–15.1) carried a high risk of suicides.<sup>106</sup> In an ongoing case-control study in Bangalore the lack of coping skills, absence of social support, dissatisfaction in life and alcoholism in the family, have emerged as major risk factors.<sup>104</sup> In the Indian situation, the causes are multi-factorial, cumulative, repetitive and progressive, leading an individual to a state of helplessness, worthlessness and hopelessness, obviously influenced by his social strengths and weaknesses along with his mental health status.<sup>105</sup>

### ***Dementia***

Dementia, defined as the 'global deterioration of the individual's intellectual, emotional and cognitive faculties in a state of impaired consciousness' has been a recent matter of interest among psychiatrists and public health researchers.<sup>98</sup> With advances in healthcare technology and increasing life expectancy, the proportion of the older generation in India will continue to grow. It is estimated that it will increase from 6% in 2001 to 8.5% by 2025, thus resulting in nearly 90 million older people (65+) with dementia in the Indian region.<sup>107</sup> Alzheimer's disease contributes to 60% of all dementias, affecting people over the age of 60 years, while a number of other conditions are responsible for non-Alzheimer's dementia.<sup>108</sup>

Geriatric psychiatric epidemiological studies have been few and limited in India. Venkoba Rao, in a study of problem of the aged seeking psychiatric help in Madurai, identified dementia in 30 while an earlier (20%) of the 150 consecutive cases among 60+ individuals.<sup>109,110</sup> Study reported a prevalence of 23.6% for depression in subjects aged 50+ in South India, Venkoba Rao and Madhavan noticed 6% of the elderly (60+ years) to be depressed.<sup>111</sup> Chandra et al. in their study in Ballabgarh, found the prevalence of dementia to be 1.36% in the 65+ age group.<sup>112</sup> Old age was significantly associated with a higher prevalence of Alzheimer's disease and all dementias, but gender and literacy did not have an influence. Dementia prevalence from other parts of India are found to be 2.7% in urban Chennai,<sup>113</sup> 3.5% in rural Thiroporur,<sup>114</sup> and 3.4% in Thiruvanniyoor, Kerala.<sup>115</sup>

With changes in the social fabric of Indian society, geriatric mental health problems will increase in the coming years. An understanding of mental health problems and needs is crucial to organise need-based and culture-specific services.

## **Methodological Issues in Psychiatric Epidemiological Studies**

There has been a tremendous growth in psychiatric epidemiology during the period 1960 to 2000. The better part of the growth has been in the last decade. Studies undertaken at different times in different parts of India using various methods have outlined various psychiatric problems in front of policy makers and indicate the abundant information available in the country to organise need-based services. As discussed earlier, different studies in different settings (population-based, hospital-based, selective populations), different sample sizes (few hundreds to several thousands), differing nature of the populations (urban, rural, mixed), and varying age groups (including children and other age groups), contribute immensely to variation in the prevalence rates. Further, different statistical techniques (representative versus convenient samples) account for differential rates. A major problem in comparison over a period of time has been the different screening techniques, preferential case ascertainment methods and several classification procedures. A compendium of instruments used in several studies has recently been published by the WHO.<sup>116</sup>

One of the major methodological problems in psychiatric epidemiology has been the definition of 'what a psychiatric case is'. While case definition and case identification may be easy in psychiatric hospital and out-patient settings, the ascertainment of a true psychiatric case in the community in a reliable manner can often be difficult. Personal, face-to-face interviews by a trained psychiatrist is generally considered as the 'gold standard' for case ascertainment in psychiatric epidemiological surveys. However, since practical feasibility and cost consideration would not permit such design in all surveys, several screening instruments for identifying psychiatric cases in the population have been developed for 'two-phase' data collection. Developments in the field of diagnostic concepts and classification, such as the use of operational diagnostic criteria, have paved the way for wide acceptance of classification systems such as the ICD-10<sup>117</sup> and Diagnostic and Statistical Manual (DSM) IV,<sup>118</sup> and systematic assessment instruments linked to the systems. These developments have no doubt contributed to methodological advancement and sophistication in psychiatric epidemiology. Although instruments such as the Indian Psychiatric Interview Schedule (IPIS) and the Indian Psychiatric Survey Schedule (IPSS)<sup>119</sup> were developed based extensively on field experiences in India, no further development has occurred in Indian measurement instruments during the last two decades.

The majority of psychiatric epidemiological research in India has remained at the level of descriptive 'cross-sectional' prevalence surveys. There have been few repeat cross-sectional surveys as well as prospective surveys to establish the incidence of mental disorders. Beyond these studies, analytical research using case-control or cohort designs to test specific hypothesis regarding risk factors, or other correlates of morbidity, are conspicuous by their absence. Studies of evaluation of specific intervention strategies (intervention studies), are also few. Psychiatric epidemiology in India should now move forward to answer specific questions relevant to India regarding risk factors, the effectiveness of interventions, the quality of mental health services, monitoring of district mental health programmes, etc. The publication of epidemiological methods should also be undertaken to investigate problems encountered in routine clinical practice to develop 'evidence-based psychiatric practice' in India.

The recent emergence of multi-centric studies by the ICMR (ICMR-DST study on severe mental morbidity, SOFACOS study on schizophrenia and the ICMR study on child and adolescent mental health problems), are a welcome sign at this juncture because of uniformity and standardised procedures of interviews and data-collection methods, thus minimising inter-observer and intra-observer errors. Recent years have seen the emergence of more standardised instruments and computer generated algorithms to reduce these errors further. The availability of instruments like CIDI, SCAN, SCID and others, have revolutionised psychiatric epidemiology from a methodological point of view. The recently initiated 10-centre study on the longitudinal study of mental health problems in defined populations would bring in country and culture-specific data in the coming years.

## Unanswered Questions

Despite the large volume of psychiatric epidemiology research in India, several questions remain unanswered. These questions are both academic and administrative in nature, thus creating a vacuum in several areas. As mentioned earlier, psychiatric epidemiology, while facilitating a greater understanding of the problem and its causes, must lead the way to organisation of services. Indian studies in the seventies undoubtedly paved the way for the formulation and launch of the National Mental Health Programme (NMHP) and several community-based service delivery mechanisms.<sup>120-125</sup>

- Since most studies are descriptive with non-comparability and lack of uniformity, national estimates even for prioritised mental health problems are not available. While it is not possible to have a single estimate (there cannot be one estimate) due to large population variation and wide spectrum of mental health problems, a rough estimate within a narrow range should be available for comparison with other health problems to compete for the meagrely available health resources. Estimates should also be available for prioritised mental health problems in India, based on scientific principles and not 'off the hat' numbers.
- India has witnessed phenomenal changes in urbanisation, industrialisation, migration, media impact and changing socio-economic levels of individuals and families. The breaking of societal mechanisms has paved the way for more individual living, with anecdotal evidence of increasing mental health problems. In this complex scenario, it is to say: whether mental disorders are on the increase, decrease or stagnant; which disorders are changing; how is this linked to changing lifestyles; correlation with changing social and micro-and macro-economic policies of successive governments and many other issues. There is no clear-cut picture emerging on the association between changing socio-economic and demographic indicators and psychiatric problems.
- In a country with a population of more than a billion, information on the causes of mental disorders is not available. Even a cursory or detailed examination does not reveal 'what is behind these numbers'. Analytical studies are totally lacking even though small-scale studies have clarified some problems in this direction. Mental illness is often an interplay of biological, social, environmental, cultural and psychological factors. In the absence of well-designed nationally representative analytical studies, it is often a guess or a clinical judgment predicting individual risks.
- The obvious lack of analytical studies has also thwarted the emergence of preventive mental health services in India. Several conditions like mental retardation, alcoholism, suicide and depression have their roots in the socio-cultural environment of communities. The lack of

information about whether it can be prevented, how it can be prevented and by what methods, has not been addressed region-wise. If genetic psychiatric epidemiology can grow by leaps and bounds, so must socio-cultural epidemiology, at an equal pace. Since the fundamental aim of psychiatric epidemiology is to prevent the occurrence of mental disorders, this issue requires urgent attention.

- Need-assessment has not been a part of psychiatric epidemiological studies in India, even though the very purpose of epidemiology is to provide the database for planning and provisioning of services. The recent tragedy at Erwady brought the wide gap between demand and supply into stark focus.
- In the Indian context, data are totally lacking at a national level on disabilities, and the resultant socio-economic impact on the quality of the life of people and their families with regard to mental illness. The health and social outcomes in the heterogeneous Indian community have remained poorly understood. In a recent global review of 20 articles, indicators of impairment, disability, handicap and low quality of life showed a prevalence of 0.1–92%, 3.6–66%, 0.6–56% and 1.8–26%, respectively.<sup>126</sup> Chisholm et al. have recently demonstrated the feasibility of undertaking economic studies even in developing countries.<sup>127</sup>
- The large number of epidemiological studies undoubtedly paved the way for the formulation and implementation of the NMHP in India (NMHP 1982), albeit at a slow pace.<sup>121</sup> At the same time, a large number of community mental health programmes have also emerged in different parts of the country.<sup>122,124,128</sup> Simultaneously, a large number of policies and programmes in related sectors of rehabilitation, social welfare, education and labour reforms, are also in motion. An obvious need for application of ‘epidemiological principles and methods’ and ‘available epidemiological data’, is conspicuous in this scenario to formulate, implement and evaluate mental health services. No clear-cut research is available to indicate the right direction for these programmes. Research in psychiatric epidemiology, combined with operational research to examine pitfalls in the progress of these schemes is strikingly absent in India. Epidemiological research integrated with health planning, management and evaluation, is the need of the hour to bridge the vacuum.
- A widening gap between the ‘researchers’ definition of a case’ and ‘community perception of mental problems’ and ‘needs of those requiring care’ are some of the key issues not addressed in the Indian region. Even in Western countries, this debate is on the increase between science and reality.<sup>129–131</sup> In India, it is quite clear that existing services do not even penetrate a small segment of the population, and this is obviously linked to the availability and affordability of mental health services. Indian psychiatric epidemiology has closely followed international growth in this area. The majority of new instruments and standardised procedures have not been tested for culture specificity and indigenous instruments are often overshadowed by Western technologies. If this gap has to be narrowed, local, culture-specific methodologies need augmentation. Any amount of research data will fail to make an impact, if it is not linked to community needs and perceptions.

## **Future Directions**

Psychiatric epidemiology is at an exciting phase of growth and development.<sup>129,132,133</sup> Moving from small surveys to multi-centric studies, symptom checklists to standardised instruments, small populations to large databases and single prevalence surveys to longitudinal studies, it holds enormous potential to improve the understanding of mental disorders in the Indian region.

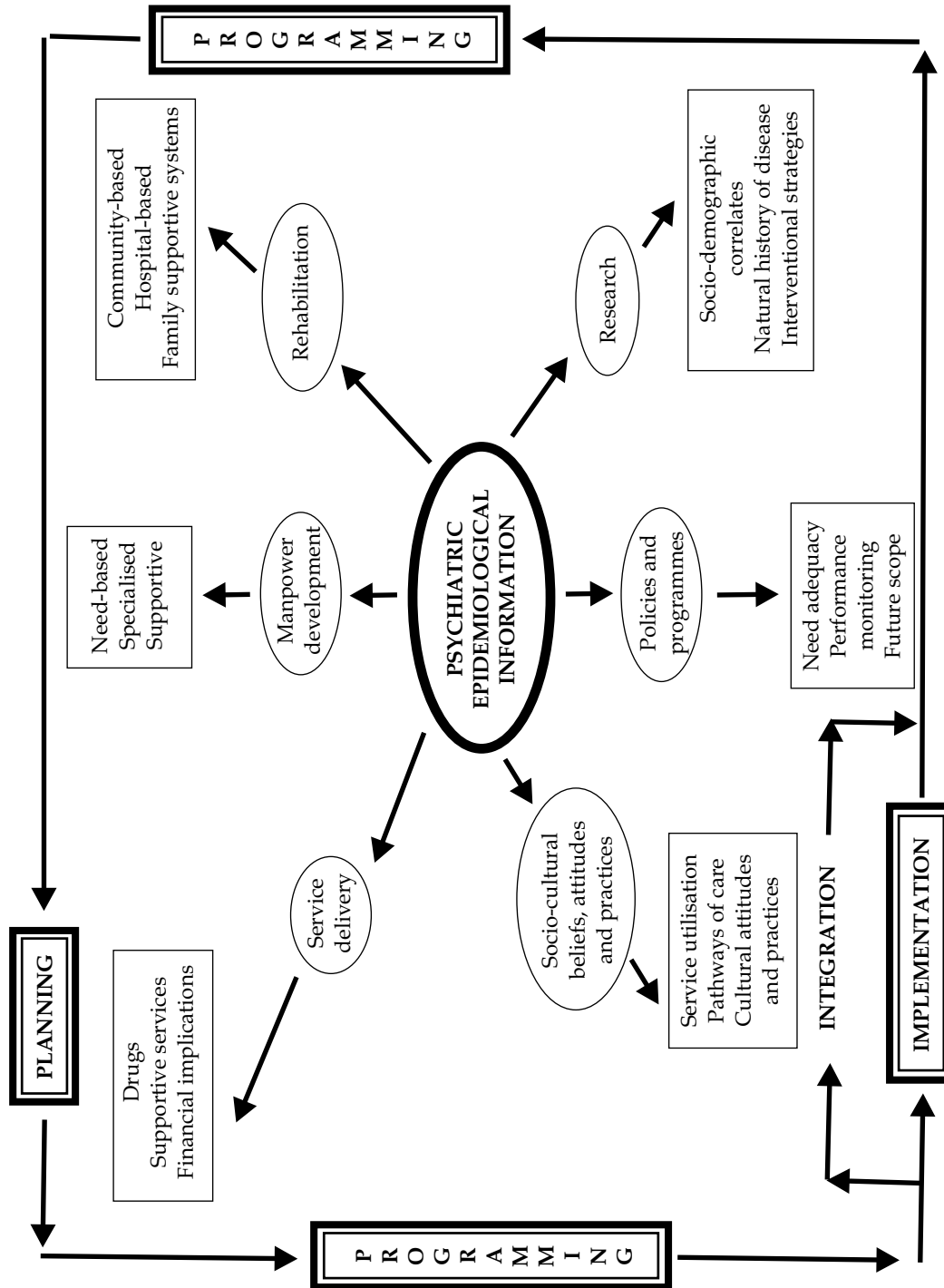
The application of these findings in mental health services will open up phenomenal opportunities for improving the quality of life of those with mental illnesses and their families. The concept of translational research must inform psychiatric epidemiology: surveys should translate into better services.

- Developing culture-specific instruments to delineate mental disorders should receive priority to improve the acceptance between researchers and community needs.
- Large-scale multi-centric studies on representative populations, by developing epidemiological databases in defined populations, is a crucial activity to be promoted in the years to come. While independent small-scale prevalence surveys will continue to add to the existing knowledge, large-scale studies are the need of the hour. Increasing funds, better coordination as well as the pooling of results will help in this process.
- Emerging problems of alcoholism, child mental health, geriatric mental health, adolescent health, urban health and behavioural risk factor studies need the attention of researchers.
- The fast pace of socio-cultural reforms and growth requires a closer look at several issues like poverty, urbanisation and changing life patterns. This growth has to occur along with biological advances in mental healthcare, in terms of genetic epidemiology and neuro-behavioural sciences.
- Establishing case registries in mental health (like cancer registries and diabetes registries) needs a closer examination and application by researchers. This would be an appropriate input into the slowly expanding district mental health programme under the NMHP in India.
- Psychiatric epidemiology needs to expand into the areas of operational research to study the utilisation pattern of services, thereby making care available to those in need.
- Epidemiological principles and methods should be adapted to answer system-related questions for requirements in drug availability, manpower development, medical curricula, removal of stigma and others (Figure 4.1).
- At the national level, there is a need to prioritise mental health problems for better research and service. Conditions resulting in greater load in general hospital-peripheral settings and posing greater burden on families deserve immediate attention for research. This prioritisation should be based on local problems and patterns.
- To evolve a consistent progress in research, there is a need for the designation of national coordinating centres to examine specific issues. A group of centres can be given collective responsibility in specific areas with adequate financial and logistic support.
- Psychiatric epidemiology especially needs trained and skilled manpower. Human resource development programmes in selected centres within India should be promoted through short-term training programmes.

## Conclusion

Psychiatric epidemiology has made significant studies in the Indian region during the last four decades. The information available from Indian studies have paved the way for the implementation of the NMHP and several community-based initiatives. In the last decade, a new wave of studies have begun to employ standardised methodological approaches to bring in greater

Figure 4.1: Applications of Psychiatric Epidemiology for Research and Service Delivery Programmes





uniformity. However, this branch has to still address many unanswered questions in both research and service delivery. There is a greater need of collaboration among mental health professionals, between psychiatrists and public health professionals, and also among researchers and policy makers and programme managers. The time is appropriate at this juncture to move beyond numbers.

## References

1. Census of India. *Provisional Population Totals. Rural-Urban Distribution of Population, Paper 2 of 2001.* Karnataka; Director of Census Operations, 2002.
2. Health Monitor, Foundation for research in health systems. Ahmedabad, 1999.
3. World Health Organization. *The ICD-10 Classification of Mental & Behavioural Disorders: Clinical Descriptions & Diagnostic Guidelines.* Geneva: WHO, 1992.
4. Sunder Lal, Vashist A. Reforms in health system in India (Editorial). *Indian Journal of Community Medicine* 2002a;27(3):99-105.
5. World Health Organization. *World Health Report 2001 Mental Health; New Understanding, New hope.* Geneva: WHO, 2001.
6. Park K. *Park's Textbook of Preventive & Social Medicine. 17th (ed).* Jabalpur: Banarsidas Bhanot, 2002.
7. Last JM. *A Dictionary of Epidemiology, 2nd (ed).* New York: Oxford University Press, 1988.
8. Shepherd M. Epidemiology and clinical psychiatry. *British Journal of Psychiatry* 1978;133:289-298.
9. Mann A. The evolving face of psychiatric epidemiology. *British Journal of Psychiatry* 1997;171:314-318.
10. Anthony JC, Eaton WW, Henderson AS. Psychiatric epidemiology. *Epidemiologic Reviews* 1995a;17:1-8.
11. Eaton WW, Regier DA, Locke BZ. The epidemiologic catchment area programme of the National Institute of Mental Health. *Public Health Reports* 1981;96:319-325.
12. Shepherd M. The contribution of epidemiology to clinical psychiatry. *American Journal of Psychiatry* 1984; 141:12-18.
13. Robins LN. Psychiatric epidemiology. *Archives of General Psychiatry* 1978;35:699-702.
14. Chandrashekar CR, Isaac MK. Development of psychiatric epidemiology in India. *NIMHANS Journal* 1999; 17(4):297-306.
15. Wig NN, Akhtar S. Twenty-five years of psychiatric research in India. *Indian Journal of Psychiatry* 1974; 16:48-64.
16. Kessler RC. The World Health Organization International Consortium in Psychiatric Epidemiology (ICPE): Initial work and future directions — The Nape Lecture 1998a. *Acta Psychiatrica Scandinavica* 1999;99:2-9.
17. Murthy RS. *Overview of Psychiatric Epidemiology in India* (unpublished). Workshop on research issues in psychiatric epidemiology in India, July 1987.
18. Bhole J. *Health Survey and Development Committee.* New Delhi: Government of India, 1946.
19. Mudaliar AL. *Health Survey and Planning Committee.* New Delhi: Government of India, 1962.
20. Director General of Health Services (DGHS). *National Mental Health Programme for India.* New Delhi: Ministry of Health and Family Welfare, Government of India, 1982.
21. Dube KC. *Keynote Address in Workshop on Research Issues in Psychiatric Epidemiology in India* (unpublished). Bangalore: National Institute of Mental Health and Neuro Sciences, 1987.
22. Dube KC. A Study of prevalence and bio-social variables in mental illness in a rural and an urban community in Uttar Pradesh—India. *Acta Psychiatrica Scandinavica* 1970;46:327-359.
23. Surya NC, Datta SP, Gopalakrishna R, Sundaram D, Kutty J. Mental morbidity in Pondicherry (1962-63). *Transactions of the All India Institute of Mental Health* 1964;4:50-61.
24. Sethi BB. 300 Urban families: A psychiatric study. *Indian Journal of Psychiatry* 1967;9(4):280-299.
25. Sethi BB. A psychiatric survey of 500 rural families. *Indian Journal of Psychiatry* 1972;14:183-196.

26. Sethi BB, Gupta SC, Mahendra RK, Kumari P. Mental health and urban life: A study of 850 families. *British Journal of Psychiatry* 1974;124:243–246.
27. Ganguli HC. Prevalence of psychological disorders in an Indian industrial population. *Indian Journal of Medical Research* 1968;56(5):754–776.
28. Gopinath PS. *Epidemiology of mental illness in an Indian village* (unpublished). MD thesis submitted to Bangalore University, Bangalore, 1968.
29. Elnagar MN, Maitra P, Rao MN. Mental health in an Indian rural community. *British Journal of Psychiatry* 1971;118:499–503.
30. Carstairs GM, Kapur RL. *The Great Universe of Kota: Stress, Change and Mental Disorders in an Indian Village*. London: Hogarth Press, 1976.
31. Verghese A, Beig A, Senseman LA, Sundar Rao SS, Benjamin V. A social and psychiatric study of representative group of families in Vellore town. *Indian Journal of Medical Research* 1973;61(4):608–620.
32. Thacore VR, Gupta SC, Suraiya M. Psychiatric morbidity in North Indian community. *British Journal of Psychiatry* 1975;126:364–369.
33. Nandi DN, Ajmany S, Ganguli HC, Banerjee G, Boral GC, Ghosh A, Sarkar S. Psychiatric disorders in a rural community in West Bengal – An epidemiological study. *Indian Journal of Psychiatry* 1975;17:87–99.
34. Shah AV, Goswami UA, Maniyar RC, Hajariwala DC, Sinha BK. Prevalence of psychiatric disorders in Ahmedabad: An epidemiological study. *Indian Journal of Psychiatry* 1980;22(3):384–389.
35. Indian Council of Medical Research and Department of Science and Technology. *Collaborative Study on Severe Mental Morbidity*. New Delhi: ICMR, 1987.
36. Mehta P, Joseph A, Verghese A. An epidemiological study of psychiatric disorders in a rural area in Tamil Nadu. *Indian Journal of Psychiatry* 1985;27(2):153–158.
37. Sachdeva JS, Singh S, Sidhu BS, Goyal RKD, Singh J. An epidemiological study of psychiatric disorders in rural Faridkot (Punjab). *Indian Journal of Psychiatry* 1986;28(4):317–323.
38. Seshadri S. Prevalence of mental disorders in India – Adults. *Community Mental Health News* 1986;2:2–3.
39. Premarajan KC, Danabalan M, Chandrashekar R, Srinivasa BK. Prevalence of psychiatric morbidity in an urban community of Pondicherry. *Indian Journal of Psychiatry* 1993;35(2):99–102.
40. Shaji S, Verghese A, Promodu K, George B, Shibu VP. Prevalence of priority psychiatric disorders in a rural area in Kerala. *Indian Journal of Psychiatry* 1995;37(2):91–96.
41. Isaac MK. *Epidemiology of mental disorders: A review of the adult psychiatric epidemiological studies in India* (unpublished). Workshop on research issues in psychiatric epidemiology in India, 1987.
42. Reddy MV, Chandrashekar CR. Prevalence of mental and behavioural disorders in India: A meta-analysis. *Indian Journal of Psychiatry* 1998;40(2):149–157.
43. Ganguli HC. Epidemiological findings on prevalence of mental disorders in India. *Indian Journal of Psychiatry* 2000;42(1):14–20.
44. Rajkumar S. Epidemiology and cause of schizophrenia in india. In: Koslow SH, Murthy RS, Coehlo GV, eds. *Decade of the Brain. India/USA Research in Mental Health & Neurosciences*. US Department of Health & Human Services. National Institute of Mental Health, USA 1995:95–100.
45. Padmavathi R, Rajkumar S, Narendra Kumar, Manoharan A, Kamath S. Prevalence of schizophrenia in an urban community in Madras. *Indian Journal of Psychiatry* 1987;31(3):233–239.
46. Indian Council of Medical Research – Centre for advanced Research on community mental health. *Report on Longitudinal Study of Mental Health Problems in a Primary Health Centre Area*. ICMR-CAR-CMH (mimeograph). Bangalore: ICMR, 1990.
47. Indian Council of Medical Research. *Longitudinal Study of Functional Psychoses in an Urban Community (ICMR - SOFPUC)*. New Delhi: ICMR, 1990.
48. Gururaj G, Gourie Devi M. Epidemiology of psychiatric and neurological disorders; Indian scenario. *NIMHANS Journal* 1999;17(4):291–294.

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49. Nandi DN, Ajmany S, Ganguli HC, et al. The incidence of mental disorders in one year in a rural community in West Bengal. *Indian Journal of Psychiatry* 1976;18:79-87.
50. Gopinath PS. Epidemiology of mental illness in an Indian village. *Transactions of All India Institute of Mental Health* 1968;8:68-73.
51. Kulhara PN. Cause and outcome of schizophrenia in India; In: Murthy RS, ed. *Mental Health in India 1950-2000: Essays in Honor of Professor NN Wig*. Bangalore: People's Action for Mental Health, 2001.
52. Sekar K, Murthy RS. Epidemiology of schizophrenia. *NIMHANS Journal* 1999;17(4):329-342.
53. World Health Organization. *The International Pilot Study of Schizophrenia*. Geneva: WHO, 1973. *Journal of Psychiatry* 1987;151:486-493.
54. Indian Council of Medical Research. *Final Report of the Longitudinal Study of Functional Psychosis in an Urban Community (ICMR-SOFPUC)*. New Delhi: ICMR, 1990.
55. Indian Council of Medical Research. *Final Report of the Multi-centred Collaborative Study of Factors Associated with the Course and Outcome of Schizophrenia (ICMR SOFACOS)*. New Delhi: ICMR, 1988.
56. Patel V. The epidemiology of common mental disorders in South Asia. *NIMHANS Journal* 1999a;17(4):207-327.
57. Krishnamurthy S, Shamasundar C, Prakash O, Prabhakar N. Psychiatric morbidity in general practice—A preliminary report. *Indian Journal of Psychiatry* 1981;23:40-43.
58. Bagadia V, Ayyar K, Lakdawala P, Susainathan U, Pradhan P. Value of the general health questionnaire in detecting psychiatric morbidity in a general hospital out-patient population. *Indian Journal of Psychiatry* 1985;27:293-296.
59. Shamasundar C, Krishnamurthy S, Prakash O, Prabhakar N, Subbakrishna D. Psychiatric morbidity in general practice in an Indian city. *British Medical Journal* 1986;292:1713-1715.
60. Sen B, Williams P. The extent and nature of depressive phenomena in primary health care: A study in Calcutta, India. *British Journal of Psychiatry* 1987;151:486-493.
61. Amin G, Shah S, Vankar GK. The prevalence and recognition of depression in primary care. *Indian Journal of Psychiatry* 1998;40:364-369.
62. Channabasavanna SM, Sriram T, Kumar K. Results from the Bangalore centre. In: Ustun TB, Sartorius N, eds. *Mental Illness in General Health Care: An International Study*. Chichester: John Wiley & Sons, 1995:79-97.
63. Patel V, Pereira J, Coutinho L, Fernandes R, Fernandes J, Mann A. Poverty, Psychological disorder & disability in primary care attenders in Goa, India. *British Journal of Psychiatry* 1998;171:533-536.
64. Gururaj G, Reddy GNN, Subbakrishna DK. Service utilization pattern in extension services of NIMHANS. *NIMHANS Journal* 1988;6(2):85-91.
65. Saraceno B, Barbui C. Poverty, Mental illness. *Canadian Journal of Psychiatry* 1997;42:285-290.
- 65a. Kiely M. The Prevalence of mental retardation. *Epidemiologic Reviews* 1987;9:194-218.
66. Patel V, Araya R, Lina MD, Ludermic A, Todd C. Women, Poverty & Common mental disorders in four restructuring societies. *Social Science & Medicines* 1999;49:1461-1471.
67. Prabhu GG, Verma N, John A, Daniel E, Elizabeth CK. *Proceedings of the 7th World Congress of the International Association for Scientific Study of Mental Deficiency*, New Delhi, 1985:12-17.
68. Madhavan T. *Childhood Psychiatric Epidemiology – Community surveys* (unpublished). Workshop on research issues in psychiatric epidemiology in India, July 1987.
69. Gupta SC, Sethi BB. Prevalence of mental retardation in Uttar Pradesh. *Indian Journal of Psychiatry* 1970;12:264-272.
70. Lal N, Sethi BB. Estimate of mental ill health in children in an urban community, *Indian Journal of Pediatrics* 1977;4:55.
71. Narayan HS. A study of the prevalence of mental retardation in southern India. *International Journal of Mental Health* 1981;10(1):28-36.

72. Subramanya B. An epidemiological study of mental retardation in rural children. MD thesis, NIMHANS, submitted to Bangalore University, 1983 (unpublished).
73. Srinath S, Girmaji SC. Epidemiology of child and adolescent mental health problems and mental retardation. *NIMHANS Journal* 1999;17(4):355-366.
74. ICMR Collaborating Centre & Central Coordinating unit. Multi-centric study of genetic causes of mental retardation in India. *Indian Journal of Medical Research* 1991;94:161-169.
75. Prabhu GG. Child & adolescent mental health research in India: An overview. *NIMHANS Journal* 1987; 5(2):79-89.
76. Seshadri S. An overview of child psychiatric epidemiology in India. In: Kapur M, Kellam S, Tarker R, Wilson R, eds. *Child Mental Health – Proceeding of the Indo-US Symposium*. National Institute of Mental Health and Neuro Sciences, Bangalore and Alcohol, Drug Abuse & Mental Health Administration, USA, 1993:61-65.
77. Kapur M. *Promotive and intervention strategies in the community*. National Institute of Mental Health and Neuro Sciences, Bangalore and Alcohol, Drug Abuse & Mental Health Administration, USA. 1993:61-65.
78. Indian Council of Medical Research. *Multi-centre Child and Adolescent Psychiatric Problems in India*. New Delhi: ICMR, 1997.
79. Isaac MK. Contemporary trends of alcoholism in India, In: Grant M, International Centre for Alcohol Policies, eds. *Alcohol and Emerging Markets: Patterns, Problems and Responses*. Ann Arbor: Taylor & Francis, 1998:145-176.
80. Singh G, Lal B. Alcohol in India. *Indian Journal of Psychiatry* 1979;21:39-45.
81. Dube KC, Handa SK. Drug use in health and mental illness in an Indian population. *British Journal of Psychiatry* 1971;118:345-349.
82. Varma VK, Singh A, Singh S, Malhotra A. Extent and pattern of alcohol use and alcohol-related problems in north India. *Indian Journal of Psychiatry* 1980;22:331-337.
83. Sethi BB, Trivedi JK. Drug abuse in rural population. *Indian Journal of Psychiatry* 1979;21:211-216.
84. Ponnudurai R, Jayakar J, Raju B, Pattamuthu R. An epidemiological study of alcoholism. *Indian Journal of Psychiatry* 1991;33:176-179.
85. Chakravarthy C. Community workers' estimate of drinking & alcohol-related problems in rural areas. *Indian Journal of Psychological Medicine* 1990;13:49-56.
86. Mathrubootham N. *Epidemiological Study of Drinking Behaviour in a Rural Population*. (Ph.D. thesis). Madras: Department of Psychiatry, Madras Medical College, University of Madras, 1989.
87. Bang AT, Bang RA. Community participation in research & action against alcoholism. *World Health Forum* 1991;12:104-109.
88. Mohan D, Desai NG, Chopra A, Sethi H. Rapid survey & substance abuse disorder in the urban slums of New Delhi. *Indian Journal of Medical Research* 1992;96:122-127.
89. Mohan D. Alcohol use among college students. In: Mohan D, Sethi HS, Tongue E, eds. *Current Research in Drug Abuse in India*. New Delhi: Jaypee Brothers, 1981.
90. Singh G, Jindal KC. Drugs on a medical campus, II: Drug use among faculty members. *Drug & Alcohol Dependence* 1980;6:123-130.
91. Sethi BB, Manchanda R. Drug abuse among medical students. *Indian Journal of Psychiatry* 1977;19:31-39.
92. Gangrade KD, Gupta K. *A Study of Drug Use among Industrial Workers*. A project report of Delhi School of Social Work, New Delhi: University of Delhi, 1978.
93. Gargi PD, Goyal BL. A study of prevalence of drug use among industrial workers of Punjab, Part I. In: Desai NG, (Head), *Abstracts of 44<sup>th</sup> Annual National Conference of the Indian Psychiatric Society*. New Delhi: Indian Psychiatric Society, 1992.
94. Babu RS, Sengupta SN. A study of problem drinkers in general hospitals. *Indian Journal of Psychiatry* 1997; 39:13-17.
- 94a. National Crime Records Bureau (NCRB). *Accidental Deaths and Suicides in India*. Government of India. Ministry of Home Affairs, 2000.

95. Satyavathi K, Murthy Rao DLN. A study of suicides in Bangalore. *Transactions of All India Institute of Mental Health* 1961;2:1-19.
- 95a. Nandi DN, Banerjee G, Boral GC. Suicide in West Bengal: A century apart. *Indian Journal of Psychiatry*. 1978; 20:155-160.
96. Ganapathy, MN, Venkoba Rao A. A study of suicide in Madurai. *Journal of Indian Medical Association*. 1966; 46:18-23.
97. Nandi DN, Mukherjee SP, Banerjee G, et al. Is suicide preventable by restricting the availability of lethal agents? A rural survey of West Bengal. *Indian Journal of Psychiatry* 1978;21:251-255.
- 97a. Ponnudurai R, Amrit Patnaik K, Sathianathan R, et al. A study on the venues of suicide. *Indian Journal of Psychiatry* 1995;37(2 suppl): 51.
98. Nandi DN, Mukherjee SP, Boral GC, Banerjee G, Ghosh A, Ajmany S, Sarkar S, Biswas D. Psychiatric morbidity in an uprooted community in rural West Bengal. *Indian Journal of Psychiatry* 1978;20:137-142.
99. Ponnudurai R, Jayakar J. Suicide in Madras. *Indian Journal of Psychiatry* 1979;22:203-205.
100. Ponnudurai R, Jayakar J, Saraswathy M. Attempted suicides in Madras. *Indian Journal of Psychiatry* 1980; 28:59-62.
101. Shukla GD, Verma BL, Mishra DN. Suicide in Jhansi city. *Indian Journal of Psychiatry* 1990;32:44-51.
102. Gopala Sarma P, Gautam Sawang D. Suicides in rural areas of Warangal district. *Indian Journal of Behavioural Science* 1993;3:79-84.
103. Hegde RS. Suicide in a rural community of North Karnataka. *Indian Journal of Psychiatry* 1993;22:368-370.
104. Gururaj G, Isaac MK. *Suicides ... Beyond Numbers*. Bangalore: NIMHANS Publication No. 44, National Institute of Mental Health and Neuro Sciences, 2002.
105. Gururaj G, Isaac MK. *Epidemiology of Suicides in Bangalore*. Bangalore: NIMHANS Publication No. 43, National Institute of Mental Health and Neuro Sciences, 2002.
106. Vijayakumar L, Rajkumar S. Are risk factors for suicides universal? A case control study in India. *Acta Psychiatrica Scandinavica* 1999;99:407-411.
107. Gururaj G, Suryanarayana SP. Health of the Elderly in India (in press), 2000.
108. Roth M. The diagnoses of dementia in late and middle age of life. In: Mortimer JA, ed. *The Epidemiology of Dementia*. Oxford University Press, 1980.
109. Venkoba Rao A. Dementia. *Neurology India* 1989;37:293-300.
110. Venkoba Rao A. *National Task Force Projects on the Study of the Problems of the Aged Seeking Psychiatric Help*. New Delhi: ICMR, 1987.
111. Venkoba Rao A, Madhavan T. Gerio-psychiatric morbidity survey in a semi-urban area near Madurai. *Indian Journal of Psychiatry* 1982;24:258-263.
112. Chandra V, Ganguli M, Pardav R, Johnston J, Belle S, Dekosky ST. Prevalence of Alzheimer's disease & other dementias in rural India: The Indo-US study. *Neurology* 1998;51:1000-1008.
113. Rajkumar S, Kumar S. Prevalence of dementia in the country; a rural-urban comparison from Madras, India. *Australian Journal of Ageing* 1996;15:9-13.
114. Rajkumar S, Kumar S, Thara R. Prevalence of dementia in a rural setting; a report from India. *International Journal of Geriatric Psychiatry* 1997;12:702-707.
115. Shaji S, Promodu K, Abraham T, Roy KJ, Verghese A. An epidemiological study of dementia in a rural community in Kerala, India. *British Journal of Psychiatry* 1996;168:745-749.
116. Janca A, Chandrashekar CR. Catalogue of assessment instruments used in the studies coordinated by the WHO mental health programme. *World Health Organization* 1993; WHO/MNH/92.5.
117. World Health Organization. *The ICD-10 Classification of Mental & Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: WHO, 1993a.
118. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th* Washington DC: 1994.

119. Kapur RL, Kapur M, Carstairs GM. Indian psychiatric survey schedule (IPSS). *Social Psychiatry* 1974;9:71-76.
120. Reddy GNN, Channabasavanna SM, Gourie Devi M, Das BS, Prabhu GG, Shariff IA, Kaliaperumal VG, Reddamma K. Extension of mental health services by satellite clinics as a model. *NIMHANS Journal* 1986a; 4(2):71-75.
121. Reddy GNN, Channabasavanna SM, Murthy RS. Implementation of National Mental Health Programme for India. *NIMHANS Journal* 1986b;4(2):77-84.
122. National Mental Health Programme for India. *Directorate General of Health Services*. New Delhi: Government of India, 1982.
123. Murthy RS. Integration of mental health with primary health care – Indian experience. In: Murthy RS, Burns BJ, eds. *Community Mental Health Proceedings of the Indo-US Symposium*. National Institute of Mental Health and Neuro Sciences, Bangalore and Alcohol, Drug Abuse & Mental Health Administration, USA, 1996.
124. Sunder Lal, Vashist A. Moving away from mental institutions – Towards community mental health care. *Indian Journal of Community Medicine* 2002b;27(4):147-150.
125. Community Mental Health Programmes. *Community Mental Health News* 1987;6&7.
126. Barbotte E, Gurilleman F, Chau N, Lorhandicap Group. Prevalence of impairments, disabilities, handicaps & quality of life in the general population: a review of recent literature. *Bulletin of World Health Organization* 2001;79(11):1047-1055.
127. Chisholm D, Sekar K, Kishore Kumar K, Saeed K, James S, Mubashaar M, Murthy RS. Integration of mental health care into primary health care. Demonstration cost outcome study in India & Pakistan. *British Journal of Psychiatry* 2000;176:581-588.
128. District Mental Health Programmes. *Community Mental Health News*. 1988;11&12.
129. Regier DA, Kaelber CT, Rai DS, Farmer ME, Knaupen B, Kessler RC, Norquist GS. Limitations of diagnostic criteria and assessment instruments for mental disorders – Implications for research and policy. *Archives of General Psychiatry* 1998;55:109-115.
130. Leeman E. Misuse of psychiatric epidemiology. *Lancet* 1998;352:1601-1602.
131. Jenkins R. Linking epidemiology and disability measurement with mental health service and planning. *Epidemiologica and Psychiatrica Sociale* 1998;7(2):120-126.
132. Anthony JC, Eaton WW, Henderson AS. Looking to the future in psychiatric epidemiology. *Epidemiologic Reviews* 1995;17(1):240-242.
133. Wittchen HV. Epidemiological research in mental disorders: Lessons for the next decade of research – the NAPE lecture 1999. *Acta Psychiatrica Scandinavica* 2000;101:2-10.

## Chapter 5

# Indian Psychiatry: The British Connection

*M. A. M. Khan*

Indian psychiatry is a child born to British parents and bred in Indian culture. Prior to the implementation of the first legislation in the area of lunacy anywhere in the world there was no organised thinking about the management of the mentally sick. The word 'lunatic' ruled supreme, until the promulgation of the first progressive Mental Act in 1937, in the UK. The Indian Lunacy Act, enacted in 1912, was based on the British legislation then in force. The history of Indian psychiatry runs parallel to British psychiatry and the basic structure remains the same even to this day. The connection is getting stronger over time.

The reasons for this are not far to seek. The British enacted in India lunacy laws similar to the English laws and tried to create asylums similar to those in England in order to ensure the same type of care to Britons serving in India as they would have received back home. In this context, two significant issues need to be highlighted: the aforesaid lunacy laws were designed primarily to protect the society from 'dangerous' lunatics, rather than for safeguarding the interests of the mentally ill, and the other major objective was to prescribe the procedure for managing the states of those found incompetent to manage their affairs due to insanity. India, on the other hand, had its own system of caring for mental patients, which is evident even to this day. Care was, and continues to be provided by families, often with the help of religious or faith healers. Asylums were seen as the last resort in severely disturbed cases, or when relatives were unable to manage them, owing to poverty or other constraints. Most of the asylums in British India were in a poor condition, as was brought out vividly in the monumental Bhore Committee Report in 1946. The only island of excellence was the European Mental Hospital, later the Hospital for Mental Diseases and now the Central Institute of Psychiatry, Ranchi. This was mainly due to its exclusive character: it was meant almost entirely for European patients and was staffed by British Army doctors.

The word psychiatry itself has gained popularity in the twentieth century, with the advances in scientific understanding of medicine in general and psychiatry in particular. Initially, the treatment of lunatics even in Europe was in the hands of the Church, which even accorded death as the severest punishment for insanity, like burning at the stake of Joan of Arc in France.

This role of faith healers, by and large, died down in the West but continues in India. It has no British connection and can be considered purely an Indian approach to treating the mentally sick. *Ayurveda* has extensive literature on this subject, which has been reviewed from time to time by Dr A. Venkoba Rao and Dr O. Somasundaram.

The law relating to the management of lunatics, or the mentally ill as they are now termed, remains deeply under the British influence. Even the current Indian MHA 1987 is considered to be a borrowed British version. The British legacy in psychiatry continues. However, it must be acknowledged that the deep-rooted association between British psychiatry and Indian psychiatry has been growing in strength and is more enduring today than ever before. It cannot be denied that there are certain very strong areas of British influence on Indian psychiatry. The area of forensic medicine in India and the Indian legal system is British in origin and, hence, that connection will always remain. Education in psychiatry shows a British flavour, to a large extent because of the influence of stalwarts like Mayer, Gross, G.M. Carstairs, and the earlier Indian teachers who had worked with British psychiatrists in the UK and India. Ranchi and Madras (now Chennai) had a notable presence of British psychiatrists, for example, the renowned Dr Carstairs. The British armed forces during the Second World War also had many psychiatrists in India, who were known as mental specialists, like Sir George McCoull and Dr Fraser.

In 1943, Dr Fraser had written an article in the *British Medical Journal* on *ganja* psychosis. From the number of publications during that period it was apparent that many other psychiatrists in the UK had also taken a lot of interest in substance abuse, which was then looked upon as a strange culture-specific addiction. They studied the cultural taboos about intoxicating substances and showed great interest in this addiction.

The birth of the Royal Medico-Psychological Association, the precursor of The Royal College of Psychiatrists in the 1960s, marks the beginning of modern scientific psychiatry in England and India. All the textbooks in Psychiatry were from England, like the famous *Text Book of Clinical Psychiatry*, by Mayer-Gross, Slater and Martin Roth, and Henderson and Gillespie's *Handbook of Psychiatry*. William Sargent's celebrated book, *Physical Methods of Treatment in Psychiatry*, was also a very popular textbook. Before the upsurge in American psychiatry, particularly after the beginning of the era of biological psychiatry, most Indian doctors used to go to the UK for further studies in medicine and psychiatry. Even today, British psychiatric hospitals have large numbers of Indian doctors on their staff and it is often said, albeit with an element of hyperbole, that the entire British National Health Service will collapse if Indian doctors opt out of it. This connection and association has been of mutual advantage to both the countries and continues to be so.

A landmark in this connection was the organisation of the regional meeting of the Royal College of Psychiatrists for the first time in India at Hyderabad in December 1996. Sir R.E. Kendell, the then President, and other eminent psychiatrists like Sir David Goldberg and Professor Gelder from Oxford attended the conference.

During this conference, it was decided to start an Asia Chapter, which is presently underway. Many Indians have made a mark in British psychiatry, such as Dinesh Bhugra who works at Maudsley's Institute of Psychiatry in the area of cultural psychiatry and is currently the Dean of the Royal College of Psychiatrists.

Until 1970, the contribution of Indian psychiatrists in England was subdued, but with a broader outlook of evolving the Royal College of Psychiatrists, the research efforts of Indian psychiatrists were acknowledged and encouraged. The contribution of Professor Norman Sartorius, who was part of the WHO team in India, to Indian psychiatry cannot be underestimated. The first Indian psychiatrist to be recognised by the Royal College of Psychiatrists is Professor Narendra Wig, who was recently honoured as a Fellow during a special session of the College in London. Through the WHO, deserving Indian psychiatrists were able to show their mettle overseas. Professor R. Srinivasa Murthy's work on mental health services is a great continuing contribution. Currently, there are many Indian psychiatrists, both in India and the UK, who are working together in



international collaborative studies like the international pilot study on schizophrenia. Indian psychiatrists have also been working with a team on the international classification of diseases and are also on the American Psychiatric Associations' task force for DSM.

Another primary force in bringing both the countries closer in the field of mental health has been the participation of Indian psychiatrists in various conferences. These not only promote active interaction at the professional as well as personal levels but also help dispel the traditional image of India as the land of *fakirs* and snake-charmers.

There are some very interesting developments which occurred with English psychiatrists who interacted with Indian psychiatrists in India and the UK. In the 1950s and 1960s, there was a very close social relationship between the two communities of psychiatrists living in the UK, which resulted in many mixed marriages in the first-generation doctors. However, in the 1970s, there was a noticeable change and the two communities, though working together professionally, became cooler in their social relationships. This segregation has continued to the present day. Most Indian doctors who had migrated to the UK (or the USA) were young, unmarried or recently married. Once they started a family, they believed that their children would be overwhelmed by Western culture, which was seen as more permissive and threatening. Thus, they started to turn inwards into their own communities. This change had two effects. In order to protect and preserve their Indian identity, they had to fortify their identity to the level of invincibility. The social consequence of this resulted in social withdrawal, not only from the majority community and culture, but also from other communities of Indian origin.

However, English psychiatrists who came to India were not so rigid about preserving their culture or identity which they considered in any event as unassailable. In fact, there were several British psychiatrists who did not hesitate to assimilate themselves with Indian culture and traditions.

Another field in which there is a very close liaison between Indian mental health workers and the UK based Samaritans and Befrienders International is through developing voluntary action for the prevention of suicide. Dr John Birley, former president of the British Medical Association and the Royal College of Psychiatrists, helped Dr Laxmi Vijayakumar in developing various suicide prevention centres in India under the auspices of Befrienders International. This is an example of a good working relationship between a UK-based international NGO working in the area of mental health in India, backed by Indian psychiatrists, mainly Dr Laxmi Vijayakumar, whose work in this area is outstanding.

A new phase of interaction is currently developing between Indian psychiatrists and the waning UK National Health Service as due to a staff shortage crisis, a recruiting agency is looking for mental health manpower in India. Senior Indian psychiatrists are being lured to the UK with handsome salaries on a contract basis. This may, however, lead to a depleted force of senior psychiatrists in India.

### **Suggested Reading**

1. Carstairs GM, Kapur RL. *The Great Universe of Kota; Stress, Change and Mental Disorders in an Indian Village*. London: The Hogarth Press, 1976.
2. Carstairs GM. Medicine and faith in rural Rajasthan. In: Paul B, ed. *Health, Culture and Community*. New York: Russell Sages, 1955.

# Chapter 6

## Mental Health and Psychiatry in West Bengal

*Ajita Chakraborty*

### Historical Context (1946–2002)

Many Indian psychiatrists seem to believe that psychiatry is only what the West has taught us. Nothing could be further from the truth. If psychiatry means treatment of the mentally ill, then *ayurveda* has been familiar with it for a long time. This ancient system of systematised medicine has a well-formulated theory and an array of psychotropic drugs. In addition, *ayurveda* (*vaidya* or *kabiraji* in Bengali) incorporated sound mental health principles. Altogether, the management of mental disorders in India was far superior and more effective than what prevailed in the West before the advent of modern psychopharmacology. As is well-known, Indian philosophy and religious practices paid great emphasis to the subject of mental health. The basic principles derived from these disciplines were incorporated not only into *ayurveda*, a sophisticated, institutionalised system, but also into folk medicine.

Folk or local, healers served the community at the grass-root level from times even earlier than the origin of *ayurveda*. The songs, dances and the weird rituals of the *atharvans* drove away a great many 'ghosts' of 'acute psychosis'. Additionally, these involved the village and the family in the process, acting as a therapeutic measure and paving the way for 'rehabilitation' of the sufferer into everyday life. Difficult or 'incurable' cases drifted away, and often found shelter in religious shrines. 'One Erwady should not undo thousands of years of community care'.

While these facts are generally true for all of India, folk traditions were particularly strong in Bengal, where *gurus*, *tantriks* and *ojhas* thrived until very recent times. It would be wrong and uninformed to devalue or deride these practitioners, as the validity of their practices has been amply demonstrated by social anthropological research.

These practices were central to the care of the mentally disordered when British colonial power established itself and started its campaign of misinformation, claiming that their knowledge was superior, and that Indian systems were inferior and wrong. We have to remember that despite all the claims, there was nothing 'scientific' about Western psychiatry in the early days. Western psychiatry was brought to India with the building of lunatic asylums, a way of thinking about care that was totally alien to India, where such care had never been institutionalised. The mental hospital was offered as a scientifically advanced treatment centre. However, as all psychiatrists now know,

institutional care proved to be detrimental to the mentally ill and is being abolished all over the world.

In the pre-independence era, two events took place in Kolkata that had a deep impact on the development of psychiatry in the country. One was the opening of departments of academic and experimental psychology by the Calcutta University in 1915 and the second was the founding of the Indian Psychoanalytical Society by Dr G.S. Bose in 1922.

Tracing the history of psychiatry in pre-independence India, we find that the first lunatic asylum was built in Bhowanipore, Calcutta in 1817 (one built in 1807 was closed down). There were many changes in asylum laws following those in Britain. In 1927, this asylum was converted into 'The Mental Observation Ward' where patients were kept before their transfer to hospitals in Ranchi, Bihar. The Hospital for Mental Diseases (HMD) came up in 1918 and, in 1952, the Ranchi Mansik Arogyashala (RMA). Initially, these beds were shared with Bengal, but the practice ended around 1960. However, the actual termination of the arrangement and transfer of the West Bengal patients to their home-state took place as late as in 1998.

### ***Psychiatric facilities in West Bengal prior to 1946***

The following facilities were available in the pre-independence era, mainly in Kolkata. Of these, only the Mental Observation Ward, Bhowanipore and the OPD at the Medical College Hospital were state-run at the time.

1. *Lumbini Park Mental Hospital*—This private hospital and clinic, founded in 1940, was managed by the Indian Psychoanalytical Society. The initial emphasis was on analytical treatment, but later other treatments became available. It attained mental hospital status under the Lunacy Act in 1952. Opening with only three beds, it finally expanded to 250. Starting with Dr G.S. Bose, many other eminent Kolkata psychiatrists, trained locally and abroad, attended this hospital.
2. *Mankundu Mental Hospital*—Dr K.K. Das started this private facility in the suburbs of Calcutta in 1933. It gained recognition as a hospital under the Lunacy Act in 1940. It had about 120 beds and ran a free clinic in the city. All types of treatment were available.
3. *Bangiya Unmad Asram*—This was an ayurvedic hospital with indoor facilities, started in 1935 by the famous *kaviraj* A.B. Dutta. It was converted into a 100-bed modern hospital with all treatment facilities in the sixties.
4. *Psychiatric Out-Patient Clinic, Carmichael Medical College and Hospital. (later Dr R.G. Kar MCH)*—The first such facility in India, was initiated in 1933 by Dr G.S. Bose, with funds from the Society for Mental Hygiene, founded by Dr Berkeley Hill. Later, the college, which was a non-governmental institution, took over the administration of the clinic and provided regular staff. Dr G.S. Bose, Dr S.N. Banerji, Dr J. Mullik and several psychologists attended. Dr D.N. Nandy joined the staff in the late sixties.
5. *Psychiatric Out-Patient Clinic of the Neurology and Psychiatry Department, Medical College Hospital, Kolkata*—It started in 1939 with eminent psychiatrists, trained abroad and in government service at the time, such as Dr N.N. De and Dr C.C. Saha.

### ***Psychiatric Wards in City Jails***

More than a 1,000 patients were lodged in various city jails. They were mainly those who were lost and vagrant, as well as criminal lunatics. Families sometimes had their disturbed relatives admitted to jails when they could not find free admission elsewhere. In later years, services of trained psychiatrists were available, as well as some medical treatment and Electro-Convulsive Therapy (ECT). All these patients were eventually released and/or shifted to other hospitals under a court order of 1994 (Appendix I).

*Vagrant's Homes* under the Department of Social Welfare, Government of West Bengal. In a study of vagrant cases in 1978, it was found that 1,500 persons were accommodated in these homes and 60% of them were mentally disordered. Extensive occupational therapy was provided, and the products made by these patients were even found to have some commercial value.

In a psychiatric field survey of Kolkata, it was estimated that there were 5,000 mentally ill vagrants, including those in vagrant homes and jails. The estimated number of cases of psychoses in the city was 72,000, or 100,000 if related cases (paranoia, abnormal personalities, etc.) were added.<sup>1</sup>

### **Development of Psychiatric Facilities since 1947**

During the decade of the fifties, very little development of psychiatry took place anywhere in India. However, from 1960 onwards, modern psychiatry took great strides under the guidance of the central government.

*Teaching courses*—The Calcutta University started the DPM in 1959 and the MD (Psychiatry) course in 1967. Several institutions jointly provided clinical teaching facilities. The University College of Medicine had only out-patient facilities. Initially Dr N.N. De and later Dr D.N. Nandy held the post of Professor and Head.

*Lumbini Park Mental Hospital* was upgraded. The bed strength increased, out-patient, and child guidance services became available. The hospital was eventually taken over by the government.

*The Mental Observation Ward* had gained mental hospital status in 1952 and admitted a few voluntary patients. From 1962, it functioned as the psychiatry unit of the Institute of Postgraduate Medical Education and Research, with 30 beds and an out-patient facility, under Dr the author.

*The Institute of Psychiatry*—The Mental Observation Ward converted itself into an Institute in 1992, with additional teaching staff and new premises for lectures and seminars. Dr A.N. Chowdhury took over charge as Professor and Head.

*Hospital for Mental Diseases* (later Pavlov Hospital) with 250 beds was opened in a converted and disused leprosy hospital in 1967. Patients from the city jails were gradually shifted here, through court orders. It has a very well-attended OPD.

*Psychiatry Units at other Medical Colleges*—All medical colleges acquired psychiatric units between 1962 and 1965, with out-patient facilities and the provision of indoor beds, staffed with highly trained teachers. These are:

- Sir Nilratan Sircar Medical College and Hospital.
- The National Medical College and Hospital.
- Psychiatry Unit at Sri Ramkrishna Mission Seva Pratisthan Hospital (later Vivekananda University, an NGO).
- North Bengal University Medical College, Siliguri.
- Burdwan University Medical College and Hospitals.
- Bankura Sammelani Medical College and Hospital.
- In Kolkata, several private institutions have psychiatric facilities.

*The following mental hospitals were opened in the nineties:*

- Baharampur Mental Hospital (350 beds).
- Purulia Mental Hospital (200 beds).
- Coochbehar Mental Hospital at Toofanganj (50 beds).

*District General Hospitals* – 18 in number, these have psychiatric out-patient facilities, trained psychiatrists and nurses. A unit for the ‘Prevention of Self-harm’ is functioning in the Sunderbans.

## **The Future of Psychiatry in West Bengal: A Vision**

Psychiatry as a subject has become more firmly based on biology in the last two to three decades. However, unlike medicine, surgery or paediatrics, the future of psychiatry is still uncertain. It has been understood by those concerned that it is a subject that cannot be left to medical specialists and medication alone; all psychiatric and mental health problems require to be looked at from a lengthy time-frame, and the community at large has to be taken into consideration.

In the early years, many meetings used to take place under the aegis of the central government or the WHO and innumerable projects were launched. The results of these efforts are hard to find now. Perhaps blueprints generated by experts under the influence of alien models did not suit the local milieu. The basic Western models (mainly institutional care) or governmental intervention have been taken for granted and have never been questioned. The intrusion of the state in common people’s lives is not always necessary or welcome, especially as a certain degree of abnormality or deviance is a part of life. We need to be very circumspect when intruding into areas where our knowledge is far from complete; being careful not to destroy healthy functional social systems in the name of fighting superstition.

Organisational and bureaucratic interventions are often counterproductive, and usually fail, no matter how well meaning the intention is. It is ironic that despite claims of superior treatment and management for decades, mental patients are often discharged too early and found out in the streets, even in Western countries. Psychiatric patients tend to fight coercion, and health agencies need to be sensitive and responsive to their needs when dealing with them. Families have always looked after the mentally ill in India, but this care has become difficult as families, as well as living spaces, are shrinking. Help from the government and other non-governmental organisations is required in this area.

### ***Plans for service***

It is suggested that psychiatric service delivery in the future takes the following course. Such service has to be at different levels, or in various centres, such as:

### *The community centre*

Community centres should be opened in different neighbourhoods. Mental health workers, social workers and counsellors should be attached to these, to hold regular sessions of counselling and advice. In particular, family matters should be dealt with at this level. Referral centres should be formed with several such local centres. A doctor and trained therapist could attend on a session basis according to needs of the area. Early psychiatric problems or follow-up of intractable cases, drug compliance, etc., as well as difficult cases referred by the local centres, should be dealt with at this level. Civil societies or NGOs could be empowered to run such centres.

### *Treatment centre-I (Private sector)*

All cities in India have several private practitioners in psychiatry, some of whom also run nursing homes in their areas. They should coordinate their work with the non-formal centres. The mental health authority of the state should have some supervisory authority over these facilities to look into the standard of medical care. One or two such homes can also function as referral centres, keeping in mind that community level services should be as cost-effective as possible.

### *Treatment centre-II (Government mental hospitals)*

A basic core of patients will need help and management all their lives, despite the best care received initially. No society has yet found a satisfactory measure to deal with them. The need for some judicious coercion in this area is always necessary, though misuse is always possible. Mental health authorities should ensure supervision of this area on a regular basis.

### *Specialty centre (Teaching hospitals, psychiatric institutes, etc.)*

These should form the top of the pyramid. Each teaching centre should have certain areas under their jurisdiction, and should preferably encourage people to come through the various levels mentioned earlier. However, people cannot be forced to take that course, and the teaching centres should render acute treatment as well as follow-up and therapy. Their main function should be, of course, training and teaching.

These should be nodal points in a defined locality for community work, as envisaged. Psychiatric training should be broad based, with much more emphasis on the social and human dimensions. Academic questions must be debated and researched, but utmost importance must be paid to local experience. For example, for an urban area, Kolkata shows low rates of chronicity and plans have to be made accordingly. The specialist centres should organise regular refresher (and training courses) for local psychiatrists, social workers, nurses and 'general duty attendants'. Urban colleges could team up with district ones for such purposes.

## **Conclusion**

It is suggested that for a broad orientation of psychiatry, rigid categories and criteria should not be imposed, even if that results in a 2-tier system of research and practical diagnosis. Mental health problems as health problems should be allowed to be defined and dealt with by the communities. Grass-root understanding should be allowed to remain at that level. The specialised opinions of experts should only percolate gradually, and not be forced or superimposed as superior. Villagers' ideas of ghostly (or that of urban Extra-Terrestrial's [ET's]) interference may not necessarily be harmful, and the psychiatrist gains nothing by challenging them. On the other hand, if beliefs are not interfered with, persuasion regarding compliance for medication may be easier. It is not the psychiatrists' duty to spread rationality.

It is envisaged that neighbourhood and village-level mental health centres, with specially trained workers, will act as communicators and mediators between various aspects of health, illness and happiness. There is no doubt that the doctor has to lead, but it is also necessary to understand that they need not necessarily have the last word. Freedom not to seek what doctors call treatment is also a fundamental freedom.

### **Annexure: Historical Legacies**

Indian psychiatry inherited three very important legacies and a short historical account of these will be of interest.

The Calcutta University was established in 1858. The British authorities wanted to provide English education to a section of Indians for their own administrative purposes. Sir Ashutosh Mukherji became vice-chancellor in 1906, and insisted on science education from the very beginning. A department of psychology was established in 1915, in spite of opposition from the government. Sir Ashutosh asked the Professor of Philosophy, Dr Brajendranath Seal to draw up a syllabus, which he did after visiting various European universities. Other universities in India soon followed.

Dr G.S. Bose joined the course immediately. He practised medicine after obtaining the MB degree from the Calcutta Medical College in 1910. He was appointed Lecturer in Psychology after obtaining the M.Sc. in 1917. Subsequently, he became Head of this department. Initially, the department functioned as an experimental psychology. Dr Bose promoted experimentation and research, and devised various testing instruments himself. The department later split into the academic and experimental psychology divisions. Dr Bose had become interested in psychoanalysis by then and he was pursuing the subject vigorously. He obtained the D.Sc. degree with his thesis on *Concepts of Repression*, and had it published in book form, which was widely appreciated. It was an original theory, which he formulated even before Freud's work was translated into English. He began to correspond with Freud and was accepted as an analyst; the only other person besides Freud himself and Ernest Jones to achieve this status without being analysed themselves.

Dr Bose founded the Indian Psychoanalytical Society in 1921, which was recognised by the International Psychoanalytical Association in 1922. It soon had many members (analysed persons) and associates (trainees). At the start, Dr Berkeley Hill, superintendent of the Ranchi Hospital, who was analysed by Freud himself, was the other analyst besides Dr Bose. The Society attracted much attention; medical doctors, psychologists and well-educated lay persons became members and started practising after attending lectures and courses. Many persons from outside Bengal came over to Kolkata for analytical training. The members wrote extensively in literary journals, as also in the vernacular journal *Chitta* and the English one, *Samiksha*, which spread psychoanalytical ideas to a wide public. Under these influences, the group of trained personnel emerged were medical men, psychologists and analysts. Dr G.S. Bose gradually deviated from Freudian theory and substituted it with his own. In his later years he tried to synthesise Indian script thoughts with analytical ones. He died in 1953.

The Society continued to flourish. It opened a nursing home (later, the Lumbini Park Mental Hospital) where general psychiatry was also practised. Dr Bose donated part of his residence to the Society, where the Girindrasekhar Clinic was opened. Its activities also combined psychiatry and psychoanalysis. Thus, psychiatry and psychoanalysis became almost synonymous!

From the seventies, psychoanalytical practice began to decline all over the world. In India, this occurred even earlier. As training in psychiatry here and abroad became easily available, few Indian students showed interest in analysis. The prestige of the Society declined as little original work was being done. Its activities also lessened considerably, and although it still exists, bereft of its past glory.

### **Suggested Reading**

1. Chakraborty A. *Mental Health Directory*, 1970.
2. Chakraborty A. *Social Stress and Mental Health: A Social Psychiatric Field Study*. New Delhi: Sage, 1990.
3. Hartnack. Psychoanalysis in Bengal. *Psychoanalysis in Colonial India*. Delhi: Oxford University Press, 2001; 87-119.





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**Section 2**

**Status of Mental Health**

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## Chapter 7

# The National Mental Health Programme: Progress and Problems

*R. Srinivasa Murthy*

“A network of decentralised mental health services for ameliorating the more common categories of disorders is envisaged. The programme outline for such a disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff. In regard to mental health institutions for in-door treatment of patients, the Policy envisages the upgrading of the physical infrastructure of such institutions at Central Government expense so as to secure the human rights of this vulnerable segment of society”.

*National Health Policy 2002.*

**T**he progress of NMHP is presented under the following sections: development and essentials of the NMHP; progress during the last two decades; barriers to reach the goals; major changes in mental health during this period and looking to the future.

### **The Development of NMHP**

The Government of India felt the necessity of evolving a plan of action aimed at the mental health component of the National Health Programme. For this, an expert group was formed in 1980, who met a number of times and discussed the issue with many important people concerned with mental health in India as well as with the Director, Division of Mental Health, WHO, Geneva. Finally, in February 1981, a small drafting committee met in Lucknow and prepared the first draft of the NMHP. This was presented at a workshop of experts (over 60 professionals) on mental health, drawn from all over India at New Delhi on 20–21 July 1981. Following the discussion, the draft was substantially revised and a new one was presented at the second workshop on 2 August 1982 to a group of experts from not only the psychiatry and medical stream but also education, administration, law and social welfare. The final draft was submitted to the Central Council of Health, India’s highest health policy making body at its meeting held on 18–20 August 1982, for its adoption as the NMHP for India. The Council discussed this programme at length and adopted a resolution for its implementation in the states and UTs as follows:

“Mental health must form an integral part of the total health programme and as such should be included in all national policies and programmes in the field of Health, Education and Social Welfare. Realising the importance of mental health in the course curricula for various levels of

health professionals, suitable action should be taken in consultation with the appropriate authorities to strengthen the Mental Health Education components. While appreciating the efforts of the Central Government in pursuing legislative action on Mental Health Bill, the joint Conference expressed its earnestness to see that the bill takes a legal shape at the earliest”.

## Summary of NMHP

The NMHP reviews the mental health situation in terms of needs, facilities and services. A wealth of information is available in India concerning the prevalence of mental disorders. According to most of the surveys, about 10 to 20 per 1,000 of the population are affected by a serious mental disorder at any point in time (point prevalence). The main burden of psychiatric morbidity in the adult population consists of acute mental disorders; chronic or frequently recurring mental illnesses; emotional illnesses such as anxiety, hysteria, neurotic depression; alcohol abuse, and alcohol and drug dependence and psychiatric disturbances among children. No factual data are currently available regarding the loss of productivity, of income and even of life, due to mental illness. However, it should be pointed out that suffering due to mental illness often is not confined to the affected individual, but causes severe social dysfunction of entire families.

From the available data, it is safe to conclude that not more than 10% of those who need urgent mental healthcare are receiving the required help with the existing services. The situation is worse in rural areas as the concentration of services and facilities is greater in the cities. Further, a simple extension of the present system of care will not be able to ensure adequate services to the vast majority of the Indian population in the near foreseeable future.

In view of the gross disparities between needs and available services, there are essentially two approaches for immediate action. They are not alternatives, since the difference between them lies mainly in the emphasis and in the level of priority assigned to different levels of service development. The first option would be to direct available resources to the establishment and strengthening of psychiatric units in all district hospitals. It would be hoped that these units would become foci of an expanding mental health service, through setting up out-patient clinics and mobile teams. In general terms, the approach would be directed from the centre to the periphery. In contrast, an alternative approach would be to train an increasing number of different categories of health personnel in basic psychiatric and mental health skills. There would thus be a functional infrastructure before completing, in all instances, a physical independent mental health infrastructure.

Most mental health facilities in India actually function as passive recipients of patients. They become operational only where coping mechanisms in the community fail. These institutions have little knowledge and hardly any impact on the coping mechanisms as they exist and operate in the community. It is essential that the role of all mental health institutions in India become more active with the social mechanisms involved, not only in the development of mental illness, but also in the more important issue of maintaining mental health.

The NMHP outlined the following objectives: (a) to ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population; (b) to encourage the application of mental health knowledge in general healthcare and in social development; and (c) to promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

Approaches to the statement of programme objectives were: diffusion of mental health skills to the periphery of the health service system; appropriate appointment of tasks in mental healthcare;

and integration of basic mental healthcare into general health services and linkage to community development and mental healthcare. The service component will include three sub-programmes – treatment, rehabilitation and prevention.

The plan of action aiming at achieving the above objectives consisted of a set of targets, and of detailed activities (Table 7.1).

**Table 7.1: Goals of NMHP (1982)**

- Within one year, each state will have adopted the present plan of action in the field of mental health.
- Within one year, the Government of India will have appointed a focal point within the Ministry of Health, specifically for mental health action.
- Within one year, a National Coordinating Group will be formed comprising representatives of all states, senior health administrators and professionals from psychiatry, education, social welfare and other related professionals.
- Within one year, a task force will have worked out the outlines of a curriculum of mental health workers identified in the different states as the most suitable to apply basic mental health skills, and for medical officers working at Primary Health Centres (PHCs) level.
- Within five years, at least 5,000 of the target non-medical professionals will have undergone a two-week training programme on mental healthcare.
- Within five years, at least 20% of all physicians working in PHC will have undergone a two-week training programme in mental health.
- The creation of the post of a psychiatrist in at least 50% of the districts within five years.
- A psychiatrist at the district level will visit all PHC settings regularly and at least once every month, for supervision of the mental health programme for continuing education. This programme will be fully operational in at least one district in every state and UT, and in at least half of all districts in some states within five years.
- Each state will appoint a programme officer responsible for the organisation and supervision of the mental health programme within five years.
- Each state will provide additional support for incorporating community mental health components in the curricula of teaching institutions (within five years).
- On the recommendation of a task force, appropriate psychotropic drugs to be used at the PHC level will be included in the list of essential drugs in India.
- Psychiatric units with in-patient beds will be provided at all medical college hospitals in the country within five years.

The programme outlined above clearly and deliberately reaches beyond the traditional tasks of a specialised psychiatric service. In the first instance, it is proposed to use the primary healthcare structure to provide basic psychiatric and mental health services. This means that at least at the grass-root level of healthcare, mental health will be totally integrated into the general healthcare delivery system. The close cooperation of mental health professionals with other providers of care is thus imperative. In fact, it is hoped that mental health consciousness will become an integral

part of all health and welfare endeavours in India. A strong linkage of the programme should be with social welfare and education sectors. Teachers would therefore have to be given adequate orientation in the early diagnosis of most of the common mental health problems. The necessary links with the mental hospitals and medical colleges have already been mentioned. They will be centres of referral for special cases, as well as centres of various teaching activities. In view of diverse and varying level of development and health infrastructure in India, a certain degree of flexibility will be essential in the implementation of this programme. The proposed plan needs to be reviewed periodically for the evaluation of goals achieved. In that aspect the present plan should be understood as an initial statement of intent, rather than a rigid blueprint for all future programmes. The National Advisory Group would have the responsibility of regularly monitoring the progress of the programme. Appropriate legislation for better implementation of the NMHP would also have to be looked into.

The main strength of the NMHP, undoubtedly, was the envisaged mutually synergistic integration of mental healthcare with general primary healthcare. There were, however, some inherent weaknesses in this otherwise sound conceptual model. The entire emphasis was on the curative, rather than preventive and promotive aspects of medicare. Community resources like families were not accorded due importance. Ambitious short-term goals took precedence over pragmatic, long-term planning. Most glaringly, no estimate, leave aside provision, of budgetary support, was made. These deficiencies were to have major long-term consequences.

### **Progress between 1982 and 2002**

Since the adoption of the NMHP, in some ways its progress can be said to be very significant. There is no doubt that it has been the guiding principle for the development of the mental health programme in India. The most important progress has been the development of models for the integration of mental health with primary healthcare, beginning with the Raipur Rani in the North and Sakalawara in South India.

The ICMR severe mental morbidity demonstration project examined the feasibility and effectiveness of this approach in four centres, namely, Kolkata, Patiala, Baroda and Bangalore. This activity showed that about 20% of people with mental disorders will be brought into care with this approach. However, the population covered was very small in comparison to the national need. In 1984, the district model for mental healthcare was initiated by NIMHANS, Bangalore, in collaboration with the district administration and the director of health services, Karnataka. This mental health team that provided care for about 2 million people was an important model, because it showed the possibility for upscaling what was done at one primary health centre to over a dozen primary health centres. It also identified the practicability of a district mental health team initiating mental healthcare. This was demonstrated by the adoption of the same model with an extension of the District Mental Health Programme (DMHP) to 25 districts in 20 states between 1995 and 2000. It is anticipated that in the Tenth Five Year Plan, it would be extended to 100 districts. In a way, India has both identified this as an approach as well as demonstrated its feasibility across many states and differing health systems.

The most important activity that has occurred in the last 20 years is the wide variety of community care alternatives essentially coming from the voluntary sector. These initiatives have included day care centres, half-way homes, long-stay homes, suicide prevention and school mental health programmes. All of these have demonstrated that there is a felt need for alternative community care facilities, as well as the fact that they would be used by the general public when they are provided in user-friendly manner.

The other major development is human resource development. At the time of the formulation of the NMHP, the number of psychiatrists was less than a 1,000 and in the last 20 years it has nearly tripled to 3,000. However, the unsatisfactory aspect is in the fields of clinical psychology, psychiatric social work and psychiatric nurses, who form a vital part of the team, have not been trained in adequate numbers.

Another major development that has occurred during the last two decades is the public awareness which has increased enormously due to community-based mental healthcare, initiatives of voluntary organisations, trained mental health professionals working in remote areas in the private sector, as well as due to a massive effort by professionals to address the general public with modern mental health information. Notable among these are the initiatives of books authored by mental health professionals, as well as the use of the media, especially the radio and television, for sharing of mental health information with the general public.

The next set of developments in the last 20 years relate to the legislations supporting mental healthcare, namely, the Narcotic Drugs and Psychotropic Substances (NDPS) Act 1985, the MHA 1987 and Persons with Disability Act 1995. All of these legislations have changed the dialogue of penal approach to mental healthcare to a promotion, prevention and rights approach. The Persons with Disability Act 1995 is significant as for the first time mental illness was included as one of the disabilities. The other developments are the recognition of human rights of the mentally ill, by the NHRC. This consisted of a systematic, intensive and critical examination of the mental hospitals in India. The pioneering study was brought out as a document in 1999. This examination showed how inadequate the existing mental hospitals are, in terms of services, as well as in upholding the human rights of the mentally ill.

The other key development is the revision of the NHP 2002. It is to be recalled that in 1983, the NHP had not referred to mental health in any significant manner. The NHP 2002 clearly recognises mental health as a part of general health and specifies how mental health has to be included as part of general health services and the importance of human rights of the mentally ill.

The growth of the mass media in the last 20 years is another very significant factor. Television and radio stations are now available in many languages and all these address mental health issues through phone-in programmes, serials, features, panel discussions and audio participation programmes. It is gratifying to note that both professionals and non-professionals participate in discussing mental health issues through these media.

The last significant development is the major contribution of professionals in mental health research. The ICMR, New Delhi, gave a big push to mental health research in the 1980s. This research has not only brought to light the importance of understanding mental disorders like schizophrenia in the cultural context, but also shown the feasibility of developing models involving schools, primary healthcare, general practitioners and working with families. This new knowledge has continuously supported the development of mental health programmes. The significant landmarks of the progress made during these two decades are summarised in Table 7.2.

## **Barriers to Reach NMHP Goals**

The goals set out in the 1982 document outlined in Table 7.1 were many. However, the goals were too ambitious to begin with and not enough attention was paid to all aspects of its implementation. The first and foremost barrier was the lack of funding. Though the NMHP came into being in 1982, the subsequent three Five Year Plans did not make adequate funding allocation. Further, even the funds allotted were not fully utilised. It was only in the Ninth Five Year Plan that



**Table 7.2: Development in Mental Health Scenario (1982–2002)**

<p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>Development of models for integration of mental health in PHC</li> <li>Community care alternatives and NGO initiatives</li> <li>Human resource development</li> <li>Public awareness.</li> </ul> <p><b>Related to Mental Health</b></p> <ul style="list-style-type: none"> <li>NDPS Act 1985</li> <li>MHA 1987</li> <li>Persons with Disability Act, 1995</li> <li>Human rights of mentally ill persons</li> <li>NHP 2002</li> <li>Growth of mass media</li> <li>Mental health research.</li> </ul>
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a substantial amount of Rs 280 million was made available and it is projected in the Tenth Five Year Plan to be about Rs 1,900 million. The availability of funds in 1995 for the district mental health programme has shown that once funds are available, states are ready to take up intervention programmes and professionals are keen to take up a wide variety of initiatives for integrating mental health with primary healthcare.

Undergraduate training in psychiatry has not changed in spite of all the efforts in this direction, and this continues to be a major barrier to have adequately trained medical doctors in psychiatry after their basic training. The inadequacy of human resources in mental health is another barrier. Even now, most districts do not have public sector psychiatrists. Some of the medical colleges do not have full departments of psychiatry, especially the government medical colleges. The lacunae of not having enough training facilities for training in clinical psychology, psychiatric social work and psychiatric nursing is a major limitation for non-medical models and community-based programmes to take roots beyond the big cities.

The community care models developed have not been adequately evaluated, especially the DMHP. Its implementation between 1995 and 2000 continues to be one of extension services by professionals rather than true integration of mental health with primary healthcare. It has been repeatedly pointed out that a manual is missing to guide the district mental health programme. The next major barrier is the uneven distribution of the resource across states and UTs. This uneven distribution limits the national level plan to be implemented in all the states and UTs. Though the National Mental Health Act 1987 was very progressive, its non-implementation has been a major drawback. Specifically, the state mental health authorities have not functioned as they should have and the norms for licensing and maintaining standards of care has been insufficient.

The other drawback has been the privatisation of healthcare in the 1990s. It is a well-known fact that globally the amount of money available for healthcare has decreased. In addition, India has the least amount of public funding for healthcare – more than 5% of its GDP is spent on health, out of which 83% comes from private, mostly out-of-pocket expenditure rather than from the public

exchequer. This is a reverse pattern of public and private funding similar to in many developing countries. In Sri Lanka, public health expenditure is about 50% of the total health expenditure (Table 7.3).

**Table 7.3: Barriers to the Implementation of NMHP**

- Poor funding
- Limited undergraduate training in psychiatry
- Inadequate mental health human resources
- Limited number of models and their evaluation
- Uneven distribution of resources across states
- Non-implementation of the MHA 1987
- Privatisation of healthcare in the 1990s.

### **Major Changes in Mental Health Scenario in the last Two Decades**

The most important changes that have occurred are the availability of increased range of treatments (Table 7.4) Luckily, most second-generation antipsychotics and antidepressants are freely available and extremely inexpensive in India because of the licensing procedures. This has allowed professionals to use them extensively. India probably represents one of the few developing countries where there is such wide use of these drugs.

The second important development is the growing importance of families in mental healthcare in the country. Families of carers are coming together and forming self-help groups in big cities. There have been two caregivers' meetings in 2001 and 2003. This development testifies that professionals are looking at families as a major resource for mental healthcare.

The community care as a primary approach to mental healthcare has become a reality all over the world. The World Health Report 2001 presented this as the model for mental healthcare for all countries. Large countries like Brazil have opted to shift from institutional care to community care. This is an advantage for a country like India where extremely limited institutional care exists. There is almost an empty canvas, so that investments in terms of large institutional infrastructure are not required.

The availability of a wide variety of both medical and non-medical care models is another development in the last two decades. Specifically, the growing role of Non-Government Organisations (NGOs) who provide suicide prevention, disaster care and school health programmes, where non-specialists and volunteers play an important role, has tremendous importance for India as it can bridge the gap of human resources.

Increasing judicial activism, the Persons with Disability Act 1995 and a growing number of psychiatrists in the private sector, the recognition by the profession of stigma and discrimination due to mental illness and the response to the Erwady tragedy point to a greater awareness among the public.

In addition to all these, the world health focus on mental health provided by the Surgeon General Report in 1999, the World Health Day 2001, the World Health Report 2001, World Health Assembly 2001 and 2002, and the mental health reforms in a large number of countries on a number of mental health areas have made mental health an integral part of general health.

**Table 7.4: Major Developments during the Past Two Decades**

- Increased range of treatments
- Greater recognition of the role of families
- Community mental healthcare
- Wide variety of care models
- Increased human resources, especially psychiatrists
- Persons with Disability Act 1995
- Judicial activism
- Recognition of stigma and discrimination
- Worldwide focus on mental health on the occasion of the World Health Day, October 2001, with the WHO World Health Report 2001 being devoted entirely to mental health.

### Looking ahead

At the beginning of the twenty-first century when NMHP enters the third decade of implementation, there is a new awareness in the public about mental health issues. A good illustration is the response of the public, press, planners, professionals and judiciary to the Erwady tragedy in August 2001. Twenty years earlier, an equally dramatic event occurred in the Ranchi Mental Hospital, when patients escaped and the pitiable living conditions of the hospitals were splashed across a leading magazine, *India Today*. However, there was no public reaction to the event. On the contrary, the Erwady tragedy not only evoked a sense of horror, but also resulted in the examination of human rights of the mentally ill in all aspects. The Parliament, the state legislatures, the Supreme Court and the High Courts are pursuing the matter for active mental health reform. It is in this altered and enlightened setting that the future should be planned. There is no doubt that there is an urgent need for reformulating the NMHP. This should be a priority. The following section presents an approach for future mental healthcare.

### Revised Goals for the Mental Health Programme

1. Strengthening families and communities for the care of persons suffering from mental disorders;
2. Organisation of a wide range of mental health initiatives to support individuals and families, with special focus on immediate delivery of the most essential services to the ones with the greatest needs;
3. Supporting through mental health initiatives rebuilding of social cohesion, community development, promotion of mental health and the rights of the persons with mental disorders.

The plan of action to achieve the goals outlined above would consist of nine components (Table 7.5).

**Table 7.5: Plan of Action for Mental Healthcare**

1. Organising services
2. Community mental healthcare facilities
3. Support to families
4. Human resource development
5. Public mental health education
6. Private sector mental healthcare
7. Support to voluntary organisations
8. Promotion and preventive interventions
9. Administrative support.

### **1. Organising services**

Organisation of community-based services is the core activity in the plan of action. Currently, most districts do not have trained professionals or the mental health infrastructure to provide essential mental healthcare. Consequently, ill persons and their families either do not seek services and prefer to suffer in silence, or reach places of care very late. Internationally, it is recognised that organising mental healthcare is through the general health services. The World Health Report 2001 recommended this approach as its first two recommendations:

#### *Provide mental health in primary care*

The management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services—it needs to be recognised that many are already seeking help at this level. This not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments. For this to happen, however, general health personnel need to be trained in the essential skills of mental healthcare. Such training ensures the best use of available knowledge for the largest number of people and makes possible the immediate application of interventions. Mental health should therefore be included in training curricula, with refresher courses to improve the effectiveness of the management of mental disorders in general health services.

#### *Make psychotropic drugs available*

Essential psychotropic drugs should be provided and made constantly available at all levels of healthcare. These medicines should be included in every country's essential drugs list, and the best drugs to treat these disorders should be made available whenever possible. In some countries, this may require enabling legislation changes. These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders and prevent relapse. They often provide the first-line treatment, especially in situations where psycho-social interventions and highly skilled professionals are unavailable.

The two recommendations mean the provision of mental health services at different levels of healthcare as appropriate and feasible at that level. There is a need to provide an essential list of psychiatric drugs at the level of PHC, taluk, district and state levels. The level of mental healthcare at the different levels of the health system, namely, primary, community health centres, district hospitals, medical colleges and state-level institutions should be worked out depending on the health infrastructure in a state. The NMHP 1982 provides such an outline of activities.

The most urgent need in all states and UTs is to train all medical officers and health personnel in the essentials of mental healthcare by short-focused training programmes. To achieve this goal within a short period of time, information technology based tele-training facilities in the states should be utilised.

## **2. Community mental healthcare facilities**

A wide variety of community care facilities are needed to meet the needs of the patients and their families. Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources. Community-based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill which were the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at the community level, along with the provision of crisis support, protected housing, and sheltered employment. The different facilities required are day care centres, half-way homes, long-stay homes, sheltered workshops, de-addiction centres and suicide prevention centres. All these facilities should be available, first at the district level and subsequently at the level of taluks and towns.

## **3. Support to families**

Families are primary care providers. They need support from the government and the society in a number of ways, including financial support. They also need an understanding of the illness in question, and the skills to care for the ill. In addition, they must ensure medication compliance, be able to recognise early signs of relapse, handle swift resolution of crisis, and reduce social and personal disability. They can be supported by visiting community nurses and other support staff, and encouraged to form networks of self-help groups. The state should facilitate these initiatives by: (a) providing financial support to such groups of families; (b) offering public places in the community for their meetings and organisation of day care activities; (c) developing visiting nurses to support families (at least one nurse for a 100 families); and (d) involving them in the planning of the mental health programmes.

## **4. Human resource development**

The availability of trained professionals forms the foundation for the organisational services. There is both a gross deficiency in the available personnel as well as unequal distribution of available specialists, leaving a majority of the districts without any professionals. The following measures are outlined for meeting this need:

### *Undergraduate training in psychiatry for medical students*

The current duration of undergraduate medical education in psychiatry is only two weeks, and it is not an examination subject in the final year examination. Keeping in mind the prevalence of mental disorders in primary healthcare as well as the approach to provide community-based mental healthcare, it is essential that the training is increased to full two months and psychiatry should be made an examination subject. Such a measure will prepare basic doctors to have the skills to care for the mentally ill as part of their general health services.

### *Psychiatrists*

Psychiatrists are required to fully staff the departments of psychiatry at the medical colleges, the district/taluk hospitals and to support voluntary organisations providing community care.

### *Psychologists*

The lacunae in this category of personnel is more acute than that of psychiatrists. In the short term, there is a need to take general psychologists and train them for a period of 3–6 months at postgraduate mental health training centres and post them to work in different settings.

### *Social workers*

The lacunae in this category of personnel is more acute than that of psychiatrists. Most of the universities train M.A. level social workers and large number of colleges train B.A. level graduates in social work. In the short-term, there is a need to use general social workers, training them for a period of 3–6 months at postgraduate mental health training centres and post them to work in different settings.

### *Nurses*

The lacunae in this category of personnel are more acute than that of all other categories of personnel. In the short-term, there is a need to train general nurses for one to three months at postgraduate mental health training centres and post them to work in different settings.

### *Rehabilitation professionals*

There is also an urgent need to train this category of professionals as they are extremely valuable for community-based mental healthcare facilities.

### *Short-term training programmes for medical officers*

The need for psychiatrists to staff the district psychiatric services is also very severe. In order to meet this need it is suggested that suitably experienced senior medical officers are selected to become programme officers and trained at postgraduate training centres, for a period of three months. In the long-term, fully qualified professionals should be providing the services at all levels.

## **5. Public mental health education**

There is a need for public education and awareness campaigns on mental health to be launched. The main goal is to reduce barriers to treatment and care by increasing awareness of the frequency of mental disorders, their treatability, the recovery process and the human rights of people with mental disorders. The care choices available and their benefits should be widely disseminated so that responses from the general population, professionals, media, policy makers and politicians reflect the best available knowledge. Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring the branches of mental and physical healthcare closer to each other.

The All India Radio, Doordarshan, the print media and the folk media can be fully utilised for this purpose. The success of the use of these media to disseminate the information on agriculture is a good indication of the value of this approach. State-level plans involving the state and district health education bureaus should be developed and implemented. In view of the vast gap in what is known about mental disorders and the lack of awareness in the general public, public mental health education should be a continuous activity.

## **6. *Private sector mental healthcare***

The private sector is a part of the total healthcare system in general and mental health in particular. In a situation of limited services, the private sector could play a major service role. Private psychiatrists can support the programme in a number of ways such as systematically recording their work to provide an understanding of the magnitude of mental health needs; clarifying the treatment utilisation and related issues; working in the medical colleges and regional hospitals as honorary consultants; training of PHC personnel; supporting the NGOs in their mental health initiatives; initiating special mental health programmes and encouraging public mental health education.

## **7. *Support to voluntary organisations***

Voluntary organisations are a valuable community resource for mental health. They are often more sensitive to the local realities than centrally driven programmes, and are usually strongly committed to innovation and change. They often play an extremely important role in the absence of a formal or well-functioning mental health system, filling the gap between community needs and available community services and strategies.

Voluntary organisations can specially play an important role in developing suicide prevention and crisis support, formation of self-groups of families, organising community-based housing facilities for short-term and long-term care of persons with chronic illnesses, setting up of day care centres, sheltered employment facilities, life skills programmes school drop-out children and public mental health education. Support to voluntary agencies for specific activities can result in services within a short period of time.

The government should develop funding mechanisms to support voluntary organisations to take up these activities to cover all states.

## **8. *Promotion and preventive activities***

A wide variety of interventions are possible to promote mental health and prevent mental disorders. Of these, the most important is the life skills education programmes for school children. Initial efforts to develop suitable material to suit the schools in Karnataka have been undertaken by NIMHANS, Bangalore, however, there is a need to encourage this programme in schools all over India. Similarly, psycho-social care of survivors of disasters should be part of all relief, rehabilitation, reconstruction and reconciliation programmes, following man-made and natural disasters.

## **9. *Administrative support***

Currently, in most states, there are only part-time administrative officers at the level of the Directorate of Health Services. The officer supports and supervises the mental health programme like many other programmes. In view of the importance of the mental health programme and the magnitude of the initiatives to be undertaken, a full-time Joint Director (Mental Health) should be appointed at the Directorate of Health Services. Such an officer should be a psychiatrist and have additional staff (statistician, etc.) to support the mental health programme. At the district there should be two mental health teams, one each in the district medical office and the other at the district hospital. Such teams will result in both clinical care and the integration of mental health at the peripheral institutions. The mental health budget is inadequate and should be increased to at least 10% of the total health budget.

**Table 7.6: Priorities for the Future**

- Family as the focus of care
- Public mental health education
- Intersectoral collaboration
- Role of voluntary organisations
- Integration with general health services
- Human resource development
- Enhancing funding for mental healthcare
- Emphasis on prevention and promotion
- Administrative structures.

### **Priorities for Future**

The positive aspects of the NMHP is the enhanced recognition and services being available to a larger population. However, it needs to be noted that the programmes and initiatives have not really spread to the population. There are large treatment gaps. The value of mental health in primary healthcare has been noted worldwide and focusing efforts in this area has become a priority. India, which has had a lead in formulating the NMHP in 1982, one of the first among developing countries, and initiating the integration of mental health in primary healthcare nearly a quarter century ago, has still not done enough. Specifically, studies need to be carried out to understand the care processes and impact evaluation of the programmes. There is also the larger problem of the chronic mentally ill in the community. The stigma of mental illness awaits major initiatives to fight the discrimination experienced by the patients and their families. The areas of truly empowering the patients, families and communities towards the three goals of mental health, namely, promotion, prevention and treatment, are still in its early days. These are the challenges and opportunities for the future (Table 7.6).

### **Suggested Reading**

1. Agarwal AK. The forgotten millions. *Indian Journal of Psychiatry* 1998;40:103-119.
2. Amin G, Shah S, Vankar GK. The prevalence and recognition of depression in primary care. *Indian Journal of Psychiatry* 199;40:364-369.
3. Bhashyam VSP. Mental health services: Implementation and evaluation. *Indian Journal of Psychiatry* 1997;39:3-7.
4. Bhattacharya D, Choudhury JR, Mondal D, Boral A. Psychological crisis and general practitioners. *Indian Journal of Psychiatry*, 1993: 35:103-105.
5. Chandrashekar CR, Issac MK, Kapur RL, Parthasarathy R. Management of priority mental disorders in the community. *Indian Journal of Psychiatry* 1981;23:174-178.
6. Channabasavanna SM, Sriram TG, Kishore Kumar K. Results from the Bangalore Centre. In: Ustun TB, Sartorius N, eds. *Mental Illness in General Health Care*. Chichester: Wiley, 1995.
7. Chatterjee S, Patel V, Chatterjee A, Weiss HA. Evaluation of a community-based rehabilitation model for chronic schizophrenia in India. *British Journal of Psychiatry* 2003;182:57-62.
8. Chisholm D, Sekar K, Kishore Kumar K, Saeed K, James S, Mubbashar M, Srinivasa Murthy R. Integration of mental health care into primary health care: Demonstration cost-outcome study in India and Pakistan. *British Journal of Psychiatry* 2000;176:581-588.



9. Devi S. Short-term training of medical officers in mental health. *Indian Journal of Psychiatry* 1993;35:107-110.
10. Gautam S. Development and evaluation of training programmes for primary mental health care. *Indian Journal of Psychiatry* 1985;27:51-62.
11. Government of India. *National Mental Health Programme for India*. New Delhi; Ministry of Health and Family Welfare, 1982.
12. Government of India. *The Persons with Disabilities Act*. New Delhi; Ministry of Social Justice and Empowerment, 1995.
13. Ignacio LL, de Arango MV, Baltazar J, Busnello ED, Climent CE, ElHakim A, Farb M, Gueye M, Harding TW, Ibrahim HH, Srinivasa Murthy R, Wig NN. Knowledge and attitudes of primary health care personnel concerning mental health problems in developing countries. *American Journal of Public Health* 1983;73:1081-1084.
14. Ignacio LL, de Arango MV, Baltazar J, Busnello ED, Climent CE, ElHakim A, Farb M, Gueye M, Harding TW, Ibrahim HH, Srinivasa Murthy R, Wig NN. Knowledge and attitudes of primary health care personnel concerning mental health problems in developing countries: a follow-up study. *International Journal of Epidemiology* 1989;18:669-673.
15. Issac MK, Kapur RL, Chandrasekar CR, Kapur M, Parthasarathy R. Mental health delivery in rural primary health care development and evaluation of a pilot training programme. *Indian Journal of Psychiatry* 1982;24:131-138.
16. Issac MK, et al. Decentralised training for PHC medical officers of a district – the Bellary approach. In: Verghese A, ed. *Continuing Medical Education, Vol VI*. Calcutta: Indian Psychiatric Society 1986.
17. Issac MK. Models utilising para-professionals and non-professional staff. In: Srinivasa Murthy R, Burns, BJ, eds. *Community Mental Health*. Bangalore: National Institute of Mental Health and Neurosciences, Publication No. 29, 1987: 171-190.
18. Issac MK, Chandrasekar CR, Srinivasa Murthy R. *Manual of Mental Health Care for Medical Officers*. Bangalore: National Institute of Mental Health and Neurosciences, 1988.
19. Issac MK, Chandrasekar CR, Srinivasa Murthy R. *Mental Health Care by Primary Care Doctors*. Bangalore: National Institute of Mental Health and Neurosciences, 1994.
20. James S, Chisholm D, Srinivasa Murthy R, Kishore Kumar K, Sekar K, Khali Saeed, Mubbashar M. Demand for, access to and use of community mental health care: Lessons from a demonstration project in India and Pakistan. *International Journal of Social Psychiatry* 2002;48:163-176.
21. Manickam LSS. Training community volunteers in preventing alcoholism and drug addiction: a basic programme and its impact on certain variables. *Indian Journal of Psychiatry* 1997;39:220-225.
22. Menon DK, Manchina M, Dhir A, Srinivasa Murthy R, Wig NN. Training in mental health for community health workers: An experience. In: Kumar V, ed. *Delivery of Health Care in Rural Areas*. Chandigarh: PGIMER, 1978: 38-41.
23. Nagarajiah, Reddamma K, Chandrasekar CR, Issac MK, Srinivasa Murthy R. Evaluation of short-term training in mental health for multipurpose workers. *Indian Journal of Psychiatry* 1994;36:12-17.
24. Naik AN, Isaac M, Parthasarathy R, Karur SV. The perception and experience of health personnel about integration of mental health in general health services. *Indian Journal of Psychiatry* 1994;36:18-21.
25. Naik AN, Parthasarathy R, Issac MK. Families of rural mentally ill and treatment adherence in district mental health programme, *International Journal of Social Psychiatry* 1996;42:168-172.
26. Parthasarathy R, Chandrasekar CR, Issac MK, Prema TP. A profile of the follow-up of the rural mentally ill. *Indian Journal of Psychiatry* 1981;23:139-141.
27. Patel V. Recognising common mental disorders in primary care in African countries; should “mental “ be dropped? *Lancet* 1996;347:742-744.
28. Patel V, Pereira J, Fernandes J, Mann A. Poverty, psychological disorder and disability in primary care attenders in Goa, India. *British Journal of Psychiatry* 1998;172:533-536.
29. Patel V. The need for treatment evidence for common mental disorders in developing countries. *Psychological Medicine* 2000;30:743-746.

30. Pereira J, Patel V. Which antidepressant is best tolerated? A randomised trial of antidepressants treatment for common mental disorders in primary care in Goa. *Indian Journal of Psychiatry* 1998;41:358-363.
31. Rajkumar S, Padmavathi R, Thara R, Sarada Menon S. Incidence of schizophrenia in an urban community in Madras. *Indian Journal of Psychiatry* 1993;35:18-21.
32. Ranganathan S. *The Empowered Community: A Paradigm Shift in the Treatment of Alcoholism*. Modern TTR Clinical Research Foundation 1996.
33. Reddy GNN. Innovations in neuropsychiatric services. *NIMHANS Journal* 1983;1:1.
34. Reddy GNN, Chennabasavanna SM, Srinivasa Murthy R. Implementation of National Mental Health Programme. *NIMHANS Journal*, 1986: 4:77-84.
35. Reddy GNN. Mental health planning and policy development at national level. In: Srinivasa Murthy R, Burns BJ, eds. *Community Mental Health*. Bangalore: National Institute of Mental Health and Neurosciences, Publication No. 29 1987;17-39.
36. Sen B. Psychiatric phenomena in primary health care: their extent and nature. *Indian Journal of Psychiatry* 1987; 19:33-40.
37. Seshadri S, Kumar KVK, Moily S, Srinivasa Murthy R. Patients presenting with multiple somatic complaints to rural health clinic (Sakalawara): preliminary report. *NIMHANS Journal* 1988;6:13-17.
38. Sell HL, Srinivasa Murthy R, Seshadri S, Kumar KVK, Srinivasan K. *Recognition and Management of Patients with Functional Complaints: A Training Package for Primary Healthcare Physicians*. New Delhi: WHO Regional Office for Southeast Asia, 1989.
39. Shaji S, Verghese A, Promodu K, George B, Shibu V. Prevalence of priority psychiatric disorders in rural area in Kerala. *Indian Journal of Psychiatry* 1995;37:91-96.
40. Shamasundar C, Kapur RL, Sundaram UK, Pai S, Nagarathna GN. Involvement of the GPs urban mental healthcare. *Journal of Indian Medical Association* 1986;72:310-313; 1978;4: 77-84.
41. Shamasundar C, Kapur RL, Issac MK, Sundaram UK. Orientation course in psychiatry for the GPs. *Indian Journal of Psychiatry* 1983;25:298.
42. Shamasundar C. Training of GPs in psychiatry – Bangalore experience. In: Verghese A, ed *Continuing Medical Education, Vol. VI*. Calcutta: Indian Psychiatric Society, 1986.
43. Sharma SD. *Psychiatry in Primary Care*. Ranchi: Central Institute of Psychiatry, 1986.
44. Srinivasa Murthy R, Wig NN. Community psychiatry in India – organisation, service and training. In: Ari Kiev, Venkoba Rao A, eds. *Readings in Transcultural Psychiatry*. Madras: Higginbothams Ltd., 1982.
45. Srinivasa Murthy R, Chandrasekar CR, Nagarajiah, Issac MK, Parthasathy R, Raghuram A. *Manual of Mental Health Care for Multi-Purpose Workers*. Bangalore: National Institute of Mental Health and Neurosciences, 1988.
46. Srinivasa Murthy R. Emerging aspects of psychiatry in India. *Indian Journal of Psychiatry* 1988;40:307-310.
47. Srinivasa Murthy R. *Status Paper on delivery of Mental Health Services in India (1947-1987)*. New Delhi: Indian Council of Medical Research, 1987.
48. Srinivasa Murthy R, Wig NN. A training approach to enhancing mental health manpower in a developing country. *American Journal of Psychiatry* 1983;140:1486-1490.
49. Srinivasa Murthy R, Issac MK, Chandrasekar CR, Bhide A. *Manual of Mental Health for Medical Officers – Bhopal Disaster*. New Delhi: Indian Council of Medical Research, 1987.
50. Srinivasa Murthy R. Integration of mental health with primary health care – Indian experience, In: Srinivasa Murthy R, Burns BJ, eds. *Community Mental Health*. Bangalore: National Institute of Mental Health and Neurosciences, Publication No. 29, 1992;111-142.
51. Srinivasa Murthy R, Burns BJ. *Community Mental Health: Proceedings of the Indo-US Symposium*, Bangalore: National Institute of Mental Health and Neurosciences, 1992.
52. Srinivasa Murthy R, Wig NN. Evaluation of the progress in mental health in India since independence. In: Purnima Mane, Katy Gandevia, eds. *Mental Health in India*. Bombay: Tata Institute of Social Sciences, 1993;387-405.

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53. Srinivasa Murthy R. Screening for primary care in community and primary care populations. *Current Opinion in Psychiatry* 1997;10:102–106.
54. Srinivasa Murthy R. Psychiatry in the Third World: managing and rationalising mental health care. *Current Opinion in Psychiatry* 1998;11:197–199.
55. Srinivasa Murthy R. Approaches to organising mental health services in developing countries with limited resources. In: Lopez-Ibor JJ, Lieh Mak F, Vistosky HM, Maj M, eds. *One World, One language*. Proceedings of the X World Congress of Psychiatry, Bern: Hogrefe and Haber, 1999:75–78.
56. Srinivasa Murthy R. Approaches to suicide prevention in Asia and Far East. In: Hawton K van Heerigan K, eds. *The International Handbook of Suicide and Attempted Suicide*. Chichester: Wiley, 2000:631–643.
57. Srinivasa Murthy R. Community resources for mental health care in India. *Epidemiologia e Psichiatria Sociale* 2000; 9:89–92.
58. Sriram TG, Kishore Kumar, Moily S, Chandrasekar CR, Issac MK, Srinivasa Murthy R. Minor psychiatric disturbances in primary health care: a study of their prevalence and characteristics using a simple case detection technique. *Indian Journal of Social Psychiatry* 1987;3:212–226.
59. Sriram TG, Chandrasekar CR, Moily S, Kumar K, Raghuram A, Issac MK, Srinivasa Murthy R. Standardisation of multiple-choice questionnaire for evaluation medical officers training in psychiatry. *Social Psychiatry and Psychiatric Epidemiology* 1989;24:327–331.
60. Sriram TG, Moily S, Kumar GS, Chandrasekar CR, Issac MK, Srinivasa Murthy R. Training of primary health care medical officers in mental health care. Errors in clinical judgement before and after training. *General Hospital Psychiatry* 1990;12:384–389.
61. Sriram TG, Chandrasekar CR, Issac MK, Srinivasa Murthy R, Moily S, Kumar K, Shanmugam V. Development of case vignettes to assess the mental health training of primary care medical officers. *Acta Psychiatrica Scandinavica* 1990;82:174–177.
62. Sriram TG, Chandrasekar CR, Issac MK, Srinivasa Murthy R, Shanmugam V. Training primary care medical officers in mental health care: an evaluation using multiple-choice questionnaire. *Acta Psychiatrica Scandinavica* 1990;81:414–417.
63. Sriram TG, Srinivasa Murthy R, Issac MK, Chandrasekar CR. *Manual of Psychotherapy for Medical Officers*. Bangalore: National Institute of Mental Health and Neurosciences, 1991.
64. Surgeon General. *Mental Health: A Report of the Surgeon General*, Department of Health and Human Services, Washington.
65. Tewari SC, Sitholey P, Sethi BB. Mental health care: Perceptions and expectations of rural population in Uttar Pradesh – a brief report. *Indian Journal of Psychiatry* 1999;41:37–41.
66. Ustun TB. WHO Collaborative study: an epidemiological survey of psychological problems in general health care in 15 centres worldwide. *International Review of Psychiatry* 1994;6:357–363.
67. Ustun TB, Sartorius N. *Mental Illness in General Health Care: An International Study*. Chichester: Wiley, 1995.
68. Vijayakumar L. Befriending the suicidal in India. *Crisis* 1994;15:99–100.
69. Wig NN, Srinivasa Murthy R, Harding TW. A model for rural psychiatric services – Raipur Rani experience. *Indian Journal of Psychiatry* 1981;23:275–290.
70. Wig NN, Parhee R. *Manual of Mental Disorders for Primary Health Care Physicians*. New Delhi: Indian Council of Medical Research, 1984.
71. Wig NN, Srinivasa Murthy R, Parhee R. Delivering mental health care in rural primary care settings: An Indian experience. In: Pichot, Berner, Wolf, Than, eds. *Psychiatry: The State of the Art. Vol. 7, Epidemiology and Community Psychiatry*. New York and London: Plenum Press 1985;259–264.
72. Wig NN. The future of psychiatry in developing countries – The need for national programmes of mental health. *NIMHANS Journal* 1989;7:1:1–11.
73. Wig NN. Stigma against mental illness (Editorial). *Indian Journal of Psychiatry* 1997;39:(3):187–189.
74. Wig NN. Mental health and spiritual values. A view from the East. *International Review of Psychiatry* 1999;11:92–96.

75. Wig NN. Development of regional and national mental health programme. In: de Girolamo G, Eisenberg L, Goldberg D, Cooper JE, eds. *Promoting Mental Health Internationally*. London: Gaskell. Academic Series, Royal College of Psychiatrists, 1999.
76. Wig NN. WHO and mental health—a view from developing countries. *Bulletin of WHO* 2000;78:502–503.
77. WHO. *Organisation of Mental Health Services in Developing Countries. Technical Report Series, 564*. Geneva: WHO, 1975.
78. WHO. *Primary Health Care*. Geneva: WHO, 1978.
79. WHO. *Prevention of Mental, Neurological and Psychosocial Disorders*. Report No. MNH/EVA/A/88, 1988.
80. WHO. *ICD-10: Diagnostic and Management Guidelines for Mental Disorders in Primary Care – ICD-10, Chapter V. Primary Care Version*. Bern: Hogrefe and Huber, 1996.
81. WHO. *World Health Report: Health Systems: Improving Performance*. Geneva: WHO, 2000.
82. WHO. *World Health Report, 2001: Mental Health – New Understanding, New Hope*. Geneva: WHO, 2001.

## Chapter 8

# The Story of Community Mental Health in India

*R. L. Kapur*

The institutional treatment for mental disorders in India and the use of allopathic medicine were introduced by the European rulers. Hospitals for physical illnesses, however, existed from ancient times. As a matter of fact, Charaka and other stalwarts of indigenous medical systems considered mental disorders to be *asadhya* (unmanageable). Thus, their treatment was left to folk-healers, who practised their art in the community setting. As late as the early 1970s, when the author carried out a survey of mental disorders in a south Karnataka district, which boasted of two medical colleges and an above average infrastructure for delivery of modern medicine, 75% of those suffering from severe mental illness were still being taken for treatment to the traditional folk-healers.<sup>1</sup> The same study showed that there were 26 traditional healers for a population of 10,000, which is a fair therapist-patient ratio by any standard. Other studies have shown that the same ratio operates in other parts of India and it is a fact that even in the twenty-first century, mentally ill patients are taken for treatment to traditional healers, exclusively or alongside visits to modern doctors. Therefore, it should be remembered that when we talk of the community mental health movement in India, it is in the context of modern psychiatric practices developed within the ambit of allopathic medicine. However, the abundant community-based resources of the traditional mould, which still continue to flourish and which have been regarded as ineffective or indeed harmful without sufficient exploration and systematic examination, are being ignored. This will be discussed later in this chapter.

The inspiration for the community mental health movement in India comes from three sources. The first source is the realisation in Western countries that the treatment of mentally ill patients in mental hospitals might, in fact, be counterproductive. In the 1960s, American psychiatrists discussed the 'Social Breakdown Syndrome', which resulted from long-term hospitalisation.<sup>2</sup> This prompted the Kennedy administration to launch the American version of the community mental health programme. The second source is the realisation that institution-based psychiatry through trained professionals can, in fact, be very expensive and that countries like India will not have the sufficient manpower and facilities to deliver services through conventional methods, for many years. The third source was the happy discovery in other poor countries,<sup>3-5</sup> that para-professionals and non-professionals could, after undergoing simple and short innovative training, deliver reasonably adequate mental healthcare. All these three factors influenced the development of community-based mental health programmes in India. What follows is a critical account of the programmes as they developed.

## **The Story of the Community Mental Health Movement**

### ***Dr Vidya Sagar – Amritsar Mental Hospital and De-institutionalisation***

It has become customary to begin the story of community psychiatry in India with Dr Vidya Sagar<sup>6</sup> who in the late 1950s began to involve family members in the treatment of mentally ill patients who were admitted to the Amritsar Mental Hospital. He did this for purely practical reasons: he had a 900-bed hospital, which was extremely short of staff. He put up army surplus tents within the precincts of the hospital, and the relatives who brought in new patients were requested to stay on to assist in providing nursing care. Every evening, he would assemble a large number of relatives and carry out an open 'case-conference', in which he encouraged them to understand the symptoms of the illness as well as methods of treatment. In these sessions, Dr Vidya Sagar drew freely upon his knowledge of classical Hindu texts, the very style of his address resembling that of a Hindu holy man. Subsequently, when asked to analyse the impact of his innovation, Dr Vidya Sagar felt that the exercise achieved much more than he had initially hoped for. First, it reduced the hostility in the minds of the patients for having been abandoned in a strange place. Second, when the family began to see the patients recovering, it helped to remove the age-old myths about the incurability of mental illness. Finally, by taking group sessions, the relatives learnt the essential principles of mental healthcare and were thus motivated towards improvement in their own ways of life. Thus, many patients actually went back with their families and the discharge statistics began to rise. All this happened before the era of major tranquilisers. This experiment helped to kick-start a major movement to involve family members in treatment of the mentally ill.

### ***Psychiatric Units in General Hospitals***

The next phase in de-institutionalisation was the establishment of the General Hospital Psychiatric Units (GHPUs). The first one was set up in 1933 at the R.G. Kar Medical College at Kolkata,<sup>7</sup> but most such units came up in the 1960s because of the availability of antipsychotic drugs which dramatically controlled the agitation, aggression and withdrawal tendencies of patients, making it possible to treat the mentally ill in general hospitals. It should be noted that while in the West, the GHPUs were created to attend to neuroses and psychosomatic illnesses, those in India, right from the beginning, handled all kinds of psychiatric problems. As Wig wrote, 'Often, the nearest mental hospital is hundreds of miles away'. Besides, the majority of existing medical hospitals are overcrowded and facilities are far from ideal. In such circumstances, how could a psychiatrist in a general hospital refuse help to a needy patient? What one remembers most is the surprise of the other hospital patients that the mentally ill were, in fact, like other people and responded to medical treatment. Even more interesting was the new sense of confidence amongst psychiatrists and a visible rise of their status amongst fellow-professionals. Wearing white coats like other doctors was a symbol of this consciousness of their higher status. A greater number of graduates began to choose psychiatry as a career. When last counted, there were about 200 such units in India.<sup>8</sup> There must be many more now. Many of these units also provide postgraduate instruction in psychiatry.

### ***The NIMHANS Crash Programme***

It was at the initiative of the director, Dr R.M. Varma and that of Dr Karan Singh, Minister of Health in the central government, that a crash programme for community-based mental health was introduced at NIMHANS.<sup>9</sup> A community psychiatry unit was also started in October 1975. This unit simultaneously launched the following experimental programmes:

- **Primary Health Centre (PHC)-based rural mental health programme:** Under this heading a manual was prepared to train the multipurpose workers to recognise cases of severe mental illness and to follow them up under the leadership of the PHC doctor. Another manual was prepared to train the PHC doctors to diagnose cases of severe mental disorder and treat patients with a given number of antipsychotic, antidepressant and antiepileptic medicines. Experiments showed that after 15 days training, the PHC personnel helped them to carry out the given tasks in a very satisfactory manner.<sup>10,11</sup>
- **General Practitioner (GP)-based urban mental health programme:** For this, a manual was prepared to teach the GPs methods of treating common mental disorders. Research showed that this also could be satisfactorily accomplished.<sup>12</sup>
- **School mental health programme:** In this programme, school teachers were trained to diagnose children with emotional problems and to counsel them. It was evaluated with satisfactory results.<sup>13,14</sup>
- **Home-based follow-up of psychiatric patients:** Here, nurses were trained to follow-up patients in their own homes through monthly visits.<sup>15</sup> It was discovered that the patients did better than a comparable group who were followed up as out-patients. Further, the burden on the family of the patients was also less in the experimental group.
- **Psychiatric camps:** Inspired by the eye camps, psychiatric camps were organised taking into account the difficulty of reaching patients to distant hospitals, cost of travel and so on. Research showed that the camps were instrumental in involving the village leaders in the therapeutic process and helped to reduce the stigma against mental patients.<sup>16</sup> When one family was willing to have its sick member treated openly, it became easier for others to follow suit.

The greatest effort was devoted to the development of the rural mental health programme and regular training programmes for 15 days were started at a health centre in the village of Sakalwada, near Bangalore. While these training programmes gave very satisfactory results in terms of the knowledge gained by the PHC personnel, it must be noted that no long-term follow-up was done in the natural PHC setting, where trained personnel carried out the work in the absence of supervision by professionals.

### *The Chandigarh Experiment*

Soon after the community psychiatry unit in NIMHANS began, a rural mental health programme was started in the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, with the help of the WHO.<sup>17</sup> After carrying out studies to estimate the prevalence of mental disorders, the psychiatry department in PGIMER also developed manuals of training for the PHC personnel. This programme too was a success, but here also no exercise was carried out to examine the success in a PHC, where personnel who had been given short periods of training, actually carried out their work without the supervision of professionals.

### *ICMR-DST Study on Severe Mental Morbidity*

This was the first<sup>18</sup> and only prospective study where the ability of doctors and health workers to recognise and manage psychotics and epileptics at the PHC level has been examined exhaustively. The study was carried out at four centres – Bangalore, Vadodara, Patiala and Kolkata. At each centre, training was provided to the Multipurpose Workers (MPWs) to detect cases in the

community and follow them up on the instruction of the doctors. Doctors were trained to diagnose as well as treat the cases with appropriate medication. Having done that, their performance was monitored over a period of one year. Subsequently, a survey was carried out at each centre by a research team on a population of 40,000 each, to identify the actual number of psychotics and epileptics in the community. It was discovered that while the knowledge gained after training for both doctors and MPWs was extremely good, their actual performance over the year was not. Only 20% of the actual cases were picked up by a few MPWs who were motivated; there were many who did not refer even a single case to the PHC doctors. Hardly any patient detected was followed up by the MPWs in the community. Most of those who went to the PHC doctor for follow-up treatment, came on their own. Many patients preferred to consult the specialist staff in the research teams. When asked why the job was poorly done, many excuses were given. Some complained about family planning targets they had to meet, which prevented them from doing this work. Others feared that if they did a good job, this would also become a national programme with targets to be met. Some also wanted to be paid for their extra efforts. There were also some MPWs who said that they knew of more cases, but could not persuade the patient's relatives to take them to the PHCs. In general, the influence of the PHC personnel in the community was very poor. Neither the doctor nor the health workers were able to organise any programme to impart mental health education, which was one of the objectives of the research project. Record keeping was extremely poor in all the four centres. In short, there was a lack of motivation and leadership. It is intriguing why this particular study has never been referred to by the enthusiasts of the PHC-based mental health programmes.

### ***The NMHP***

Without taking into account the results of the ICMR-DST study, the NMHP was launched<sup>19</sup> with the ambitious aim, amongst others, of ensuring the availability and accessibility of minimum mental healthcare for all in the foreseeable future. A number of targets were set. The most prominent were: the training of at least 5,000 MPWs and of at least 20% of the PHC doctors; the creation of the post of a psychiatrist in at least 50% of the districts and necessitating this psychiatrist to visit all PHCs in his district regularly at least once a month for continuing education. All this was to be accomplished within five years! This was more a wish list than a serious exercise. The programme was adopted after some change by the planning commission and Rs 10 million was sanctioned in the Seventh Plan to achieve these aims. What happened during the subsequent five years is a sad story, with hardly any target met except the holding of meetings, seminars and workshops. In the dusk of this plan, a workshop was held<sup>20</sup> in which the planners talked of the difficulties encountered in putting the programme into action because of the lack of 'clear-cut models to be adopted'.

#### **It appears that the poor progress was due to the following factors:**

1. The programme looked good on paper, but was extremely unrealistic in its targets, especially considering the available resources of manpower and funds. Just to give an example, the cost of psychotropic drugs required for minimum mental healthcare would be three to four times the total budget of a PHC. The setting up of district hospital psychiatry units would also be very expensive. The sum of Rs 10 million was obviously sanctioned without working out the costs.
2. The approach was top down and did not take into account the ground realities. The poor functioning of the PHCs in India in general as well as the poor morale of the health



workers were not taken into account. A structure that was attending to given tasks so inadequately, would certainly be unable to absorb new targets. We seem to have learnt little from the failure of the family planning programme.

3. There was a lack of enthusiasm for the programme in the profession as a whole. Without the help and active cooperation of professionals across India, no large-scale training programme or supervision is possible.
4. There was a lack of an administrative structure to monitor the progress of the programme in a decentralised manner.

### ***The DMHP***

Notwithstanding the result of the ICMR-DST study, in the 1980s, NIMHANS launched a pilot model programme in the Bellary district to implement the NMHP, at a district level. In some ways, this was a more rational exercise compared to the ambitious aims of the NMHP, as the scope was limited to just one district. Here also, the personnel of the PHCs in the district were trained to recognise and manage mental patients in the community. A specially trained programme officer was appointed to conduct a regular mental health clinic and also to monitor the progress in PHCs all over the district. Good results were described,<sup>21</sup> but on close-examination, the picture did not appear to be as rosy as claimed. In a paper read at the 23<sup>rd</sup> Annual Conference of IPS-South Zone on 14 October 1990, the programme officer in charge of the Bellary model<sup>22</sup> talked of the difficulties in correct diagnosis, the choice of appropriate medication, as well as dosage and difficulty in handling side effects of medicines. He also talked of administrative problems like the transfer of personnel who became acquainted with the programme, poor motivation on the part of personnel and the erratic supply of drugs. Being an optimistic person, he gave suggestions regarding measures which could be taken to make the model programme more effective, but was transferred himself, before he could carry out these measures. An informal enquiry by the author to people working in the Bellary district revealed that the model actually fizzled away in the very district where it was first tried out. Unfortunately, the documents from NIMHANS or the Karnataka Health Ministry continue to paint a glowing picture of the Bellary model. Perhaps, if the programme had been evaluated by a research team, whose members were not involved in administering the programme, one would have learnt many things which would have been useful for future programmes.

The national workshops on mental healthcare for the state health administrators held at NIMHANS in 1996 and the workshop to review the district mental health programme in October 2000 showed that this district model has been adopted in many states. It is also encouraging that in the workshop held in 2000, participants frankly admitted several difficulties in the implementation of the programme and gave several realistic suggestions. This candour makes one believe that if nothing else, various states administrations, through their experience with this programme, will remain sensitive to the mental health needs of the community and later, when the programme goes beyond the trial stage to become a part of the national health policy, they will not ignore the mental health component. As for the ultimate implementation at the grass-root level, the success will depend on the motivation level of the personnel at all levels. There is no conviction that these personnel will show any greater enthusiasm for mental health work than they have for other areas of health. Even in the case of the AIDS programme, where funds flow in from all over the world, there is criticism regarding the misuse of resources and poor motivation, so much so, that the AIDS cases are increasing in number and in proportion to the total population.

### ***The Barwani Experiment***

People selected on the basis of high motivation can work wonders can be seen from the excellent study carried out by Chaterjee et al.<sup>23</sup> This study used a 3-tier model for the delivery of mental health services. The first tier was the out-patient programme. The second tier employed mental health workers *drawn from local community*. The third tier consisted of family members and key people in the community who formed the local health groups. The 'compliance with treatment' rate was much higher (63%) compared with another group, who used only the out-patient service (46%). The authors stress that the mental health workers, 'being members of the local community communicated effectively with patients and their families, used shared cultural idiom, thus promoting greater adherence to treatment'. The village *samitis* also added a positive atmosphere, which surely improved the motivation of all involved in providing services.

This particular experiment can become a model not only for the treatment of mental disorders, but also for primary healthcare in general. The aim should be to provide healthcare through local bodies, like Panchayati Raj institutions.<sup>24</sup>

### ***Care of Chronically Ill and Role of the Family***

It has been repeatedly suggested that since the family unit in India is a very strong institution, it will take care of the mentally ill patient better than in a hospital atmosphere. The author has examined this issue in greater detail elsewhere<sup>25</sup> and has suggested that family support cannot be taken for granted in the changing socio-economic climate. There is an increasing migration to the cities, a gradual diminution of the family size and fewer people available at home to look after the patient.

Under these circumstances, it is frightening to see how several mental hospitals are shortening the length of stay as an in-patient, hoping that the family would take care of the patient instead. The NMHP and DMHP are also designed in a manner in which family has to play a major supportive role. Will the Indian family be able to respond to the challenge? It appears uncertain, not because it does not want to but because it cannot. The voluntary and private sector efforts to look after the chronically ill are puny in comparison to the current needs and also very expensive. It is suggested that the community mental health programmes should divert a significant part of their funds to the care of chronically ill, because ultimately it is the state, which has a moral duty to look after its weak and dependent population.

### **Common Mental Disorders**

Around 8-10% of the population suffers from anxiety, depression and somatic symptoms in response to the stress and strain of life. Poverty, being a member of a lower caste, being a woman, increasing urbanisation, dislocation and dilution of the old social values have a direct relation to increase of these disorders and that of substance abuse. Modern psychiatry has very little to offer for these conditions except an increasing use of minor tranquilisers, which has become a curse in its own right. Fortunately, attempts are being made in India to use psycho-social methods to attend to this major need. We have programmes in which lay volunteers after a short period of training are able to counsel such patients.<sup>26</sup> There is also a rise in growth therapies.<sup>27</sup> Many industrial organisations provide personality enhancement programmes for their employees. The elites are willing to pay large sums to learn exotic techniques like Reiki, transactional analysis and past-life therapies. According to some estimates, more than 5,000-6,000 people in Bangalore enter such programmes every year and this must also be true for other big cities also. All these resources have their uses but once again, they are too little in comparison to what is required. It is in this context

that the role of folk-healing, spiritual and religious counselling, and ancient techniques like yoga and medication acquire significance. Many people with emotional problems go to folk-healers and spiritual teachers. It is easy for a modern psychiatrist to decry these institutions as unscientific, but what have they to offer instead? Constant criticism of these community resources will only create a vacuum. There are attempts to evaluate the impact of these resources by scientific statistical techniques. However, counting the reduction in the number of symptoms is a poor way to evaluate these resources. Evaluation must be done by assessing the subjective sense of well-being, experienced by the person who uses these resources. What is needed are qualitative studies.<sup>28</sup> What one requires when assessing the impact of religious figures like Sai Baba is to first look at the contented smiles on the faces of thousands of devotees who attend his prayer meetings every day, and then to interview a few to find out how he has changed their lives. Is going to spiritual healers worse than doling out expensive tranquillisers under the pressure of various drug companies?

We must not also forget that religious institutions in the country also give shelter to chronically ill patients who are left there by relatives who cannot cope. A fire in one such institution<sup>29</sup> which burnt to death many chronically ill people, shook up the liberal and liberated people of India who raised a hue and cry to close down such institutions. Further, where would these people go and who will keep them? Also, do the mental hospitals run by professionals have an over all better record in this respect? Instead of closing down these religious centres, would it not be better to offer some state funding so that these institutions could employ more caretakers? Also, it must be remembered that while some religious institutions provide very poor living conditions, others do much better. A recent paper by Raguram et al.<sup>31</sup> gave a very positive report on temple healing and showed that the affectionate and caring atmosphere lowered the Brief Psychiatric Rating Scale (BPRS) count in patients, without the use of medication. This sounds similar to the Amritsar experiment mentioned earlier, which reduced the hospital stay before modern tranquillisers were introduced. Perhaps, the judicious enrolling of such institutions into awareness programmes and some funds and resources to distribute minimal medication would lower the BPRS scores even more. It goes without saying that all institutions that provide shelter to mentally ill people, whether they are religious institutions or mental hospitals run by professionals, must be monitored adequately.

## **Suggestions for the Future**

1. While innovative programmes are necessary for taking mental healthcare to all in need; continued efforts to improve psychiatry education in the MBBS courses must be made. If psychiatry is taught well in MBBS courses, there would be little need of manuals for the PHC doctors. After all, PHC doctors treat many medical conditions without the use of such manuals!
2. PHCs should employ local people in the delivery of services, to ensure a high level of motivation. This sounds simple, but requires a major change in administrative structure.
3. The state must not give up the responsibility of looking after chronically ill patients and innovative programmes should be developed to help the state take up these challenges.
4. There should be a networking of non-professional counselling services, training courses for lay counsellors and better monitoring of the services they provide.
5. New programmes should be continuously evaluated by researchers who have not taken part in the development of these programmes.
6. Professionals should make contact with religious and spiritual centres which provide

help to the mentally distressed. There is great scope for both groups to learn from each other in providing care for the needy.

7. Special focus should be kept for the groups most at risk – women, children and the elderly people.
8. Mental health professionals should remain sensitive to the changing values and attitudes accompanying socio-economic uplifting programmes and should exercise their democratic right to influence public opinion in this regard.

## Conclusion

We are living in a fast changing world where political, economic and social conditions are changing at a rate faster than what a human mind can comprehend. Our community care programmes should be flexible enough to adjust to such changes. No model is so sacrosanct that it carries on out of sync with the social environment. There are, however, some values that are eternal, or should be. Those who are weak and powerless should be supported and helped by others to live in a manner which raises their self-respect. This eternal value has correlates, which lead to stability, prosperity and the dignity of the nation.

## References

1. Kapur RL. Mental health care in rural India: A study of existing patterns and their implications for future policy. *British Journal of Psychiatry* 1975;127:286-93.
2. Gruenberg EM. Can the reorganization of psychiatric services prevent some cases of social breakdown? *American Journal of Psychiatry* 1967;132:1135-1140.
3. Haworth A. Training schemes for psychiatric medical assistants in Zambia. In: *Mental Health Services in the Developing World*. Commonwealth Foundation, 1969.
4. Schmidt KE. Mental health services in a developing country in Southeast Asia (Sarawak). In: Freeman H Land, Ferndale I, eds. *New Aspects of the Mental Health Services*. Oxford: Pergamon Press, 1967.
5. Swift CR. Mental health programming in a developing country: Any relevance elsewhere? *American Journal of Orthopsychiatry* 1972;42:517.
6. Kapur RL. Priority in mental health workshop on priorities in developing countries. *Indian Journal of Psychiatry* 1971;13:175-182.
7. Wig NN. Psychiatrists units in general hospital. Right time for evaluation. *Indian Journal of Psychiatry* 1978;20:1-5.
8. Srinivasa Murthy R, Burns BJ. *Community Mental Health*. Proceedings of the Indo-US Symposium. Bangalore: National Institute of Mental Health and Allied Neuro Sciences, 1992.
9. NIMHANS Governing Body Report. A crash programme for community psychiatry. 1975.
11. Isaac MK, Kapur RL, Chandrashekhar CR, Kapur M, Parthasarathy R. Mental health delivery in rural primary healthcare – Development and evaluation of a pilot training programme *Indian Journal of Psychiatry* 1982;24:131-138.
12. Shamsundar C, Kapur RL, Sundaram UK, Pai S, Nagarathna GN. Involvement of the general practitioners in urban mental healthcare. *Journal of Indian Medical Association* 1978;71:310-313.
13. Kapur M, Cariapa I. Evaluation of training programme for schoolteachers in a student counselling. *Indian Journal of Psychiatry* 1978;20:289-291.
14. Kapur M, Cariapa I. An orientation court for schoolteachers on emotional problems of schoolchildren. *Indian Journal of Clinical Psychology* 1979;6:75-80.

15. Pai S, Kapur RL. Evaluation of home care treatment for schizophrenic patients. *Acta Pschiatrica Scandinavica* 1983;67:(2):80-88.
16. Kapur RL, Chandrashekhar CR, Shamsundar C, Isaac Mohan K, Parthasarathy R, Shetty S. Extension of mental health services through psychiatric camps: A new approach. *Indian Journal of Psychiatry* 1982;24: 237-241.
17. Wig NN, Srinivasa Murthy R, Harding TW. A model for rural psychiatric services: The raipur rani experience. *Indian Journal of Psychiatry* 1981;23:275-290.
18. ICMR-DST A Collaborative study of severe mental morbidity. A report, 1987.
19. DGHS. National Mental Health Programme for India, 1982.  
DGHS. National Mental Health Programme in Retrospect and Prospect. New Delhi, 1989.
20. DGHS. A Progress Report (1982-90). GDHS and WHO-SEARO, New Delhi, 1990.
21. Issac MK. Models utilising para-professionals and non-professional staff. In: Srinivasa Murthy R, Burns BJ, Eds. *Community Mental Health*. Bangalore: NIMHANS Publication No. 29, 1987:171-190.
22. Karur BV. Experiences of the last four years as a programme officer in the District Mental Health Programme at Bellary. Paper read at 23rd Annual Conference of Indian Psychiatric Society, South Zone Conference at Bangalore, 1990.
23. Chatterjee S, Patel V, Chatterjee A, Weiss HA. Evaluation of a community-based rehabilitation model for chronic schizophrenia in rural India. *British Journal of Psychiatry* 2003;182,57-62.
24. Kapur RL. Report on "Panchayat Raj and health care: The Karnataka Experience". *Health Action* 1990; 3:10.
25. Kapur RL. Community involvement in mental healthcare, *National Medical Journal of India* 1994;7:(6): 292-294.
26. Ranganathan M, Reddy GNN, Shariff IA, Parthasarathy R, Kaliaperumal VG. College student volunteers in mental hospital programmes. *The Indian Journal of Social Work* 1991;L11:(2):151-160.
27. Chopra P. A rising market of mind, *India Today*, 1994; July, 19:14:148-155.
28. Kapur RL. Qualitative methods in mental health research. *NIMHANS Publications* 1999: SP4-99; Community therapy. *Bull NIMHANS* 1979.
29. Hindu, An incurable malady *The Hindu*, July 2001.
31. Raghuram R, Venkateswaran A, Ramakrishna J, Weiss MG. Traditional community resources for mental health: A report of temple healing from India. *British Medical Journal* 2002;325:38-40.
32. Report on National workshop on Mental Health Care for The State Health Administrators. NIMHANS, 1996.

# Chapter 9

## Origin and Growth of General Hospital Psychiatry

*N. N. Wig • Ajit Awasthi*

In many parts of the world, mentally ill patients were occasionally treated in general hospitals in special sections or in separate buildings, along with patients suffering from other diseases. In Islamic medical literature, there are references to the first 'humane' psychiatric hospitals and psychiatric wards in general hospitals, in the Middle East, in cities like Baghdad, Damascus and Cairo in the ninth and tenth centuries.<sup>1</sup> In 1284, the Kalaoon Hospital in Cairo had separate sections for medical, surgical, eye diseases and mental disorders.<sup>2</sup> In the UK, there were some general hospitals in the eighteenth and nineteenth centuries, which had separate sections for seriously mentally ill patients.<sup>3</sup> However, the modern general hospital psychiatric units in the sense we understand them today are essentially the phenomenon of the twentieth century. Prior to these, in the nineteenth century, seriously mentally ill patients were treated at lunatic asylums, while illnesses described then as hysteria, hypochondriasis, neurasthenia, etc., were managed by physicians in their clinics or in general hospitals. Gradually, towards the second half of the nineteenth century, neurology emerged as a respectable medical speciality and many psychiatric disorders, termed 'nervous disorders', were increasingly diagnosed by 'nerve specialists'. Around this time the advent of Sigmund Freud and psychoanalysis had a profound impact on twentieth century medicine and changed for ever the image of psychiatry as a mere appendix of neurology. Suddenly, the psychological origins of physical and mental symptoms were now well accepted and even considered fashionable. The new psychiatry encompassed not only psychoses and dementias, but also all types of neurotic and psychosomatic disorders. Under this new liberal atmosphere, many physicians in general hospitals began to accept and treat these psychiatric patients. The first liaison psychiatric service began in 1902 at Albany Hospital, New York. Another landmark development was the formulation of guidelines in 1929 for psychiatrists willing to collaborate with other specialities.<sup>4</sup> This laid the foundations of consultation-liaison psychiatry. The real push, however, came in the 1950s with the appearance of a number of psychotropic drugs, which made it relatively easy to treat a wide variety of psychiatric disorders in general hospitals, both in out-patient clinics and in-patient wards.

### **The Concept of General Hospital Psychiatry**

General hospital psychiatry is a broad term that implies the existence of psychiatric service as one of the many speciality services available in a general hospital. This psychiatric service may

exist in one or more of the several forms, viz., out-patient, indoor and referral (including one or both of the two components—consultation and liaison). The psychiatric wing of such a hospital is called the GHPU. Compared to the past, when psychiatric services were available only in a few mental hospitals or asylums, these services are now available widely in general hospitals. This change of locus of treatment has brought in a number of benefits like the proximity of the GHPU to the community, easy accessibility and approachability,<sup>5,6</sup> opportunity for interaction with other clinical departments,<sup>4-8</sup> enhancement of research, especially in biological domains of psychiatry,<sup>6</sup> exposure and training of staff in a broad range of psychiatric disorders, including the minor ones<sup>5,6</sup> and finally, reduction of the stigma associated with having a psychiatric illness or going to a psychiatrist or even for the medicos who opt for psychiatry as the subject of their postgraduation.<sup>5,6</sup>

### **General Hospital Psychiatry in India**

One of the forerunners of the general hospital psychiatry movement in India was the formation of the Indian Association of Mental Hygiene in Mumbai on the pattern of similar organisations in the USA. It is interesting to note how in an editorial in *The Times of India* (TOI) in 1931, the need for psychiatric services outside mental hospitals is reflected.

Every person who learns to regard mental disorders, as he does other diseases, directly contributes to the success of the campaign for prevention. One of the objectives of the Indian Association of Mental Hygiene is to bring about a rational attitude towards mental disease. This means teaching people early warning symptoms of disorders of the mind. It also means establishment of mental clinics and other mental health centres to which people will feel impelled to go without delay for advice and treatment (TOI, Editorial, 1 April 1931).

In India, the early attempts to start psychiatric services outside mental hospitals began with the initiative of psychoanalysis pioneers. Dr Girendra Shekhar Bose, the founder of the first psychoanalysis society in India, started the first GHPU at R.G. Kar Medical College in Kolkata in 1933.<sup>9</sup> Another psychoanalysis enthusiast, Dr K.K. Masani, opened a similar unit in Mumbai in 1938 at J.J. Hospital. A little later in the 1940s, Dr N.S. Vahia started a psychiatric unit at K.E. Medical College in Mumbai, which was more eclectic in scope.<sup>10</sup> In the mid-1950s, the movement rapidly spread to many centres in India. In 1957, Dr Dutta Ray started a psychiatric out-patient service at Irwin Hospital (now G.B. Pant Hospital), New Delhi. In January 1958, N.N. Wig (co-author of this chapter), started the first GHPU at Medical College, Lucknow, with both in-patient and out-patient psychiatric services and a teaching programme as a part of the Department of Medicine. Dr J.S. Neki started a similar unit at Medical College, Amritsar, a few months later.

There are a number of reasons for this rapid spread of GHPUs in India in the 1950s and 1960s. The first reason was that the psychoanalysis movement in the 1930s and 1940s in the USA and Europe had already created a liberal medical atmosphere, in which non-psychotic disorders like neurosis and psychosomatic diseases became a legitimate part of the clinical work of psychiatrists, and this was much better carried out in general hospitals. The military psychiatric services of some centres in India during the Second World War had also shown the way for the new pattern of psychiatric services. The second and more important reason was the arrival of a new crop of Indian psychiatrists trained at the newly started All India Institute of Mental Health, Bangalore (later NIMHANS). The first batch of Diploma in Psychological Medicine (DPM) came out in 1957. Very soon, there was a regular supply of 10–12 new psychiatrists every year to the GHPUs in all states. The third important reason was the availability of a whole new series of antipsychotic, antidepressant, and anti-anxiety drugs in the 1950s, which made it much easier to practise

psychiatry in general hospitals. The fourth important reason was the sheer economic necessity<sup>6</sup> as new mental hospitals were too expensive to open and maintain. It was therefore much cheaper to provide psychiatric services in existing general hospitals.

The community responded whole-heartedly to this development. The patients and their families found it much easier to visit these general hospital services than go to remote mental hospitals with the stigma they carried. Even when a patient was admitted in a psychiatric ward in a general hospital, the family could regularly visit and provide help. Follow-up of treatment was also easier. Surprisingly, early resistance came from the medical profession itself. Hospital administrators felt threatened with the thought of these 'little mental hospitals' inside general hospitals. It was feared that mental patients would disturb peace, create law and order problems, and that other patients would resent their presence and so on. In reality, no such problems arose. In fact, the general hospital atmosphere proved soothing for psychiatric patients who felt less disturbed. Gradually, the other medical colleagues also accepted the presence of psychiatric services in the general hospital. The number of referrals to psychiatrists have progressively increased over the years. Many new liaison services with other specialities like paediatrics, obstetrics and gynaecology, cardiology, nephrology and many others have emerged in different settings.

## **A Comparison of GHPUs in India and the West**

In the USA or Europe, there are extensive networks of psychiatric hospitals. For example, the mean number of psychiatric beds per 100,000 population in Europe is 89.3, while in Southeast Asia, it is only 5.7.<sup>10</sup> Thus, one can imagine the pressure on general hospital units in India. In the UK or the USA, if a patient becomes acutely disturbed while admitted to a general hospital, he or she is quickly evacuated to the nearest mental hospital. In India, this is not an easy option as mental hospitals are few in number and are situated far away from city limits. Procedures for admission are cumbersome. Social and legal support systems are also very weak. As a result, it is encouraging to note that a majority of acutely disturbed patients are managed in general hospitals quite effectively. Hence, the psychiatric services as provided in general hospitals in India are much more comprehensive than their counterparts in Europe or the USA, and these units handle the whole range of ICD-10 psychiatric disorders.

## **The Progress of GHPUs in India**

The rise of general hospital psychiatry has been a remarkable phenomenon in post independent India. As Wig observed, 'With the coming of general hospital psychiatric units, psychiatry has come of ages in India'.<sup>9</sup> In the next 25 years since then, this movement has further matured. Most of the teaching hospitals and major general hospitals in the private or government sector now have psychiatric services available. This is a remarkable change in the history of psychiatry in the last 50 years. The many benefits of this historic change are:

1. Psychiatric services have become easily available in the community, nearer to where people live. The quality of service has also improved compared to earlier mental hospitals.
2. The patient's family is more involved in the treatment.
3. The stigma and discrimination attached to mental illness has been reduced and public acceptance of psychiatry has increased.



4. Communication with the other medical specialities has greatly improved.<sup>10</sup> Physical problems associated with psychiatric illnesses are much better investigated and treated in a general hospital. Inter-departmental collaborative studies have revealed high figures of psychiatric morbidity in patients undergoing treatment in other specialities like nephrology,<sup>12</sup> cardiology,<sup>13</sup> obstetrics and gynaecology,<sup>14,15</sup> endocrinology,<sup>16</sup> neurology<sup>17,18</sup> and others.<sup>19-24</sup> Attempts have also been made to screen medically ill patients for possible concurrent psychiatric illnesses through simple tools.<sup>25,26</sup>
5. The atmosphere of the general hospital is more conducive to research and training in psychiatry. Many more young medical graduates are now attracted to psychiatry as a career choice.
6. The availability of emergency psychiatric services is a unique feature in GHPUs. This facility runs in tandem with the general emergency framework of the hospital and gives the opportunity to newly graduated psychiatrists to treat the patient in less than ideal circumstances, often in units which are not adequately equipped or staffed to deal with psychiatric emergencies.<sup>26-28</sup>

### **Psychiatric Training at GHPUs**

Instead of sending undergraduates to distant mental hospitals, most of the psychiatric units in general hospitals now provide training locally. Such training is more meaningful and relevant for medical students. Unfortunately, the Medical Council of India still prescribes a barely 15-day posting in a psychiatric unit, which was the same as it did 50 years ago and woefully inadequate in modern times. GHPUs have recently taken initiatives in the development of models for training primary care physicians in psychiatry.<sup>29-31</sup>

### ***Postgraduate Training***

The postgraduate training in psychiatry for MD (Psychiatry) and DPM has been greatly consolidated in the general hospital setting. The majority of these training centres in India are now based in general hospitals at Chandigarh, Delhi, Mumbai, Lucknow, Kolkata, Vellore, Varanasi, and so on. The training is quite comprehensive and generally popular with the students. Some centres like the Postgraduate Institute of Medical Education and Research, Chandigarh require students to undergo two months' additional training at a suitable mental hospital.

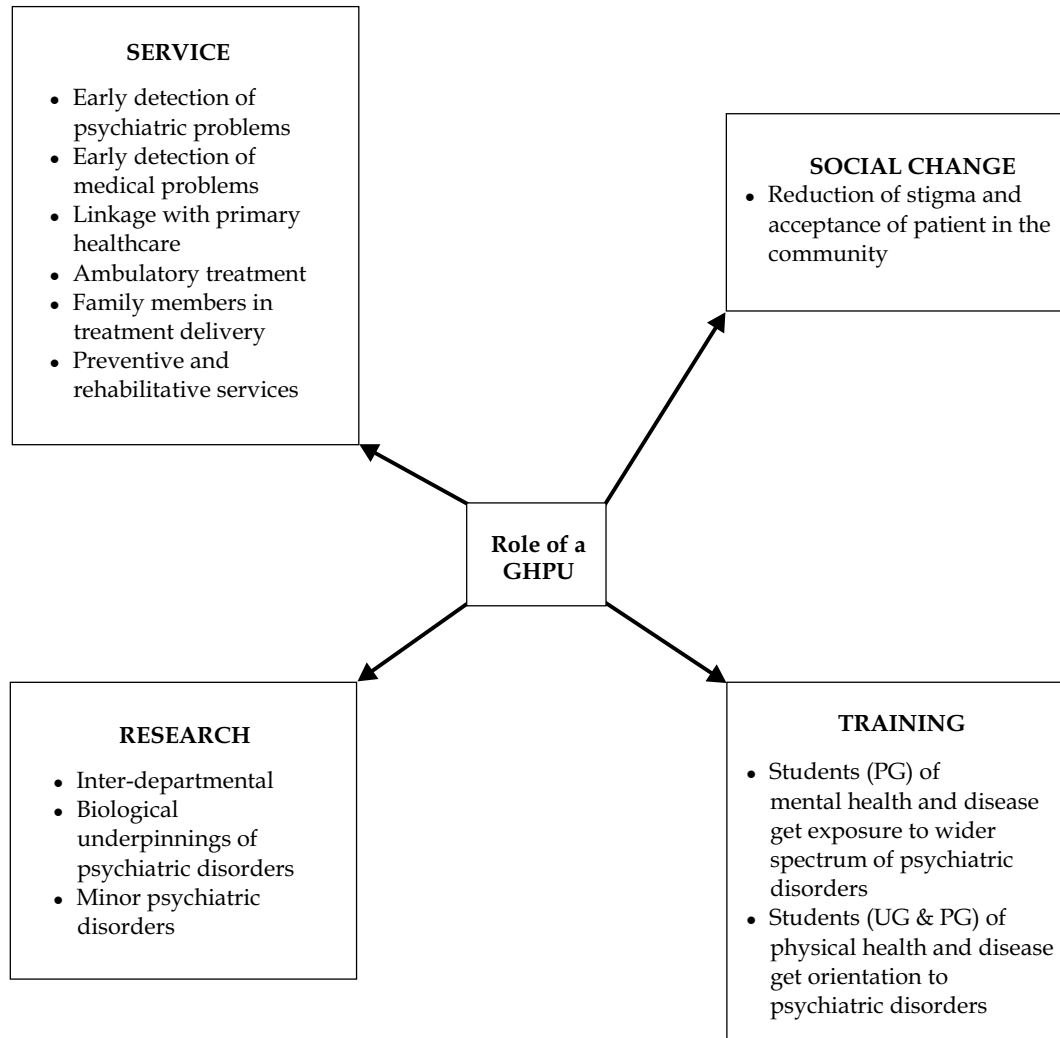
### ***Psychiatric Research***

In the area of psychiatric research, GHPUs have made significant contributions. In India, more research publications come from general hospital settings than from mental hospitals. Psychiatric research linked with other specialities of medicine such as nephrology, cardiology, gastroenterology, obstetrics and gynaecology, oncology are largely general hospital based.<sup>6</sup>

### **Future Directions**

The establishment of GHPUs has given a boost to the provision of psychiatric service. It has opened vistas for referrals and cross-referrals to and from as many specialties as are available in general hospitals, of course, depending on the clinical indications of the patient. The same approach provides opportunities for teaching of not only the psychiatry residents, but also of the faculty and staff of other specialties. The psychiatry team, in turn, is enlightened about the medical/surgical

**Figure 9.1: Role of a GHPU**



developments and their impact on psychiatric service, teaching and research, especially the biological factors related to psychiatric disorders and their treatment.<sup>1,2</sup> General hospital psychiatry has consolidated its position in the last 50 years. In many ways, it is now the mainstream of psychiatry in India and its future is bright and challenging. What can be achieved largely depends on the resourcefulness of the individual psychiatrist and the local resources available. It can also extend to community psychiatry or link with other medical specialities. Figure 9.1 illustrates various possibilities of GHPUs in the field of service, training, research and social change in the community.

## References

1. Mohit A. Mental health and psychiatry in the Middle East: historical development. *Eastern Mediterranean Health Journal (special issue on Mental Health)* 2001;7(3):336 .

2. Okasha A. Egyptian contribution to mental health. *Eastern Mediterranean Health Journal (special issue on Mental Health)* 2001;17(3):377–380.
3. Mayou RA. British view of liaison psychiatry. *General Hospital Psychiatry* 1987;9(1):18–24.
4. Schubert DS, Billowitz A, Gabinet L. Effect of liaison psychiatry on attitudes towards psychiatry, rate of consultation and psychosocial documentation. *General Hospital Psychiatry* 1989;11(2):77–87.
5. Kuruvilla K. Challenges in general hospital psychiatry. *Indian Journal of Psychiatry* 1993;35(4):191–192.
6. Behere PB, Behere M. General hospital psychiatry in India. In: Srinivasa Murthy R, eds. *Mental Health in India 1950–2000: Essays in Honour of Professor NN Wig*. Bangalore: People's Action for Mental Health 2000; 140–149.
7. Lipowski ZJ. Current trends in consultation liaison psychiatry. *Canadian Journal of Psychiatry* 1983;28(5): 329–338.
8. Malhotra S, Malhotra A. Liaison psychiatry in an Indian general hospital. *General Hospital Psychiatry* 1984; 6(4):266–270.
9. Wig NN. Psychiatric units in general hospitals – right time for evaluation, editorial. *Indian Journal of Psychiatry* 1987;20:1–5.
10. WHO. Atlas Mental Health Resources in the World, 2001.
11. Vahia NN, Doongaji DR, Jeste DV. Twenty-five years of psychiatry in a teaching hospital (in India). *Indian Journal of Psychiatry* 1974;13:253.
12. Kuruvilla K, Pandey AP, Shastri JCM. Psychiatric aspects of renal transplantation – observations on donors. *Indian Journal of Psychiatry* 1979;21:155–158.
13. Reddy KR, Chamabasavasna SM. Psychosocial factors influencing the recovery after myocardial infarction. *Indian Journal of Psychiatry* 1987;29(2):155–159.
14. Aggrawal P, Khastgir U, Bhatia MS. Psychological profile of females with chronic pelvic pain. *Indian Journal of Psychiatry* 1996;38(4):212–216.
15. Vyas JN, Rathore RS, Sharma P. A study of psychiatric aspects of hysterectomy. *Indian Journal of Psychiatry* 1989;31(1):83–89.
16. Jainar A, Sharma M, Agarwal CG. Frequency and severity of depressive symptoms among diabetic patients. *Indian Journal of Psychiatry* 1992;34(2):162–167.
17. De Jonge P, Huysse FJ, Herzog T. Referral pattern of neurological patients to psychiatric consultation liaison services in 33 European hospitals. *General Hospital Psychiatry* 2001;23(3):152–157.
18. Chaturvedi SK, Balaraju KB, Upadhyaya M. Psychiatric referrals in neuro-psychiatric centers. *International Journal of Social Psychiatry* 1989;35(2):197–203.
19. Prasad C, Krishnamurthy K, Murthy K. Psychiatric disorders in patients receiving antitubercular drugs. *Indian Journal of Psychiatry* 1985;27(4):311–314.
20. Sharma P, Avasthi A, Chakrabarti S. Clinical profile of depression in hospitalized medically ill patients. *Journal of Mental Health and Human Behaviour* 2002;7(1-2):3–14.
21. Sharma P, Avasthi A, Chakrabarti S. Clinical profile of depression in hospitalized medically ill patients – a two stage screening study. *Journal of Affective Disorders* 2002;70:205–209.
22. Avasthi A, Sharan P, Kulhara P. Psychiatric profiles in medical-surgical populations: Need for a focused approach to consultation liaison psychiatry in developing countries. *Indian Journal of Psychiatry* 1998; 40(3):224–230.
23. Khurana PS, Sharma PSVN, Avasthi A. Prevalence of delirium in geriatric hospitalized general medical population. *Indian Journal of Psychiatry* 2002;41–46.
24. Khurana PS, Sharma PSVN, Avasthi A. Risk factors in delirious geriatric general medical inpatients. *Indian Journal of Psychiatry* 2002;44:266–272.
25. Bagadia VN, Ayyar KS, Lakdawala PD. Value of general health questionnaire in detecting psychiatric morbidity in a general hospital out-patient population. *Indian Journal of Psychiatry* 1985;27(4):293–296.

26. Satija DC, Agrawal SM. Psychiatric emergencies in general hospitals. *Journal of Indian Medical Association* 1973;60:243.
27. Kelkar DK, Chaturvedi SK Malhotra S. A study of emergency psychiatric referrals in a teaching general hospital. *Indian Journal of Psychiatry* 1982;24:366.
28. Galgali RB, Rao S, Ashok MV. Psychiatric diagnosis of self-poisoning cases: A general hospital study. *Indian Journal of Psychiatry* 1998;40(3):253-259.
29. Workshop: general hospital psychiatry. *Indian Journal of Psychiatry* 1984;26:253-290.
30. Sriram TG, Moily S, Kumar GS. The training of primary health care medical officers in mental health care: errors in clinical judgement before and after training. *General Hospital Psychiatry* 1990;12(6):384-389.
31. Adityanjee A, Wig NN, Mohan D. Assessment of functioning of non-psychiatric physicians in the management of psychiatric emergencies. *Indian Journal of Psychiatry* 1986;28:347.

## Chapter 10

# The National Human Rights Commission Report 1999: A Defining Moment

S. M. Channabasavanna • Pratima Murthy

**M**ental disorders represent four of the 10 leading causes of disability worldwide and amount for approximately 12% of the global burden of disease.<sup>1</sup> According to most surveys, approximately one to two people per 100 in the community are affected by a serious mental disorder at any given moment. With the psychiatrist: population ratio in India 1:1,00,000 and in-patient beds available for less than 10% of those with psychiatric illness, mental healthcare delivery for serious psychiatric problems is grossly deficient. In-patient care still occurs largely through the 37 government-run mental hospitals in India.<sup>2</sup>

The state of mental hospitals in India has been a source of concern for centuries. Several government enquiries both in the nineteenth century (the Bengal Enquiry of 1818, *An Investigation into the State of Native Lunatics in Bengal in 1840*) and those in the twentieth century, the *Bhore Committee Report 1946*, reflect concerns that are relevant even in current times. They reported deplorable living conditions, overcrowding, understaffing and a general indifference to the needs of the mentally ill. Moore Taylor summarised the state of the mental hospital at the time of independence thus: 'The majority of the mental hospitals in India are out of date and designed for detention and safe custody without regard for curative treatment'.

The deplorable conditions prevalent in the mental hospitals in India have periodically come under professional scrutiny during various workshops for medical superintendents of mental hospital held between 1960 and 1990.<sup>3,4</sup> However, it was only following several Public Interest Litigations in the 1980 that the plight of the mentally ill in mental hospitals became apparent, and led the Supreme Court of India to order a detailed enquiry into the conditions of mental hospitals in Shahdara, Agra, Ranchi, Gwalior and Tezpur.<sup>5,6</sup>

### Background to the National Human Rights Commission (NHRC) Project in India

The shocking situation in the mental hospitals led the Supreme Court to issue several directions

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to remedy the situation. The NHRC was entrusted by the Supreme Court with the responsibility of monitoring the status of these mental hospitals. During its visits to these hospitals the NHRC became greatly concerned about the conditions prevailing there as well as about the state of mental healthcare in the country. The fundamental/human rights enshrined in Article 21 of the Indian Constitution includes the right to live with human dignity and the right to health. The Supreme Court ruled in several cases that the maintenance and improvement of public health is one of the obligations that flow from Article 21. Evidence of violation of this precious human right of the mentally ill led the NHRC to examine the problem and recommend appropriate remedial measures. It thus took up the issue of quality assurance in mental health and assigned NIMHANS to carry out the project.<sup>4</sup>

### **The NHRC Project on Quality Assurance in Mental Health**

The main objectives of the project were to analyse the conditions prevailing in government and private mental hospitals in various parts of India and to generate possible solutions for improving standards of care. Initially, a comprehensive assessment of the prevailing conditions of government-run mental hospitals in India was carried out through an exhaustive questionnaire. These were also sent to private psychiatric hospitals as well as general hospital psychiatry units in government and private hospitals. This was followed by personal visits by project teams, primarily to the government-run hospitals. A physical inspection, interaction with patients, staff, administrators (including the chairperson of the state mental health authority, the state health secretary or his nominee) and family members. The case records and documentation procedures were scrutinised. In-camera meetings were held with some of the staff and patients. The visit was non-inquisitorial and emphasis was placed on developing a dialogue with the hospital authorities and state administration to discuss lacunae and generate ideas for remedial action. Zonal meetings conducted in Bangalore, Kerala, Agra, Ahmedabad and Goa during the project brought together families of the mentally ill, representatives from NGOs and administrators to discuss specific lacunae in mental health services.

#### ***Findings of the NHRC project***

There were 59 facilities, including government-run mental hospitals (32), general hospital psychiatry units (16) and private psychiatric treatment centres (10), personally visited by the project team. This chapter focuses primarily on the findings in relation to the state-run mental hospitals and is based on the information provided by the 37 hospitals run by the government.

#### ***Archaic structures and practices***

In many of the hospitals visited, to quote Moore Taylor, 'It was as if time had stood still'.

Of the 32 hospitals visited 19 had been constructed in the 1800s. Of these, 14 (38%) still retained a prison-like structure and ambience, and 21 (59%) had high walls. Terms such as 'enclosures', 'warders' and 'overseers' are still common parlance, and prison practices like roll call and lining up for handover still exist. Exclusively closed wards existed in 19 hospitals (59%). Building maintenance was extremely unsatisfactory in 26 (70%), and leaking roofs, eroded floors, overflowing toilets and broken doors were a common sight. The huge campuses were neglected in more than half of the hospitals visited, with poor lighting and frequent reports of robbery and assault. Problems of water supply (70%) and electricity (73%) were common.

### ***Living environment and basic facilities***

The overall bed strength across the 37 hospitals was 18,024. Overcrowding was noticed in many of the large (strength more than 500) and medium (bed strength 250–500) hospitals, to the tune of 200% overcrowding in a hospital in Kerala. The overall ratio of beds to patients was 1:1.4, indicating that many patients slept on the floor. There were four hospitals that had no toilets, and in the older hospitals, the average toilet per patient was 1:16. There were four hospitals that did not have toilets at all for any of the male in-patients.

Cells continued to exist and be used in 16 out of 32 (44%) hospitals. In many such centres, single cells did not have water, light, bed linen or toilets. Food was pushed through the bars. Patients had to urinate and defaecate in the cell itself.

The quality of food given to patients was variable and the dietary budget per day was as low as five rupees per day in some hospitals. In hospitals being monitored by the Supreme Court, this was as high as Rs 30 per day. In many of the hospitals the patients complained about the way food was served to them as all the items were just lumped together on the plate.

In 10 hospitals (27%), uniforms were mandatory. Shaving of the head was a routine practice in 26 (70%) of the hospitals for male patients and in 17 (46%) for females. In one hospital, suicidal patients were kept naked for fear of self-harm if clothes were provided.

### ***Cost per patient and budget***

Only 14 (38%) of the hospitals had a planned budget sanctioned, but even among them, funds were not regularly received. Cost spent per person per day ranged from as low as Rs 29.60 in a hospital in Kerala to Rs 239 in a hospital in Gujarat.

### ***Admission procedures and special facilities***

A majority of the hospitals had mostly involuntary admissions (22, 69%). However, the number of voluntary admissions has steadily been increasing. There were 26 hospitals (70%) which reported that the MHA of 1987 governed admissions. Further, seven hospitals (19%) used both the MHA and the repealed Indian Lunacy Act of 1912, while two (5.4) still used only the Indian Lunacy Act.

Criminal wards were present in 20 hospitals (54%). Out-patient services had started in 36 (97%) centres and free drugs were provided. Emergency services were available in 22 hospitals (60%). Separate substance abuse services had been started in 12 hospitals (32%). Family treatment services were present in five (14%) of the centres visited. Separate facilities for children were reported in only four (11%) hospitals.

In many of the hospitals, the number of chronic patients (patients in hospital for two years or more) varied between 10 and 20%. However, in some hospitals in the states of Madhya Pradesh and Tamil Nadu, chronic patients constituted 62% and 34% of the total in-patients, respectively.

### ***Investigations and treatment facilities***

Even routine investigations were not available in more than 20% of the hospitals. Necessary facilities like (serum lithium estimation, blood, Venereal Diseases Research Laboratory (VDRL) test and Electroencephalography (EEG) were present in less than one-third of the hospitals. Modified electro-convulsive therapy facilities were available in only 50% of the hospitals. Drugs like clozapine and risperidone were available in five or six hospitals.

### ***Staffing***

Psychiatrists were not found in two of the hospitals. The psychiatrist patient ratio in many of the hospitals was as low as 1:200, raising doubts as to whether patients received even minimum psychiatric care. One-fifth of the hospitals did not have a clinical psychologist, and in 11 (30%), there was no post of a psychiatric social worker. There were 19 hospitals (51%) that did not have the post of psychiatric nurses. In fact, four (11%) hospitals were functioning without the services of any nursing personnel. Vacancies at all levels of staff were commonly noticed. A majority of the hospitals had a large number of Class D staff; who were often the only ones to supervise patient care and treatment. High-handedness, physical and sexual abuse, corrupt practices and coming intoxicated to duty were common problems reported.

### ***Rehabilitation***

Half of the hospitals did not have any organised rehabilitation programme. However, 36% had separate facilities for vocational training. Awareness among staff in most hospitals regarding the principles of rehabilitation was poor. Only seven (19%) offered some form of day care facilities.

### ***Documentation***

While individual case notes were maintained in 33 (89%) hospitals, very little information was recorded in them. However, most hospitals (70%) had a separate medical record department, although grossly understaffed in many places.

### ***Communication of patient rights***

In 26 (70%) of hospitals, it was reported that patient rights were explained at admission, but it was clear during the visit that this was not actually being practised.

### ***Grading of the hospitals***

The 32 hospitals personally visited were graded on a four-point scale, based on the basic facilities and services available. Of these seven were rated very poor, eight poor, 11 average and six good.

### ***Summary of findings***

The findings of the NHRC project on quality assurance in mental health highlighted the gross inadequacies and sub-human living conditions in mental hospitals.<sup>1,4,7</sup> Many still embodied totally outdated custodial concepts of mental healthcare, and merely served as dumping grounds for desperate relatives. Poor amenities and inadequate treatment facilities were evident in many places. The lack of sensitivity was evident among many different levels of staff in many of the hospitals, and in many states, the state administration was clearly unaware of the needs of the mentally ill and of psychiatric hospitals under their jurisdiction.

While the project mainly highlighted the gross inadequacies in care, there were very positive changes in some of the hospitals, especially the smaller hospitals. In these hospitals, there had been a conscious attempt to make the institution therapeutic rather than custodial, with a shift to less restrictive and more integrated care. Specific examples included an increase in voluntary admissions, a well-developed out-patient department, the conversion of cells to single rooms with modern amenities, improvement in the diet, involvement of families and networking with other systems of care. Faster improvements were noted in hospitals where monitoring mechanisms had been initiated.



The NHRC report made several specific recommendations with respect to the structure, function and treatment facilities within government hospitals, the strengthening of general hospital psychiatry units and community-based mental health services, human resource development and training, monitoring mechanisms to prevent rights infringement of the mentally ill, and the need for a comprehensive range of services for the mentally ill.

## Winds of Change

The process of dialogue initiated during the NHRC project led to changes, both direct and indirect. In many states, sensitisation of the administration led to efforts at improving basic amenities. During a visit of the NHRC team, a minister abolished the practice of compulsory uniforms in a mental hospital in Gujarat. Financial support to many of the hospitals for structural improvements was also sanctioned. During the tenure of the NHRC project, the Ministry of Health, Government of India, initiated two parallel efforts in the area of mental health: the first was to sensitise the state health secretaries, and the other was to evolve minimal standards of care in mental hospitals in consultation with medical superintendents.<sup>7</sup> However, although there were positive steps, the changes were slow and sporadic, as is evident in the findings of a subsequent survey carried out by the Ministry of Health in 2002. It was once again judicial intervention in response to a Public Interest Litigation, now in the context of the Erwady tragedy that the spotlight focused once again on the status and need to improve mental healthcare in the country.<sup>8</sup>

## Conclusion

While the NHRC project was a defining moment in bringing diverse issues relating to care of the mentally ill into focus, it must be re-emphasised that the antecedent and subsequent changes in mental healthcare have emerged largely from Public Interest Litigation and judicial intervention. It is now time for the government, mental health professionals and the voluntary sector to proactively take up issues relating to the care and rights of the mentally ill. It is crucial that they all work together for quality assurance in mental healthcare.

## References

1. The World Health Report 2001. Solving mental health problems. In: Murthy RS, ed. *Mental Health: New Understanding, New Hope*. WHO: Geneva, 2001:49-73.
2. Trivedi JK. Implication of Erwady tragedy on mental health care system in India (Editorial). *Indian Journal of Psychiatry* 2001;43:4.
3. Sharma S, Chadda R. *Mental Hospitals in India. Current Status and Role in Mental Health Care*. New Delhi: Institute of Human Behaviour and Allied Sciences, 1996.
4. National Human Rights Commission. *Quality Assurance in Mental Health*. New Delhi: National Human Rights Commission, 1999.
5. Dhanda A. Laws relating to the custody, care and treatment of persons with mental disorder. In: Dhanda A, ed. *Legal Order and Mental Disorder*. New Delhi: Sage, 2000:34-78.
6. Sharma D. Mental health patients face primitive conditions. *Lancet* 1999;334:495.
7. National Institute of Mental Health and Neuro Sciences. *Minimum Standards of Care in Mental Hospitals: Recommendations and Report*. Bangalore: NIMHANS publication No. 39, 2000.
8. Saarthak Registered Society and others versus Union of India and others. SC (civil) No. 334/2001.

## Chapter 11

# National Survey of Mental Health Resources

*S. P. Agarwal • R. N. Salhan  
• S. Shrivastava • D. S. Goel*

The entire nation was shaken by the tragedy at Erwady in the Ramanathapuram district of Tamil Nadu, where 26 chained mental patients were burnt alive in a fire which engulfed the thatched shed in which they were housed, on 6 August 2001. These unfortunate victims were inmates of an unauthorised asylum being run in a *dargah* which attracted a lot of patients suffering from mental disorders owing to the miraculous curative powers attributed by the believers to its presiding saint. Moved by this terrible outrage, the Hon'ble Supreme Court of India took *suo moto* notice of the incident in the form of a PIL (CWP No. 334 of 2001). Notices were issued to the Union of India and to the state of Tamil Nadu. Subsequently, the Hon'ble Court directed the Union of India, vide its order, dated 15 October 2001, to 'conduct a survey on All India basis with a view to identify registered and unregistered asylums as also about the state of facilities available in such asylums for treating mentally challenged'.

Pursuant to the orders of the Hon'ble Supreme Court, the Government of India constituted a number of teams to inspect and report on the state of mental health services, with a special focus on mental hospitals. These teams visited all the state capitals and government-run mental hospitals across the country between November 2001 and January 2002 and submitted their report on a standard format.

### Materials and Methods

In order to collect the required information, two questionnaires were devised. The first questionnaire (Appendix C) dealt with issues related to the implementation of the Mental Health Act 1987 and the Rules framed thereunder, as well as functional issues concerning the state mental health authorities and the state of the mental health services in various states. The second questionnaire was designed to evaluate the current status of the 37 government-run mental hospitals with regard to their:

- Infrastructure
- Staff
- Clinical services (including investigative aids)
- Availability of drugs and other treatment modalities

- Quality of food/kitchen facilities
- Availability of linen/patient clothing
- Recreational facilities
- Vocational/rehabilitation facilities
- Other relevant information.

The data so generated were analysed, tabulated and evaluated. While the state-wise inferences and the tabulated status report in respect of the mental hospitals are depicted in Appendix C, the qualitative results of the study are detailed in this chapter.

## **Observations**

As regards the status of implementation of the Mental Health Act 1987 is concerned, most of the states have implemented the same, but Rules thereunder have not been framed by all the states. While sufficient copies of the Act have been circulated to the concerned officers/institutions, the knowledge with regard to these statutes is rather sketchy/partial. Mental health cells have not been established in most of the states, though state mental health authorities have been constituted in a majority. However, meetings are not held regularly and their functioning needs considerable improvement. The situation in respect to licensing authorities and appointment of visitors/inspections required to be carried out by them is also unsatisfactory.

In general, the state of the mental hospitals surveyed is not satisfactory. Generic observations in respect to these mental hospitals are as under:

1. The infrastructure in most of the hospitals surveyed still leaves much to be desired though significant progress has been made in several areas following the National Human Rights Commission (NHRC) report 1999. Many of the buildings are old, dilapidated and beyond economic repair. They were built when the role of these hospitals was custodial rather than therapeutic. While renovation/repairs are underway at most of the places, there is a need to plan for modern structures which will conform to current needs, subject to the availability of resources.
2. The situation with regard to staffing has improved since the NHRC report, but there are still significant gaps. Significant deficiencies or complete absence of psychiatric nurses, psychiatric social workers, clinical psychologist, occupational therapist and lab technicians were found in a majority of the mental hospitals surveyed. Posts of pathologists, radiologists, anaesthetists and even the directors/medical superintendents were also vacant in many of the hospitals. Inadequacy of staff impacts adversely on the functioning of the hospitals and optimum utilisation of the available infrastructure and facilities. This aspect needs to be addressed and monitored on an ongoing basis.
3. Clinical services and the availability of investigative facilities are largely inadequate/barely adequate, mainly due to the lack of proper staff and equipment. Modern investigations like CT scans, ultrasound, etc., are mostly unavailable in these hospitals and in some, the services are on payment of user charges. Further upgradation with regard to investigative facilities is also required.
4. Availability of drugs is generally adequate and has improved to a considerable extent in all the hospitals. However, old antipsychotic drugs are still widely used. The new

- generation formulations of antipsychotic drugs, which have a friendlier side-effect profile and are more cost-effective, need to be added to the formularies of the hospitals.
5. The quality/quantity of food for the patients is better than before, but offers scope for improvement, especially with regard to variety and the way it is served. Most hospitals do not have dining halls or proper utensils for patients to eat their food.
  6. Linen is usually inadequate or even non-existent in some hospitals. Many patients lie on the floors, often without mattresses. This aspect needs urgent attention.
  7. Recreational facilities are an integral part of any mental hospital. The facilities for indoor as well as outdoor games are missing in most of the mental hospitals. Some institutions have made efforts in this direction, but overall recreation facilities need considerable augmentation and improvement. Colour/black and white TVs have been installed in a majority of the hospitals.
  8. Vocational and rehabilitation facilities are still rudimentary and mostly obsolete, patterned for the old custodial mode of mental hospitals. They lack workshops and equipment as well as proper trained staff. Radical changes are required to bring these facilities in tune with current realities.
  9. The lingering custodial atmosphere in mental hospitals can be traced to one common malady: the high proportion (up to 50% or even more) of long-stay patients, i.e. patients who have been in hospital for two years or more, often for five years or more. The most unfortunate aspect of this problem is that these patients have been in hospital for years, not because of treatment-related reasons but because their families have abandoned them. Prolonged hospitalisation has further impaired their socio-vocational skills. The second common problem faced by every mental hospital is that of poor staffing, particularly in relation to paramedical staff. This appears to be because of non-availability of these personnel as a consequence of inadequate training/facilities.

## Discussion

In order to place the above observations in their proper perspective, it might be worthwhile going back to the monumental report of the Health Survey and Development Committee, generally referred to as the 'Bhore Committee' report, submitted to the Government of India in 1946. The Committee had entrusted the task of evaluating the 19 existing mental hospitals to Col. Moore Taylor, Medical Superintendent, Ranchi European Mental Hospital and Hon' Consultant Psychiatrist, Eastern Command. His observations remain relevant even to this day and merit careful consideration:

"Every Mental Hospital, which I have visited, in India is disgracefully understaffed. They have scarcely enough professional workers to give more than cursory attention to the patients, to say nothing of carrying a teaching burden. With an average ratio of one Medical Officer to 200 patients or more, there can be little time for the instruction of students. Government will have to work on the theory that more and better-trained professional personnel is the urgent need of Mental Hospitals. The policy of increasing bed capacity, which incidentally has led to gross overcrowding in most of the Mental Hospitals rather than personnel, has been stressed in the past, but the cure of mental patients and the prevention of Mental Diseases will not be accomplished by the use of bricks and mortar.

The general standard of Mental Hospitals, I have seen is poor. Economic factors will always affect scientific considerations. It may not be possible to do as much psychiatric research as one desires because sufficient money is not available, but certainly the quality of professional work is subject to no such limitations. There may be too few physicians, but this is not legitimate reason why administrative medical officers should not get the best ones available, and hold them to a high level of professional performance. Financial security is not the first requisite to hospital progress—the desire and enthusiasm for progressive change must always come first...

There is an urgent necessity for better-trained nurses. On the nursing staff of Mental Hospital depends the harmony which exists between the hospital and patient, and that may mean the difference between success and failure of treatment. If a patient is consistently irritated by tactless handling, exasperated by petty tyrannies, and annoyed by inflexible rules enforced by poorly informed attendants, and improperly trained nurses, he soon develops the idea that his welfare is not the first consideration. There is a type of psychological abuse of mental patients which may be much more disastrous than any kind of physical abuse.

An institution with a poorly trained and inadequate nursing staff starts with a definite handicap, which will seriously interfere with its efforts. The social environment as represented by the nurse and attendant is of much greater importance than the colour of the Wards, selection of the furniture, cinemas, radios, etc. Pleasant-surroundings are a hollow mockery when a small minded unintelligent attendant constantly thwarts the patient in his attempts to enjoy them...

It is surprising that many of the individuals placed in a ward of filthy, destructive, violent, profane, noisy patients, can maintain their emotional equilibrium and remain human. It is only because of their fundamental decency, and not because they have any spark of real understanding of the basic situation. I have been connected with Mental Hospitals too long not to appreciate the difficulties inherent in this situation, but, in spite of these difficulties, I cannot feel that attempts to change the situation are impossible. Something can and must be done to increase the number and improve the quality of ward personnel. At the European Mental Hospital, Ranchi, all attendants, male and female, are required to attend courses of instruction in First Aid, and Home Nursing, and a very large number have already obtained the St. John's Ambulance Certificate in both subjects, and it is amazing what this small beginning has achieved. The nursing care and treatment of the patients improved to an enormous extent. The utilisation of young and immature people—and there is much of it—for ward work, is, in my opinion, a very questionable procedure. Adolescents should not be in charge of psychiatric patients. They are not sufficiently stabilised emotionally to be placed in such a situation...

The custom of generalising about ratio of Ward Personnel which takes no account of admission and discharge rates, the kind of service given to the patient, or the number of essential subsidiary departments carried on, is a mistake. All of these must be considered when Ward Personnel ratio are being worked out (see notes under European Mental Hospital, Ranchi)

Psychotics adjust themselves at different levels:

- A. Social Recovery—the ideal aim
- B. Social Institutional Adjustment
- C. Institutional Adjustment
- D. Deterioration.

It was depressing to find the enormous number of patients who have deteriorated, and what was worse, the general attitude of pessimism and indifference which characterised the situation.

The standards of care which prevail in the hospital are responsible to a considerable extent for the level at which patients adjust. If the ideal of the institution is the discharge of patients, if the professional staff is held to a high level of accountability for such discharges, and if the administration is called upon to defend continued residence in the institution, the last three groups will not be as large as they are. The fourth group is a definite indictment of the therapeutic standards in the Mental Hospitals in India. The vast majority of these patients have been permitted to slump into this condition of deterioration because the routine was not sufficiently insistent and compelling to keep them in reality even for brief intervals...

In spite of considerable progress towards a more healthy attitude in regard to Mental Disease, the old ideas of disgrace and stigma diehard, and the prejudice of the people must be taken into account. The relationship of Psychiatry and the Law requires attention. If the Mental Hospital is to do good work it must have the sympathy and support of the community. The walls of ignorance, superstition and suspicion will have to be torn down and a friendly relationship established. We must teach the people that we will staff our hospitals correctly, and that Mental Hospitals re-directed by honest well-trained scientific men who are trying to render service to the patients. Good-will towards Mental Hospital must be created. The process will be long, but may be built by:

- (1) Letting the community know that the Mental Hospital has a real service to be given
- (2) Convincing people that they need what it has to offer
- (3) Making it easily obtainable
- (4) Making people glad that they can have what the institution has to offer.

The goal of such education effort should be more than to add to the prestige of the hospital. The ultimate purpose should be Mental Health. This is the day of Preventive Medicine. Psychiatry should be thought in terms of prevention as well as cure...

The cardinal points in the Indian Lunacy Act, 1912, have outlived their usefulness. Legal restraint has undoubtedly made the public reluctant to avail themselves of Mental Hospitals, and has militated against the early treatment of mental illness. Legal changes are imperative which will make provision for treatment of patients without the stigma of certification, but this is a subject outside the scope of this report. It might be suggested, however, that all private Mental Hospitals, Nursing Homes and pay-beds for mental patients should be brought under Government control and supervision. Many patients of this category are being treated in Mental Hospitals and the arrangement is most unsatisfactory".

It is apparent that while there has been improvement in certain areas, the generic problems inherent in our mental hospitals remain. This is perhaps due to the lingering custodial mindset and obsolescent managerial practices. Radical restructuring of these hospitals, combined with more enlightened and forward-looking techno-managerial strategies, will be required to bring about long overdue reforms. The winds of change must sweep away the ancient cobwebs of psychiatric mythology.

## **Conclusion**

This comprehensive survey revealed perhaps for the first time the actual ground realities with regard to the various domains related to mental health in India. The earlier NHRC report (*Quality assurance in mental health, 1999*) had focused exclusively on mental hospitals. No information was available in respect to the progress of the implementation of mental health laws and other community-based services. The data generated by the aforesaid survey constitute vital inputs for planning of mental health services and related activities. These have been taken into account while formulating the restrategised national mental health programme for the Tenth Five Year Plan. It is hoped that the findings of this study will continue to provide useful information to those working in the field of mental health.

## Chapter 12

# Restructuring the National Mental Health Programme

*S. P. Agarwal • R. L. Ichhpujani • S. Shrivastava • D. S. Goel*

**T**he National Mental Health Programme (NMHP), launched in 1982, had envisaged:

- the integration of mental healthcare services with the existing general health services;
- the utilisation of the existing primary healthcare infrastructure in the form of primary healthcare centres and community healthcare centres to provide community-based mental healthcare services;
- to provide appropriate task-oriented training to the existing health staff;
- to link mental health services with the existing community development and other welfare programmes.

The District Mental Health Programme (DMHP), the basic unit of the NMHP, was field tested in 1985 in the Bellary district of Karnataka under the auspices of National Institute of Mental Health Neuro Sciences (NIMHANS), Bangalore. Based on the results of this pilot project, phased implementation of the DMHP was undertaken during the Ninth Five Year Plan (1997–2002), with an outlay of Rs 2.8 billion and eventually 25 districts were covered. The programme, however, failed to gain the desired momentum and progress was tardy. An exercise aimed at identifying the causes of underperformance and formulating remedial measures was, therefore, undertaken by the Directorate General of Health Services in early 2001. Chief among the contributory factors identified was the one-dimensional nature of the programme, which focused exclusively on, and had become virtually synonymous with, the DMHP. This had led to a relative neglect of the other components of the mental healthcare delivery system. The resultant asymmetry had affected the effective implementation of the DMHP itself. Stagnation in vital sectors like departments of psychiatry in medical colleges and mental hospitals had not only robbed the DMHPs of vital managerial support, but had also led to an attitude of indifference and apathy among mental health professionals, particularly those working in such institutions.

### **Restrategising the NMHP**

After an in-depth situation analysis and extensive consultations with various stakeholders, the NMHP underwent radical restructuring aimed at striking a judicious balance between various components of the mental healthcare delivery system, with clearly specified budgetary allocations.



After approval by the Ministry of Health and Family Welfare, the Planning Commission, the Ministry of Finance and, finally, the Cabinet Committee on Economic Affairs (CCEA) the restructured NMHP was formally launched by the Secretary (Health) at a National Workshop held at Vigyan Bhawan, New Delhi on 22 October 2003. The programme comprises five closely networked/interdependent strategic components, with a total outlay of Rs 19 billion during the Tenth Five Year Plan:

1. Redesigning the DMHP, around a nodal institution, which in most instances will be the zonal medical college.
2. Strengthening the medical colleges with a view to develop psychiatric manpower, improve psychiatric treatment facilities at the secondary level, and to promote the development of general hospital psychiatry in order to reduce and eventually eliminate to a large extent the need for large mental hospitals with a huge proportion of long-stay patients.
3. Streamlining and modernisation of mental hospitals to transform them from the present mainly custodial mode to tertiary care centres of excellence with a dynamic social orientation for providing leadership to research and development (R&D) in the field of community mental health.
4. Strengthening of central and state mental health authorities in order that they may effectively fulfil their role of monitoring ongoing mental health programmes, determining priorities at the central/state level and promoting intersectoral collaboration and linkages with other national programmes.
5. Research and training aimed at building up an extensive database of epidemiological information related to mental disorders and their course/outcome, therapeutic needs of the community, development of better and more cost-effective intervention models, promotion of intersectoral research and providing the necessary inputs/conceptual framework for health and policy planning. Focused Information, Education and Communication (IEC) activities, formulated with the active collaboration of professional agencies, such as the Indian Institute of Mass Communication and directed towards enhancing public awareness and eradicating the stigma/discrimination related to mental illness, will form an important component of this policy objective.

The budgetary allocations for the programme are as under:

DMHP	Rs 775 million
Modernisation of mental hospitals	Rs 600 million
Strengthening of medical college departments of psychiatry	Rs 375 million
IEC & Training	Rs 100 million
Research	Rs 50 million
<b>Total</b>	<b>Rs 1,900 million.</b>

### **Operationalising the NMHP**

Detailed operational guidelines for the implementation of the restructured NMHP have been formulated. Socio-economically backward districts, currently under-served in respect of mental health services, will now receive priority for DMHP, provided these have a functioning health infrastructure and adequate connectivity. The state will also have to ensure the availability of

a psychiatrist and other personnel for the programme. A time-bound schedule for the implementation of various services/training/IEC/research components has been prescribed, along with the provision for online monitoring and periodic evaluation of the relevant performance parameters. The revised budget and salary structure for the DMHP are given in Tables 12.1 and 12.2.

**Table 12.1: DMHP Budget (Rs in million)**

S. No.	Item	1 <sup>st</sup> Year	2 <sup>nd</sup> Year	3 <sup>rd</sup> Year	4 <sup>th</sup> Year	5 <sup>th</sup> Year	Total
1.	Staff	9.5	10.1	11.0	12.0	13.1	55.7
2.	Medicines/ stationery, contingencies, etc.	5.5	6.5	7.5	8.5	10.0	38.0
3.	Equipment, vehicles, etc.	9.0	—	—	—	—	9.0
4.	Training	5.0	5.0	2.0	—	—	12.0
5.	IEC	2.0	2.0	2.0	2.0	2.0	10.0
	<b>Total</b>	<b>31.0</b>	<b>23.6</b>	<b>22.5</b>	<b>22.5</b>	<b>25.1</b>	<b>124.7</b>

**Table 12.2: Salary Scales for DMHP Staff**

S. No.	Name of the post	Scale of pay (in Rs)	Approx. annual cost (in Rs)
1.	Psychiatrist (specialist)	10000-15000	268800
2.	Clinical psychologist	6500-10500	162000
3.	Psychiatric social worker	5500-9000	146000
4.	Psychiatric nurse	5000-8000	136600
5.	Record keeper/clerk	3050-4950	80000
6.	Vehicle driver	3050-4950	80000
7.	Nursing orderly	2550-3200	69000
	<b>Total</b>		<b>942400</b>

The grant of Rs 5 million for each medical college department of psychiatry is to be used for creating/augmenting the infrastructure, including the construction of wards and the procurement of essential equipment, with the aim of providing quality secondary care as well as for developing postgraduate training facilities for various categories of mental health personnel. On its part, the institution will have to take on the responsibility of providing techno-managerial support and referral facilities to a designated DMHP being implemented in a district other than the one in which the medical college is located.

The financial package for the 37 government-run mental hospitals, which together account for a total of 18,024 beds, is aimed at improving the clinical and infrastructural element in these institutions which have been found to be grossly inadequate by various surveys, including the monumental

National Human Rights Commission (NHRC) report on quality assurance in mental health in 1999. In keeping with current thinking worldwide, these institutions will have to undergo radical functional as well as structural metamorphosis, to convert from the custodial care mode to a community-oriented mode. Systematically planned de-institutionalisation of old long-stay patients will go hand-in-hand with rationalised admission policies comprising brief hospitalisation, involvement of families in the therapeutic process and Community-Based Rehabilitation (CBR) of treated patients.

Special efforts will be made to energise the State Mental Health Authorities (SMHAs) in order to enable them to play their designated role as envisaged in the Mental Health Act 1987 and central/state Mental Health Rules 1990. These statutory bodies will form the first tier of the 3-tier monitoring system incorporated in the restructured NMHP.

Substantial funds have been allocated for scientifically formulated IEC initiatives at the central level. A multidisciplinary workshop, involving experts from the field of mass communication, advertising, media and other related fields, will help to evolve focused strategies in this area. This will be over and above the funds provided for such activities at the local level in the DMHP budget.

Research often receives step-motherly treatment in the matter of funding. The restructured NMHP has a dedicated budget for operational research, relevant to planning more effective/cost-effective interventions or models of community-based mental healthcare. Such research is also expected to provide significant inputs, relevant to policy reform and improved programme implementation. Simplified, transparent and non-bureaucratic machinery for implementing this research agenda has been created.

Although important, good intentions, an elegant plan, and adequate fiscal resources by themselves cannot ensure successful implementation. The adequacy or otherwise of the existing infrastructure, technomanagerial competence and, in its broadest sense, the quality of governance are vital intervening variables which determine the eventual outcome of any plan or project. Special emphasis has been given, therefore, to motivation, training and effective management of the human resource component to ensure effective implementation at the ground level. A 3-tier machinery for monitoring at the state level (by the SMHA and a designated nodal officer), continuing online performance appraisal at the central level by a working group headed by a Joint Secretary level officer in the Directorate General of Health Services and periodic review by a High-Level Steering Committee in the Ministry of Health and Family Welfare, chaired by the Secretary (Health) has been put in place. Real-time acquisition of information and e-governance will be ensured through the networking of all components of the NMHP, each with a dedicated interactive website. A provision has also been made for the mid-term evaluation of programme implementation by an independent external agency.

## Conclusion

The restructured NMHP provides a balanced framework for the provision of comprehensive, community-based mental health services with a closely networked referral system. It is hoped that, with an adequate fiscal allocation during the Tenth Five Year Plan, the programme will not suffer from the much maligned 'resource crunch'. In the ultimate analysis, however, effective implementation will depend on the active involvement of the health machinery of the states concerned and the morale/motivation of the human resource component.

## Suggested Reading

1. *Quality Assurance in Mental Health*. The National Human Rights Commission, New Delhi, 1999.

# Chapter 13

## Clinical Psychology: Coming of Age

*G. G. Prabhu • Rashmi Shankar*

The scientific roots of clinical psychology lie in the work of the nineteenth century European psychologists, who developed laboratory techniques for the measurement of psychological processes. Drawing on these methods, Lightner Witmer founded the first psychological clinic in 1896 at the University of Pennsylvania, for children with learning problems. Based on his belief that a systematic approach to the study of individual differences could be of benefit to society, Witmer coined the term 'clinical psychology' to describe the new profession.

In international literature, allowing for minor shifts in emphasis, there has been a broad agreement on the definition of clinical psychology. Generally, it is understood that the profession is concerned with the understanding, prevention, assessment and treatment of maladaptive behaviour. According to the American Psychological Association (APA), Division-12, the field is involved with:

...research, teaching and services relevant to the applications of principles, methods and procedures for understanding, predicting and alleviating intellectual, emotional, biological, psychological, social and behavioural maladjustment, disability and discomfort applied to a wide range of client populations.<sup>1</sup>

The Indian Association of Clinical Psychologists (IACP) preferred to define clinical psychology as:

...an applied branch of psychology which, drawing heavily from the biological, medical and social sciences, aims to study systematically all kinds of pathological deviations of human behaviour and experience from the normal pattern with a view to develop and apply adequate diagnostic, therapeutic, rehabilitative and preventive (including legal) techniques and measures.<sup>2</sup>

Kendall and Norton-Ford succinctly summarised the cardinal attributes of clinical psychologists as:

They are psychologists because they have been trained to use the guidelines of knowledge of psychology in their professional work. They are clinicians because they attempt to understand people in their natural complexity and in their continuous adaptive transformations. They are scientists because they utilise scientific method to achieve objectivity and precision in their professional work. Finally, they are professionals because they render important human services by helping individuals, social groups and communities to solve psychological problems and improve the quality of life.<sup>3</sup>

## Early Developments in India: The Golden Era

The work of Dr Girindrasekar Bose (1886–1953) placed a therapeutic emphasis on psychology from its very inception. Being a qualified medical practitioner interested in the treatment of mental illness, Bose felt the need to increase his knowledge of human behaviour and chose to join the postgraduate programme in psychology begun at Calcutta University in 1915. In 1921, he was the first candidate to obtain a doctorate in psychology for his thesis on *The Concept of Repression*. He started his academic career as a lecturer in the Department of Psychology and in 1938, headed the Department of Applied Psychology at Calcutta University, when a separate department was created.

Developing his interest in dynamic psychology independent of the Freudian literature, Bose made original contributions on the theory of mental life and on the *gunas* (temperament).<sup>4</sup> He drew substantially on the cultural, religious and psychological ethos of India, as he worked on concepts related to repression, defiance, ambivalence, free association and opposite wishes. He maintained cordial relations with Freud but differed from him on some of the cultural assumptions of psychoanalysis. He advocated for the practice of psychotherapy in the Indian context as a didactic, cognitive venture, suggesting the culture-specific *guru-shishya* paradigm in therapy.<sup>5–11</sup> Focusing his effort on carving a professional niche for dynamic psychology in India, Bose pioneered formal training courses. He introduced a course in psychoanalysis for postgraduates in psychology at the Calcutta University, during the early twenties and in 1930, began the training programme in psychoanalysis at the Indian Psychoanalytic Institute. Further, his professional contribution extended to the formation of the Indian Psychoanalytic Society (IPS, 1922), establishing a research journal *Samiksha* in 1947 and in 1948, founding the Lumbini Park Mental Hospital and Research Centre.<sup>7,12</sup>

The first half of the twentieth century may be described as the golden era of scientific and applied psychology in India. In some respects, it seemed more robust than the early Witmerian clinical psychology in the USA.<sup>13</sup> Witmer focused on corrective work with children and advocated a pedagogical approach. In contrast, the emphasis in India was on developing a therapeutic approach for the alleviation of a broad range of problems that concerned all age groups. By the early 1950s, at a time when psychiatry provided little more than custodial care to severely mentally ill patients in psychiatric institutions, psychology had acquired professional status. Dube drew attention to this divergence in his presidential address to the IPS:

“Psychology has now become a password and order of the day. Psychologists are being employed right and left. Psychological bureaus are being set up. The word has now acquired mystical power. In our country we seldom hear the voice of the psychiatrist who is being constantly ignored”.<sup>14</sup>

At the time that India attained freedom, psychology with a strong clinical orientation was seen to thrive in the academic milieu. Drawing on both psychodynamic and psycho-social models, it kept pace with the *Zeitgeist* (German for ‘spirit of the time’), as it was applied to the affairs and concerns of society. In addition to the field of psychology and mental health, Bose and his students left their impact on professional psychology, organisational behaviour, anthropology, art and culture.

In the aftermath of the golden era, the path of clinical psychology in the university environment was somewhat impeded. In 1945, the Calcutta University started a certificate course in applied psychology with an option to specialise in advanced abnormal psychology. A 12-month training

programme in clinical psychology was introduced at Banaras Hindu University (BHU) in 1951. During the late seventies, the founder President of the IACP, the late N.N. Sen, initiated a programme at the Kashi Vidyapeeth. An applied psychology course at the Aligarh Muslim University and clinical psychology programmes at the Karnatak University, Dharwar and SNDT Women's University, Mumbai existed for a few years. Although efforts were made to provide the trainees on these programmes with some amount of exposure to clinical material, adequate clinical supervision proved to be a challenge. In the face of reduced facilities to impart clinical skills, most of these programmes remained low profile, less popular with the students and in time, most became extinct.

### **Later Developments and Current Status**

In 1954, the Government of India established the All India Institute of Mental Health (AIIMH) at Bangalore which is known, since 1974, as the National Institute of Mental Health and Neuro Sciences (NIMHANS). A postgraduate Diploma in Medical Psychology (DMP) was started as a full-time, structured programme with an inbuilt supervised internship. The training was based within a psychiatric hospital and there was a marked adherence to the medical model. Subsequently, the qualifications attained on this programme went through a series of changes: Diploma in Medical and Social Psychology (DM & SP, 1960); MPhil Medical and Social Psychology (1978); MPhil Clinical Psychology (current).

Over the last five decades, the growth in infrastructure at NIMHANS has been a positive development for training. Increased facilities in both library and laboratory have broadened access to training resources. The staff-student ratio of 1:1.5 (approx.) has provided ample scope for clinical and research supervision. An expansion in faculty positions has attracted specialisation in a number of areas (for example, cognitive and behaviour therapies, child and adolescent mental health and neuropsychology) which (until the time of writing) remain unique to the institution.

Whilst the setting of a reputable, medical institution has provided the programme with important resources, it has also imposed limitations. The trainee is exposed, predominantly, to the problems of enduring mental illness and, to a lesser extent, to neurological and neurosurgical difficulties. The option of developing professional autonomy and expertise in working with a broader range of problems (for example, health psychology) is therefore not available to the trainee.

Within the conceptual theoretical frameworks that formed the understanding of mental health during the mid-fifties, a progressive mental hospital, arguably, provided a fairly adequate setting as a training centre. However, the last five decades have witnessed a metamorphosis in the area of mental health and the relevance of such centres to training in mental health has been questioned. Kuruvilla remarked on the unsatisfactory role of psychiatric institutions as training centres for Residents in Psychiatry.<sup>15</sup> Needless to say, such centres would be even less suitable for the provision of adequate training in clinical psychology. Whereas, training programmes in psychiatry increased rapidly and from 1964, most were located outside the mental hospital setting, a parallel course is not apparent for clinical psychology. The growth of training centres for the latter has been slow and the BM Institute Programme at Ahmedabad 1972 did not provide a viable alternative to the medical model.<sup>16</sup> In 1962, the AIIMH programme was replicated at the Central Institute of Psychiatry (CIP : then known as the Post-Graduate Training Centre of the Hospital for Mental Diseases), Ranchi. Since then, similar training is also provided at the Ranchi Institute of Neuropsychiatry and Allied Sciences (RINPAS). More recently, during the last five years, two centres have located their programmes in general hospital settings (Kasturba Medical College, Manipal and Sri Ramachandra Medical College and Research Institute at Porur, Chennai). In addition, doctoral programmes in clinical psychology are available at NIMHANS, CIP, and at the

Post-Graduate Institute of Medical Education and Research (PGIMER) Chandigarh.

Since their inception, each of the centres at Bangalore and Ranchi had a maximum annual intake of 12 trainees, while the Ahmedabad centre took in a smaller number. Theoretically, the maximum possible annual output was approximately 30 trainees. Hence, over the last four decades, a little over 1,000 clinical psychologists could have been trained. However, during the critical years (1955–1965), the programme was little known and the Bangalore centre had an average annual intake of only eight trainees. In addition to lower rates of intake, candidates dropping out before the successful completion of the course further reduced output. A survey carried out with the existing training centres in 1997 showed that over four decades a little over 600 clinical psychologists have been trained, of which 365 were from NIMHANS, 220 from CIP and the rest from other centres.<sup>17</sup> During the last five years, the maximum possible annual output is a little over 50 clinical psychologists. It is not possible to say how many of these professionals are absorbed in clinical jobs. The author (GGP) pointed out that migration, matrimony and misplacement causes considerable drainage.<sup>6</sup> According to recent figures, the IACP had 340 professional members/fellows.<sup>18</sup> It is suggested that there is one clinical psychologist per 3 million of the population. Many centres that provide physical and mental healthcare are without the services of a clinical psychologist. The need for the immediate future, therefore, is for there to be more standard training programmes and for the services of trained personnel to be utilised in a systematic manner.

In 1949, at a conference at Boulder, Colorado, the philosophy and models of training were considered by American psychologists from universities, clinical centres, federal agencies and members of allied professions. The aspiration for the clinical psychologist was that she/he should be a 'scientist-professional', trained to a doctoral level in a university psychology department with an internship in clinical settings.<sup>19</sup> The NIMHANS programme was conceived as a utilitarian programme with conceptual similarity to the Boulder vision of a systematic union between the art of clinical intuition and the logical empiricism of science.<sup>20</sup> Although changes have been incorporated following a process of evaluation (internal monitoring and an external review in 1979), the history and the institutional goals of NIMHANS with its predominant emphasis on clinical service delivery, has restricted the extent to which the Boulder framework can be operationalised.<sup>12</sup> Thus, it can be rather hazardous to consider the NIMHANS programme as a 'model'<sup>21</sup> for uncritical replication.<sup>12</sup> The time may be appropriate for the newer centres to plan courses that are more in tune with contemporary societal needs.<sup>12</sup>

## **Professional Regulation**

It is usually the responsibility of a professional body to prescribe the standards of competence that govern practice. In a helping profession, one of the purposes of professional regulation is to protect the public from sub-standard services by quacks, imposters or by professionals who are unable to function at a minimum level of competence. At the time of writing, there is no statutory body in India which can provide professional registration to clinical psychologists. Also, there is no mechanism for the monitoring, evaluation and official accreditation of training programmes. In 1968, the IACP was formed, in part, as a response to some of the challenges faced by the profession. It holds annual conferences regularly, the 29th having been in March 2003. An IACP newsletter has been published since 1998. Criteria for admission to the association as a professional member/fellow are laid down. In addition, during the silver jubilee conference 1993, a code of conduct was formulated to provide ethical guidelines for members. In the absence of a statutory body, it may be considered the responsibility of the IACP to maintain professional standards and define what constitutes sound professional practice.

## The Professional Role of the Clinical Psychologist

There have been various opinions expressed concerning the role of the clinical psychologist in India and these have been documented at length by the author (GGP)<sup>17</sup> During the first half of the twentieth century, mainly due to the influence of Bose, the role of the clinical psychologist inclined towards psychodynamically oriented therapy and socio-cultural research. However, at the AIIMH, during 1955–1970, the emphasis was on diagnostic assessment. Later, aided by the beginning of a Behaviour Therapy Unit, there was a conceptual shift towards the therapeutic role. the author (GGP) has drawn attention to the perceived disparity in the professional role of the clinical psychologist.<sup>6,22,23</sup> An excessive emphasis was placed on the diagnostic function and the therapeutic, teaching and research roles were relatively neglected.<sup>24,25</sup>

Authors have indicated the importance of redressing the balance between the different roles in various ways. Sen-Mazumdar and Ghosh stressed the need for greater responsibility in the care and management of the client.<sup>26,27</sup> Suggesting possible reasons for the difficulties in role definition, the author (GGP) pointed to the reduced numbers in the profession, the range of clinical problems and the varied demands of the professional function.<sup>6,28</sup> Such a situation calls for greater innovation in professional functioning, where clinical psychologists experience the need to draw on more generalist perspectives in their work in a broad range of settings.<sup>6,29,30</sup> In her presidential address to the IACP, Murthy commented on combining a redefinition of their roles by clinical psychologists in traditional settings (for example, schools, general hospitals), along with their participation in social action programmes (for example, population control).<sup>31</sup> Information gained from a survey of clinical psychologists, adds further weight to the case for a redressal of the balance between disparate roles. Rao and Mehrotra found that clinical psychologists perceived an ideal work distribution as consisting of about a 50% split between clinical and teaching/research, respectively.<sup>32</sup> In their clinical duties, most preferred to spend two-thirds of the time in intervention and the remainder in psychological assessment.

Due to the heavy demands for assessment and intervention in dense clinical settings, the professional investment in research is likely to be disregarded. Rao and Mehrotra point out that the time spent in research by clinical psychologists in India is significantly less than that perceived by them as desirable—13% as against the desired 23%.<sup>32</sup> Most of the research studies in clinical psychology carried out in India are published in three journals: the *Indian Journal of Clinical Psychology*, *Journal of Personality and Clinical Studies*, and the *Indian Journal of Psychiatry*. A critical review is available in the research surveys commissioned since 1972 by the Indian Council of Social Science Research.<sup>33–37</sup> If the research citation and citation index is taken as the indicator, research published in India is yet to make an international impact.<sup>38</sup> In spite of the magnified role in diagnostic assessment, the research output in this area was limited<sup>39,40</sup> and much confidence was reposed in psychological tests that had yet to achieve scientific validation. Contextual and culturally sensitive assessment strategies are essential to ensure the development of appropriate clinical services.<sup>41</sup> The attempts at the construction of simple tests for use in India<sup>42</sup> have been a development since the mid-seventies, augmenting the research activity in this area.

## Current Dilemmas

In its 85-year history clinical psychology in India has experienced fluctuating fortunes. The first half of the twentieth century constituted its golden era before it faced a decline in position over the ensuing 25 years (1950–1975). As developments occurred in the broader mental health field (for example, the growth of psychiatry), clinical psychology seemed to be in search of a



clearer professional identity in relation to other disciplines. Although a redefined role in the shift from psychometrician/diagnostician to therapist can be discerned in the progress during the last 20 years, at least three main dilemmas need urgent consideration.

First, the issue of professional registration and licensing has remained unsolved for the last 25 years.<sup>43</sup> If due to reduced numbers, the formation of a council is not viable, alternative solutions may need to be sought.<sup>44</sup> Second, the question of monitoring, evaluating and accrediting clinical training programmes requires conclusive attention. In addition to the programmes mentioned above, several other programmes need to be considered which are of shorter duration and may deal with a circumscribed function of the clinical psychologist. These programmes may equip successful candidates to provide services at different levels of functioning in a country with a dearth of trained professionals.

The third set of problems is related to the area of legislation. A fully trained clinical psychologist has approximately five years of general training in the principles underlying human behaviour, followed by at least two years specialised training in the area of mental health at national institutions established by the Government of India. In contrast, the undergraduate medical education is woefully lacking in appropriate training in the social and behavioural sciences and in psychiatry. However, graduates of modern medicine along with those trained in indigenous systems of medicine and homeopathy find a place in the Mental Health Act 1987, wherein the profession of clinical psychology is not mentioned. Under the provisions of this Act, however, a clinical psychologist is mentioned as a member for the central and state mental health authorities.

In the Rehabilitation Council of India (RCI) Act 1992, a clinical psychologist is recognised as one of the rehabilitation professionals and accordingly s/he can be registered by the RCI under the provisions of the Act. The RCI has a prescribed code of conduct and it is authorised under the Act to discipline erring members. The RCI also has the power to inspect, evaluate and accredit training programmes. As the training and functions of clinical psychology cover a broader area compared to that of rehabilitation psychology, differences of opinion between the RCI and the IACP emerged on the issue of the review and revision of clinical psychology training programmes, with a view to programme accreditation. A mature resolution of this conflict is in the national interest.

Finally, practicing clinical psychologists have felt the need for a mechanism that would offer protection from litigation under the Consumer Protection Act 1986. As these professionals provide diagnostic, therapeutic and rehabilitation services, they can be sued under the provisions of this Act. In the absence of professional registration or insurance, the position of clinical psychologists is thus made highly vulnerable.

## **Future Developments**

In order to strengthen the developments that have occurred within clinical psychology over the last few decades, some cardinal issues require attention. For a country of the size of India, both the existing number of members in the profession and the annual output of trained clinical psychologists is grossly inadequate. The first priority, therefore, is to increase the number of appropriately trained professionals.

During the last 50 years the concept of mental health and its care pattern has changed. The role of psycho-social factors in health and illness is well recognised.<sup>45</sup> Although the NIMHANS training programme has proven its utility, it could be argued that the setting has its constraints and the programme is cost intensive. Currently, the need may be more for a clinical psychologist who can offer a broad range of services to a diverse group of clients rather than replicate the NIMHANS model training centres that emerge in the future could evolve programmes which are based on the

mental health needs of the community. The inclusion of certain specialist areas requires consideration: for example, rehabilitation psychology, health psychology, counselling psychology and clinical neuropsychology.

Strategies need to be worked on to prevent the current loss to India of highly trained professionals through migration and misplacement. A significant reason for seeking opportunities elsewhere may be the reduced availability of professional posts in the public sector. As the expansion of such jobs is not without its constraints within a developing economy, clinical psychologists may look to private entrepreneurship. However, the hiatus in the legal and administrative framework needs to be rectified so as to make the necessary provision for registration and licensing and for insurance coverage.

As the inclusion of a clinical psychologist as a non-official member of the central and state mental health authorities is mentioned in the Mental Health Act 1987, the Government of India can lay down the relevant qualifications and experience for professional classification. Centres for the training of such professionals can also be notified. Additionally, the professional body of clinical psychologists can introduce a set of ethical principles and a code of conduct for its members. Procedures for disciplining erring members would be another step towards increased professional responsibility.

Rao and Mehrotra point out that clinical psychologists in India do not like to involve themselves in administrative responsibilities.<sup>32</sup> International literature confirms the diminished appeal that managerial responsibilities hold for clinical psychologists. Contributions to policy formulations, programme development and implementation, training initiatives, etc., are possible within a profession only if there are individuals with sound managerial experience. In the absence of such expertise, there may be a risk for the profession to be deprived of a sense of direction and of appropriate goals for development. Managerial vision and skills usually evolve over a period of time through a process of training and participation in such tasks. Clinical psychologists need to consider giving priority to managerial and administrative duties, in order to maintain the leadership function within the profession.

Positive changes occurring at a fairly fast pace lead to the development of a profession. During the second half of the previous century, the pace at which changes occurred in the field of clinical psychology were rather slow. If the issues raised herein bring about changes within the next 15–20 years, it would be in the interest of the field of health in general and that of clinical psychology in particular.

## References

1. Resnick JH. Finally, a definition of clinical psychology: A message from the President, Division 12. *The Clinical Psychologist* 1991; 44:3–11.
2. IACP. *IACP Constitution: Amended 1995*. Jaipur: IACP Secretariat, 1985.
3. Kendal PC, Norton-Ford JD. *Clinical Psychology: Scientific and Professional Dimensions*. New York: John Wiley, 1982.
4. Bose G. A new theory of mental life. *Indian Journal of Psychology* 1933; 8:122–123.
5. Bose G. A new technique of psychoanalysis. *International Journal of Psychoanalysis* 1931;12:387–388.
6. Prabhu GG. Clinical psychology: Then and now. *Indian Journal of Clinical Psychology* 1983; 10:i–xvi.
7. Prabhu GG. Indian clinical psychologists of the millennium: The 3G phenomena. *Indian Journal of Clinical Psychology* 2001a; 28:149–154.
8. Hartnick C. Vishnu on Freud's desk: Psychoanalysis in colonial India. *Social Research* 1990; 57:921–949.
9. Kakar S. Stories from Indian psychoanalysis: Context and text. In: Stigler JW, Shweder RA, Herdt G, eds. *Cultural Psychology: Essays on Comparative Human Development*. New York: Cambridge University Press, 1990;427–445.

10. Nandi A. *The Savage Freud*. New Delhi: Oxford University Press, 1995; 81–144.
11. Vaidyanathan TG, Kripal JJ. *Vishnu on Freud's Desk: A Reader in Psychoanalysis and Hinduism*. New Delhi: Oxford University Press, 1999.
12. Prabhu GG. Identifying limitations and gaps in the development of clinical psychology in India (Symposium: Presentation II). *Indian Journal of Clinical Psychology* 2001b;28:164–172.
13. Prabhu GG. Lightner Whitmer (Recognition delayed or totally denied?). *NIMHANS Journal* 1992; 10:75–83.
14. Dube KC. Presidential Address: Psychiatry in distress. *Indian Journal of Neurology and Psychiatry* 1953; 4:101–112.
15. Kuruvilla K. Towards greater integration with other medical specialities (Editorial). *Indian Journal of Psychiatry* 1996;39:194–195.
16. Prabhu GG. Training Programmes In Clinical Psychology (Editorial). *Indian Journal of Clinical Psychology* 1975;2:7–11.
17. Prabhu GG. Progress of clinical psychology in India. In: Hassan Q, ed. *Applied Psychology; Indian Perspectives*. New Delhi: Gyan Publishing House, 1998;47–64.
18. IACP. Secretary's Report to the General Body IACP. 28<sup>th</sup> Annual Conference, IACP, Chennai, 2001.
19. Korchin, S. *Modern Clinical Psychology*. New York: Basic Books, 1976.
20. Phares EJ. *Clinical Psychology : Concepts, Methods and Profession (3rd.)* Chicago: Dorsey, 1998.
21. IACP. Tentative proposal for the open university diploma in clinical psychology. News and Views: *IACP Newsletter* 2000; 2:2–3.
22. Prabhu GG. New perspectives in clinical psychology. *Indian Journal of Clinical Psychology* 1976; 3:203–212.
23. Prabhu GG. Editorial. *Indian Journal of Clinical Psychology* 1977; 4:1–5.
24. Ramalingaswamy P. Clinical psychology in India: Need for a new perspective. *Indian Journal of Clinical Psychology* 1976; 3:53–58.
25. Ramalingaswamy P. Letter to the Editor. *Indian Journal of Clinical Psychology* 1997; 4:87–90.
26. Sen-Mazumdar DP. Editorial: A profession in search of its image. *Indian Journal of Clinical Psychology* 1976; 3:1–4.
27. Ghosh A. Role of a clinical psychologist : A Psychiatrist's point of view. *Indian Journal of Clinical Psychology* 1977; 4:198–199.
28. Prabhu GG. Letter to the Editor. *Indian Journal of Clinical Psychology* 1977a; 4:91–93.
29. Prabhu GG. Clinical Psychology in India. Expanding Horizons–Panel discussion. *Indian Journal of Clinical Psychology* 1997; 24:7–11.
30. Thapa K. Clinical Psychology in India: Dilemmas and Challenges. *Indian Psychological Abstracts and Reviews* 2000; 7:233–272.
31. Murthy VN. New directions in clinical psychology. *Indian Journal of Clinical Psychology* 1982;9: iii–xvi.
32. Rao K, Mehrotra S. Clinical psychologists in India. A time for reflection and action. *Indian Journal of Clinical Psychology* 1998; 25:124–135.
33. Krishnan B. Clinical psychology: A trend report. In: Mitra SK, ed. *A Survey of Research in Psychology*. Bombay: Popular Prakashan, 1972; 1–55.
34. Murthy HN. Counselling and therapy. In: Pareek U, ed. *A Survey of Research in Psychology 1971-76. Part I*. Bombay: Popular Prakashan, 1980; 333–371.
35. Prabhu GG. Deviance and pathology. In: Pareek U, ed. *A Survey of Research in Psychology, 1971-76. Part-I*. Bombay: Popular Prakashan, 1980; 257–332.
36. Sathyavathi K. Mental health. In: Pandey J, ed. *Psychology in India: The State of Art, Vol. 3*. New Delhi: Sage Publications India Pvt Ltd., 1988;217–287.
37. Verma SK. The development of standards and regulation of the practice of clinical psychology in India. In: Bellak AS, Hersen M, eds. *Comprehensive Clinical Psychology*. Oxford: Pergamon, 1998; 83–92.

38. Nathawat SS. An evaluation of papers published in Indian Journal of Clinical Psychology in 25 years (Editorial). *Indian Journal of Clinical Psychology* 1998; 25:117-119.
39. Prabhu GG. Personality assessment in the clinical setting. In: Neki JS, Prabhu GG, eds. *Personality Development and Personal Illness*. New Delhi: AIIMS, 1973; 75-96.
40. Prabhu GG. Clinical Psychology in India: A review of clinical and research trends. VI All India Convention of Clinical Psychologists. Department of Psychology, BHU, Varanasi, *Souvenir* 1975a; 7-15.
41. Kazarian S, Evans D. *Cultural Clinical Psychology*. Oxford: Oxford University Press, 1998.
42. Verma SK. Clinical psychology in India from 1950-2000. In: R. Srinivasa Murthy, ed. *Mental Health in India 1950-2000*. Bangalore: Peoples Action for Mental Health (undated), 200-208.
43. Prabhu GG. Clinical psychology in India-In retrospect and prospect. *Indian Journal of Clinical Psychology* 1974;1:3-7.
44. Prabhu GG. Whither registration? *Souvenir*, 27<sup>th</sup> NACIACP, IHBAS, Delhi, 2001.
45. Hamburg D, Sartorius N. *Health and Behaviour*. Cambridge: Cambridge University Press, 1989.

## Chapter 14

# Psychiatric Nursing: The Perpetual Cinderella

*K. Reddemma • Nagarajaiah*

Family members of individuals suffering from severe mental disorders have witnessed different kinds of problems in their care and management. From time immemorial, it was believed that mental disorders were caused by evil spirits. Witchcraft hunting and the exorcism of demons were common. Accordingly, the mentally ill were treated with different modes of traditional healing, which were mostly inhuman in nature. For example, in order to expel evil spirits from the head of the patient, a bony part of the skull was opened and brain tissue removed. Similarly, patients were physically restrained by seclusion and chaining. Measures like starvation and the neglect of basic needs were also crude methods of treatment. The Unani system consisted of bleeding and purging at an early stage, but the patient was provided with a nutritious diet. A massage with milk on the head and body and change of climate were also recommended. This was due to the non-availability of modern treatment facilities, including mental health professionals.

In the 1840s, Florence Nightingale made an attempt to meet the needs of psychiatric patients with proper hygiene, better food, light and ventilation and the use of drugs to chemically restrain violent and aggressive patients. Reports based on Florence Nightingale's crude research suggested that the mortality rate had reduced and improvement in the behaviour of patients was also noticed to some extent. Thus, nursing care of the mentally ill received appreciation around the 1840s.

In India, psychiatric nursing has undergone a dramatic change, from the crude custodial care of asylums to community approaches and to open door policies of mental health institutions. Some of the major significant milestones that could be identified for the development of psychiatric nursing in India are:

- 1950s – introduction of drugs;
- 1960s – opening psychiatric units at general hospitals;
- 1970s – community mental health approaches;
- 1982 – the national mental health programme and the adoption of the new Mental Health Act 1987;
- 1990 – open door policies of mental health institutions.

History reveals, as early in fourth century AD, during the period of Emperor Ashoka, hospitals with 15 beds for mentally ill with two male and two female nurses. The role of the nurses was to

administer herbal medication to psychiatric patients in addition to meeting their basic needs. Administration of the indigenous drug *Acorus calamus* in psychiatric disorders and the weekly recording of the patients progress was reported.<sup>1</sup>

The first lunatic asylum was established at Mumbai in 1745 and the second at Kolkata in 1787, followed by the Central Mental Hospital Asylum at Yeravada in 1889, the Thane Mental Hospital in 1902 in Mumbai the Central Lunatic Asylum at Ranchi in 1918 and the Berhampur Asylum in 1925. Nurses primarily provided custodial care, in addition to attending the basic physical needs of the patients. Due to the influence of pioneers like Col. Owen Berkeley Hill, the name 'Lunatic Asylums' was changed to 'Mental Hospitals' in 1922. Nurses also played the role of guardians. In addition to providing the basic needs of psychiatric patients, they helped to ensure a suitable environment, proper ventilation, sanitation and involved patients in recreational activities.<sup>2</sup>

The treatment of the mentally ill along with regular patients was initiated at the Civil Hospital, Govindgarh, Patiala, as early as in 1957. Two nurses along with the doctors cared for the mental patients. Although the care provided was almost similar to that given to patients with physical illnesses, there was also mention of electric shock treatment and drugs like chlorpromazine, reserpine and hypnotics. Reports were also available about the involvement of nurses in social training and coaxing of patients in games.<sup>3</sup>

Nurses' participation in insulin-coma therapy and carbutamide in combination with insulin were also reported in 1958 and 1960.<sup>4</sup> Succinyl chloride drip for the treatment of psychoneurosis in the Department of Psychiatry at the Christian Medical College (CMC), Vellore was reported in 1962.<sup>5</sup> Nursing, thus, became vital in the management of psychiatric patients.

Nurses were also involved in caring for the mentally ill at the Hospital for Mental Diseases, at Ranchi in 1955. There is also reference of the use of the drug, chlorpromazine, in 1956 and Electro-Convulsive Therapy (ECT) in 1959 at the Kishore Nursing Home in Ranchi. Leucotomy was performed up to 1962. The nursing staff were involved in the care of patients for 24 hours a day.<sup>6</sup> In 1958, all wards at the Agra Mental Hospital were ordered to be kept open and all ward locks were removed from the charge of the ward attendant. Nurses took an active role in patient care and handled their newer responsibilities with great conscientiousness and devotion. It has been observed that nursing staff have better opportunities to judge the behaviour of the patient and there are more interpersonal contacts between patients and staff.<sup>7</sup>

For the first time in India, 11 British nurses along with one matron were brought from the UK to work in the mental hospital at Ranchi in the 1930s. Later on, three to six months' lectures were arranged for English-speaking nurses at the end of which certificates recognized by the Royal Medical Psychological Association were given to them. To begin with, nurses helped patients in occupational and recreational therapies. The introduction of somatic therapy in 1917 gave nurses a definitive role in psychiatric care. Treatments like deep sleep therapy (in 1930), insulin shock therapy (in 1935), Metrozol shock therapy (in 1935), ECT (in 1937), and psychosurgery (in 1936) necessitated key roles to be played by nurses in treating the mentally ill. Somatic therapies such as ECT also made patients accessible to psychological methods of treatment. As there were few psychiatrists, nurses began to get actively involved in the psychological treatment of patients in hospital wards. Individual therapy and group therapy were developed and taught gradually to nurses in 1960. These techniques emphasised the importance of the personality and behaviour of the nurse as a factor in therapeutic interaction with patients. During 1930-1960 principles and practices of psychiatric nursing were derived from practical experiences of caring for psychiatric patients.<sup>8</sup>

By and large, the management of the mentally ill was considered to be more challenging than other types of nursing care, because more than physical care, the task involves interpersonal skills, imagination, sensitivity, knowledge of human behaviour and interviewing skills. However, it is essential to prepare nurses to care for the total needs of all patients than just for the mentally challenged. By the early twentieth century psychiatric nursing training was well organised in the West. Psychiatric nursing became a speciality by the late nineteenth century in England and by 1930 in other European countries. The registration of psychiatric nurses was done by 1920 in the UK. Degree courses in psychiatric nursing began in the USA. Psychiatric nursing was included in the basic nursing curriculum by the International Council of Nurses in 1961. Short training courses of three to six months were conducted in Ranchi in 1921, which were recognised by the Royal Medical Psychological Association. From 1943, the Chennai Government organised a three months' psychiatric nursing course (subsequently stopped in 1964), for male nursing students at the Mental Hospital, Chennai (in lieu of midwifery). During 1948–1950, four nurses were sent to the UK by the Government of India, for training for Mental Nurses' Diploma. During 1954, the Nur Manzil Psychiatric Centre, Lucknow gave psychiatric nursing orientation courses of four to six weeks duration.<sup>8</sup>

During 1953–1954, the urgent need for nurses trained in psychiatric care was felt by the Government of India along with the need for psychiatrists and clinical psychologists. This resulted in the first organised course at the All India Institute of Mental Health (AIIMH), Bangalore, in 1956. The first group of 15 students was admitted for the Diploma in Psychiatric Nursing (DPN) and were trained with the help of WHO technical assistance. There were only 20 seats to begin with. Later, in 1965, the seats were increased to 30 per year. So far, 668 candidates with DPN have passed out of the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore.

In 1963, the then Mysore Government started a nine-month' course in psychiatric nursing for male nursing students, in lieu of midwifery. From 1976, the duration of the course was reduced to six months as the course for midwifery was reduced to six months. In 1964–1965, the Indian Nursing Council (INC) made it a requirement to integrate psychiatric nursing in the nursing diploma and degree courses. In 1967, a separate Psychiatric Nursing Committee was formed in the Trained Nurses Association of India. During 1970–1972, one-month orientation courses were organised on an all-India basis at AIIMH, Bangalore, for nursing tutors, funded by the Directorate General of Health Services (DGHS) and UNICEF. These courses were conducted in June between 1970 and 1972. Currently, the DPN course is being conducted at the NIMHANS, Bangalore; Central Institute of Psychiatry (CIP), Ranchi and Lokpriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tejpur, Assam.

The Master of Psychiatric Nursing (MPN) course is presently conducted in 17 centres in India. So far, 172 candidates have passed out from various institutions/colleges in India. The doctoral programme in psychiatric nursing (Ph.D.) has been introduced at NIMHANS, Bangalore.

Psychiatric nursing is an essential component of the healthcare delivery system. Psychiatric nurses should receive their appropriate place in the system, particularly while delivering mental healthcare in hospitals and in the community.

Presently, psychiatric nurses holding diploma in psychiatric care play a vital role in the assessment of the needs of psychiatric patients, providing care to acute and chronic psychiatric patients in child and adolescent settings and in de-addiction and geriatric psychiatric centres. They contribute to the general improvement of patients by involving patients in occupational and recreational therapies and conducting individual and group therapy sessions.<sup>9</sup> They also play a key role in the areas of family therapy and community mental health specialities. In specialised institutions like

NIMHANS, psychiatric nurses actively participate in the community care of neuro-psychiatric patients in neuro-psychiatric extension clinics, in home care of psychiatric patients, in school mental health programmes and district mental health programmes.<sup>10,11</sup> In education and training, their active participation in training of para-professionals and non-professionals, particularly health workers trained in mental healthcare and college teachers trained in students mental health counselling are commendable.<sup>11</sup> In addition to service and training, they also participate in research activities, both in hospital and in community mental healthcare.<sup>12,13</sup> The experiments at Chandigarh<sup>14,15</sup> and at Bangalore<sup>16</sup> are particularly noteworthy. An innovative model to involve psychiatric nurses in the home care of psychiatric patients at NIMHANS has also been effectively demonstrated.<sup>17-19</sup>

### **Current Issues, Future Prospects and Challenges**

- Many psychiatric settings are almost entirely staffed having persons with limited training who perform tasks for which they are not adequately equipped.
- There is a lack of clearly enunciated definitions of the roles of professional psychiatric nurses.
- At present, a psychiatric nurse is more of a coordinator than a therapist, due to the paucity of qualified psychiatric nurses.
- There is a need for psychiatric nurses to be free from time-consuming and emotionally exhausting work of a ward manager, and focus on their role as nurse clinicians.
- Psychiatric nurses should teach non-professional workers. Greater emphasis should be given to encourage a Master's Degree in Psychiatric Nursing, so that nurses become pioneers in teaching non-professionals and play active roles in specialised treatment modalities like behaviour therapy, family therapy and individual and group counselling.
- To offer DPN courses in more colleges so that trained psychiatric nurses will be available for psychiatric units in general and district hospitals.
- Though in 1964–1965 the integration of psychiatric nursing was considered and the INC made it a requirement, till the present day, most schools do not have properly prepared teachers to teach this subject. They also do not have the facilities to send students for psychiatric nursing affiliation. Though Colleges of Nursing have started teaching psychiatric nursing since 1964–1965, it was only in 1970 that this subject was made an examination subject. Hence, there is an urgent need to achieve the integration of psychiatric nursing into basic curricula in the real sense and to make it compulsory to have three months' exposure to practice as a registered nurse. It is time to integrate this subject to enable nurses to give comprehensive nursing care in general healthcare settings, considering the emotional needs of patients.<sup>20</sup>
- To maintain the minimum standards of psychiatric nursing care in mental hospitals, the recommended psychiatric nurse: patient ratio as per the INC is 1:5 in non-teaching and 1:3 in teaching hospitals, high priority needs to be given to increase psychiatric nursing manpower at the diploma, master's and doctorate levels.<sup>21</sup>
- At present there are only 756 qualified diploma holders in Psychiatric Nursing, 172 Master's degree holders in Psychiatric Nursing and only six doctorates in Psychiatric Nursing in India. The figure is meagre compared to the number of qualified psychiatrists in India (the above number is based on the information received from various institutions in India).



- The quality of mental health services delivered will ultimately depend on the persons equipped to deliver it. Psychiatric nurses are capable of playing vital roles in specialised areas like community mental health centres, family and marital counselling centres, child and adolescent centres, geriatric and school mental health programmes. Greater emphasis needs to be given in the appropriate use of their services. Many such highly qualified psychiatric nurses opt for foreign assignments because of problems in appropriate placement and disparities in pay scales as compared with other mental health professionals in India.
- There is ample evidence as far as the vital role of psychiatric nursing is considered, both in the hospital and the community.<sup>10,18,22</sup> There is a crucial need to create proper jobs at par with other professionals, particularly in the community. High priority must be given to fill vacant positions in educational institutions. This will facilitate adequate manpower development in psychiatric nursing.
- An integrated and coordinated role, both in service and training, is essential in maintaining the quality and standard of psychiatric nursing.
- Unfortunately, most psychiatric centres do not have qualified psychiatric nurses, even today. High priority should be given to place qualified psychiatric nurses in mental health centres, guidance and counselling centres, community mental health and school mental health programmes, if necessary with special allowances.
- Adequate promotional avenues in psychiatric settings for qualified psychiatric nurses should be created. As they do not have promotional avenues in psychiatric settings, they prefer to work in general healthcare delivery and even choose foreign services.
- The national mental health programme for India (1982) recommended the formation of a District Mental Health Team (DMHT), in order to decentralise mental healthcare at the district level, with two qualified psychiatric nurses and one psychiatrist. The role of the psychiatric nurse in the district mental health programme is to provide care to the in-patients. The care includes meeting their basic needs, conducting occupational therapy, recreational therapy and individual and group therapy, along with mental health education to families and the public in general. In addition to the above, qualified psychiatric nurses will actively participate in decentralised training to professionals and non-professionals working at taluk and Primary Health Centres (PHCs). They will also supervise the task of multipurpose workers in mental healthcare delivery. They will assist psychiatrists in research activities in monitoring mental healthcare at district and PHC levels. Their active participation in mental health education to the public will go a long way in creating public awareness in the care of individuals with various mental disorders.

## Conclusion

With the increasing demand, there is an acute shortage of psychiatric nurses in mental hospitals, psychiatric units in general hospital settings, mental health centres and in educational institutions. Most nurses, after they qualify, are reluctant to work with psychiatric patients. Those available are often utilised for doing either paper work or other routine tasks, seldom having the time to constructively contribute to the observation and therapeutic progress in patient care. This

is partly due to the paucity of psychiatric nurses in such institutions and also ignorance about the effective utilisation of qualified psychiatric nurses in the mental health field. The psychiatric nurses' contribution in this field could be invaluable, for they spend the longest number of hours with patients and could keep a methodological report on patients' progress after establishing a good rapport with them.

## References

1. Bhaskaran K, Satyanand D, Subramanyam P. Experience with the use of carbutamide in combination of insulin in insulin coma therapy. *Indian Journal of Psychiatry* 1960;2(2):63-68.
2. Davis RB, Davis AB. The first ten years: Some phenomena of private psychiatric hospital. *Indian Journal of Psychiatry* 1965;2(4):231-245.
3. Dube KC. Unlocking of wards: An Agra experiment. *Indian Journal of Psychiatry* 1963;5(1):2-6.
4. Fernandes S. Succinyl chloride drip : A method of treatment for psychoneurosis. *Indian Journal of Psychiatry* 1962;4(4):197-206.
5. Fozdar NG, Doongaji, Bagadia VN, Wahia NS. Preliminary report on indigenous drug 'Acorus Calamus' in psychiatric disorder. *Indian Journal of Psychiatry* 1962;4(1):12-16.
6. Gurumukh Singh. Treatment of mental patients in civil hospital. *Indian Journal of Psychiatry* 1962;4(3):156-160.
7. Kapur RL. Community Psychiatry at NIMHANS. Bangalore, 1981 (Mimeo).
8. Nagarajaiah, Parthasarathy R, Isaac MK, Reddemma K. Psychiatric nursing outside the hospital: some observations. *The Nursing Journal of India* 1993;LXXXIV(9):203-204.
9. Nagarajaiah, Reddemma K, Chandrashekar CR, Parthasarathy R, Shivaji Rao. Perceived skills of multipurpose health workers in the management of mental disorders. *NIMHANS Journal* 1994;12(1):15-20.
10. Nagarajaiah. Home care of schizophrenics. *Health for the Millions* 1994;20(4):30-34.
11. Nagarajaiah. Nursing interventions in neurosis, Ph.D. thesis, Bangalore University, 1995.
12. Nagarajaiah. Role of nurse in mental health research. *NIMHANS Journal* 1984;2(1):41-45.
13. NIMHANS. Minimum Standards of Care in Mental Hospitals: Recommendations and Report of National Workshop for Medical Superintendents of Mental Hospitals and State Health Secretaries, NIMHANS, 2000.
14. Pai S and Nagarajaiah. Community care of psychiatric patients in India. *International Journal of Nursing* 1984;31(5):149-151.
15. Pai S, Channabasavanna SM, Nagarajaiah, Raghuram R. Home care for chronic mental illness in Bangalore. An experiment in the prevention of repeated hospitalization. *Bangalore Journal of Psychiatry* 1985;147:175-179.
16. Pais. Hospital v/s home care treatment for acute psychotic patients (Ph.D. thesis). Bangalore University, 1980.
17. D'Souza eds, *Psychiatry in India* 1984;1-20.
18. Reddemma K, Nagarajaiah, Ramchandra. Integration of mental health with general care nursing. *The Nursing Journal of India* 1989;XXX(9):231-232.
19. Reddemma K. Psychiatric nursing. *The Nursing Journal of India* 1982;LXXIII(5):144-146.
20. Suman C, Baldev S, Srinivasa Murthy R, Wig NN. Helping the chronic schizophrenics and their families in community: Initial observations. *Indian Journal of Psychiatry* 1980;22:97-103.
21. Usha Sundaram K, Shamasunder C, Kapur RL, Nagarajaiah, Pai S. Where do we stop? *Indian Journal of Psychological Medicine* 1982;5(1):7-12.
22. Wig NN, Srinivasa Murthy R, Harding TM. A model for rural psychiatric services: Raipur Rani experience. *Indian Journal of Psychiatry* 1981.

# Chapter 15

## Psychiatric Social Work: Past, Present and Future

*R. Parthasarathy • M. Ranganathan*

“Considering the rate at which the Schools of Social Work are growing, it is within the realms of reason to forecast that in about 20 more years, there will be about 110 schools of social work. This is not an overwhelming number in the light of the fact that India’s population at that time will not be less than 1,000 millions. One can visualise that medical and psychiatric social work will receive greater emphasis and play a dominating role during the coming years...”

Dr M.V. Moorthy

The last six decades of professional social work have witnessed many changes and developments in India. Consequently, social work educators have been seriously involved with making suitable attempts to change the curricular framework to suit the needs of the people and also accord with developments that have occurred in the fields of welfare, education, health, science and technology.

As early as in 1961, Gauri Rani Banerjee observed that psychiatric social work in India should be the practice of social work and not just social case work in a psychiatric setting. In the practice of psychiatric social work, other methods such as group work, community organisation and social work research are also made use of. The emphasis on each method will depend on the nature of the psychiatric setting in which the psychiatric social worker is going to practise – promotion of mental health and prevention of mental health problems, psycho-social intervention, treatment and rehabilitation services.

Some important milestones:

- 1936 – Sir Dorabjee Tata Graduate School of Social Work established in Mumbai.
- 1937 – The first post of psychiatric social worker in the Child Guidance Clinic run by the Tata Institute of Social Sciences, Mumbai.
- 1944 – The establishment of the Indian Council of Mental Hygiene.
- 1946 – The Bhore Committee report recommended the appointment of medical social workers and psychiatric social workers. The Tata Institute of Social Science (TISS) was requested to start training programmes.

- 1947 – The first post of medical social worker in J.J. Hospitals, Mumbai.
- 1948 – Gauri Rani Banerjee returned from the USA and started a medical and psychiatric social work programme at TISS, Mumbai.
- 1954 – The establishment of the All India Institute of Mental Health, Bangalore. Other schools of social work, like Delhi, Lucknow, Chennai and Agra also started the specialised course.
- 1960 – World Mental Health Year.
- 1966 – Mental Health Advisory Committee recommended starting of a Diploma in Psychiatric Social Work (DPSW) at the All India Institute of Mental Health, Bangalore.
- 1968 – A DPSW course was started at the All India Institute of Mental Health, Bangalore.
- 1970 – A DPSW course began at Central Institute of Psychiatry (CIP), Ranchi.
- 1970 – The Indian Society of Psychiatric Social Work (ISPSW) was founded by R.K. Upadhyay, Ranchi.
- 1973 – The First Annual Conference of ISPSW was held at Varanasi.
- 1974 – The Second Annual Conference of ISPSW was held at Chennai.
- 1975 – The WHO Report on Organising Mental Health Services in Developing Countries.
- 1977 – The Third Annual Conference of ISPSW, Bangalore.
- 1978 – The Fourth Annual Conference of ISPSW, Miraj.
- 1979 – A Joint Conference of Neurology, Psychiatry, Psychology and Psychiatric Social Work at NIMHANS, Bangalore.
- 1981 – The ISPSW Conference in collaboration with Indian Social Science Association (ISSA) at Jabalpur.
- 1982 – The formulation of National Mental Health Programme for India by the Government of India.
- 1987 – The Mental Health Act 1987 enacted. Subsequent national conferences of the ISPSW were held at Chennai, Cochin, Kolkata, Visakhapatnam, Dharwad, Kolhapur, Hyderabad, Tirupati and Trichi.
- 2002 – XXI Annual National Conference of the ISPSW was held at the University of Lucknow, Lucknow, along with the Association of Schools of Social Work in India.

## **Present Context**

The scope of psychiatric social work is expanding in tandem with the progress and development in the field of mental health. In the present context, psychiatric social work could be defined as the application of methods of social work, that is, social case work, social group work, community organisation, social welfare administration, social action and social work research in the field of mental health for the purposes of:

- Promotion of mental health and prevention of mental health problems;
- Early social diagnosis and prompt psycho-social intervention;
- Psycho-social rehabilitation and aftercare of persons with psychiatric disabilities.

Psychiatric social workers play a vital role in the following areas:

*In-patient and out-patient services*

The services rendered by psychiatric social workers to the patients in the psychiatric, de-addiction, neurological and neurosurgical wards and their respective out-patient departments are a meaningful mixture of independent psycho-social therapeutic activities at individual, family and group levels and programmes of interdisciplinary nature. The activities focus on the psycho-social study of the patients and their families, formulation of a social diagnosis and providing appropriate social treatment. This takes the form of systematic gathering of information, recording of case histories, making home visits, collateral contacts, explaining and educating distressed family members, and group interaction with patients. Depending on the problems, family-centred casework services are offered. In such service activities, psychiatric social workers make special efforts to involve the 'significant others' in the helping process. Mobilisation and utilisation of resources in the family and the community for the welfare of the patient have been the guiding principles of psychiatric social work services. Each psycho-social situation and problem has posed a great challenge to psychiatric social workers. Efforts have been made to improve the quality and quantity of such services to the out-patients and in-patients, mainly through a social network approach and involvement of volunteers from welfare agencies.

*Child guidance clinics*

Psychiatric social work and child psychiatry have a long history of cooperation. Considering the nature of psychiatric manifestations in children, the focus on psycho-social situations has been well emphasised in working with disturbed children and adolescents as well as their family members. Therapeutic group activities with children and parents, individual counselling sessions with siblings, interpretation of the problem to the school authorities and liaison with child welfare agencies are the important components of psychiatric social work intervention in clinics. These services have been offered both at out-patient and in-patient levels. In addition to such services, the psychiatric social workers collaborate with psychiatrists and clinical psychologists in organising different welfare-oriented therapeutic programmes for the children and their families. Social work services in the child and adolescent unit have immense potential for being models to their counterparts in India and other developing countries.

*Family psychiatric centres*

The psychiatric social work services focus on the marital problems, family pathology and other interpersonal adjustment difficulties in the family. These are handled at individual as well as family levels. All the family members admitted to the centre are guided to participate in group sessions in order to explore the possible solutions to their problems. Family therapeutic programmes which are applicable to our socio-economic and cultural milieu have been extended to the families, through the staff and students of psychiatric social work. On the basis of the services rendered in this unit, psychiatric social workers have been developing indigenous models for understanding marriage and family related problems as well as preventive/promotive and therapeutic intervention models for them.

*Services in rehabilitation and aftercare*

Rehabilitation is one of the core activities of psychiatric social work. Disability assessment, employability, integration into the community and resocialisation are the important areas where services of psychiatric social workers have been extended. Some of the rehabilitative services extended to patients include aftercare and resettlement for long-stay patients, jobs for the mentally

and neurologically disabled, social skills development programmes, sponsorship programmes and self-help groups. The possible rehabilitation of the patient is assessed in accordance with the potential help from family members, relatives, friends and community resources. Problems to be encountered at each and every stage of vocational and social rehabilitation have been studied individually and appropriate psycho-social solutions were offered to the patients and their families.

Involvement of philanthropists, industrialists, welfare agencies and coordination of welfare agencies is a *sine qua non* of psychiatric social work programmes in the rehabilitation unit. Professional knowledge and efforts have been invested in organising rehabilitation programmes, development of psycho-social rehabilitation avenues and guidance in utilising available and potential resources. Psychiatric social workers are actively involved in raising funds for psychiatric and neuro rehabilitations, especially for wheelchairs, recreation, medicines and investigations, vocational training and orthosis. Special attempts have been initiated to evolve indigenous means of rehabilitation of the mentally ill and handicapped in urban and rural settings.

#### *Neurological and neurosurgery services*

Patients with neurological illness and disabilities are offered psychiatric social work services. This help is in the form of educating the patients and their family members, the use of case work and group work services to the disturbed family and providing specific rehabilitation services. Particular attention has been given to chronic disabled patients. Families have been counselled and guided with regard to future activities and are informed about the social security services and other resources of help. Regular home visits, agency contacts and social and vocational rehabilitative measures have been undertaken whenever necessary.

#### *Community mental health programmes*

The method of community organisation and social action have been the main models of delivering mental health services in rural and urban communities. Community participation and mental health education have been the important domains of psychiatric social work services. Psychiatric social workers actively participated in community care programmes and training programmes for the medical and non-medical personnel. Local leaders have also been involved in mental health programmes. The involvement of students, teachers, volunteers and others interested in mental health programmes from welfare agencies is also a focal area. Psychiatric social workers take an active role in organising the neuro-psychiatric extension services at different taluk headquarters. In pioneering programmes like the district mental health programmes, as advocated by the national mental health programme for India in 1982, psychiatric social workers have significantly contributed to psycho-social components like community education, community participation, intersectoral cooperation and coordination, training of multipurpose health workers and evaluation of the programmes.

In all the above mental health-related settings, the psychiatric social workers offer the following services:

- Psycho-social study of the patients and families
- Home visits for diagnostic and therapeutic services
- Community agencies contacts for resource mobilisation
- Educating the patients/family members about illness, treatment and rehabilitation
- Marital counselling/therapy/intervention services

- Family counselling/therapy/intervention services
- Group interaction/intervention services for patients and their family members
- Liaison services with the families, schools and communities
- Training the para-professionals and non-professionals in mental health services
- Community participation, voluntary agencies involvement, mental health camps and outreach programmes.

These services are offered in various permutations and combinations depending on the nature of the problems, felt needs of the patients, families and communities. In addition to therapeutic or treatment services, certain promotive/preventive services are also undertaken by professionals in collaboration with voluntary agencies, industries and educational institutions. Some of the programmes are orientations to teachers about mental health problems of children and adolescents, counselling skills orientation to teachers, student enrichment programmes, participation in parent-teacher association meetings and pre-retirement counselling orientation.

There is a trend to employ psychiatric social workers in industrial settings to work as social counsellors, specially to take care of various psycho-social problems, family-related issues and psychiatric problems, including alcohol and drug dependence among the industrial workers. Likewise, a considerable number of educational institutions in big cities like Mumbai, Delhi, Chennai and Bangalore make use of the services of psychiatric social workers for student counselling and guidance programmes. Psychiatric social workers are employed in de-addiction centres for psycho-social therapies. In the family courts, counselling services extended by psychiatric social workers are highly recognised. Many psychiatric social workers provide their services to the juvenile service bureau, family counselling centres, the integrated child development scheme and to correctional institutions.

In addition to the above clinical and psycho-social services, psychiatric social workers have been actively involved with psycho-social orientation to trainees in the fields of psychiatry, psychology and nursing. Similarly, they are involved with other short-term programmes offered to non-specialists, para-professionals, non-professionals and members of voluntary organisations.

In all these activities in different fields, psychiatric social workers have been actively involved in the promotional and preventive components of the mental healthcare delivery system, at all levels. It is worth mentioning that all social workers irrespective of their fields would be doing some promotional aspects of mental health in the population groups they are serving.

Research activities form indivisible components of psychiatric social work intervention. Research projects are undertaken in the areas related to social and psychological aspects of mental health and mental illness. They undertake either independent or collaborative research projects sponsored by the Government of India, the Ministry of Social Justice and Empowerment, the Ministry of Health, ICMR, WHO and Council for the Advancement of Peoples' Action and Rural Technology (CAPART). In many schools of social work, the students submit their research dissertation as part of their Master of Social Work (MSW), M.Phil or Ph.D. programmes. These researchers focus on areas like:

- Marital and family systems
- Efficacy of family counselling, family therapy, group intervention, etc.
- Schools of mental health and community mental health

- Social work aspects of child and adolescent problems
- Life skills education
- Stress coping and social supports
- Resource mobilisation for psychiatric rehabilitation
- Disaster management
- Training of volunteers to work with the disabled in the community
- Psycho-social aspects for de-addiction and mental retardation
- Psychiatric social work in neurology and neurosurgery settings
- Other issues related to welfare, development, education and health.

### **Future Trends**

Extrapolating the present developments, it is realistic that the psychiatric social work in the new millennium would help to:

- Strengthen the psycho-social intervention services to children, adolescents, adults and the elderly, seeking the services of the mental health institutions, rehabilitation centres, family counselling centres, child and adolescent guidance centres, neurology and neurosurgery services.
- Augment community-based mental health services—extension services in rural tribal and slum areas, training of para-professionals, non-professionals and personnel from voluntary agencies.
- Develop newer areas like crisis intervention, disaster management.
- Facilitate the formulation of appropriate policies for social security measures for people with disabilities.
- Convince the government and non-governmental agencies about the contribution of psychiatric social workers and their absorption into agencies for health, mental health, development, education, industries and welfare services.
- Update the Bachelor of Social Work (BSW), MSW and M.Phil syllabi with modern concepts of mental health and psychiatric social work.
- Develop Indian research literature related to psychiatric social work.
- Appropriately incorporate the developments in information technology into psychiatric social work.
- Focus on promotional activities like organising stress management programmes, school mental health programmes, effective parenting, life skills orientation, marital and family enrichment and community-based rehabilitation services.
- Initiate social action programmes for the cause of mental health—counteracting the stigma attached to mental illness and the active implementation of welfare policies for disabled persons.
- Undertake useful research activities to understand the felt needs of the public, evaluating the effectiveness of psychiatric social work intervention and other such issues related to the improvement of the quality of services.



- Strengthen professional societies interested in the development of psychiatric social work.

These activities call for concerted efforts of professional social workers in general and psychiatric social workers in particular. The schools of social work, medical and psychiatric social work teachers, practitioners, researchers and policy makers need to play a vital role in developing the activities of psychiatric social workers in the expanding fields of mental health. The new millennium will bring forth such spirit and energy, creative ideas, and wisdom and experience, leading to collective action for the development of the psychiatric social work, services, training and research and consultation-related mental health and neurosciences in India.

### Suggested Reading

1. Banerjee GR. Psychiatric social work. In: *AR Wadia, ed. History & Philosophy of Social Work*. Mumbai: Allied Publishers.
2. Janardhan N, Parthasarathy R. Psycho-social problems of people with epilepsy: Implications for professional social work services. *Contemporary Social Work* 2000;XIX:23-37.
3. Krishnan Nair T. *Social Work Education and Social Work Practice in India*. Madras: Association of Schools of Social Work in India, 1981.
4. Parthasarathy R. Working with groups of adolescents for promotion of mental health : Some observations. In: Kapur M, Poornima Bhola, eds. *Psychological Therapies with children and Adolescents. Proceedings of the Seminar*. Bangalore: NIMHANS, 2001:197-205.
5. Parthasarathy R. Community mental health: Proposed models and remedies. In: Paranjothi Ramalingam, ed. *Proceedings of the UGC sponsored National Seminar on Social Work practice and Models in Rural and Urban settings beyond A.D. 2000*. Coimbatore: P.G. Department of Social Work, Sri Rama Krishna Mission Vidyalaya College of Arts and Science, 1999.
6. Parthasarathy R. Professional social work and promotion of mental health. In: Joseph G, George PO, eds. *Social Work Education Emerging Concerns*. Kalamassery, Kerala: Rajagiri College of Social Sciences, 1997; 131-140.
7. Purnima Mane, Gandevia KY, eds. *Mental Health in India*. Mumbai: Tata Institute of Social Sciences, 1993.
8. Ranganathan M, Parthasarathy R. Vocational rehabilitation of the mentally disabled persons: An Indian perspective. *The Journal of Rehabilitation in Asia* 1984;XXV(3):27-33.
9. Ranganathan M, Narayana Reddy GN, Shariff IA, Parthasarathy R, Kaliaperumal VG. College student volunteers in Mental Hospital Programmes. *Indian Journal of Social Work* 1991;LII(2):151-160.
10. Ranganathan M, Shariff IA, Rajaram S, Parthasarathy R. Social work in community resource building for psychiatric rehabilitation. In: Kalyanasundaram, Mathew , ed. *Innovations in Psychiatric Rehabilitation*. Bangalore: Richmond Fellowship Society, 2000;154-160.
11. Rao VN, Parthasarathy R. Training in psychiatric social work: Some issues. *Contemporary Social Work* 1996;XIV: 67-73.
12. Shariff IA, Parthasarathy R. Social Work is community mental health: an appraisal of practice and teaching components. Background paper for the seminar on 'Changing Trends in Health Care and Implications for Social Work Education, Tata Institute of Social Sciences, Bombay, 1985.
13. Srinivasamurthy R, Burns BJ, eds. *Community Mental Health-Proceedings of Indo-US Symposium*, NIMHANS, Bangalore, 1992.
14. Verma R. *Psychiatric Social Work in India*. New Delhi: Sage, 1991.
15. *Organisation of Mental Health Services in Developing Countries*. Geneva: WHO, 1975.
16. *Life Skills Education for Children and Adolescents in Schools*. Geneva: WHO, 1994.
17. *Mental Health: New understanding, New Hope*. Geneva: WHO, 2001.

## Chapter 16

# NGOs and Mental Health: Search for Synergy

*Vikram Patel • Mathew Varghese*

### Historical Aspects

Non-Governmental Organisations (NGOs) are recognised by governments as non-profit or welfare-oriented organisations, which play a key role as advocates, service providers, activists and researchers on a range of issues pertaining to human and social development. Historically, they have played a critical role in promoting and facilitating health and educational activities in India. Prior to independence, religious bodies set up a number of educational institutions, health facilities and other charities. These movements were often led by charismatic individuals, driven by a sense of missionary zeal. Many NGOs were born in response to major disasters and crises with the aim of providing emergency relief and rehabilitation. Since independence, there has been a meteoric rise in the profile, breadth and range of NGOs in India.

There were three key changes that occurred in the evolution of NGOs: first, the greater degree of professionalisation of NGO activities; second, the widening of sources of funds for NGO activities to include major national and international donor agencies; and third, the secular origins of NGOs. In the 1960s, several NGOs began to focus on health issues. These NGOs increasingly filled gaps in providing healthcare, focusing primarily on under-served populations. Some of these NGOs have now become large institutions in their own right, providing primary care services and strengthening community action for change. The activities of internationally acclaimed NGOs, such as the Self-Employed Women's Association (SEWA) and the Child in Need Institute (CINI), have become models for wider adoption by the government in its own programme development.

Much has already been written and documented on the work of NGOs in a variety of sectors of community development issues, including health.<sup>1</sup> However, there was no such initiative in the specific area of mental health until the recent documentation of a number of NGO programmes in mental health in India.<sup>2</sup> This chapter offers a brief overview of the programmes discussed in this book.

### Diversity of Mental Health NGOs (MHNGOs)

Despite the considerable challenges faced in developing mental health programmes, it is gratifying to note the achievements made by many MHNGOs. These organisations are located throughout India, although there are a greater number in urban areas, and in states where there are relatively

fewer pressing problems posed by poverty and communicable diseases (for example, the southern states). Although many MHNGOs are found in urban areas, many have begun to extend services into rural areas. Most MHNGOs provide services which are restricted to a defined community; however, the work of some, such as the Alzheimer and Related Disorders Society of India (ARDSI), which was begun in Kochi, has now spread to more than a dozen centres in India. The oldest MHNGOs in India are probably those working in the field of child mental health, and, in particular, mental retardation. This may not be surprising, given the close nature of the relationship between mental retardation and the concept of childhood disabilities, which has been one of the bedrocks of the MHNGO movement for several decades. The concept of child mental health has broadened from its earlier focus on mental retardation to include the far commoner mental health problems seen in children, such as autism, hyperactivity and conduct disorders. MHNGOs, such as Sangath Society (Goa), The Research Society (Mumbai) and Samadhan (New Delhi), provide out-patient and school-based services for such problems.

Other than mental retardation, the other early MHNGOs focused on care, treatment and rehabilitation as their priorities and developed appropriate models of rehabilitation in diverse settings and for diverse clinical populations. Their primary focus was on severe mental disorders and many of these MHNGOs (such as the Schizophrenia Research Foundation [SCARF] and the Medico-Pastoral Association [MPA] in Bangalore) were started by psychiatrists who already held full-time faculty positions in the local medical schools. These MHNGOs were started as a means to fulfil the need for a broader, holistic approach to the management of severe mental disorders. Thus, activities ranging from family counselling to vocational rehabilitation, which were rarely provided in psychiatric out-patient clinics, were given greater attention. Another area of mental health which attracted considerable interest and attention was substance abuse. Alcohol abuse and, in particular, drug abuse, captured the public imagination and received considerable media interest in the 1970s and 1980s. This public attention, and the obvious need for community-based rehabilitation services for people affected by substance abuse, led to the development of numerous MHNGOs working in this area. The T.T. Krishnamachari Foundation in Chennai, the TRADA (Total Response to Alcohol and Drug Abuse) in Kerala and Karnataka, Alcoholics Anonymous, and the Samaritans in many parts of the country and the National Addiction Research Centre in Mumbai, are examples of MHNGOs that focus on substance abuse problems.

More recently, the scope of activities of MHNGOs has broadened further. Perhaps, this has to do with the broadening of our understanding of the range and nature of mental health problems. Thus, stress-related disorders, such as anxiety and depression, are increasingly recognised as major causes of sickness and disability. MHNGOs providing community-based counselling and suicide prevention activities have mushroomed. Reports highlighting the rising rates of suicide in India, in particular amongst young people, has alerted health professionals and the community about this serious mental health problem. Sneha (Chennai), MPA (Bangalore), Saarthak (Delhi) and Prerna (Mumbai) work on suicide prevention activities. Some MHNGOs focus on women's mental health; common mental disorders, which are often linked to stress and oppression, are not surprisingly, more frequent in women. The activities of the Bapu Trust (Pune) demonstrate how feminist theory can contribute to the discourse on the linkages between women's lives in a gender-biased society and their mental health. It also serves as a good example of how an academic enquiry can lead to pragmatic action in the form of training through networking with clinicians and other MHNGOs. Some MHNGOs, such as AMEND (Bangalore), are entirely run by, and focus on families of those affected by severe mental disorders. ARDSI works with families who have a member affected by dementia. The growth of this non-professional, family-oriented MHNGO sector is to be welcomed, for it is very

likely that the needs of the mentally ill may be expressed and met in different ways by families and by mental health professionals.

There are some MHNGOs which, though originally intended to work on issues other than mental health, have broadened their areas of work to include mental health. An example of such an MHNGO is Ashagram in Madhya Pradesh, whose primary focus was physical disabilities, especially persons affected by leprosy but which expanded its community-based rehabilitation programme to include severe mental disorders which also produce a profound disability in some people. Other examples of broad-based NGOs which are integrating mental health in their agenda include the Voluntary Health Associations of India (VHAI) and the Community Health Cell (Bangalore). These are healthy trends facilitating the view of mental health as an integral component of the broader rubric of public health.

### **MHNGOs: Activities and Programmes**

Despite considerable diversity in the range of objectives and activities of various MHNGOs, there are several common features shared by many of them. The perceived need of the community appears to have been a major catalysing factor for the sustainability of all these organisations. In some cases, personal tragedies and first-hand experiences have been inspirational factors. Scepticism and cynicism, especially of the medical community, non-cooperation and lack of sensitivity of government officials have been similar experiences especially in the founding years. Not unexpectedly, a high premium is placed on the involvement of families and other stakeholders in the activities and programmes of all the MHNGOs. For many of them, government funding support is minimal, and most are dependent on the general public or donor agencies for financial resources. A few have been able to mobilise research funds, by virtue of having established research credentials. Many MHNGOs charge fees for services. The kinds of activities which MHNGOs are engaged in, towards their objectives of improving the health of those affected by mental disorders are considered below.

#### ***Clinical care and rehabilitation***

Many MHNGOs provide services for specific mental disorders. The Research Society in Mumbai even provides for laboratory facilities for genetic tests for the diagnosis of genetic syndromes associated with childhood mental disabilities. Some MHNGOs provide facilities for in-patient care, in particular for the management of severe mental disorders. Virtually all of them provide some type of out-patient clinic. The clinical interventions provided reflect the diverse strategies available for the management of mental disorders. These include medical (i.e. drug) treatment and psychological treatment, including individual counselling, marital and family therapies and group therapies.<sup>3</sup> Many people require long-term care to minimise the disability associated with some mental disorders. Typically, about one-third of patients with schizophrenia will show signs of long-term disability associated with a variety of factors, such as chronic symptoms, stigma and the side effects of medication. Most MHNGOs working in this area have comprehensive services focusing both on the control of symptoms of the acute phase of the illness as well as rehabilitation to ensure optimal functioning in the long term. Providing vocational training in skilled professions, such as carpentry and printing, social skills training and family therapy, are some examples of the kind of activities undertaken. MHNGOs provide linkages with potential employment by sensitising employers to the needs of those suffering from chronic mental disorders. Childhood mental disorders also require a range of rehabilitation interventions, particularly in the educational field. MHNGOs working in other areas, such as substance abuse, also provide a range of rehabilitation services.

### ***Community outreach programmes***

Unlike hospital-oriented health service providers, MHNGOs have a strong commitment to extending care into the community. This can be seen in virtually all their activities. Indeed, by their very location within non-institutional structures in the community, MHNGOs essentially provide community-based services. The nature of some community outreach programmes focus on prevention. Examples of primary preventive programmes run by MHNGOs include: the telephone helplines for immediate access to counselling and advice for anyone in distress, early intervention for babies born at risk for developmental delay, and education programmes in schools and workplaces for prevention of substance abuse. Secondary prevention focuses on minimising the handicaps associated with existing mental disorders. Examples of such programmes include community-based rehabilitation for childhood and adult mental disabilities and school programmes to help children with hyperactivity and dyslexia stay in school.

### ***Support groups***

As part of the broad perspective on healthcare, many MHNGOs are adopting methods to enhance the effectiveness of treatments provided to individuals. Support groups are widely used as a way to ensure that people recovering from substance abuse can remain sober. The globally recognised organisation, Alcoholics Anonymous, is an example of the kind of support group philosophy which becomes the core to the process of treatment of alcohol dependence. Support groups are also evident in the residential and daycare facilities geared to those with severe mental disorders. Some MHNGOs run support groups not for those actually affected by a particular disorder, but for their families. Here, families of elders with Alzheimer's disease, adults with schizophrenia and children with autism meet regularly to discuss common problems, support each other and provide practical solutions to everyday difficulties.

### ***Training***

Many of the MHNGOs actively invest in the development of skills of their staff. Participation in workshops, conferences and seminars, and formal training in courses such as rehabilitation are often offered as opportunities for career development. Most of the MHNGOs provide opportunities for training other professionals and health workers in specific areas of mental health, such as counselling skills. Many colleges, for example, send their students to MHNGOs for field placements. Workshops with health workers, teachers and other key groups are a standard feature of the activities of many MHNGOs. The Richmond Fellowship has successfully established a full two-year M.Sc. programme in psycho-social rehabilitation. Many of these organisations regularly organise local, national or international conferences, seminars, workshops or symposia to discuss current issues in the field.<sup>4</sup>

### ***Advocacy and building awareness***

Advocating for the needs of the under-served and underprivileged sections of the population has been the *raison d'être* for most MHNGOs. At present, there is very low awareness of the considerable advances in our knowledge of the causes and treatment of mental disorders in India. This low awareness, coupled with the enormous stigma attached to mental illness, means that the needs and rights of the mentally ill are largely ignored. MHNGOs have raised the awareness in different sectors of the community, such as health workers, teachers and lay persons, a priority area. The documentation and dissemination of relevant facts and research, and lobbying policy makers for changes in the law are vital instruments for improving mental healthcare. Prominent

examples of the success of the efforts of MHNGOs are the inclusion of mental disabilities in the disability legislation of India. Many of the MHNGOs publish their work in annual reports and souvenirs. Others publish regular newsletters and host websites, marking the close affinity of MHNGOs with contemporary technological advances.

### **Research**

Until relatively recently, MHNGOs were primarily concerned with service provision and advocacy-related activities. Research was considered an academic exercise, best reserved for the ivory towers of universities and teaching hospitals. This has changed so much in recent years that today, MHNGOs are at the forefront of ground-breaking research in India. Major research programmes in health areas as diverse as infectious diseases to nutrition are now conducted under the aegis of MHNGOs. The SCARF studies on schizophrenia are the most widely cited research on the subject from any developing countries.<sup>5</sup> All three published studies of dementia in the community in India are from work done by MHNGOs (see Chapter 30 on the Graying of India, Mental Health Perspective for more information on these studies). Sangath's studies on the treatment of depression are amongst the largest such studies from India.<sup>6</sup> Ashagram's community programme for schizophrenia has generated the first scientific evidence of the use of the community-based rehabilitation approach for rehabilitation of a mental disorder.<sup>7</sup> These are just some examples of innovative, action-oriented research emanating from MHNGOs.

### **Networking**

All the MHNGOs are strongly committed to collaboration and intersectoral partnerships. Networks are established between MHNGOs, with government organisations and with academic institutions. Paripurnata is, for example, a member of the Forum for Mental Health, an umbrella organisation of more than a dozen MHNGOs that are located in West Bengal. Sneha has actively supported the development of similar organisations in other parts of India. Partnerships with government are also a notable feature in some MHNGOs. Sangath currently runs a woman's health clinic in a government primary health centre, as part of a larger research project on women's mental health. Partnerships with academic institutions are encouraged by many MHNGOs, particularly those with a key interest in research.

### **MHNGOs: Strengths and Limitations**

Why is it that the MHNGO movement has continued to survive despite the lack of resources and other problems? This is probably because MHNGOs have some inherent and intrinsic advantages. The advantages of MHNGOs can be considered under three broad categories:

- *Working in partnerships:* One of the great strengths of MHNGOs is their ability to strike up collaborations and partnerships with other agencies or individuals with ease, unlike the public health sector, where layers of permissions stifle the scope for collaboration and unlike the private health sector, where collaborations may be perceived as a threat to the practice. Most MHNGO activities are provided by multidisciplinary teams of doctors, therapists, health workers, other professionals and volunteers. Partnerships are built not only between medical and non-medical professionals, but also between professionals and families. The close collaboration between academics, clinicians, social workers, rehabilitation workers, remedial teachers and clinical and educational psychologists are a distinct feature, which marks MHNGOs as being a very different breed of animal from traditional psychiatric clinics in hospitals or private psychiatry.

- *Innovations in practice:* MHNGOs are typically, closer to the community they serve and hence, in a better position to be more sensitive to changing needs and perceptions. Furthermore, MHNGO services may be attached with much less stigma than formal psychiatric services, and may thus attract a much wider range of clients. Clinical support, involving diagnosis and treatment of specific mental disorders, is the key to many MHNGO activities. Their success lies in providing services which are accessible, such as through outreach camps, and which rely on available human resources, such as the community participatory model of rehabilitation. Many MHNGOs provide a wide range of services which are especially suited for severe childhood mental health problems. By taking up the process of promoting attitudinal changes in the community and amongst policy makers, MHNGOs also play a key role in the advocacy for changes which can benefit all those with mental illness.
- *Transparency in administration:* The activities of MHNGOs are driven not by profit but by the desire to achieve a basic quality of care for all clients, irrespective of their ability to pay. They are governed by a relative flexible set of regulations. Employment and promotional avenues can be based on merit as opposed to the traditional governmental holy grail of seniority. Since they are dependent on external funding, MHNGOs are constantly pressured to achieve programme objectives and ensure fiscal accountability. MHNGOs can explore, with remarkable entrepreneurial dynamism, collaborations with any other organisation or individual to achieve their objectives.

However, MHNGOs have their fair share of limitations and problems. These may be considered under the following broad themes:

- *Sustainability:* A key problem facing most MHNGOs is the source of their funding which is largely project based. The periodic fund raising required to augment resources can take up a good deal of time and energy. Also, staff have no guarantee of employment beyond a defined project period. Some MHNGOs suffer a high turnover of staff. This is partly because staff are appointed on specific funded projects and their continuity depends on the funding available. There might be a temptation to dilute goals and objectives as a response to the availability of funding. Donor funding is notoriously fickle; priorities change over time, and MHNGOs often have to reinvent their objectives to stay afloat. The current trend for massive investment in HIV/AIDS-related work, though important in its objectives, is concentrating the bulk of donor money to this one-disease issue. Many MHNGOs are adding HIV/AIDS as core priorities to secure these funds. While this may broaden the scope of MHNGOs by enabling an integration of existing priorities with new ones, there is equally a need not to allow the focus on mental health to be diluted to the point that it becomes irrelevant.
- *Accountability:* Some MHNGOs have poorly established mechanisms for evaluation and monitoring. Although networking is actively sought for project collaboration, there is no similar zeal for review and monitoring from external assessors. There has been considerable public concern regarding the misuse of funds and lack of financial accountability of NGOs in general. Although this may not be as significant an issue in the context of MHNGOs where funds are scarce, they would be well advised to ensure transparency in accounting for their funds. As MHNGOs become larger and more professionalised, there is the danger of greater bureaucratisation with increasing administrative costs. MHNGOs should be wary of this from the beginning, since it could

well dampen creativity and flexibility, two elements which give MHNGOs their unique flavour.

- *Scope:* Finally, and perhaps the most important limitation is the limited scope of individual MHNGOs. The world of most MHNGOs is confined to a city or a few villages. There is, however, a need to transplant the wide experience of these onto a larger canvas, ideally through influencing policies and programmes for the entire state and country. For changes to occur on this wider canvas, there is little doubt that the public or government health sector must play a key and leading role. MHNGOs can, in this context, be seen as innovators who develop locally relevant models which can then be implemented on a national scale.

## Conclusion

MHNGOs have made tremendous strides in mental health promotion and care, against massive odds, ranging from low awareness about mental illness to the lack of motivation by donors. Although there can be little dispute whether MHNGOs have a definite role to play in meeting mental health needs in India, there is also little doubt that their impact on mental healthcare at the national level has been marginal. For example, there are very few MHNGOs working in rural or impoverished areas. The strength of MHNGOs does not lie in their ability to reach out to the millions of people with mental disorders, but in evolving and perfecting quality programmes and models which have the character of replicability. Through innovation and accountability, MHNGOs can provide models for the public healthcare system to emulate and partner. However, they cannot meet the needs of the under-served and underprivileged sectors of our population. That responsibility, was, is, and must rest principally with the public health sector. It is believed that the time and setting is right not only for the emergence of new MHNGOs, but also for the consolidation and strengthening of existing ones. Donor and government agencies must take note of the huge public health implications of mental disorders and the lack of organised services for the mentally ill and provide support for MHNGOs especially in rural and remote areas of India. Given a favourable climate, we are sure that the MHNGO movement will not be a sporadic or isolated phenomenon as it is now, but a more enduring and unified force in the realm of mental health in India.

## References

1. Pachauri S, ed. *Reaching India's Poor: Non-Governmental Approaches to Community Health*. New Delhi: Sage (India), 1994.
2. Patel V, Thara R. eds. *Meeting Mental Health Needs in Developing Countries: NGO Innovations in India*. New Delhi: Sage (India), 2003.
3. Isaac MK, ed. *Psychosocial Rehabilitation: A Handbook*. Bangalore: Medico Pastoral Association, 1998.
4. Kalyanasundaram S, Varghese M, eds. 'Innovations in psychiatric rehabilitation, *Proceedings of the RF-ASPAC International Symposium 1995 at Bangalore*. Bangalore: Richmond Fellowship Society, 2000.
5. Thara R, McCreadie R.G. Research in India: Success through collaboration. *Advances in Psychiatric Treatment* 1998;5:221-224.
6. Patel V, Chisholm D, Rabe-Hesketh S, Dias-Saxena F, Andrew G, and Mann A. The efficacy and cost-effectiveness of a drug and psychological treatment for common mental disorders in general healthcare in Goa, India: a randomised controlled trial. *Lancet* 2003;361:33-39.
7. Chatterjee S, Patel V, Chatterjee A, Weiss H. Evaluation of a community-based rehabilitation model for chronic schizophrenia in a rural region of India. *British Journal of Psychiatry* 2003;182:57-62.



## Chapter 17

# Psychiatric Rehabilitation in India: Issues and Challenges

*T. Murali • Kiran Rao*

People with severe mental disorders, such as schizophrenia and bipolar affective disorder, represent a heterogeneous group with different problems and varying levels of need. Severe mental disorders figure among the 10 leading causes of disability and burden to the world.<sup>1</sup> With the emphasis on integrating psychiatric care with primary healthcare and the emergence of General Hospital Psychiatric Units (GHPUs), the delivery of mental healthcare has been centred on the amelioration of symptoms during acute phases of the illness. More often, severe mental disorder tends to run a chronic course and has a devastating impact on the person's functioning. It affects activities of daily living, such as self-care and personal hygiene, social relationships in terms of communication skills and occupational functioning, such as the ability to acquire a job and retain it. Due to this global impact, it affects not just the individual, but also his family and in turn, the community at large. Treatment for severe and chronic mental illness, in addition to medical management, comprises a variety of therapeutic approaches, all aimed at helping the individual function at his/her optimal capacity. Psychiatric rehabilitation is the term used to represent this broad range of services that use a combination of learning procedures and environmental supports in a holistic and integrated manner, to provide life-long care for persons with mental illness.

The extent and range of rehabilitation services in India vary markedly. While some of the settings provide 'state-of-art' services, there are other centres where facilities are grossly inadequate. A substantial number of people with disability due to mental illness do not have access to the range of services that are necessary to improve their quality of life. This chapter provides a brief overview of the services and concerns related to psychiatric rehabilitation in India. The interested reader is also provided with a list of references for a more detailed and comprehensive understanding of the area.

### **Delivery of Rehabilitation Services**

Psychiatric rehabilitation in India can be divided into two phases. In the first phase, comprising the first 25 years since independence, most of the services were hospital based and largely confined to the government mental hospitals. The emphasis was on keeping the long-stay patient occupied with some form of work or activity. It is the second phase, from the early 1970s that saw concerted

efforts being made to reintegrate the patient with the family and the community. This period is characterised by several initiatives taken by Non-Governmental Organisations (NGOs). It is in this phase that rehabilitation, in the true sense of the term, emerged as a felt need. The developments in the delivery of rehabilitation services can, therefore, be viewed under two sections: hospital-based services and community-based initiatives.

### ***Hospital-based services***

The Bhole Committee report stated that '... in occupational therapy we have a powerful therapeutic weapon for the psychiatric patient. Organised systematic work is better treatment than the careless haphazard occupation in some of the hospitals.<sup>2</sup> The important thing is to create throughout the hospital an atmosphere of industry and to make occupation an activity that is approved by the patients'.<sup>3</sup> This statement reflects the emphasis given to occupational therapy as part of the treatment for the psychiatrically ill. The Central Institute of Psychiatry (CIP), in Ranchi had, at that time, the best occupational therapy unit in India and compared favourably with those abroad.<sup>4</sup> Persons were deputed for training to Ranchi and, as a result, vocational training units were set up in Mysore and Chennai. It is a sad reflection that, 50 years later, the National Human Rights Commission (NHRC) report 1997 on quality assurance in mental healthcare stated that rehabilitation services were practically non-existent in the 40 government hospitals situated in 18 states of India. While 64% reported some rudimentary form of rehabilitation activity, only four hospitals had structured occupational therapy facilities in the form of day care centres. These were at NIMHANS, Bangalore; the Karnataka Institute of Mental Health, Dharwad; the Institute of Mental Health, Chennai and the Mental Health Centre, Thiruvananthapuram.

Day care centres, especially those attached to psychiatric hospitals, tend to be used more by chronic patients with greater disability and from lower socio-economic strata.<sup>5</sup> Poor work performance is related to the persistence of residual symptoms.<sup>6</sup> However, the use of activity therapy, behaviour modification techniques and monetary incentives for work reduces the behavioural problems and improves the social and occupational functioning of the patient.<sup>7,8</sup> Cognitive remediation can be used to improve the quality of life.<sup>9</sup>

The day care programme is effective in reducing the burden on the family and also gives them the much needed respite from patient care.<sup>10</sup>

The main reason that these efforts have not been replicated in many hospital settings is due to the paucity of mental health professionals other than psychiatrists. Most of the posts of clinical psychologists and psychiatric social workers lie vacant with little effort made to fill them.<sup>11</sup> This has resulted in hospital care becoming synonymous with medical management of the mentally ill. Mental hospitals provide mainly in-patient care with the number of long-stay patients remaining constant. The GHPUs provide mainly out-patient based care with little time to attend to rehabilitation needs of the patient or concerns of the family.

### ***Community-based initiatives***

In contrast to the slow and sporadic growth of psychiatric rehabilitation in the hospital setting, the response in the community has been very encouraging. These initiatives have largely come through NGOs. The first half-way home in India was started by the Medico-Pastoral Association in Bangalore in 1972, and the first day care centre, also in Bangalore, was started by a group of housewives in 1974, under the name of FRIENDS of NIMHANS. Today, there are more than 50 such centres located in different parts of India. Although, a majority is concentrated in the southern states, it is heartening to note that such facilities are also available in Kolkata, Guwahati

and Gurgaon. One of the centres in Kolkata (Paripurnata) is unique because it was primarily started to address the rehabilitation needs of women with mental illness in judicial custody. Yet another first, is the establishment of a day care centre by family caregivers at Chennai (Aasha). In response to concerns expressed by caregivers, many of the NGOs have started long-stay residential facilities.

The quality of care, however, varies markedly across these centres. Financial difficulties are the main constraints and, for most of them, pegging down running costs seems to be an uphill task. This has resulted in a class divide, with some facilities offering professional services and quality care at a price far beyond the reach of the average patient and family; other centres offer mainly custodial care, with patients being given food and shelter and engaged in routine, monotonous activities.

Thus, there is a need for better partnerships between mental health professionals, NGOs and the community at large. A success story here is the example of the MS Chellamuthu Trust, Madurai (Tamil Nadu) that has been able to provide low cost, but effective care and a comprehensive range of services. For the NGO sector to be viable, it would require active support and commitment from mental health professionals. There is however, a need to develop a cadre of well-trained and qualified rehabilitation workers who have the basic aptitude and skills to work with people who suffer from mental illness.

The community has several resources that can be tapped. A survey of involvement and participation of the community in psychiatric rehabilitation,<sup>12</sup> showed that the community is willing to volunteer time, provide financial support, as well as avenues for income generation activity through self-employment schemes, home-based programmes and sheltered employment. These resources are yet to be utilised optimally. The level of contact and interaction between the community and the mentally disabled must increase so that the community becomes more aware of the skills that they possess. Organising educational programmes, cultural activities to showcase skills and exhibitions to market the products made by persons with mental disabilities would be some of the ways of increasing the visibility of the rehabilitated mentally ill.

There have also been community initiatives for the mentally ill that have been less visible. Several individuals and families in Kerala have been involved in providing food, clothing, shelter, medicine and occupational therapy free of cost for the destitute mentally ill. These are largely charitable efforts sustained by the active support, in cash and kind, of the local community.<sup>13</sup> These services need to be further examined with regard to the quality of care provided.

Community-based rehabilitation (CBR) is very appropriate in the Indian cultural setting, where social and community bonds are quite strong and deep-rooted. The challenge of CBR, and its success, depends on whether people with disabilities, their families and communities, and the concerned governmental agencies pertaining to health, education, welfare and social service can work together to make use of the resources in the community. The emerging view is that CBR programmes for the mentally ill should integrate with existing community development programmes, especially in the area of disability, so that there is no duplication and waste of resources.

### **Felt Needs: A Consumer Perspective**

An understanding of the felt needs of the consumer (both patient and family caregiver), will help us evaluate whether existing services are addressing their needs and also help in planning a more effective service delivery system. The most important felt need expressed by patients is the

need to work or 'find a job'.<sup>14</sup> It is not at all surprising that several studies have corroborated this finding. Work is an intrinsic component of one's self-esteem and identity and provides a sense of self worth and social status. Several studies have, however, reported that persons with severe mental illness have difficulty finding and holding on to a job in open employment. Hence, there needs to be a greater emphasis on vocational training and income generating activities that can be undertaken in sheltered workshops or day care centres.

Both rural and urban patients perceive low social support from the family and feel that families are less encouraging of independence.<sup>15,16</sup> Patients have also expressed the need for family members to be educated so that caregivers can have a better understanding and develop a more positive attitude towards mental illness.<sup>14</sup>

These concerns of the patient appear to be borne out by Dr Bhaskaran's observation that a patient with severe and chronic mental illness is 'unwanted' by the family.<sup>17</sup> Almost 93% of the patients in the hospital at the time of his study did not need active psychiatric help and 75% had no visits at all from family and friends. This is a sentiment shared, even today, by many clinicians especially those working in government hospital settings. However, studies indicate that this neglect is not due to a negative attitude towards the patient, but because of financial difficulties, fear and stigma. In the absence of viable alternatives, families that are both financially and socially marginalised may be left with no choice but to abandon their mentally ill relative.

The family in India plays an active role in initiating treatment, ensuring compliance with treatment and in providing the much needed emotional support. The family, rather than the patient, is acknowledged as the consumer of psychiatric services and has received more attention from mental health professionals. Family members are most distressed by patients' symptoms such as poor personal care, being slow and inactive, and aggressive/psychotic behaviour.<sup>18</sup> Most caregivers would like to see their patient engaged in some gainful employment and leisure time activities are not seen as that important. For older caregivers it is the question of 'what after us'. Residential care is a concern expressed by about one-third of the caregivers, especially those with poor financial and social supports.<sup>19</sup> Caregivers express a high need for education and guidance about the illness and its management.<sup>20</sup> They also expect more empathy, active support and encouragement from professionals.<sup>21</sup>

A large number of studies have documented the attitudes and interaction of the family with the ill member. Families in India have been found to be more tolerant of deviance and less rejecting of the ill family member.<sup>22</sup> The presence of a supportive family environment has been highlighted as being responsible for the more benign course and outcome of severe mental disorders in India. Dr Vidya Sagar in 1952 was one of the first to recognise the important role played by the family when he put up tents in the campus of the Amritsar hospital and had the patient stay with the family member. He found that recovery was faster and the patient could be sent home and reintegrated in the community. This led to the concept of 'open wards' in mental hospitals where patients could be admitted with a family member. Today, the large numbers of psychiatric beds in GHPUs fall in this category. However, many of the government mental hospitals still keep the patients locked behind high walls. This not only isolates the patient from the family, but also continues to contribute to the stigma of mental illness.

The high level of support provided by the family to the patient has also resulted in psychiatrists taking the family for granted.<sup>23</sup> Treatment has largely meant the use of pharmacotherapy to manage the patient, especially violent and disturbing behaviour with psychiatrists expecting the family to do the rest. In fact, a home-based treatment model which was hailed as being a viable, low-cost model for the treatment of persons with mental illness was later acknowledged as being insufficient in

addressing the rehabilitation needs of the patient and short-sighted in terms of understanding the family's role and burden.<sup>22,24</sup> Today, professionals are more ready to acknowledge the burden and distress experienced by caregivers in the process of long-term care.

Rural and urban families experience a similar burden.<sup>15</sup> Caring for a person with chronic and severe mental illness affects several areas of the family's functioning, especially the financial burden (cost of treatment and loss of wage earner), family leisure, routine and interaction.<sup>25</sup> Burden is more in low-income families and when the patient is a young, unemployed male.<sup>26</sup> High levels of distress, anxiety and depression are reported in caregivers but, paradoxically, they also report high levels of wellbeing.<sup>20,26,27</sup> Greater attention needs to be paid to understand and strengthen the coping strategies used by caregivers.<sup>28</sup>

Families have come together to provide emotional support to each other, address common concerns and fight for the rights of people with mental disabilities. Family self-groups such as Aasha in Chennai and AMEND in Bangalore have been pioneers in this movement. Today, there are several such groups that are formally registered in different parts of the country and plan to join under a national umbrella organisation (Dr Radha Shankar, personal communication).

The shift towards the decentralisation of mental health services has put a greater emphasis on the role of the family. However, if we expect the family to continue to be actively involved, much more has to be done in order to support it in its caregiving role. Both patients and family members have expressed the need for devising income generating rehabilitative activities to limit disability and simultaneously augment family finances. This indicates that government and NGO agencies must address this concern by setting up day care centres and sheltered workshops. Some patients and families may require residential facilities in the form of short- and long-stay homes. A few patients, especially non-responders to treatment, may continue to require long-term hospital care. The spectrum of rehabilitation services, providing affordable quality care closer to, or in the community, is essential if incidents such as the Erwady tragedy are to be avoided.

## **Research and Training**

Research and training has largely centred around three institutions: one governmental (NIMHANS) and two non-governmental, that is the Schizophrenia Research Foundation (SCARF), Chennai and the Richmond Fellowship Society India (RFSI), Bangalore. NIMHANS has been involved in providing short-term training in psychiatric rehabilitation for mental health professionals, doctors, nurses, occupational therapists and physiotherapists and numerous personnel deputed by NGOs. It has conducted several training workshops in CBR and also published a book on the subject. RFSI has been extending professional expertise and support to other NGOs to help them start day care and residential facilities. It has also addressed the need for human resource development in the area by starting the first Master's level course in psycho-social rehabilitation. SCARF has developed instruments for rating psychiatric disability and social functioning as well as training manuals and educational materials. It has carried out several community-based studies and evaluated the efficacy of different intervention techniques including social skills training and cognitive remediation. Several national and international workshops and conferences have been held at these centres, providing a platform for consumers and professionals to interact and work together. This has been further strengthened through the setting up of the Indian chapter of the World Association for Psycho-social Rehabilitation in 1989.

The Indian Psychiatric Society (IPS) has recognised the importance of this area by establishing a sub-speciality for psychiatric rehabilitation. Several editorials in its journal have addressed the

rehabilitation needs of the mentally ill. However, psychiatrists need to be sensitised and trained in this area if rehabilitation is to be recognised as an essential part of the treatment process. Training for professionals in psychiatric rehabilitation will need to be taken up on a war footing if the gap between demand and supply has to be bridged. A greater emphasis on the training of non-medical professionals, such as clinical psychologists, rehabilitation psychologists, psychiatric social workers, psychiatric nurses and occupational therapists, is indicated. Short-term courses for rehabilitation workers, voluntary and family care providers will also be required. It is necessary to provide for more funding support for empirical research in psychiatric rehabilitation. The effectiveness of alternative models of community-based care in disability reduction and improving the quality of life have to be examined and pilot tested before implementing them at the national level.

## **Legal and Ethical Issues**

At the time of independence, mental healthcare in India was confined to mental hospitals and was governed by the Indian Lunacy Act 1912. In 1987, the Mental Health Act (MHA) was enacted, but there was considerable delay in its implementation and, significantly, the word psychiatric rehabilitation did not find a place. It took another 12 years to form the Persons with Disabilities Act (PWD, equal opportunities and full participation) 1995, pertaining to the prevention and early detection of disabilities, protection of rights, education, training, employment and rehabilitation of person with disabilities. Although mental illness was included as one of the disabilities, the definition of mental illness was not clear. In fact, difficulties in quantifying disability led pressure to remove mental illness from the purview of the Act. Fortunately the IPS acted quickly and introduced the Indian Disability Evaluation Assessment Schedule (IDEAS).<sup>29</sup> Although, there is still no clear understanding of the actual benefits that will accrue for the disabled mentally ill, the government has begun initiatives for the development of rehabilitation services.

The Government of India declared the year 1981 as the year of the disabled and the subsequent decade as the decade of the disabled. During this period, there were positive initiatives from the government for disabilities like locomotor, hearing, speech, blindness, and mental retardation. One of the significant developments was the setting up of the National Institute of Mental Handicap at Secunderabad in 1984. However, the National Mental Health Programme of 1982, a major policy document for the care of the mentally ill, did not pay enough attention to rehabilitation and left it largely as the responsibility of the community and the NGO sector. A proposed plan for the development of district rehabilitation centres did not materialise.

In 1982, the Rehabilitation Council of India (RCI) was established by an act of parliament. Some of the important functions of the RCI are: licensing of rehabilitation professionals, and monitoring and accreditation of training facilities and short- and long-term training courses in rehabilitation. The RCI has recently taken a positive step by addressing the issue of psychiatric rehabilitation.

What have we gained from the new legislations? The MHA deals with the treatment and the PWD Act deals with rehabilitation of the mentally ill. According to the MHA, all agencies that care for the mentally ill come under the purview of the state mental health authority. As per the PWD Act, the monitoring and control of rehabilitation facilities, both residential and non-residential, come under the purview of the Commissioner of Disabilities. While the government sector is exempted from all regulation, these two Acts have made it difficult for the various rehabilitation agencies in the voluntary and NGO sector to operate. In effect, there are parallel controls from two different ministries. The RCI has become a third monitoring agency. This has only resulted in a lot of

confusion, a sense of mistrust that the government is only interested in a 'Licensing Raj' and very little improvement in the actual development and delivery of services.<sup>30</sup> If scarce resources are not to be wasted, it is imperative that there is better coordination among these agencies/ministries. The need of the hour is to: (a) improve hospital-based services and ensure that the minimum standards outlined by the NHRC are implemented; (b) develop practical norms and guidelines for the voluntary and NGO sector and actively encourage the setting up of CBR services, especially in the form of supportive therapeutic environments; and (c) establish a single-window regulatory authority so that persons with disability and those working in the area can access help easily.

All the stakeholders must be actively involved for the development of a comprehensive mental health policy. Reforms in mental health legislation, in keeping with the mental health policy, can then be brought about. The law must protect the rights of the mentally ill and disabled as well as play a role in changing public attitudes towards mental illness.

## Conclusion

Psychiatric rehabilitation in India has largely been a result of efforts of individual persons and organisations. It is yet to be recognised as an integral part of the routine treatment offered for the care of the mentally ill. If comprehensive care is to become a reality for every person with chronic mental illness, mental health professionals need to be educated and trained in psychiatric rehabilitation. In order to address the needs of the patient and family and reduce the stigma of mental illness, rehabilitation programmes will have to be community-based rather than hospital centred. Income generation activities and different levels of supportive environments, from day care to residential facilities are required. The voice of the consumer, both patient and family, is still largely unheard. Policy makers and service providers need to be particularly concerned to protect the rights of the mentally ill and provide value based, ethical care. Persons with psychiatric disability have a right to rehabilitation. To make this a reality, better coordination among governmental agencies, between the government and voluntary sector, and between the consumer and service provider is called for.

## References

1. World Health Report. *Mental Health: New Understanding, New Hope*. Geneva: World Health Organization, 2001.
2. Bhore J. *Health Survey and Development Committee*. New Delhi: Government of India, 1946.
3. Sharma S. *Mental hospitals in India*. New Delhi: Directorate of General Health Services, 1990.
4. Thomas G, Bose S. Value of work in mental disorders. *Indian Journal of Psychiatry* 1967;9:73-80.
5. Sharma PSVN, Gopinath PS, Reddy MV. Patients attending a psychiatric day hospital – Analysis of one year's referrals. *NIMHANS Journal* 1987;5:39-45.
6. Gopinath PS, Chaturvedi SK, Murali T, Saleem PP. Work performance of schizophrenic day boarders in an occupational therapy center. *Indian Journal of Psychiatry* 1985;27:207-212.
7. Rao K, Barnabas IP, Gopinath PS. Behaviour modification. Letter to the Editor. *Hospital and Community Psychiatry* 1988a;39:1311.
8. Rao K, Barnabas IP, Gopinath PS. Behaviour modification in a rehabilitation setting. *Journal of Personality and Clinical Studies* 1989;5:23-27.
9. George RM, Chaturvedi SK, Murali T, Gopinath PS, Rao S. Cognitive deficits in relation to quality of life in chronic schizophrenics. *NIMHANS Journal* 1996;14:1-5.

10. Rao K, Barnabas IP, Gopinath PS. Family burden in chronic schizophrenia: The role of the day hospital. *Indian Journal of Psychological Medicine* 1988b;11:131-135.
11. NHRC. *Quality Assurance in Mental Health*. New Delhi: National Human Rights Commission, 1999.
12. Ranganathan M, Channabasavanna SM, Murali T, Bharathi BK, Padankatti BS. An exploratory study on the participation of the community in psychiatric rehabilitation. *Indian Journal of Clinical Psychology* 1996; 23:57-61.
13. Murali T. From the secretary's desk. World Association for psychosocial rehabilitation Indian chapter. *Bulletin* 2002;6:5.
14. Nagaswami V, Valecha V, Thara T, Rajkumar S, Menon MS. Rehabilitation needs of schizophrenic patients- A preliminary report. *Indian Journal of Psychiatry* 1985;27:213-220.
15. Ali RM, Bhatti RS. Social support system and family burden due to chronic schizophrenia in rural and urban background. *Indian Journal of Psychiatry* 1988;30:349-353.
16. Kamal P, Gautham S. Family environment of psychiatric patients: Study of a north Indian sample. *Indian Journal of Psychiatry* 1992;34:231-235.
17. Bhaskaran K. The unwanted patient. *Indian Journal of Psychiatry* 1970;12:1-12.
18. Gopinath PS, Chaturvedi SK. Distressing behaviour of schizophrenics at home. *Acta Psychiatrica Scandinavica* 1992;86:185-188.
19. Padmavathi R, Joseph L, Joseph A. A study of postal enquiries made to a voluntary organization. *Indian Journal of Behavioural Sciences* 1997;6:22-25.
20. Sovani A. Understanding schizophrenia: A family psycho-educational approach. *Indian Journal of Psychiatry* 1993;35:97-98.
21. Shankar R. First national meeting of caregivers of people with major mental illness held at Chennai on 25 and 26 May 2001. World Association for psychosocial rehabilitation Indian chapter. *Bulletin* 2002; 6:20-21.
22. Kapur RL. The family and schizophrenia: Priority areas for intervention research in India. *Indian Journal of Psychiatry* 1992;34:3-7.
23. Gopinath PS, Rao K. Rehabilitation in psychiatry: An overview. *Indian Journal of Psychiatry* 1995;36:49-60.
24. Pai S, Kapur RL. Evaluation of home care treatment for schizophrenic patients. *Acta Psychiatrica Scandinavica* 1983;67:80-88.
25. Gautham S, Nijhawan M. Burden on families of schizophrenic and chronic lung disease patients. *Indian Journal of Psychiatry* 1985;26:156-159.
26. Roychaudhuri J, Mondal M, Boral A, Bhattacharya D. Family burden among long-term psychiatric patients. *Indian Journal of Psychiatry* 1995;437:81-85.
27. Rammohan A, Rao K, Subbakrishna DK. Religious coping and psychological well being in carers of relatives with schizophrenia. *Acta Psychiatrica Scandinavica* 2002a;105:356-362.
28. Rammohan A, Rao K, Subbakrishna DK. Burden and coping in caregivers of persons with schizophrenia. *Indian Journal of Psychiatry* 2002b;44:220-227.
29. Indian Psychiatric Society. Indian Disability Evaluation and Assessment Scale (IDEAS), 2002.
30. Bhatti RS, Mathew BK. Licensing raj. Editorial in the world association for psychosocial rehabilitation Indian chapter. *Bulletin* 2002;6:1-4.

### Suggested Reading

1. Agarwal AK. Dr DLN Murti Rao oration: The forgotten millions. *Indian Journal of Psychiatry* 1988;40:103-119.
2. Bachrach LL. Psychosocial rehabilitation and psychiatry in the treatment of schizophrenia – What are the boundaries? *Acta Psychiatrica Scandinavica* 2000;102:Suppl.:407:6-10.



3. Dhanda A. *Legal Order and Mental Disorder*. New Delhi: Sage Publications.
4. Hume C, Pullen I. *Rehabilitation in Psychiatry: An Introductory Handbook*. Edinburgh: Churchill Livingstone, 1986.
5. Kalyanasundaram S, Varghese M, eds. *Innovations in Psychiatric Rehabilitation*. Bangalore: Richmond Fellowship Society (India), 2000.
6. Liberman RP, ed. *Psychiatric Rehabilitation of Chronic Mental Patients*. New York: American Psychiatric Press, 1988.
7. Menon MS. Psychosocial rehabilitation: Current trends. *NIMHANS Journal* 1996;14:295-305.
8. Murali T, Sudarsan B, Nair KPS, Taly AB. *Foundations and Techniques in Psychiatric Rehabilitation. Manual for CBR Workers and Caregivers*. Bangalore: NIMHANS, 2001.
9. NHRC. *Quality Assurance in Mental Health*. National Human Rights Commission, New Delhi, 1999.

## Chapter 18

# Private Sector Psychiatry: Phenomenal Growth and Persistent Myths

*A. K. Kala*

The establishment of a 'private lunatic asylum' in 1780, recognised by the Medical Board under the charge of William Dick, and later rented to the British East India Company at a rent of Rs 400 per month, interestingly forms the earliest reference to private sector psychiatry in India. It is also interesting to know that the current Institute of Mental Health, Chennai was established as a private psychiatric hospital in 1794, on a site of 45 acres.<sup>1</sup>

However, private practice in modern psychiatric methods started in India much later and is essentially a post-independence phenomenon. It has been a welcome by-product of the general hospital psychiatry movement in India and has been greatly facilitated by it. It was the general hospital psychiatry movement which brought psychiatry face-to-face with other medical colleagues and the community, in the 1970s and 1980s, and convinced them that psychiatric disorders can be treated like other medical disorders, thus reducing the stigma and isolation attached to them.

This in turn fuelled the progress of the private psychiatry movement. In fact, general hospital psychiatry in India, unlike its counterparts in the USA and Europe, has aggressively tackled the whole range of psychiatric problems in young and old people, including acute and chronic, psychotic and non-psychotic conditions.<sup>2</sup>

This revolutionary phase of general hospital psychiatry also coincided with the establishment of a large number of postgraduate training centres in psychiatry all over India. Young psychiatrists graduated from these centres recognised the need and opportunity for private psychiatric services and spread out their services not only to metropolitan cities, but to mofussil cities and towns as well. While there has been a tremendous progress in the field of private sector psychiatry, from an almost non-existent stage in the 1950s to the present time, where almost all average-sized cities and towns in India have private psychiatric facilities, there has been very little documentation of this phenomenon except some empirical observations highlighting the rapid expansion of private sector mental healthcare, particularly in the South, in tandem with an increasingly, prosperous middle-class, willing to pay for such services.<sup>3</sup>

### **The Characteristics of Private Psychiatric Services in India**

To delineate the characteristics of private sector psychiatry in India, a one-page structured proforma was sent to all 1,890 psychiatrists who were engaged in full-time or part-time private

practice, listed in the directory of the Indian Psychiatric Society, to be filled and returned. In fact, these forms were part of the process of registration for membership of the newly formed Indian Association of Private Psychiatry of which the author was the chairperson.

### **Location of Private Psychiatrists**

It is often wrongly presumed that private psychiatrists are confined to metropolitan and other large cities. Nothing could be farther from truth.<sup>4</sup>

In reality, two-thirds of private psychiatrists (67%) in India are working in cities and towns which are not even state capitals; 7% out of these are practising at tehsil/taluk level towns. Only 15% are located in four metros and 18% in other state capitals.

This bears out the fact that private psychiatric services in India have the most outreach, are the most decentralised and are almost at the doorstep of the patient. In fact, most acute and fresh cases are seen in the private sector. Thus, calling the private sector psychiatric services a community mental health movement will not be an overstatement.

### **Profile of a Private Psychiatrist in India**

In India, 89.5% private psychiatrists are male, while only 10.5% are female. This is a little surprising because psychiatry does seem to be one of the specialities preferred by women postgraduates. This ratio will probably change in some years from now.

Age-wise, one-fourth (26%) of respondents were less than 40 years and two-thirds (65%) were between 40 and 60 years of age. It seems that a fairly large number joins private practice some years or immediately after postgraduation, unlike the pattern 20–30 years ago, when more people used to find a job or work in an academic institute before starting practice.

A typical profile of a private psychiatrist in India is that of a young man with a degree (MD 70%; DPM 19%) from an Indian University. Psychiatrist with foreign qualifications were very few in number (6%). It is also clear that there are very few psychiatrists who go abroad, qualify from foreign institutions and come back to start private practice in India. A reverse acculturation process described by Ananth could be a deterrent factor.<sup>5</sup>

It is encouraging to note that, by and large, private psychiatrists are interested in keeping themselves academically updated: 41% subscribe to more than one medical journal, with 22% patronising over 10 journals, while 35% use the internet to stay informed.

Most respondents (79%) are actively involved in the mental health education of the community in which they live, in the form of public lectures or other interactions. A fairly good number, especially in the four metro cities, are actively involved in handling mental health issues in collaboration with NGOs. Some are involved in intersectoral efforts with schools or the police in counselling and crisis intervention among the vulnerable sections of the population.<sup>6</sup>

These facts reflect not only a public acceptance of mental health professionals but also the community's need to know about psychological problems, and a healthy reciprocation from the profession. At another level, it indicates integration of the city psychiatrist in the community where he resides.

Of these, 70% of respondents were engaged in full-time practice, while others were in part-time private practice who also worked on a fixed remuneration with the government, a corporate or a charitable organisation, About 5% retained their academic position in a medical college. Several state governments allow their medical employees to have part-time private practice.

A fairly large number of private psychiatrists (28%) have their own admission set-ups. Typically, these are 10–20 patients who are given bed for a short period, with rapid turnover

facilities and average stay of 7–10 days. The majority, however, admit their patients in polyspeciality nursing homes. The licensing provisions of the Mental Health Act with its unrealistic regulations have hindered the growth of both these types of set-ups. The Mental Health Act has alienated most of the psychiatrists in private practice. There are two specific provisions of the Act—those pertaining to licensing and visitors boards—which are perceived as oppressive and unnecessary for units which admit patients only for 8–10 days on an average.<sup>4</sup>

## **Myths**

Myths about private sector psychiatry in India which need to be put in perspective are :

1. The presumption that private psychiatrists are concentrated only in large cities has been belied by facts as pointed out earlier.
2. The presumption that private psychiatrists cater only to the upper socio-economic status is wrong. In fact, a vast majority of psychiatric patients belong to the middle-class.
3. The presumption that psychiatrists in cities treat only urban patients is again not true. The majority of psychiatrists working in an average-sized cities and towns treat rural patients.
4. It is often presumed and implied that stigma about psychiatric disorders is greater in illiterate and rural patients. The common experience is that stigma appears worst in the urban middle class.

## **Perceived Challenges**

Private psychiatrists (70%) today see the current Mental Health Act as the biggest challenge to their practice. They view it as isolationist, stigmatising and against the growth of psychiatry. The next important challenge is perceived in social factors (52%) of the lack of awareness and stigma. In fact, 45% felt that the opening up of the health sector to insurance has the potential of another form of over-regulation and adversely affecting the way they practise. Also, 32% strongly believed that general practitioners treating psychiatric patients posed a major challenge to their profession.

## **Long-Term In-Patient Care in the Private Sector**

The private sector has ventured into this area to a very small extent, in spite of a great need. A small number of centres is all that are available and almost all of them are in Bangalore.<sup>7</sup> This is because a long-term care facility of reasonable standards is much more expensive to establish, costlier to run and entails far more responsibility than acute care. Additionally, the Mental Health Act with its unrealistic staff: patient ratio is a strong deterrent.

## **Future Trends in Private Sector Psychiatry**

With a steady flow of postgraduates from various postgraduate departments of institutions in India, a majority of them will choose private practice. This inevitably would mean moving to even smaller towns. It would further increase the penetration of private sector psychiatry into remoter areas and hence, the accesibility for patients will improve.

Another possible scenario, where one psychiatrist practises within a defined community is that he or she would possibly treat several members of the same family, even across generations, thus fulfilling the role of a family psychiatrist.

Another foreseeable trend is a change in the client-profile which presently exists in big cities, i.e. where normal people seek professional help for temporary difficulties like during or after a divorce or other interpersonal crises. Easy accessibility and assured confidentiality makes a private psychiatrist an obvious choice.

Till now, most psychiatric patients pay for treatment as out of pocket expense. With psychiatric treatment being of a recurrent and chronic nature, this may not be possible for all sectors of society. Gradually, pre-payment methods like insurance will emerge. This would also involve the insurance companies requiring justification for clinical decisions. The next step could be insurance companies being stake holders or owners of treatment facilities like Managed Healthcare Organisations (MHOs) in the USA. With all its shortcomings, the system would have some advantages because MHOs ensure a fixed number of psychiatrists, per million of insured lives.<sup>8</sup>

A related development would be the corporatisation of psychiatric services with a greater number of private psychiatrists working for big hospitals with dilution of the spirit of individual enterprise. However, what works in the USA may not work in India. Indian patients have a high regard for doctor-patient relationships, and will not accept a situation where a patient cannot choose his own psychiatrist.

Also, since psychiatric treatments are fortunately not technology intensive, the cost of treatment is not very high and all patients may not have to depend upon third party reimbursements. In addition, they can depend on family support for some time.

## **Suggestions and Recommendations**

1. There should be a two-way interaction between private sector psychiatry and the teaching departments of psychiatry. Psychiatrists in private practice would benefit from periodical short stays in teaching departments, both as students to update their concepts, as well as teachers, in order to impart experimental information about actual practice in the field. Similar to residents posted in mental hospital and neurology departments, they could be posted in private centres of repute. This would give them hands-on training in pragmatic clinical psychiatry and would also encourage transparency in the functioning of private units.
2. The private sector should further strengthen the area of infrastructure. This will not only fulfil the requirement of regulatory authorities and insurance agencies but will also facilitate research in the private sector.
3. The Mental Health Act should be amended to limit its licensing provisions to long-term custodial facilities. Acute care units that allow patients to stay up to two weeks should be excluded.
4. Private psychiatrists should have a reasonable minimum expertise in psychological and behavioural methods of treatment, as in private practice, it is often not feasible to refer patients since very few non-medical professionals are available.
5. The government should have group insurance schemes for the poorer sections of society. The insurance regulatory authority should also ensure that the minimum health insurance package has a mental health component.
6. Private psychiatrists should work in collaboration with other agencies like NGOs, police and government health departments. The district mental health programme could be greatly strengthened with private sector collaboration.

## References

1. Sharma SD. *Mental Hospitals in India*. New Delhi: Directorate General of Health Services, 1990.
2. Wig NN. Looking ahead: The challenge of being a psychiatrist. In: Srinivasa Murthy R. (PAMH, Bangalore), ed. *Mental Health in India: 1950-2000*, Bangalore, 2000.
3. Wig NN. Psychiatry in India; Present, Past and Future. Souvenir issued on the occasion of Mid-term CME 1994, Indian Psychiatric Society, North Zone, Delhi, 1994.
4. Kala AK. Developments in private sector psychiatry. In: Srinivasa Murthy R. (PAMH, Bangalore) ed. *Mental Health in India: 1950-2000*. Bangalore, 2000.
5. Ananth J. Is Western training relevant to Indian psychiatry? *Indian Journal of Psychiatry* 1981;23:2:120.
6. Kala R, Sidhu HS, Singh DJ. Counselling in Police, a study of 544 cases. *Journal of Mental Health and Human Behaviour* 2000;7:31.
7. Murthy RS. Development of Mental Healthcare in Karnataka State. Souvenir issued at the 48th Annual Conference of the Indian Psychiatric Society, Bangalore, 1996.
8. Detre T, McDonald Margaret. Managed care and the future of psychiatry. *Archives of General Psychiatry* 1997;54:201.

## Chapter 19

# The Indian Psychiatric Society and the Indian Journal of Psychiatry: Witness to an Era

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### The Indian Psychiatric Society (IPS)

The necessity to take care of mentally ill patients (or the insane as they were then called) by confining them inside the closed walls of an asylum was felt at the end of the eighteenth century, during the rule of the British East India Company. The first lunatic asylum was thus established in Chennai in 1794. Several other asylums were set-up in other provinces a few years later. To begin with, the charge of these asylums was given to the civil surgeons of the respective districts, who neither were interested in these additional burdens nor were capable of providing any psychiatric services.<sup>1</sup>

The Indian Lunacy Act was passed in 1912 and lunatic asylums were designated as mental hospitals in 1920. Berkeley Hill of Ranchi organised the Indian Association of Mental Hygiene in 1929. This association, affiliated to the National Council of Mental Hygiene in Great Britain, was open to the public, arranged popular lectures and also published a bulletin. However, its activities and organisation faded with the retirement and subsequent demise of Berkeley. In 1935, six years later, Banarsi Das of Agra made an attempt to organise a conference of superintendents of mental hospitals. However, his attempts bore fruit only four years later, when a meeting actually took place under the auspices of the Royal Medical Psychological Association (RMPA) in January 1939, attended by 20 psychiatrists. The second meeting was held at Agra in 1941, under the chairmanship of Dr Banarsi Das. Subsequently, no meetings were held due to the Second World War. The Indian division of the RMPA could be considered the predecessor of the IPS, which was founded in 1947 after the Independence.<sup>1</sup>

The aims and objectives of the IPS at the time it was founded included: the promotion of mental health, the prevention, control and treatment of mental disabilities; giving advice on the standards of education and training of medical and paramedical personnel in psychiatry; the promotion of research in psychiatry and mental health; cooperation with other professional bodies and advising the government and other bodies on various aspects of psychiatry and mental health. The publication of papers and periodicals were in furtherance of its aims and objectives.

The first annual conference of the IPS was held at Patna in January 1948. Since then, annual conferences have been held regularly at different places in India.

In the last five decades, the IPS has grown into one of the largest scientific societies in India. There were only 42 members of the IPS in 1947, but it now has more than 2,000 members. The IPS has been instrumental in replacing the outdated Indian Lunacy Act 1912 with the Mental Health Act 1987, and now is trying to push for relevant changes in the latter to make it more practical and in keeping with modern psychiatry. The IPS has also tried to remove some of the prejudices against psychiatry and also the psychiatrist, but a lot of work still remains to be done.<sup>1</sup>

Mental health literacy is quite low in India and most of the beliefs about mental illnesses are based upon personal experience, advocacy and hearsay. What is needed is a great amount of information, education and communication as well as activities aimed at reducing the gulf between the public and professional belief about mental disorders.

## **The Indian Journal of Psychiatry**

The *Indian Journal of Psychiatry* (IJP) came into existence in 1958 with the publication of Vol. I, No. (1) under the auspices of the IPS, with Dr P.N. Bardhan as the editor. This issue consisted of 39 pages with six articles related to the basic subjects in psychiatry. The IJP gradually changed and improved over time, attaining its present shape finally in April 1973.<sup>2</sup> The IJP has grown tremendously since its inception, both in quality as well as in volume. It is a true reflection of the progress made by Indian psychiatrists in the field of psychiatric research, carried out in India in the last five decades. Through the publication of editorials, presidential addresses and orations, it also reflects the contemporary thinking of Indian psychiatrists and also the Indian Psychiatric Society as a whole. The journal also publishes original research papers in the different areas of mental health in India.

The IJP began with the publication of papers pertaining to the trials of antipsychotic and antidepressants and gradually covered almost all the areas of psychiatric practice. However, psychopharmacological research continues to be a popular area of research.

Agarwal and Aga overviewed the psychiatric research carried out in India between 1973 and 1992.<sup>3</sup> They scanned all the journal issues published between 1973 and 1992 and divided articles into 30 major categories on the basis of the subject. They concluded that there was not much change in the publication pattern of the articles subject-wise and that the trends in research remained almost similar in these two decades.

Earlier, the issues of IJP reflected the interest of workers in psychology, including psychoanalysis. There was a relative scarcity of phenomenological studies. The number of therapeutic trials published increased with the passage of years. The seventies, eighties and nineties saw a surfeit of these papers. The more recent of these have used standardised diagnostic criteria, blinded designs, better experimental controls and have a larger sample size. However, the majority of these trials are a duplication of the trials conducted outside India. Work on electro-convulsive therapy has remained limited to a few centres and is also relatively less as compared to the pharmacological treatment modalities.

Epidemiological and phenomenological studies attracted researchers in the sixties, continuing well into the eighties and nineties. Epidemiological studies have been conducted on a multitude of topics like, mental morbidity in the general population, the prevalence of suicide, correlation between the social class and mental illness, student failure, industrialisation and migration, and drug abuse, both in a specific population like students and in the general population. Clinical studies formed a substantial part of the studies published in the last 30 years, most of the work



being centred on depression and schizophrenia, with a smattering of reports on rare syndromes and culture-bound syndromes. Studies on unipolar-bipolar distinction of depression, positive/negative schizophrenia, prognosis of schizophrenia, the Indian Psychiatric Survey Schedule study and Study of Factors Associated with the Course and Outcome of Schizophrenia (SOFACOS) are some of the outstanding works in Indian research that have been published. These studies showed the interest of Indian psychiatrists in keeping with current trends in research abroad.

Psychological studies published mainly pertain to the adaptation of scales in Hindi, establishing norms of performance for the Indian population and designing of some new psychometric tools. The studies on the psychological methods of treatment have been relatively less. By and large, research on psychological issues never formed the brunt of studies published.

The number of studies related to child psychiatry has also increased over the years since the inception of the IJP; however, this number is less than the studies in adult psychiatry. The works published in child psychiatry has been varied, and include those from surveys, case reports, specific problems, parental deprivation, autism, psychosis, drug trials and mental retardation.

Research in the area of biological psychiatry has achieved major breakthroughs in the international arena. Research in this area has not only helped in the medicalisation of psychiatric illness, but also has contributed towards the development of new drugs. The studies published in these areas in the IJP, however, are mostly limited to psychopharmacology and less on basic biological measures. Immunology, computerised tomography studies, biochemical studies, dexamethasone suppression tests, etc., are a few of the areas that have undergone research. Brain mapping, evoked potentials and estimation of monoamine metabolites in psychiatric illness have also been investigated in recent times.<sup>4</sup>

What is very obvious from the studies published in the IJP is that the methodology is usually not of an international standard and the statistical methods used are old. The current trend of utilising the help of a qualified bio-statistician from the inception of a project is unfortunately lacking in most of the studies. Hence, the interpretation of findings does not carry much input. Similarly, very few multi-centre studies have been published. The better designs of some recent community studies indicate that it is more the attitude of a lack of initiative, rather than cooperation on the part of Indian psychiatrists, which is responsible for this deficiency.

Contemporary issues have always found a place by way of editorial comment as well as in original articles over the years. There was a special supplement on mental health in administration where Dr Mafatia raised the issue of students' unrest (Vol. 9, No. 2). The necessity, urgency and national importance of family planning was recognised as early as in 1968, and as many as six papers on the psychiatric aspects of family planning were published.<sup>2</sup>

Editors at IJP have always addressed the contemporary issues relevant to the society at large and also those related to the psychiatric community. Larger issues like urbanisation,<sup>5</sup> youth and drug abuse, laws to prevent bride burning, burden of care of the mentally ill, suicide and issues directly related to the profession like psychiatric education,<sup>6,7</sup> research and emerging aspects in psychiatry have been given due recognition. The relevance of ancient Indian knowledge to modern psychiatry and the historical perspective of mental health in ancient Indian philosophy and literature have also been the areas of discussion in certain editorials and articles published in the IJP. It is considered important as culture and history has had a great impact upon the presentation and phenomenology of mental illness in addition to the attitude of the public in general about mental illnesses being shaped by them. The IJP is a true reflection of contemporary thinking of psychiatrists in India, at least of those who are in academics or are inclined towards it.

The IJP is now indexed by the WHO and also by Indian Medlars Centre (IndMED), a bibliographic database of Indian bio-medical research. The efforts are now towards getting it indexed in the index medicus.

Keeping pace with modern developments in the field of information technology, the IJP is now also available online and in CD-ROM versions. This has made the work of researchers very easy as they can now scan the whole literature by just pressing a few buttons.

## **Conclusions**

The IJP and the IPS have come a long way since their inception and are now fully mature with firm ground bases. It is only through the efforts of its learned and enthusiastic members that these endeavours have been a great success, though there is still a lot that has to be done.

## **References**

1. Singh K. The Indian Psychiatric Society. Souvenir, *ANCIPS-2000*, Kochi. 20–23 January, 2000.
2. Sethi BB. Twenty-five years of IJP. *Indian Journal of Psychiatry* 1983;25:1.
3. Agarwal AK, Aga VM. Overview of psychiatric research in India (1973–1992). Souvenir, *ANCIPS-94*. Madras, 1994.
4. Palaniappun V. Research in biological psychiatry in India. Presidential address. *Indian Journal of Psychiatry* 2002;44(1):3–8.
5. Trivedi JK. Urbanisation and mental health: a new challenge. *Indian Journal of Psychiatry* 2002;44(1):1–2.
6. Channabasavanna SM. Psychiatric education. *Indian Journal of Psychiatry* 1986;28:4.
7. Trivedi JK. Importance of undergraduate psychiatric training. *Indian Journal of Psychiatry* 1998;40(2): 101–102.

# Chapter 20

## Law and Mental Health: Common Concerns and Varied Perspectives

*Amita Dhanda • D. S. Goel • R. K. Chadda*

Laws generally reflect the prevailing values, attitudes, aspirations and practices in a society at any given point of time. The Mental Health Act 1987 (MHA 1987) was enacted after considerable debate.<sup>1</sup> It has, however, failed to address the apprehensions of a considerable section of those involved in or affected by its implementation. There appears to be a growing gulf between the law enforcement apparatus and mental health professionals. This is unfortunate. For MHA 1987 to attain its legislative intent, this divide must be bridged. Despite concerns being expressed to the contrary, the disciplines of law and mental health share a number of common spaces. This chapter aims to describe those common spaces whilst highlighting the variance of standpoints.

The interaction between law and mental health occurs in the following realms:

- *Capacity and civil status:* While adjudging the legal validity of a transaction, the state of mind of the participants assumes relevance. For example, to decide on the validity of a contract under the Indian Contract Act 1872, it is necessary to know whether the parties to the contract understand the terms of the contract and its impact on their interests. The contractual capacity of a person with mental illness is subject to interrogation under the law.
- *Rights and immunities:* In view of their psychological and social vulnerabilities, there are legislations which recognise the need for affirmative action measures for persons with mental illness. These affirmative action measures may take the shape of a special pension scheme, or a medical reimbursement programme. An example of a legislation allowing for such possibilities is the Persons with Disabilities (protection of rights, equal opportunity and full participation) Act 1995. It may also be appropriate to include within this head, legislations whereby lowered standards of accountability are put in place for persons with mental illness. Such immunity is illustrated by the defense of insanity included in Section 84 of the Indian Penal Code 1860.
- *Care and treatment:* Where the procedures for obtaining voluntary and involuntary treatment are prescribed by law. An example being the MHA 1987.

Both law and psychiatry have roles to play in each of these areas. There is, consequently, a common sphere of operation. However, the coexistence is uneasy, as each discipline operates

with its own internal logic. It is these varied perspectives on questions of common concern that we wish to highlight in this chapter. The objective is not to provide an exhaustive description of all laws impacting on persons with mental illness, but to present the cohorts of various laws and highlight the points of discord between the two disciplines. This is because we believe that for accord to be reached, it is firstly important to enumerate and comprehend the points of discord. Finally, to promote the case for dialoguing we have reproduced a discussion that ensued around a study that the author (AD) had undertaken to make for a more gender-friendly MHA.

## **Capacity and Civil Status**

As already mentioned, the law is concerned with psychiatric illnesses in this context because such disorders are believed to have an impact on the capacity of the individual to undertake a spate of legal activities. Such questionable capacity could have an adverse impact on the legal validity of a transaction. However, does the fact of psychiatric illness alone make a person incapable of entering into a contract? Or, continue with a marriage? Or, retain a job? When should these consequences occur, if at all? Can mental health sciences assist the law in the performance of this adjudatory function? Should the use of medical records be allowed in legal contexts to decide on the civil status of an individual with psychiatric illness? Or, should there be a case for confidentiality? How should the issue of civil status of persons with mental illness be addressed?

Until now, the interaction of the law and mental health science has only occurred where, within a legally dictated normative context, mental health expertise is sought and processed as the courts deem fit. There has been little or no input from the mental health science on the normative content of the law.

## **Rights and Immunities**

Suicide attempts and the plea of defence on the basis of insanity are two areas in which there is substantial disagreement between legal and mental health sciences. On both counts, mental health professionals have been advocating an expansion of the immunities extended to persons with psychiatric illness. Mental health professionals desire that the offence of attempting suicide should be removed from the statute book. It is interesting that the Supreme Court of India was forced to do a 180-degree turn on this question. After holding the statute which categorised attempted suicide as an offence to be unconstitutional in the Rathinam case,<sup>2</sup> the Court in Gian Kaur's case<sup>3</sup> was forced to restore the act to the status of an offence, because it found punishment for abetment of suicide was not possible without the attempt itself being an offence. In a country where a number of women are pushed into taking their lives, how should the law deal with the question of attempt to suicide? This is surely a case for more dialogue!

On the subject of defence by reason of insanity, the mental health sciences have been seeking a revision of the McNaughten Rule. They contend that the defence should be available not only for impairment of cognitive capacities: the impact of psychiatric illness on emotions and impulses should also be taken into account. Even as there are individual cases where the psychiatric perspective has prevailed, at the level of legislation the legal position remains the same. Here, it may be pertinent to ask whether the legal and mental health sciences need to shift gears and also begin to worry about the disposition of persons to whom the defence is granted. Until now, such an individual could be kept in indefinite confinement in a place of safe custody. If this is the unfortunate consequence, then how justified is it to seek a further expansion of the domain of defence based on insanity?

## Care and Treatment

With regard to care and treatment, questions on the jurisdiction of law have been continually raised. The legal regulation of the area has been often referred to as a singling out of the psychiatrically ill. After all, such legal intervention does not happen in the case of physical illness. It is true that, ordinarily, physical illness is not compulsorily treated against an individual's will and without his or her consent. However, for physical illnesses of the infectious variety, compulsory treatment is provided and legislations allowing that to happen are on the statute book, for example, the Epidemic Diseases Act 1897. Without such legislation, therapeutic intervention could be termed assault. The rationale for legal intervention on mental illness operates on a similar logic. Mental illness could cause a person to be a danger to self or others, a situation which may necessitate compulsory treatment. Therefore, there is this need for legislation.

If the necessity for compulsory treatment is conceded, then the need for a law has also to be accepted. Questions, however, arise and need to be answered on how should that legal intervention take place? Who should have the authority to make the compulsory treatment decisions? Should it be a panel of doctors? Should it be magistrates and courts? Or, should it be a multidisciplinary body? What about the concerns of the persons with mental illness? How should their concerns be addressed in the law? What kind of rights should be granted to them in terms of treatment? Autonomy? Choice? What about the cruel practices which are often unleashed on persons with mental illness by indigenous practitioners of various kinds? Should the law regulate them, or prohibit them or leave them unregulated? What about suspect psychiatric interventions like unmodified Electro-Convulsive Therapy (ECT)? Should such therapies be the subject of legal regulation? Or, should the whole sphere of permissible treatments be professionally controlled? The reason for raising these questions is to highlight the fact that there is much more to mental health law than rhetorically and emotively raised questions on the need for a law. Yet, if the proceedings of the Joint Parliamentary Committee on the Mental Health Bill were studied, it would be found that the committee spent much more time deliberating on the question of need than worrying about the content of the law. The entire question of amending the MHA revolves around such questions. The need for seeking these answers has been further enhanced by the fact that the rights of persons with psychiatric illness are a central concern in the debate relating to the proposed UN Convention on Disability.

## Concerns of the Mental Health Fraternity

Although MHA 1987 is based on a draft prepared by eminent psychiatrists, it has aroused strong reactions from mental health professionals themselves, following its implementation in the wake of the Supreme Court orders in the Erwady case. In what follows, some of the major areas of concern to the psychiatric fraternity have been described and possible solutions explored.

### *Unrealistic minimum standards/discrimination*

Perhaps, the most frequent criticism voiced by the psychiatric fraternity against the MHA 1987 relates to what are perceived as unrealistic minimum standards prescribed for private psychiatric nursing homes/hospitals. The sense of injustice is compounded by the fact that government hospitals, especially with regard to staffing, are excluded from the purview of these provisions. These dual standards are a source of considerable heartburn among psychiatrists in the private sector. The apex court is also seized of the matter, and the central government has constituted an expert group to explore the whole question. The underlying issues merit further examination.

The statutory provisions responsible for the aforesaid dialectics are as under:

1. MHA 1987, Section 6(2): 'Nothing contained in sub-section (1) shall apply to a psychiatric hospital or psychiatric nursing home established or maintained by the Central Government or State Government'.
2. State Mental Health Rules (SMHR) 1990, Rule 20:  
MANNER AND CONDITIONS OF MAINTAINING PSYCHIATRIC HOSPITALS OR PSYCHIATRIC NURSING HOMES— Every Psychiatric hospital or nursing home shall be maintained subject to the condition that,—
  - (i) Such hospital or nursing home is located only in an area approved by the local authority;
  - (ii) Such hospital or nursing home is located in a building constructed with the approval of the local authority;
  - (iii) The building, where such hospital or nursing home is situated, has sufficient ventilation and is free from any pollution which may be detrimental to the patients admitted in such hospital or nursing home;
  - (iv) Such hospital or nursing home has enough beds to accommodate the patients;
  - (v) The nurses and other staff employed in such hospital or nursing home are duly qualified and competent to handle the work assigned to them;
  - (vi) The supervising officers-in-charge of such hospital or nursing home are duly qualified having a postgraduate qualification in Psychiatry recognised by the Medical Council of India.
3. SMHR 1990, Rule 22:  
MINIMUM FACILITIES FOR TREATMENT OF OUT-PATIENTS— The minimum facilities required for every psychiatric nursing home for treatment of patients mentioned in Section 14 of the Act shall be as follows:
  1. Staff for 10-bedded hospital or nursing home—
    - (a) One full-time qualified Psychiatrist.
    - (b) One Mental Health Professionals Assistant (clinical) Psychologist or Psychiatric Social Worker.
    - (c) Staff Nurses in the nurse : patient ratio of 1 : 3.
    - (d) Attenders in the attender : patient ratio of 1 : 5.
  2. Physical features— Adequate floor space depending on the number of beds shall be provided.
  3. Support/facilities— The minimum support/facilities shall be as under:
    - (a) Provision for emergency care for out-patients and for handling medical emergencies for out-patients and in-patients;
    - (b) A well-equipped ECT facility;
    - (c) Psycho-diagnostic facilities;
    - (d) Provision for recreational/rehabilitation activities;
    - (e) Facilities for regular out-patient care.

Section 6(2) of the MHA 1987 has far reaching implications. This provision explicitly excludes government facilities from the requirement of licensing, thereby ousting the jurisdiction of the licensing authority and rendering Sections 7, 8, 9, 11 and 12 inoperative. The situation with regard to Sections 10, 13 and 14 appears to be rather ambiguous and may be open to more than one interpretation. Applying the principle of harmonious construction, however, the jurisdiction of these sections also seem to be ousted in respect to government mental health institutions. The jurisdiction of Section 82 is similarly ousted.

The scope of the SMHR 1990, Rules 20 and 22 which lay down qualitative/quantitative minimum standards, has been also curtailed with regard to government hospitals and has been limited only to such facilities in the private sector.

Certain issues arise from the foregoing:

1. Should there be uniform standards at all in respect of mental hospital/nursing homes in the private/government sector? It needs to be noted here, that while most government mental hospitals cater mainly to 'chronic', long-stay patients, private sector psychiatric nursing homes generally attract acute, short-stay cases. Staff requirements are therefore different. In fact, it might be more rational to prescribe staffing standards according to the type of service provided: 'acute' (short-stay) or 'chronic' (long-stay).
2. Considering that most government mental hospitals face severe staff shortages, particularly with regard to psychiatrists, clinical psychologists and psychiatric nurses, and that some do not even have a single full-time psychiatrist on their rolls, what will be the results if they are treated at par with private sector psychiatric facilities in this regard? All government mental hospitals will have to be immediately closed down or drastically downsized. In this context, it also needs to be noted that government jobs, more so in mental hospitals, no longer attract young psychiatrists, as is vividly illustrated by the ground realities even in well-established academic institutions. Perhaps, this factor weighed the most with those, including leading mental health professionals, who framed the MHA 1987.
3. Are the 'minimum facilities' prescribed by the SMHR, Rule 22 in respect of staff, realistic or even required, assuming that enough members of such mental health professionals were available in the first place? The Armed Forces Medical Services, which have the best organised psychiatric facilities in India, lay down a scale of one psychiatrist for 25 beds.

This leaves us with the following options, which need to be debated in the appropriate forum, in order to arrive at a consensus.

The first option is that Section 6(2) of the MHA 1987 should either be deleted through an amendment to the original Act, or struck down by judicial pronouncement, thereby bringing government mental health facilities under the purview of the provisions at par with the private psychiatric institutions.<sup>4</sup>

The second option is that Section 6(2) of the MHA 1987 gives government mental hospitals a grace period of five years to upgrade themselves to the level prescribed in the SMHR (Rule 22), with the provision that those unable to meet this deadline should close down. This may, in fact, prove to be a blessing in disguise, given the worldwide consensus on deinstitutionalisation and the shift to community-based mental healthcare.<sup>5</sup>

The third possibility is to allow the status quo to continue, but modify the staff standards prescribed in the SMHR (Rule 22). This may be a good option, but the state also needs to take concurrent action in other directions as well, as proposed above.

### ***Restrictive/unreasonable licensing requirements***

Mental health services as listed in Section 4 of the MHA 1987, include psychiatric hospitals and psychiatric nursing homes, observation wards, day care centres, in-patient treatment in general hospitals, ambulatory treatment facilities and convalescent homes and half-way homes for mentally ill persons. Of these, the psychiatric hospitals and nursing homes are required to get a license from the appropriate state mental health authorities. Some of the related issues, which need deliberation include:

#### *Definition of psychiatric hospital/nursing home*

Section 2(q) of the MHA defines a psychiatric hospital/nursing home as a hospital, or as the case may be, a nursing home established or maintained by the government or any other person for the treatment and care of mentally ill persons and includes a convalescent home established or maintained by the government or any other person for such mentally ill persons, but does not include any general hospital or general nursing home established or maintained by the government which provides also psychiatric services.

The Act is thus, *prima facie*, discriminatory towards private psychiatric hospital/nursing homes, since no such licensing requirement has been spelt out for psychiatric hospitals and nursing homes maintained by the state. More so, some of the requirements like those of clinical psychologists and psychiatric social workers are very difficult or sometimes even impossible to meet, since there are not enough qualified personnel available. Only two institutions in the country have facilities for training for these two categories of mental health professionals.

#### *Definition of a psychiatrist*

If one goes strictly by the definition of the psychiatrist as given in Section 2(r) of the Act, many 'qualified' psychiatrists in India would not pass muster, since the degrees of many of them are not recognised by the Medical Council of India. The definition reads as under:

"Psychiatrist means a medical practitioner possessing a postgraduate degree or diploma in psychiatry, recognised by the Medical Council of India, constituted under Indian Medical Council Act 1856 (102 of 1956), and includes, in relation to any State, any medical officer who, having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act".

A psychiatrist with a degree, which is not recognised by the Medical Council of India, might need a declaration from the respective state government. The Act also empowers state governments to designate any medical officer a psychiatrist, based on his/her knowledge and experience in psychiatry. The clause has the possibility of misuse, since the precise nature of 'knowledge' and the duration of 'experience' in the speciality have not been specified in the definition. There is a possibility that in the absence of suitable norms, the state governments may declare medical officers with inadequate knowledge, and insufficient experience as psychiatrists. The aforesaid provision evidently suffers from the vice of excessive, unguided and uncontrolled delegation of power.

#### *Minimum facilities for psychiatric hospitals and nursing homes*

The issues relating to the minimum facilities required for every psychiatric hospital or nursing home for the treatment of patients as per the Rule 22 of SMHR 1990, have been already discussed with regard to their discriminatory scope and the limitations imposed by the shortage of mental



health manpower in the country. Some of the norms appear difficult or even impossible to achieve in the foreseeable future, especially in the case of qualified clinical psychologists and psychiatric social workers. It may not be justified, therefore, to deny a license to the applicant for a psychiatric hospital/nursing home, for not being able to employ a qualified clinical psychologist/psychiatric social worker for his/her establishment. Finding trained people to man these posts has been a major problem for the large majority of government-run psychiatric institutions and even for well-established postgraduate teaching departments of psychiatry.

This should not be, however, construed to mean that there is no requirement for these professionals in the psychiatric hospitals/nursing homes. They are definitely needed. Especially for administering psycho-social interventions and for running rehabilitation programmes. The solution lies in identifying and developing potential training centres. Postgraduate psychiatry departments in various medical institutions and mental hospitals should be strengthened to enable them to provide the relevant training facilities therein. The central and the state governments alike need to take major initiatives in this regard on a priority basis.

Before turning away from the topic, one last issue merits attention. While the Act has provided for the definition of a psychiatrist, the clinical psychologist and psychiatric social worker have not been defined. In the absence of a precise definition, a large number of self-styled clinical psychologists, without the training/requisite qualification are practising in an unregulated manner, often doing great harm to unsuspecting patients. A solution to this problem is urgently required.

#### *Psychiatric units in private general hospitals/nursing homes*

The issue of treating General Hospital Psychiatry Units (GHPUs) functioning in the private sector at par with private psychiatric hospitals/nursing homes for the purpose of the regulatory provisions of the Act and the Rules is another issue, which needs careful deliberation. The issue of their licensing as psychiatric hospital/nursing homes while excluding similarly placed government-run institutions has been already discussed in the context of the Supreme Court order on the subject.

The creation of GHPUs marked the beginning of major revolutionary reforms in the history of psychiatric practice. These units have played a significant role in reducing stigma associated with psychiatric disorders and in the identification of psychiatric morbidity occurring in general hospital practice/primary care settings. Early diagnosis and treatment of common anxiety and depressive disorders, which are quite disabling and frequently encountered in general medical care, has been made possible only because of this development.

Against this backdrop, it becomes difficult to comprehend why psychiatric units in a general hospital setting should be dealt differently from other medical and surgical disciplines and why there should be a separate licensing requirement for them. Does this not constitute stepmotherly treatment? There are, however, some important differences which cannot be wished away. A number of psychiatric patients, especially those suffering from psychotic disorders and severe depression, are often brought in by apparently well-meaning family members against their wishes, since the patient is not even aware of his/her illness. The possibility of abuse is inherent in this scenario, as evidenced by the Anamika Chawla case (refer to Appendix F for the relevant decision of the Hon'ble Supreme Court). Cases of violation of rights of psychiatric patients are not uncommon. In this background, it may be justified to have a provision for the licensing of private sector GHPUs, but through a less elaborate procedure.

### ***The gender perspective***

Amongst other concerns voiced in relation to the MHA, a singular one relates to the impact of the law on women. It is this concern, which caused the National Commission for Women to take up the issue and require a concept note to be prepared on the question. In what follows, we reproduce the concept note along with the dialogue emanating around it. This is being done to strengthen our case for greater communication between law and the mental health sciences.

**Amita Dhandra:** At the outset, it may be pertinent to enquire as to why an exercise to modify a statute which impacts on both men and women equally is being undertaken from a gender perspective. The fact that the enquiry has been initiated by the National Commission for Women which has been expressly mandated to promote and protect the rights of women may be a response, but is a far from adequate explanation. Various reasons can be put forth as to why the MHA needs to be examined from a gender perspective. Epidemiological studies the world over have found that women— more than men are sufferers of mental illness—a trend endorsed by the epidemiological surveys carried out in India.<sup>6</sup> Figures show that a significant number of the population with mental illness are women. If the mental illness status is more analytically examined, it is found that women to greater degree than men, are marginalised by it. Inmates of mental hospitals who cannot go back home because their families do not want them back and they have nowhere else to go, illustrate this point. A majority of these are women. Women, more than men, are found to be languishing in these institutions without any communication or contact with the outside world.

Finally, women are not just bearers of mental illness, they are also primary caregivers of people with mental illness. Hence, they are on both sides of the divide. This dual placement of women should ensure that a critical examination of the MHA would be undertaken from both the perspective of society and that of the person with mental illness. It is in this background that the following changes are being suggested in the MHA.

### **Greater Diversification of Mental Health Services**

Even as women are amongst the major sufferers of mental illnesses, the illnesses they are afflicted with are not the major concern of mental health services. It is the severe mental disorders that the NMHP places on its agenda. These disorders afflict 13.10 men and 11.50 of women per 1,000 of the adult population; whereas common mental disorders are found to afflict 68.00 men and 103.50 of women per 1,000 of the adult population.<sup>6</sup>

In tune with the policy, the law also primarily concerns itself with those persons with mental illnesses who are 'dangerous and unfit to be at large'. The MHA does not speak of the need for care and treatment of such people, except by ordering admission of the afflicted person in a psychiatric hospital. Insofar as women are more often afflicted with mental disorders which need care and treatment but not hospitalisation, the law either causes them to be victims of needless confinement or totally abandons them. It is this absolutist position of the statute which becomes highly problematic for women with mental disorders.

A person with a mental disorder can obtain treatment under the MHA in two kinds of settings: (a) the family, accessing out-patient services, and (b) hospitalisation. The procedure for hospitalisation changes depending upon the period for which such hospitalisation is required. People with mental disorders, who need care and treatment, but do not have family support—the condition of a large number of women—are not on the agenda of the statute.

Therefore, one of the major changes required in the Act relates to diversification of services. There is a necessity for creating services mid-way between the family and the hospital. This

diversification is needed both by the women who need the care and treatment and by those who have to provide it.

At present, the only section of the MHA which recognises the existence of a wide range of services is the explanation to Section 3. Thus, mental health services are defined to include observation wards, day care centres, in-patient treatment in general hospitals, ambulatory treatment facilities, convalescent homes and half-way homes for mentally ill persons. The only reason for including this definition in the statute is to bring this range of services within the supervision and control of the central mental health authority to be set up by the central government under Section 3 of the Act.

As it stands, this mental health authority was not established for very long. Even after it was established, it remained a passive and inactive body. The authority has in no way attempted to promote the integration of persons with mental illness within society by liaising between the institutional and less restrictive services. It has also not in any way attempted to promote the creation of such services. A desire to keep less restrictive services away from the wrangles of bureaucratisation and formalism could be one possible explanation for not providing procedures routing people to less restrictive services. The net result of this omission, however, is that all those persons who reach psychiatric care through legal functionaries, such as magistrates, are only allowed to obtain access to institutional care.<sup>7</sup> This is because they have the power to either admit or not admit a person with mental illness into a psychiatric hospital or nursing home.<sup>8</sup> The need for less restrictive services, even if felt, cannot be addressed by the magistracy nor are there any procedures by which they can refer this function to any other agency.

This omission of the statute needs to be addressed by placing obligations on the central and state mental health authorities, psychiatric institutions and the magistracy. In order to ensure that the authorities are in place, time limits must be prescribed within Sections 3 and 4 of the MHA, which lay down the period within which the central and state governments shall establish the central and state mental health authorities, respectively.

A new sub-section should be introduced whereby these authorities are obliged to liaise with magistrates and superintendents of psychiatric hospitals, in order to:

- provide treatment to persons with mental illness in the least restrictive environment, and
- interact with welfare agencies within civil society to assist the rehabilitation and integration of persons with mental illness.

The authorities should be further obliged to make national, regional and local plans for the achievement of these goals and also issue periodic public reports of the activities undertaken by them. The plans devised by the mental health authorities should be finalised in consultation with survivor groups, disability organisations and mental health professionals.

Undeniably, a legal recognition of less restrictive services would not create them. A legal recognition, however, would provide the impetus for the creation of such services. Further, this recognition would not just be restricted to services but would also have to extend to personnel. As it stands, the MHA only recognises the psychiatrist.<sup>9</sup> A mental health team, however, also includes the clinical psychologist, the psychiatric social worker, the psychiatric nurse and counsellors. The Act, however, neither recognises these other members nor spells out their functions. Thus, it needs to be amended to include within its aegis a larger range of mental health services. Statutory recognition also needs to be accorded to all members of the mental health team. In Section 2 of the MHA, the definition of clinical psychologist, psychiatric nurse and psychiatric social worker should also be included.

**D.S. Goel:** Provision for 'less restrictive' services, such as psychiatric out-patient treatment exists not only in the explanation of Section 3 of the MHA 1987, but also in Section 14. There is no requirement of a magisterial order for availing such services by a patient willing to do so herself or under the care of her relations. The creation of such services within the community falls under the domain of the executive and, beyond a limit, such facilities cannot be created through legal procedures. A major augmentation of facilities in this area is contemplated during the Tenth Five Year Plan.

**Amita Dhanda:** It is true that a magisterial order is not required to access these services. However, the question is of making these services available to inmates of mental hospitals who no longer need hospitalisation, but cannot also be discharged into society.

The change from voluntary to involuntary status should be made impermissible. Section 18(3) of the MHA allows the status of a voluntary patient to be changed to an involuntary one. The basic difference between a voluntary and involuntary patient is that the former has been granted the choice to both start and stop treatment. A voluntary patient has to be discharged by the superintendent-in-charge of the hospital or nursing home within 24 hours of the request for such discharge. The involuntary patient has no such choice. She will be discharged from the hospital only when the superintendent considers her fit for the same. Thus, this provision robs the patient of her identity and denies her a role in the healing process. It is both anti-libertarian and anti-therapy. If a patient in a treatment setting needs to continue treatment, a good doctor should be able to persuade her to do so.

The coercive retention of the patient in the institution both torpedoes this dialogue as well as undermines the bargaining position of the patient with the doctor. Viewed from a gender perspective, the psychiatrists' profile in India is predominantly male. Studies show that psychiatrists approach women with assumptions about female mentality that conditions what they see, and influence how they respond. When considering men and women, for instance, clinicians tend to maintain parallel distinctions in their concepts of what is behaviourally healthy or pathological. A healthy woman is seen as having traits differing from those of mentally healthy men; or indeed, of healthy human beings. It has also been found that male psychiatrists identify more easily with males and may therefore tend to accept the perceptions of the husband, father or policeman seeking a woman's commitment and either ignore or be less sensitive to the woman's version of the facts. This legal provision, thus, would only further skew the balance against the female patient. The deletion of Section 18(3) of the Act is therefore strongly recommended.

**D.S. Goel:** There is a need for safeguards to prevent misuse, rather than for the deletion of Section 18(3) of the Act, which serves a useful role in the case of patients rendered incapable to exercising their own discretion/judgment as a result of mental illness. The composition of the Board prescribed in this section needs to be reviewed/revised in the interest of all patients not merely female ones.

**Amita Dhanda:** This seems to be a case where we have to agree to disagree.

Section 40 of the MHA allows for discharge if the psychiatrist in charge of the mental hospital on the recommendation of two medical practitioners of whom one shall preferably be a psychiatrist decides that a person no longer requires in-patient treatment. Discharge is also permissible if a friend or relative offers to take the patient upon executing a bond of safe custody.<sup>10</sup> A person with mental illness can seek discharge on the ground that she has recovered from mental illness. Such application has to be supported with a certificate from the medical officer-in-charge of the psychiatric hospital, or a psychiatrist.<sup>11</sup> Reports on the discharge practices of mental hospitals

have, however, shown that women mental patients even if cured are not discharged unless a friend or relative comes to receive them in custody, or protection is available to escort them home.<sup>12</sup> As family abandonment is a common phenomenon and escort services are meagre, a large number of women fit to be discharged continue to reside in mental hospitals. A legal recognition to the social welfare and nursing services spoken of earlier, would allow for these women to be discharged even in the absence of a friend or relative.

A new sub-section needs to be incorporated within Section 43 of the MHA, which allows a person to be discharged under the supervision of a psychiatric nurse or social worker. The discharge provisions also need to create a procedure whereby a person can be discharged from more to a less restrictive service. Illustratively, from a psychiatric hospital to a half-way home.

**D.S. Goel:** There is no bar in Section 43, as it stands, for such discharge (under the supervision of a psychiatric nurse or social worker) if the patient requests for the same.

**Amita Dhanda:** The distinction is between a bar and permission, and when it comes to the law, personnel do not act without express permission.

Admission into mental hospital results in not just deprivation of liberty or provision of treatment. There are a number of civil rights consequences of this procedure. A person with mental illness could be deprived of the right to contract, to get married or stay married, to dispose of property or to hold public office. Deprivation does not occur automatically upon institutionalisation. Such institutionalisation, however, operates as primary evidence of the justification for such disqualification. In the case of women, examination of case law in the matrimonial context has shown that institutionalisation is often undertaken as a mode of getting rid of an inconvenient wife. Out of 62 appellate decisions surveyed from 1950 to 1999, 59 petitions were filed against women.<sup>13</sup> Only in three cases did women seek legal relief. Considering their low social and economic status, the over-representation of women as respondents in all divorce cases can be hypothesised. However, their disproportionate presence in this arena does merit special examination.<sup>14</sup>

This phenomenon can be partially explained by the fact that role model deviations, such as not knowing how to work,<sup>15</sup> failing to consummate the marriage,<sup>16</sup> talking freely with strangers,<sup>17</sup> crying in front of guests,<sup>18</sup> and the rude treatment of relatives,<sup>19</sup> have been offered as manifestations of mental disorders. In some cases, such allegations have been made for obtaining relief from original courts. In some cases, original courts have granted divorce merely on the affidavit of the husband alleging unsoundness of mind.<sup>21</sup>

A number of cases reveal efforts to create medical evidence for the purposes of litigation. Another mechanism of fabricating such evidence is to seek the respondent's commitment in a mental hospital and to allege that the respondent was suffering from a mental disorder.<sup>20</sup> The case history of a psychiatric patient is put together with information supplied by a relative. The advantage of this practice has been taken in order to include facts, which would demonstrate both the length and seriousness of the illness.<sup>21</sup>

The linkage between the law relating to mental hospitals and the civil rights law is especially required, because the law relating to institutionalisation has been greatly simplified by the MHA. It is, therefore, suggested that an express disclaimer be incorporated in the Act, which states that the mental hospitalisation shall in no way be proof of the patient's capacity to exercise her civil rights. The denial of civil rights can be ordered only subsequent to a separate judicial determination. To the same end, a provision ensuring the confidentiality of medical records needs to be included.

**D.S. Goel:** These apprehensions are not related to the legislative intent/scope of the MHA and appear to be driven by a worst case scenario mindset. Reasonable protection against possible abuse is usually incorporated in the relevant statute itself. The fact of institutionalisation alone will not be accepted by any court as the sole basis for an adverse verdict, and the decision is, or ought to be, based on evaluation of all relevant inputs (of which hospitalisation is one). There is, however, a need to sensitise the judiciary to this issue. There is no justification for an 'express disclaimer' which will be, in fact, bad law, as it will exclude a relevant input from the process of arriving at a reasoned judgment.

**Amita Dhanda:** Case law citations where evidence of institutionalisation has resulted in divorces being granted can be provided. Further, the disclaimer has been recommended in the UN Principles for Protection of Persons with Mental Disorders.

In the light of the misuse documented above, the procedure of medical admission needs a re-examination. Section 19 allows a relative or friend of a person with mental illness to seek her admission in a psychiatric hospital or nursing home supported by two medical certificates, which certify the aforesaid need for in-patient treatment. In the event, the medical officer-in-charge of the psychiatric hospital considers it proper to do so, he can allow admission of the person without the certificates, provided two medical practitioners of the hospital endorse the need for such hospitalisation. On a positive diagnosis being given, institutionalisation can be undertaken. Such hospitalisation can be questioned by the person hospitalised only by filing an application before a magistrate, a procedure that is far from easy to undertake for a person within a hospital.

The inadequacies of this procedure can be appreciated if the facts of *Anamika Chawla vs Metropolitan Magistrate* are kept in mind. In this case, the alleged mentally ill person and her family were not in agreement on her state of mind.<sup>22</sup> The family, with the help of two verbatim medical certificates, sought a magisterial reception order to compulsorily commit Anamika into a psychiatric nursing home. Anamika was able to escape the reception order and have it initially stayed and subsequently quashed by the apex court,<sup>23</sup> a procedure, which may not have been open to her if the institutionalisation was effected through medicalised procedures.

Hence, it is suggested that even if this section is to be retained, safeguards more potent than magisterial appeal need to be incorporated. For example, all medicalised admissions should be subject to compulsory review by either the State Mental Health Authority or the State Human Rights Commission or the local magistrate.

**D.S. Goel:** A friend or a relation (including the wife's parents or brother/sister) can also move the court under Section 19(3), and the scope of 'friend' is broad enough to include even NGOs. Anamika Chawla's case was a gross, and hopefully rare, aberration. There is no bar to a legal challenge to 'medicalised procedures' and the provision of visitors prescribed in Sections 37 and 38 guards against medical abuse of the hospitalisation process.

**Amita Dhanda:** Diversification of mental health services would reduce the reliance on psychiatric hospitalisation; it would not however eliminate it. Safeguards, therefore, need to be statutorily introduced to ensure that psychiatric hospitals and nursing homes are centres of treatment and not houses of custody. Simplified procedures can facilitate access to treatment; they cannot, in the absence of adequate resource allocation for mental health services, provide it. Both official and unofficial reports on the conditions of mental hospitals have testified towards the severe lack of resources, abysmal living conditions and non-existent treatment. To usher in a therapeutic regime in psychiatric hospitals, the colonial reticence to provide adequate funds has to be overcome.

Section 8(b) of the MHA requires minimum treatment facilities to be available in private

psychiatric institutions. The statute makes no such express declaration with regard to public psychiatric hospitals. Section 10 of the MHA only provides that psychiatric institutions have to operate in accordance with the rules prescribed for them. It does not provide that the rules with regard to living and treatment conditions of psychiatric hospitals and nursing homes shall be the same for both public and private institutions.

Public psychiatric institutions would be accessed by a large number of poor people with mental illness. This population is once again more female than male. An express provision guaranteeing standards would enhance the quality of the treatment facilities available for these marginalised groups. The Supreme Court of India, in a number of public interest actions relating to mental hospitals, has laid down that minimum treatment condition and an adequate living environment is a right guaranteed to persons with mental illness under Article 21 of the Indian Constitution. The statutory provision suggested above only furthers the constitutional mandate for persons with mental illness. Section 10 of the MHA should be amended accordingly.

**D.S. Goel:** This pertains to the domain of the executive and the pernicious tendency to abdicate the same in favour of judicial 'activism' needs to be halted. In any event, the NHRC as well as the judiciary have already taken action in the matter in response to public interest litigations and even on the basis of media reports. Inadequacies in the realm of mental health services are part of a wider picture of grossly inadequate/sub-standard health services in the government sector, and are related to the paucity of resources, an unsustainable level of population and the quality of governance in its widest sense. Cosmetic changes in the MHA will not automatically result in qualitative improvements.

**Amita Dhandra:** The MHA accorded recognition to the rights of persons with mental illness by incorporating a human rights chapter within it. Unfortunately, the chapter does no more than make a symbolic acknowledgement to the human rights of persons with mental illness. Section 81(2) of the MHA contains the procedure for sanctioning therapeutic and non-therapeutic research. This section requires that whenever a mentally ill person is able to give consent for therapeutic or non-therapeutic research, such research is to be conducted only with his/her consent. Where the patient is unable to give such consent, the research, whether or not for the benefit of the mentally ill person, may be carried out with the consent of her parent or guardian. This procedure does not make a distinction between experimental and therapeutic research. It has been contended that there is a certain degree of experimentation inherent in clinical practice. Even if this contention is accepted, the distinction between experimental and therapeutic research cannot be argued out of existence, especially when the mentally ill person is exposed to greater risk in experimental research and the benefit to society is still within the realm of speculation.

A total embargo on therapeutic research could be contended to be a discrimination against the mentally ill as a class, by denying them the fruit of new knowledge. At the same time, an unregulated sanctioning procedure would reduce persons with mental illness to guinea pigs in the research process. A continual balance of the benefit to society and the harm to the mentally ill person is therefore required. By permitting such research merely on the written consent of the guardian, the MHA fails to introduce, either substantively or procedurally, any balancing considerations.

It can be contended that by introducing the provision, the MHA has subjected to at least some regulation, an activity that is totally within the discretion of the medical authorities. This view, however, fails to appreciate the fact that once a medical practice is legislatively regulated, it is not just regulated, but also empowers. Thus, Section 81 of the MHA not only requires that the consent of a guardian be obtained before a mentally ill person is used as a subject of experimental research,

it also authorises a mental health professional to conduct such research subject to such consent. For women with mental illness, this provision could be utilised for performing hysterectomies and sterilisation operations. It is important to ensure that institutions do not utilise these procedures as devices of management and control.

The statute should, therefore, expressly prohibit the use of hysterectomy and sterilisation, unless required for medical reasons. The section needs to be amended to distinguish between therapeutic and non-therapeutic research. Further, to establish, minimal safeguards to protect persons with mental illness unable to consent to such research, an ethics committee should be setup to regulate permission for such research. A definition of informed consent, along with the procedure by which it could be obtained, needs to be provided as a minimal safeguard for persons who are required to give consent.

Clause 81 of the Mental Health Bill (2<sup>nd</sup> Reading) prohibited the use of mechanical restraint and solitary confinement. The provision to the section permitted their use if a medical officer recorded his reasons in writing. The committee found the use of such practices objectionable and the safeguard of recording reasons insufficient. However, instead of recommending the deletion of the provision, it recommended the deletion of the prohibition. Thus inadvertently, instead of absolute prohibition, absolute permission has resulted. This provision needs to be reintroduced.

Section 81(3) of the MHA provides that no letters or other communications sent by, or to a mentally ill person under treatment, shall be intercepted, detained or destroyed. This right, however, is not provided in absolute terms. The sub-section permits the interception of communications prejudicial to the treatment of mentally ill persons. This could include objections by persons with mental illness against their institutionalisation, or against the care and treatment given to them within the institutions. An approach consonant with human rights would not allow for such an interpretation, but the marginalised status of persons with mental illness raises fears of the same. It, therefore, seems appropriate to expressly prescribe procedures for forwarding petitions by persons with mental illness to public authorities, questioning their institutionalisation or the conditions at the institutions shall not be intercepted. Again, the reports of sexual abuse and exploitation emerging from mental hospitals show the extent to which women in institutions are in need of this safeguard.<sup>20</sup>

**D.S. Goel:** The scope of Section 81 is wide enough to cover all such human rights and their violations. There is no need to limit the scope of this provision which cannot be termed merely 'symbolic' or ornamental. The ICMR guidelines for regulating clinical research already exist. The concept of 'informed consent' is well defined in law and practice, and no doctor is going to risk prosecution under the Consumer Protection Act 1985 by violating the same. Section 81(1) prohibits unwarranted mechanical restraints and solitary confinement by implication. Section 81(3) clearly specifies the types of communications which may be intercepted and a petition against illegal detention or ill-treatment cannot be lawfully held back by the medical officer-in-charge of the psychiatric hospital/nursing home.

**Amita Dhandia:** Section 91 of the MHA grants to a person with mental illness the right to be represented by a legal practitioner in any proceeding before a magistrate or a district court. The above discussion on the liberalised procedures of admission, experimental research, solitary confinement and freedom of communication shows that most persons with mental illness need legal representation, not just when they reach the magistrate or district court, but to be able to access the magistrate or district court in the first place. It is, therefore, essential that legal aid and representation should not be only confined to proceedings before a district court or a magistrate. Instead, such services should be available to any person with mental illness who wishes to



approach the judiciary or human rights authorities. The section should be amended accordingly.

**D.S. Goel:** The provision of legal aid prior to initiation of legal proceedings prescribed under the Act cannot be made part of the statute itself. Such legal aid can be accessed through the existing district legal aid committees.

**Amita Dhanda:** This can be done, but ordinarily a special statute dealing with a specific group is a better place to secure the rights of that group than the general law of the land.

## Conclusion

This narrative is an attempt at outlining an agenda for law and mental health, whereby common concerns can override the variant perspectives to arrive at a mutual understanding. It will, hopefully, help initiate a dialogue between the various players, abjuring adversarial postures. Considerations of equity and ethics, rather than partisan self-interest should prevail. In the interim, many of the difficulties of the statute can be addressed through well-thought out amendments to the SMHR. The expert committee constituted by the central government has already deliberated upon some of the issues involved and a workable solution may emerge. In the meanwhile, mental health professionals can play a significant role through organised efforts aimed at sensitising the police and the judiciary to mental health issues.<sup>24</sup>

## References and Further Notes

1. A brief account of the chronology of mental health legislation in India is at Appendix J.
2. P. Rathinam vs Union of India (1994) 3 SCC 648. See also Maruti Shripati Dubal vs State of Maharashtra 1987 CR LJ 743.
3. Gian Kaur vs State of Punjab (1996) 2 SCC 648.
4. The feasibility/possibility of the various government-run mental health facilities reaching the standards as mentioned in the SMHR is doubtful, given the paucity of available manpower in India and the general reluctance on the part of the mental health professionals, especially psychiatrists, to join the state mental hospitals as mentioned earlier. A solution, in such a situation, is to depute in-service medical officers for the DPM course, with a bond to serve the state for at least five years thereafter. Another, more draconian step could be to compulsorily post all newly qualifying psychiatrists to these psychiatric hospitals for some specified period. Such a radical policy change will, however, evoke strong protests and legal challenges.
5. The option should be viewed in the background whether it would be possible for the state governments to upgrade these institutions within the given time-frame. In the event of closure, will there be alternative facilities in the community to take care of the long-stay and other patients discharged from these institutions? This requires serious thought, as we presently do not have adequate alternative community-based facilities. Such facilities need to be developed even otherwise, in addition to the improvement of the existing mental hospitals, as the process of deinstitutionalisation cannot be deferred indefinitely. The future lies in the realm of community-based mental healthcare.
6. Bhargavi Dawar. *Mental Health of Indian Women*. New Delhi: Sage Publications, 1999:43, where averaging the prevalence rate of various epidemiological studies she concludes the prevalence to be 10.48% for men and 14.45% for women.
7. Amita Dhanda. 'Non-communication between Law and Psychiatry: A focus on the victims of this cold war. In: Upendra Baxi, ed. *Law and Poverty: Critical Essays*, N.M. Tripathi Private Limited, 1988.
8. Section 22(7) of the MHA.
9. Section 2 (R) of the MHA.
10. Sections 41 and 42 of the MHA.
11. Section 43 of the MHA.

12. Report of the Supreme Court Commission on Mentally Ill in the Jails of West Bengal 80-82 (1993) (Appendix I).
13. Col. 2 of Table in Appendix 4.1 in Amita Dhanda. *Legal Order and Mental Disorder*. New Delhi: Sage Publications, 2000;210.
14. Col.7 of Table in Appendix 4.1 in Amita Dhanda. *Legal Order and Mental Disorder*, New Delhi: Sage Publications, 2000; 210.
15. Jagdish Prasad Sharma vs Shashi Bala FAO 179/75 decided on 5 August 1977, Delhi.
16. Anima vs Mohan Roy AIR 1969 Cal 304.
17. Vijay Kapur vs Neelam Kapur 1982(2) SMC 279.
18. Pronab Kumar vs Krishna AIR 1975 Cal 109.
19. Meena Deshpande vs Prakash Deshpande, AIR 1983 Bom 409; Asha Rani vs Amratlal AIR 1977 P&H 28; Durga Bai vs Kedarmal 1980 HLR 166.
20. Santhosh Negi vs Nandan Negi 1980 HLR 528.
21. Mohanjit Singh vs Ravinder Kaur 1985(2) HLR 490.
22. Writ Petition (Crl) No. 432 of 1995.
23. For a more detailed analysis of the Anamika Chawla case, see Amita Dhanda, Psychologising dissent: psychiatric labelling and social control. In: Dhanda A, Parasher A, eds. *Engendering Law Essays in Honour of Lotika Sarkar*. Lucknow: Easter Book Company, 1999. A copy of the Hon'ble Supreme Court order in the case is reproduced as Appendix F.
24. The proceedings of a workshop on the subject held in September 2002 are reproduced at Appendix G.





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**Section III**

**Research and Training**

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## Chapter 21

# Mental Health-Related Research: The Need for New Directions

*Parmanand Kulhara • Nitin Gupta*

Research in psychiatry has made tremendous advances over the last century. There is emerging evidence regarding the magnitude of the burden of morbidity and disability resulting from mental illness. There is also better understanding of the aetiology of mental disorders and new cost-effective treatment modalities have become available.<sup>1</sup> Psychiatry has shown a paradigm shift from the psychodynamic/psychological perspective to the bio-psychosocial (or predominantly biological) perspective. However, this paradigm shift can be attributed to a great amount of research from the West. Notwithstanding the above statement, mental health-related research has been of paramount importance to Indian psychiatrists. The last 50 years have seen considerable research activity in various aspects of mental health. An attempt will be made to highlight the areas/issues of research till date in various mental health specialities and delineate areas for future research.

### Schizophrenia and Related Psychotic Disorders

**Research till date:** The contribution of Indian researchers in this area is noteworthy. Since the sixties, epidemiological studies have been carried out from different parts of India. The issue of diagnosis and classification has been addressed, especially from Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh. The existence of acute and transient psychotic disorders as being distinct from schizophrenia was the outcome of such research. Follow-up and phenomenological studies have influenced the understanding of the course and outcome of schizophrenia across the world.<sup>2</sup> Seminal work in relation to community care and social aspects of schizophrenia is also available.<sup>3</sup> Biological studies gained impetus in the eighties and have continued thereafter.<sup>4</sup> However, the focus till date has been mainly on the immunological, biochemical and genetic aspects.

**Lacunae in research and need for the future:** Functional and structural neuroimaging studies in schizophrenia are sparse. Upcoming concepts, such as the quality of life (QoL), needs of caregivers, cost and quality assurance in relation to the illness and its treatment, are also areas for future research. Childhood onset and late onset schizophrenia, which are as yet not validated entities, are other areas requiring research input.

## Affective Disorders

**Research till date:** Apart from schizophrenia, affective disorders have been extensively studied. The aetiology of affective disorders has received considerable attention, both from the psycho-social and biological perspectives, the latter being more frequently researched. Studies on the biology of affective disorders have focused on biochemical, neurohormonal, electrophysiological and genetic aspects.<sup>5-7</sup> Socio-cultural issues (in relation to aetiology, presentation and management) have been addressed in detail and have contributed to the understanding of the similarity in the prevalence and manifestations of affective disorder, especially depression, worldwide.<sup>8</sup> Treatment modalities especially lithium and electro-convulsive therapy have received considerable attention.

**Lacunae in research and need for the future:** A striking aspect has been the predominance of studies in unipolar depression and a relative neglect of focus on bipolar disorders. Additionally, neuroimaging studies (and its correlates) are very few in number. Though socio-cultural issues have been addressed reasonably well, newer concepts, such as QoL, disability, quality assurance and newer modes of pharmacological therapies, have not been addressed in a sufficiently rigorous manner.

## Anxiety and Somatoform Disorders

**Research till date:** The disorder in this category that has received maximum attention is obsessive-compulsive disorder (OCD). Phenomenological studies on OCD have had a worldwide impact. Stress-related disorders (and related life events research) is the other group of disorders to have received some attention. The concept of somatisation in a cross-cultural perspective has additionally been addressed.<sup>9</sup>

**Lacunae in research and need for the future:** Other common anxiety disorders like Generalised Anxiety Disorder (GAD), panic disorder and phobic disorders require further research. Psycho-social and biological studies addressing this category are far and few. Cross-cultural variations, if any, related to the profile, treatment and outcome of these disorders, also need to be explored.

## Childhood Psychiatric Disorders

**Research till date:** Research in child psychiatry has come up in the last 30 years only. The main input has been in relation to the presentation (or clinical profile) of disorders, and also to the development of instruments to measure various aspects of child development and psychopathology. A few epidemiological studies are available. Noteworthy work on childhood disintegrative disorders, childhood affective disorders and childhood psychosis has been carried out.

**Lacunae in research and need for the future:** Input has been from a few centres across India. Issues related to the biology of childhood disorders, the natural course and outcome of these management strategies, etc., have not received much research attention. Despite cross-cultural variations in child psychology and pathology, culture-specific strategies addressing assessment and management are not available, leading to a near absence of specific, special or innovative management facilities for disordered children in India.

## Psychosexual Disorders

**Research till date:** The biggest contribution in this area has been the research on 'Dhat syndrome' that has led to its inclusion in the official classification systems.<sup>10</sup> Some studies on the profile and management of male sexual disorders are also available.

**Lacunae in research and need for the future:** There is a lack of epidemiological data and practically no focus or data available on the aspects of female sexual dysfunction, paraphilias, etc. Most of the studies are clinic-based, retrospective and descriptive.<sup>10</sup> Research is also scanty in relation to the management (especially pharmacological) guidelines for sexual disorders.

## Substance Abuse-Related Disorders

**Research till date:** Epidemiological studies from various parts of India have highlighted the prevalence of this problem. Clinic-based studies have been carried out with respect to the nosology, profile, aetiology, course and outcome, and management strategies. The major substances of focus have been alcohol, opioids and *Cannabis*.

**Lacunae in research and need for the future:** Despite considerable research, data on other common substances, for example, nicotine, benzodiazepines and volatile solvents, are sparse. Development of aetiological and treatment models on the basis of research is not the norm till date. The research focus on issues of audit, burden of care, QoL, etc., is still required.

## Consultation-Liaison Psychiatry

**Research till date:** Numerous studies have been carried out highlighting the prevalence of psychiatric disorders in medical-surgical out-patient and in-patient populations.<sup>11</sup> The focus of research has been on cardiovascular, gastrointestinal, gynaecological and oncology-related disorders.<sup>11,12</sup>

**Lacunae in research and need for the future:** Research on general hospital psychiatry has not been intensive and consistent. Although psychological morbidity has been identified, its bio-psychosocial correlates have not been addressed. This aspect needs to be focused on, so as to provide an impetus to the development of general hospital psychiatric units.

## Mental Health-Related Research: Where do We Stand?

To answer this question, the summary above needs to be looked at more closely. Although major specialities/areas of psychiatry have been dealt with, it does not imply that research is absent or neglected in other areas. On the contrary, research in other specialities is available. Unfortunately, it is not consistent and has, on most occasions, been unable to provide a focus/perspective to the concerned area/speciality. Important areas in the West, for example, women's mental health,<sup>12,13</sup> geriatric psychiatry, and psychopharmacology,<sup>1</sup> have not received the necessary attention from Indian researchers till date. This has contributed to the lack of development of speciality training and services across the country. Additionally, the seriousness of the issue of mental health has not percolated to the administration and policy makers. Regrettably, this is the current scenario, despite the WHO's focus on mental health activities.<sup>1</sup>

Another perspective to mental health-related research could be that researchers and research centres alike have not yet reached a focused bio-psychosocial approach, in terms of studying mental health and mental illnesses. Indian research lags behind in the field of biology due to the lack of resources and infrastructure.<sup>14</sup> Important worldwide health and economic issues such as QoL, disability, burden of care, pharmaco-economics and clinical governance are yet to receive comprehensive or rigorous assessment across various disorders.

It can be said that despite the availability of subjects and researchers, the disproportionate lack of funds, infrastructure and collaboration have led to a relative stunting of excellent research from India. The lack of translation of research data into clinical practice (or more commonly – policy decisions) has tended to retard the momentum and impetus to further research.



## Mental Health-Related Research: Where do we go from here?

India has always placed great emphasis on mental health.<sup>1,13</sup> In addition, Murthy has also emphasised on establishing greater credibility to India's cultural resources, such as spirituality, yoga, and meditation.<sup>13</sup> The important role of psychological and social factors should never be overlooked. For this, there is the ever-growing need to develop and standardise concepts and measures of mental health. This psycho-social approach, therefore, needs to be appropriately integrated with biological research.<sup>1,13</sup>

To enable better mental health-related research, the availability of basic resource and infrastructure needs to be improved. Second, there is a need for collaborative, multidisciplinary/multispeciality research, so as to integrate mental health with the mainstream of medicine.<sup>1</sup> Third, the national and international community alike should be made aware of the research carried out. One such step is the introduction of a section on international publications by Indian researchers in *The Indian Journal of Psychiatry*. Lastly, research should be focused and oriented towards evidence-based practice.<sup>6</sup> This will help in the clinical practice of private and non-private psychiatrists alike by providing a defence to possible malpractice suits/litigations by patients.

To conclude, psychiatric research in India has been growing steadily and is, in fact, a leader in certain areas. A more focused and pragmatic approach of our policy makers would go a long way in benefiting both the research and clinical practice of mental health.

## References

1. Wig NN. World Health Day 2001. *Indian Journal of Psychiatry* 2001;43:1-4.
2. Kulhara P. Transcultural variations in schizophrenia: some research issues. *Indian Journal of Psychiatry* 2001;43:99-111.
3. Wig NN. Schizophrenia: the Indian scene – Keynote address. In: Kulhara P, Avasthi A, Verma SK, eds. *Schizophrenia: the Indian Scene*. Chandigarh: Department of Psychiatry, PGIMER, 1997:5-16.
4. Trivedi JK, Srivastava S. Biological aspects of schizophrenia: appraisal of Indian research. In: Kulhara P, Avasthi A, Verma SK, eds. *Schizophrenia: the Indian Scene*. Chandigarh: Department of Psychiatry, PGIMER, 1997:66-84.
5. Venkoba Rao A. Aspects of depression: Bio-psycho-social-cultural interplay. In: Kulhara P, Avasthi A, Sharan P, eds. *Affective Disorders: the Indian Scene*. Chandigarh: Department of Psychiatry, PGIMER, 2000:1-7.
6. Trivedi JK. Neurobiology of affective disorders. In: A Kulhara P, Avasthi A, Sharan P, eds. *Affective Disorders: the Indian Scene*. Chandigarh: Department of Psychiatry, PGIMER, 2000:8-18.
7. Mohandas E, Dineshkumar MK. Affective disorders: structural, neurophysiological and genetic aspects. In: Kulhara P, Avasthi A, Sharan P, eds. *Affective Disorders: the Indian Scene*. Chandigarh: Department of Psychiatry, PGIMER, 2000:19-44.
8. Chakrabarti S. Sociocultural issues in affective disorders. In: Kulhara P, Avasthi A, Sharan P, eds. *Affective Disorders: the Indian Scene*. Chandigarh: Department of Psychiatry, PGIMER, 2000:53-77.
9. Chadda RK. Somatization: nosology to biology. *Indian Journal of Psychiatry* 2000;42:225-236.
10. Avasthi A, Nehra R. Sexual disorders. In: Srinivasamurthy R, ed. *Mental Health in India 1950-2000. Essays in Honour of Professor NN Wig*. Bangalore: People's Action for Mental Health, 2000:42-53.
11. Behere PB, Behere M. General hospital psychiatry in India. In: Srinivasamurthy R, ed. *Mental Health in India 1950-2000. Essays in Honour of Professor NN Wig*. Bangalore: People's Action for Mental Health, 2000:140-149.
12. Chandra PS. The interface between psychiatry and women's reproductive and sexual mental health. *Indian Journal of Psychiatry* 2001;43:295-305.
13. Murthy RS. Emerging aspects of psychiatry in India. *Indian Journal of Psychiatry* 1998;40:307-310.
14. Palaniappun V. Research in biological psychiatry in India. *Indian Journal of Psychiatry* 2002;44:3-8.

## Chapter 22

# Psychiatric Genetic Research in India

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Research into the genetic basis for human diseases has received substantial support in the West, presumably due to the promise of finding disease susceptibility genes. This promise has been fulfilled for a number of severe diseases that are fortunately rare. It is now feasible to provide genetic counselling for many such diseases. Efforts are also underway to understand the mechanism of pathogenesis, based on knowledge about the function of the relevant gene products. It is argued here that similar, sustained efforts are necessary in India, not only to foster a sound foundation for genetic research in the country, but also because findings from developed countries may not be directly applicable here.

The concept of *vansha* or family tree is extremely important in Indian culture. Family traditions and family histories are cherished and preserved universally. The genealogy of specific families is preserved with the *pandas* (priests and record keepers) of Varanasi and Haridwar, and Indian mythology is full of stories of valour and courage that run through the history of a family. Family traits seem to run through generations, and family honour assumes great importance. It is natural for Indians to believe that behavioural traits and by extension, behavioural illnesses, run through families. Mental illness was also well recognised and described in *Ayurveda*. Measures were described not only to treat mental illnesses but also to promote wellbeing. Thus, interest in genetics and mental illness runs high in India. Not surprisingly, there is a growing interest in human genetics in India with the progress of the human genome project.

Genetic diseases damage patients and their families in terms of health, economic and hidden costs due to disability, as well as obvious costs of medical care and lost work hours.<sup>1</sup> In Indian cities, congenital malformations and genetic disorders are important causes of morbidity and mortality. Hence, there is a widely felt need for more knowledge about genetics and for genetic counselling among patients. As part of a survey of psychiatrists' attitudes towards genetic counselling conducted by Venugopal et al.<sup>2</sup> respondents were asked for their opinions about the heritable nature and risk of inheritance of mental illnesses among patients and their relatives. Most psychiatrists (76%) felt that genetic counselling is feasible in practice, but 24% felt that this would be difficult, citing inadequate knowledge, illiteracy among patients and time constraints as hindrances. The paucity of reliable familial risk rates for even prevalent psychiatric disorders is another significant hurdle for genetic counselling services in the Indian population. Another hurdle is presented by the virtual absence of reliable laboratory services for testing for known mutations.

In the following sections, we have reviewed currently available information about these important issues. Epidemiological information is presented first; ongoing gene mapping efforts have also been summarised.

## **Early Studies**

One of the earliest research reports into the familial aspects of mental illness was a paper by Bagadia et al.<sup>3</sup> which discussed 'ecology and psychiatry'. Early in India, as elsewhere, genetic studies in dermatoglyphics<sup>4</sup> and the study of blood groups.<sup>5</sup> were popular. Still other authors wrote of genetic markers at a stage when this type of research was just beginning. Sethi et al. quoted a paper by Chatterjee and Basu which found sex chromosome abnormalities in five of 287 schizophrenic cases.<sup>6</sup> The authors proposed that the possession of an extra X chromosome increased susceptibility to schizophrenia.

## ***Mental Retardation (MR)***

A large multi-centre study reported on 1,314 children with MR who had no obvious environmental cause. The study, sponsored by the Indian Council of Medical Research (ICMR) was conducted at Bangalore, Mumbai, Delhi and Lucknow. It was designed to determine the extent and pattern of genetic causes of MR in different parts of India. Approximately, 41.3% children had mild, 25.3% moderate, 19.2% severe and 13.1% profound MR. Chromosomal anomalies were found in 23.7%, metabolic defects in 5.0% and an identifiable genetic syndrome in 11.6%. Of the remaining children (59.7%) no known genetic cause could be identified.<sup>7</sup> This ground-breaking study provided valuable demographic information about MR.

Consanguinity may be associated with MR in some Indian communities. Rao and Narayanan investigated a group of hospital-based patients with mental retardation and reported a high degree of parental consanguinity (30.3%).<sup>8</sup> Index cases with parental consanguinity showed a relatively high prevalence (more than one sibling affected) and more cases with metabolic defects. The disorder most often associated with consanguinity was found to be Down's syndrome (1:920 births in the Indian population).<sup>9</sup> Translocations leading to Down's syndrome were associated with younger rather than older mothers.<sup>9</sup>

Verma focused on the community burden of genetic disorders and called for a concerted effort in the area.<sup>1</sup> Due to the high birth rate in India, a very large number of infants with genetic disorders are born every year. This number was estimated at half a million children with malformations and 21,000 with Down's syndrome in his study. Verma recommended routine screening for hypothyroidism and glucose 6-phosphate dehydrogenase (G-6 PD) deficiency, while screening for amino acid and other metabolic disorders could be restricted to symptomatic infants.

Fragile X syndrome has been another area of interest for Indian scientists. Prevalence of fragile X syndrome in a sample of 1,111 subjects attending a genetics clinic in north India was found to be 1.8%, with no female cases.<sup>10</sup> Estimating the frequencies of fragile X syndrome and the variant, FRAXE syndrome, in an institutionalised population (n = 130) in New Delhi, Sharma et al. observed a frequency of 0.077 of the syndrome in the sample population.<sup>11</sup> The frequency of CGG/GCC repeat variation at FMR1 and FMR2, the loci conferring susceptibility to fragile X syndrome were different in the sample population from those reported previously for other Caucasian and Asian populations.<sup>1</sup>

## ***Alzheimer's Disease (AD)***

A large epidemiological study of AD was recently carried out in a geographically defined area at Ballabgarh, Haryana (near Delhi) by a joint Indo-US group. Subsequently, genetic

epidemiological studies were also performed. This well-designed study comprised a large, well-defined, representative, rural, population-based sample, aged 55–95 years (n = 4,450). Subsequent analyses revealed interesting differences from Western samples. The prevalence of AD was relatively low. The overall prevalence rate for AD was on an average 0.62% in the population aged 55+ and 1.07% in the population aged 65+. Greater age was significantly associated with higher prevalence of both AD and all dementias, but neither gender nor literacy were associated with prevalence.<sup>12</sup>

The well-known association of APOE\*E4 with AD was also noted in the Indian samples.<sup>13</sup> However, the frequency of APOE\*4 was among the lowest reported anywhere in the world. The overall APOE E\*2, E\*3 and E\*4 allele frequencies were 0.039, 0.887 and 0.073, respectively. These studies highlight an important observation: common psychiatric disorders are noted worldwide, but local variations in the prevalence and incidence can be expected. Though genetic aetiological factors are likely to be shared in different ethnic groups, the risk conferred may vary. Chandak et al. analysed 49 AD cases for risk association with APOE E\*4 allele at apolipoprotein E gene (APOE) and presenilin-1 (PS-1) intron-8 polymorphism.<sup>14</sup> They compared AD cases with a 100 age- and sex-matched non-demented controls. While genotype analysis confirmed the association of APOE E\*4 allele with AD, the frequency for allele 1 at PS-1 intron-8 polymorphism was the highest among all studies reported, but did not demonstrate any significant association with AD.

### ***Obsessive Compulsive Disorder (OCD)***

Khanna and his group from Bangalore carried out several clinical investigations into this disorder, some of which reported on familial risk. In contrast to several studies in Western countries that reported increased morbid risk for OCD among relatives of OCD patients, Guruswamy et al. did not detect statistically significant differences in the familial risk for selected psychiatric disorders among relatives of 148 OCD probands who were compared with the relatives of 151 control subjects.<sup>15</sup> In contrast, the same group reported an increased familial risk for OCD among probands with early onset OCD. Familial segregation of OCD and tics in juvenile OCD sufferers was not detected, though such segregation has been reported in developed countries.<sup>16</sup> The authors speculated that juvenile onset OCD might represent a more familial form of the illness in India.

### ***Schizophrenia (SZ) and Bipolar Disorder (BD)***

Both these disorders can have a devastating impact, due to frequent onset during adolescence or early adult life. They are associated with significant morbidity and disability among the sufferers themselves. The burden of care may be reflected by an increased prevalence of depression among relatives who care for these patients. Though a large number of epidemiological studies have been conducted in India over the past seven decades, relatively few have investigated familial risks. Attempts to map susceptibility genes have begun recently.

## **Genetic Epidemiological Studies in SZ and Mood Disorders**

Family studies all over the world have documented that members of families with an affected relative are at an increased risk for the disorder. In India, family history (indirect interviews from a single informant) and family study (direct interviews of available relatives) methods have been employed. The latter are considered as more reliable, as the stigma associated with SZ can lead to underestimation using the family history method.<sup>17</sup> A pioneering study of familial segregation in south India detected rates of familiarity similar to US samples. However, the Indian sample was

clinic-based and lifetime risks were not reported.<sup>18</sup> A family history study of 102 patients with SZ suggested a polygenic mode of inheritance.<sup>19</sup> In a study presented at the World Congress of Psychiatry in 2002, Linda et al. assessed psychiatric morbidity among 798 first-degree relatives of 126 cases with SZ and related disorders and found that the risk for SZ was elevated among relatives of probands, the spectrum ranging from affective disorders to psychotic disorders.<sup>20</sup>

Somnath et al. found elevated rates of SZ and bipolar disorder among the relatives of SZ and bipolar probands, but there was no clear evidence for co-segregation of these disorders.<sup>21</sup> The risk for major depression was significantly elevated among the relatives of SZ probands and was comparable to the risk in the relatives of bipolar probands. The findings suggested that SZ and bipolar disorders segregated independently, but there could be a familial relationship between the predisposition to SZ and to major depression.

The Schizophrenia Research Foundation, Chennai has published extensively on the outcome of SZ, among other clinical aspects. This group has also published on fertility in SZ.<sup>22</sup> Investigations into the reproductive patterns of three generations of families of 100 SZ probands showed reduced fertility among probands and elevated fertility among their parents and siblings. The authors hypothesised that increased fertility in parents and siblings, who may be carriers of the disease gene, could compensate for the reduction in genetic contribution to morbid risk for SZ due to reduced reproductivity of the patients themselves.

In one of the earliest studies of clinical pharmacogenetics, Geetha and Channabasavanna investigated a 100 manic patients treated with lithium.<sup>23</sup> In the course of a pedigree study, colour blindness and ABO blood groups were used as genetic markers. The study supported autosomal dominant inheritance of lithium responsiveness, with incomplete penetrance. There was no significant difference between responders and non-responders in the mode of transmission and in the family history of mental illness or ABO blood groups.

Kumar et al. investigated the possibility of imprinting in a group of 79 consecutive out-patients who had received a diagnosis of bipolar affective disorder, first episode, current episode mania. The age of onset of the illness was used as an indicator for imprinting. Family history was ascertained from the patients and their relatives. Available data did not suggest any evidence for imprinting.<sup>24</sup>

## **Gene Mapping Studies**

Some Indian groups have led the effort to map genes for SZ and mood disorders, using modern DNA technology. These include a group at the National Institute of Mental Health and Neuro Sciences, Bangalore (NIMHANS) and a group based at Pune. Our group at Dr Ram Manohar Lohia Hospital, New Delhi has been conducting mapping studies for the past 10 years. In the following sections, progress from these groups is summarised.

### ***Studies at Pune***

The Pune group initially began by investigating the relationship between SZ and nutrition: specifically essential polyunsaturated fatty acids.<sup>25</sup> This group also presented a study at the 53rd Annual Conference of the Indian Psychiatric Society, in which they reported on polymorphisms involving trinucleotide repeat sequences (CAG) in four genes. Association between these polymorphisms and SZ was investigated.<sup>26</sup> Further results are awaited.

### ***Studies at NIMHANS***

The NIMHANS group investigated several loci for SZ and bipolar disorder. Initial studies investigated the distribution of trinucleotide repeat polymorphisms that have been implicated in

the aetiology of Machado–Joseph disease (MJD) locus among a group of patients with the major psychoses. Two patients were found to have alleles that were two repeat lengths above the maximal length detectable among the controls. The difference in allele sizes was larger in the patient sample as compared to the controls.<sup>27</sup> Investigating *KCNN3*, a potassium channel gene, that includes a polymorphic CAG repeat, the authors did not detect statistically significant evidence for association with the alleles with longer repeats. However, an analysis of the difference of allele sizes revealed a significantly greater number of patients with SZ having differences of allele sizes  $>$  or  $=$  5 when compared to normal controls.<sup>28</sup> Their initial results did not suggest any significant association with alleles of the Variable Number Tandem Repeat (VNTR) in the Serotonin Transporter (SERT) gene and bipolar disorder in Indian patients, when the VNTR polymorphism was analysed among 50 Indian patients with bipolar disorder and ethnically matched controls.<sup>29</sup> Saleem et al. investigated a polymorphism of the *CLOCK* gene, which was first identified in mice and subsequently in a large number of organisms, including humans.<sup>30</sup> Their analysis of 190 unrelated individuals, which included patients suffering from bipolar disorder and SZ, indicated that a trinucleotide repeat, which consisted of six CAG triplets, was not polymorphic in humans. Saleem et al. investigated CAG repeat polymorphisms on Chromosome 22q (this region has previously been reported to be linked to schizophrenia and bipolar disorder).<sup>31</sup> An eight-repeat allele was significantly over-represented among both SZ and bipolar patient groups when compared to ethnically matched controls, while alleles at the other three loci did not show any such difference.

### ***Studies at Dr Ram Manohar Lohia Hospital, New Delhi***

Our group initiated family-based genetic studies in India under the aegis of the US-India dollar fund. The main objective is to identify genetic susceptibility factors for SZ. We have investigated DNA polymorphisms at selected genomic regions. In addition, we have investigated familial co-occurrence of certain clinical traits. Parallel studies are conducted at Delhi and at Pittsburgh, using identical designs. This synergy enables replicate studies as well as cross-national comparisons. Thus, it is feasible to investigate the impact of susceptibility genes against very different environmental backgrounds.

We conduct linkage as well as association studies in order to exploit the strengths of each type of analysis. Briefly, linkage analysis involves the investigations of co-segregation of genetic polymorphism among affected (and unaffected) relatives. Association studies typically involve comparisons of cases and controls. Classical case–control comparisons involve cases and unrelated controls. Modifications in the form of controls drawn from among relatives are also popular. One modification of family-based association tests called the Transmission Disequilibrium Test (TDT) is particularly useful, as it detects both linkage and association.<sup>32</sup> TDT has become the workhorse for our analyses, as described below.

It was felt that India, with its steady and loyal family structures, would be ideal for these studies. Indian families break-up relatively infrequently and three generations often live together. More distant relatives, such as cousins, are also usually in touch with each other. Family histories are easily available and the concept of familial transmission of disease is accepted. Children are brought up by both parents who are usually quite willing to participate in research. Larger family size, family stability, low refusal rates and reduced selection bias, simplified genetic interviews, as parents and even the entire family participate, trust in the medical profession as a whole. Good relations between doctors and patients and the low prevalence of drug abuse all contribute to the chances of a positive result. These investigations are now continuing with a grant for the National Institute of Health, USA.

Initially, the English versions of internationally accepted interview schedules were translated into Hindi. Thus, the Schedule for Affective Disorders and Schizophrenia was translated first.<sup>33</sup> Next, the group translated into Hindi, and validated the Diagnostic Interview for Genetic Studies.<sup>34</sup> A Hindi version of the Family Interview for Genetic Studies is also now available.

Nuclear families with two or more affected siblings and additional nuclear families with one affected proband are being ascertained and diagnosed according to DSM IV (Diagnostic and Statistical Manual).<sup>35</sup> Samples are genotyped using a range of polymorphic markers at candidate genes or candidate loci, the choice and number of markers being determined by ongoing research, as well as the resources and expertise available. Genotype data are then analysed using association and linkage strategies. Initially, linkage studies are conducted using the affected sibling pair strategy. Suggestive linkage findings are tested further using the TDT.<sup>32</sup> A range of private and publicly funded mental health facilities including both hospitals and clinics in Delhi are approached for suitable participants. Help was provided by all the mental health colleagues who were approached in Delhi. They have painstakingly assigned preliminary diagnosis, obtained permission from patients and then referred them to our research group for written informed consent. Over 300 families have thus participated in our studies.

### ***Genomic targets***

We have analysed the following genomic targets: biological candidate genes, positional candidate gene and linked candidate regions.

#### *Biological candidate genes*

This group includes genes which have been implicated in pathogenesis during the course of non-genetic investigations; for example, pharmacological or biochemical analyses of cases and controls. Such analyses have enabled replicable associations, such as an association with the dopamine D3 receptor gene (DRD3).<sup>36</sup> Other biological candidate genes include the Serotonin 2A receptor (HT2A, TDT); Tryptophan Hydroxylase (TPH, TDT); Catechol-o-methyl Transferase (COMT, case-control and TDT); Notch (*Drosophila*) homolog 4 (NOTCH4, TDT) and phospholipase A2, group IVA, cytosolic, calcium-dependent (PLA2G4A, case-control and TDT). Consistent associations have been detected at DRD3 in the US samples, and further analysis of the Indian samples is in progress. Similarly, we are investigating suggestive evidence for association at NOTCH4 in our samples. Consistent evidence for association has not been detected at any of the other loci. This work is described in detail elsewhere.<sup>37-39</sup>

#### *Positional candidate genes*

This group includes genes that have been implicated through prior non-genetic studies and because they are localised to genomic regions previously implicated in linkage or association studies. For example, we have extensively analysed the Regulator of G Protein Signalling 4 (RGS4), which was recently implicated as a biological candidate following expression analyses of post-mortem brain samples.<sup>40</sup> As RGS4 is localised to chromosome 1q22, a region thought to be linked to SZ,<sup>41</sup> we postulated RGS4 as a plausible positional candidate gene. We re-sequenced RGS4 and flanking genomic regions, using a panel of cases and controls at Pittsburgh. Selected single nucleotide polymorphisms were simultaneously evaluated among our US and Indian samples. We have suggested association and linkage with this locus on the basis of our analyses.<sup>42</sup> The results are gratifying, because our analyses suggest evidence for linkage and association in

the US as well as the Indian samples, though the magnitude of the risk may vary. We are analysing other polymorphisms at this locus in order to clarify the primary variant conferring susceptibility. We are also investigating the clinical features of our Indian and US samples, in order to see if RGS4 polymorphisms are more strongly associated with particular sub-groups of the disorder.

#### *Candidate regions*

We are also investigating 'candidate regions' implicated from prior genome wide scans. Our principal efforts are being focused on chromosome 6p and 13q.

#### *Chromosome 6p21-p24*

Encouraged by reports of significant linkage in this region, we followed up our earlier reports of associations between HLA DQB1\*0602 with SZ among African-Americans.<sup>43,44</sup> We also detected significant associations at HLA DQB1 between two independent samples of Chinese cases and controls, albeit with different alleles.<sup>45,46</sup> Associations with flanking markers consistent with the HLA DQB1 association were noted in both samples.<sup>46</sup> Associations have not been detected among the Caucasians or Indians.<sup>47,48</sup> We have also conducted TDT analyses using Short Tandem Repeat Polymorphisms (STRPs) and Single Nucleotide Polymorphisms (SNPs) among US and Indian families. The analyses include NOTCH4, a locus reported to be associated and linked with SZ.<sup>49</sup> No significant associations were detected at NOTCH4.

#### *Chromosome 13q32*

Linkage with SZ has been reported in two independent samples.<sup>50</sup> Supportive evidence is also available from another Canadian sample.<sup>51</sup> We conducted TDT analyses using 159 US case-parent families from Pittsburgh. We selected six STRPs with the strongest evidence for linkage in the published studies (D13S1271, D13S1323, D13S174, D13S888, D13S280, D13S779). Selected STRPs from this region have also been investigated in our Indian samples, but significant associations have not been detected.

### ***Molecular genetics of tardive dyskinesia***

In a related set of investigations, our group is collaborating with Professor Bernard Lerer at the Jerusalem University. We have established and implemented a closely coordinated collaboration in order to identify genes associated with Tardive Dyskinesia (TD). We are investigating clinical samples gathered simultaneously at Delhi and in Israel. Our studies involve Israeli case-control samples and Indian family-based samples. We have examined a panel of candidate genes proposed to be associated with TD by the Israeli group (Principal Investigator – B. Lerer).

Significant difference was found between the two samples in the ages of the subjects, the Israeli subjects being approximately two decades older than those from India.<sup>30</sup> A high degree of concordance was observed in the association of TD with the candidate genes examined notably a serine<sup>9</sup> glycine polymorphism in the dopamine D3 receptor gene in the Israeli sample also supported by a meta-analysis but no association was detected in the Indian sample. Age was not an explanation for the dichotomy since the Israeli group did not observe an effect of age on the association of DRD3 with TD. This lack of concordance in the Indian group remains an unresolved question. The Israeli group observed an association with the 5-HT2A and 5-HT2C receptor genes. This was age-related and was found only in their older subjects.<sup>52-54</sup>



### ***Other clinical studies at Dr Ram Manohar Lohia Hospital***

#### *Symptom sharing in sibling pairs*

We described our initial set of 25 affected sibling pairs in 1997.<sup>55,56</sup> We investigated possible concordance for selected symptom/s as well as suicide attempts. Significant correlations in suicidal behaviour as well as the presence of hallucinations were detected. These results are being examined in a larger sample.

#### *Outcome studies*

We are presently conducting cross-national comparisons of the severity and course of SZ among US and Indian cases. Initial results suggest distinct variations in patterns and severity of psychotic symptoms.

We are also attempting to identify familial effects by initially evaluating concordance for selected traits among Affected Sibling Pairs (ASPs) from Pittsburgh, USA and New Delhi, India. For each ASP proband, an unrelated patient is selected randomly from the same sample (Sibpair-Control or S-C pairs). Correlations between the ASP and S-C pairs are then compared in order to evaluate familial associations. Using this novel design, familial factors did not appear to have a significant impact on course/severity (manuscript under preparation). Some of these findings were presented in the symposium organised by our group.<sup>57</sup>

#### *Occupational drift*

Downward occupational drift due to SZ has been documented in numerous studies, with a variation in the degree and frequency of downward drift. A study was undertaken to assess the presence, if any, of occupational downward drift among relatively young Indian probands with SZ or schizoaffective disorder living in Delhi. We also investigated the factors that affected drift in this (unselected for occupation) group. Unmarried males drifted downward more than their married counterparts. In most cases where occupational change occurred, the proband was presently unemployed or doing a less responsible job. Significant factors associated with downward drift were: present occupation, most responsible occupation, marital status, pattern of symptoms, pattern of severity of illness and global assessment of functioning at worst point of illness.<sup>58</sup>

#### *Neurocognitive deficits*

There has been a surge of interest in the functional consequences of neurocognitive deficits in SZ. Unfortunately, most neuropsychological tests are derived from and are thus primarily applicable to cultural groups in English-speaking countries. The application of a majority or mixed norms to specific ethnic sub-cultures may introduce systematic bias. The Trail Making Test (TMT): part of the Army Individual Test Battery, 1944 and a standard component of the Halstead-Reitan Battery is being used in by our group to estimate visual, conceptual or visuomotor tracking and mental flexibility.<sup>59</sup> The test has also been used on psychiatrically normal individuals to ascertain population norms. The results are being analysed.

#### *Fertility*

Fertility was found to be similar in Indian male and female sufferers, while it was much reduced among US males.<sup>60</sup>

## Conclusion

In conclusion, genetic epidemiological studies of several psychiatric disorders are in progress in India, but these studies do not appear to be coordinated. It is vital in the national interest, to develop a coherent core of clinical genetic research programmes. Such a strategy may enable progress in therapy, counselling and prevention for several very disabling illnesses.

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## References

1. Verma IC. Burden of genetic disorders in India. *Indian Journal of Pediatrics* 2000;67(12):893–898.
2. Venugopal D, Ranjith G, Isaac MK. A questionnaire survey of psychiatrists attitudes towards genetic counselling. *Indian Journal of Psychiatry* 2000;42(2):163–166.
3. Bagadia VN, Pradhan PV, Shah LP. Ecology and psychiatry in Bombay – India. *International Journal of Social Psychiatry* 1974;20(3-4):302–310.
4. Balgir RS, Murthy RS, Wig NN. Genetic loadings in schizophrenia: a dermatoglyphic study. *Israel Journal of Medical Science* 1993;29(5):265–268.
5. Balgir RS. Serological and biochemical genetic markers and their association with psychiatric disorders: A review. *Indian Journal of Psychiatry* 1983;25(4):275–285.
6. Sethi BB, Dube S, Sharma M. Markers in psychoses: studies from India. *Journal of Psychiatric Research* 1984; 18(4):361–372.
7. Indian Council of Medical Research. Multicentric study on genetic causes of mental retardation in India. ICMR Collaborating Centres & Central Co-ordinating Unit. *Indian Journal of Medical Research* 1991; 94:161–169.
8. Rao Sridhara Rama BS, Narayanan HS. Consanguinity and familial mental retardation. *Journal of Medical Genetics* 1976;13(1):27–29.
9. Jyothy A, Rao GN, Kumar KS, Rao VB, Devi BU, Reddy PP. Translocation Down Syndrome. *Indian Journal of Medical Science* 2002;56(3):122–126.
10. Elango R, Verma IC. Fragile X syndrome among children with mental retardation. *Indian Journal of Pediatrics* 1996;63(4):533–538.
11. Sharma D, Gupta M, Thelma BK. Expansion mutation frequency and CCG/GCC repeat polymorphism in FMR1 and FMR2 genes in an Indian population. *Human Biology* 2001;73(1):135–144.
12. Chandra V, Ganguli M, Pandav R, Johnston J, Belle S, DeKosky ST. Prevalence of Alzheimer's disease and other dementias in rural India: the Indo-US study. *Neurology* 1991;52(7):1517.

13. Ganguli M, Chandra V, Kamboh MI, Johnston JM, Dodge HH, Thelma BK, Juyal RC, Pandav R, Belle SH, DeKosky ST. Apolipoprotein E polymorphism and Alzheimer's disease: The Indo-US cross-national dementia study. *Archives of Neurology* 2000;57(6):824-830.
14. Chandak GR, Sridevi MU, Vas CJ, Panikker DM, Singh L. Apolipoprotein E and presenilin-1 allelic variation and Alzheimer's disease in India. *Human Biology* 2002;74(5):683-693.
15. Guruswamy R, Relan, Khannas. A clinical genetic study of adult obsessive-compulsive disorder from India. *Indian Journal of Psychiatry* 2002;44(3):240-245.
16. Reddy PS, Janardhan Reddy YC, Srinath S, Khanna S, Sheshadri SP, Girimaji SC. A family study of juvenile obsessive compulsive disorder. *Canadian Journal of Psychiatry* 2001;46:346-351.
17. Mohandas E, Dinesh Kumar MK. Genetics of schizophrenia – current trends. In: Deshpande S.N., ed. *Schizophrenia: From Gene to Behaviour: Bench to Bedside*. Released at Annual National Conference of Indian Psychiatric Society Hyderabad, 9-11 January 2003.
18. Rajkumar SRP, Thara R, Menon MS. Incidence of schizophrenia in an urban community in Madras. *Indian Journal of Psychiatry* 1993;35(1):18-21.
19. Ponnudurai R. Schizophrenia-a genetic study. *Indian Journal of Psychiatry* 1989;31(3):219-220.
20. Linda FK, Tripathi BM, Sagar R, Pandey RM, Chumber S. A family study of schizophrenia in India. Paper presented at the World Congress of Psychiatry, 2002.
21. Somnath CP, Janardhan Reddy YC, Jain S. Is there a familial overlap between schizophrenia and bipolar disorder? *Journal of Affective Disorders* 2002;72(3):243-247.
22. Srinivasan TN, Padmavati R. Fertility and schizophrenia: evidence for increased fertility in the relatives of schizophrenic patients. Schizophrenia Research Foundation, Chennai. *Acta Psychiatrica Scandinavica* 1997;96(4):260-264.
23. Geetha PR, Channabasavanna SM. Utility of some genetic marker in predicting response to lithium. *Indian Journal of Psychiatry* 1983;25(2):94-97.
24. Kumar R, Chopra VK, Parial A, Khess CRJ. Genomic imprinting in bipolar affective disorder. *Indian Journal of Psychiatry* 2000;42(2):167-171.
25. Aravindakshan M, Sitasawad S, Debsikdar V, Ghate M, Evans D, Horrobin DF, Bennett C, Ranjekar PK, Mahadik SP. Essential polyunsaturated fatty acid and lipid peroxide levels in never-medicated and medicated schizophrenia patients. *Biological Psychiatry* 2003;53(1):56-64.
26. Saraph A. Nucleotide polymorphisms in schizophrenia. Annual Conference of Indian Psychiatric Society, Pune, India. 53rd ANCIPS, January 2001.
27. Saleem Q, Vijayakumar M, Mutsuddi M, Chowdhary N, Jain S, Brahmachari SK. Variation at the MJD locus in the major psychoses. *American Journal of Medical Genetics* 1998;7: 81(5):440-442.
28. Saleem Q, Sreevidya VS, Sudhir J, Savithri JV, Gowda Y, B-Rao C, Benegal V, Majumder PP, Anand A, Brahmachari SK, Jain S. Association analysis of CAG repeats at the KCNN3 locus in Indian patients with bipolar disorder and schizophrenia. *American Journal of Medical Genetics* 2000a; 4:96(6)744-748.
29. Saleem Q, Ganesh S, Vijaykumar M, Reddy YC, Brahmachari SK, Jain S. Association analysis of 5HT transporter gene in bipolar disorder in the Indian population. *American Journal of Medical Genetics* 2000b; 3: 96(2):170-172.
30. Saleem Q, Anand A, Jain S, Brahmachari SK. The polyglutamine motif is highly conserved at the Clock locus in various organisms and is not polymorphic in humans. *Human Genetics* 2001a;109(2):136-142.
31. Saleem Q, Dash D, Gandhi C, Kishore A, Benegal V, Sherrin T, Mukherjee O, Jain S, Brahmachari SK. Association of CAG repeat loci on chromosome 22 with schizophrenia and bipolar disorder. *Molecular Psychiatry* 2001b;6(6):694-700.
32. Spielman RS, Ewens WJ. The TDT and other family-based tests for linkage disequilibrium and association Editorial. *American Journal of Human Genetics* 1996;59(5):983-989.
33. Endicott J, Spitzer RL. A diagnostic interview: The schedule for affective disorders and schizophrenia. *Archives of General Psychiatry* 1978;35:837.

34. Deshpande SN, Mathur MNL, Das SK, Bhatia T, Sharma SD, Nimgaonkar VL. A Hindi version of the diagnostic interview for genetic studies. *Schizophrenia Bulletin* 1998;24(3):489-493.
35. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Washington D.C.: American Psychiatric Association, 1994.
36. Nimgaonkar, VL, Bennett PJ, Foroud TM, Hawi ZH, Jonsson E, Kalsi G, Krebs MO, Labuda MC, Macciardi FM, Maziage M, Rietschel MDC, Hsaw SH, Straub RE, Williams J. Chromosome 3 workshop report. *Psychiatric Genetics* 1998b;8:63-65.
37. Prasad S, Deshpande S, Bhatia T, Wood J, Nimgaonkar V, Thelma B. An association study of schizophrenia among Indian families. *American Journal of Medical Genetics* 1999; 88:298-300.
38. Semwal P, Prasad S, Bhatia T, Deshpande SN, Wood J, Nimgaonkar VL, Thelma BK. Family-based association studies of monoaminergic gene polymorphisms among north Indians with schizophrenia. *Molecular Psychiatry* 2001;6:220-224.
39. Chowdari KV, Brandstaetter B, Semwal P, Bhatia T, Deshpande S, Reddy R, Wood J, Weinberg CR, Thelma BK, Nimgaonkar VL. Association studies of cytosolic phospholipase A2 polymorphisms and schizophrenia among two independent family-based samples. *Psychiatric Genetics* 2001a;11(4):207-212.
40. Mirnics K, Middleton FA, Stanwood GD, Lewis DA, Levitt P. Disease-specific changes in regulator of G-protein signalling 4 (RGS4) expression in schizophrenia. *Molecular Psychiatry* 2001;6(3):293-301.
41. Brzustowicz LM, Hodgkinson KA, Chow EW, Honer WG, Bassett AS. Location of a major susceptibility locus for familial schizophrenia on chromosome 1q21-q22. *Science* 2000;288(5466):678-682.
42. Chowdari KV, Mirnics K, Semwal P, Wood J, Lawrence E, Bhatia T, Deshpande SN, BKT, Ferrell RE, Middleton FA, Devlin B, Levitt P, Lewis DA, Nimgaonkar VL. Association and linkage analyses of RGS4 polymorphisms in schizophrenia. *Human Molecular Genetics* 2002;11(12):1373-1380.
43. Nimgaonkar VL, Ganguli R, Rudert WA, Vavassori C, Rabin BS, Trucco M. A negative association of schizophrenia with an allele of the HLA DQB1 gene among African-Americans. *Schizophrenia Research* 1992;8(3):199-209.
44. Nimgaonkar VL, Rudert WA, Zhang XR, Trucco M, Ganguli R. Negative association of schizophrenia with HLA DQB1\*0602: evidence from a second African-American cohort. *Schizophrenia Research* 1996a; 23:81-86.
45. Nimgaonkar VL, Rudert WA, Zhang XR, Tsoi WF, Trucco M, Saha N. Further evidence for an association between schizophrenia and the HLA DQB1 gene locus. *Schizophrenia Research* 1995a;18:43-49.
46. Chowdari KV, Xu K, Zhang F, Ma C, Li T, Yong Xie B, Wood J, Trucco M, Tsoi W, Saha N, Rudert WA, Nimgaonkar VL. Immune related genetic polymorphisms and schizophrenia among the Chinese. *Human Immunology* 2001b;62(7):714-724.
47. Jonsson EG, Zhang F, Nimgaonkar VL, Rudert WA, Sedvall GC. Lack of association between schizophrenia and HLA DQB1 alleles in a Swedish sample. *Schizophrenia Research* 1998b;29(3):293-296.
48. Wright P, Nimgaonkar VL, Donaldson PT, Murray RM. Schizophrenia and HLA: a review. *Schizophrenia Research* 2001;47(1):1-12.
49. Wei J, Hemmings GP. The NOTCH4 locus is associated with susceptibility to schizophrenia. *Nature Genetics* 2000;25(4):376-377.
50. Blouin JL, Dombroski BA, Nath SK, Lasseter VK, Wolyniec PS, Nestadt G, Thornquist M, Ullrich G, McGrath J, Kasch L, Lamacz M, Thomas MG, Gehrig C, Radhakrishna U, Snyder SE, Balk KG, Neufeld K, Swartz KL, DeMarchi N, Papadimitriou GN, Dikeos DG, Stefanis CN, Chakravarti A, Childs B, Pulver AE. Schizophrenia susceptibility loci on chromosomes 13q32 and 8p21. *Nature Genetics* 1998;20(1):70-73.
51. Brzustowicz LM, Honer WG, Chow EWC, Little D, Hogan J, Hodgkinson K, Bassett AS. Linkage of familial schizophrenia to chromosome 13q32. *American Journal of Human Genetics* 1999;65(4):1096-1103.
52. Lerer B, Segman R, Deshpande SN, Thelma BK. Molecular genetics of complex phenotypes: focus on

- schizophrenia and tardive dyskinesia. Final report, Department of Biotechnology, Government of India, 2002.
53. Segman RH, Heresco-Levy U, Finkel B, Goltser T, Shalem R, Schlafman M, Dorevitch A, Yakir A, Greenberg D, Lerer A, Lerer B. Association between the serotonin 2A receptor gene and tardive dyskinesia in chronic schizophrenia. *Molecular Psychiatry* 2001;6:225-229.
  54. Segman RH, Lerer B. Age and relationship of dopamine D3, serotonin 2C and serotonin 2A receptor gene polymorphisms on abnormal movements in chronic schizophrenia. *Molecular Psychiatry* 2002;7: 137-139.
  55. Bohra N, Deshpande SN, Bhatia T, Thelma BK, Nimgaonkar VL. Suicidality and comorbidity among schizophrenic sibling pairs: poster at the International Conference on Current Trends in Psychosocial Rehabilitation and Family Intervention, Bangalore, March 1997.
  56. Deshpande SN, Bhatia T, Thelma BK, Nimgaonkar VL. Schizophrenic symptoms in sibling pairs and their effect on rehabilitation: International Conference on Current Trends in Psychosocial Rehabilitation and Family Intervention, Bangalore, March 1997.
  57. Deshpande SN, Nimgaonkar VL. Better outcome for schizophrenia – myth or reality – the grassroots Indian experience. Symposium, Annual National Conference of Indian Psychiatric Society. Pune, India, 2000.
  58. Bhatia T, Nimgaonkar VL, Deshpande SN. Clinical Symptoms, Severity of illness and employment change in schizophrenia. *Journal of Mental Health and Human Behaviour* 2002;7:35-41.
  59. Reitan RM, Wolfson D. *The Halstead-Reitan Neuropsychological Test Battery: Theory and Clinical Interpretation*. 2 ed. Tucson A.Z.: Neuropsychology Press. SAS Institute, 1989.
  60. Bhatia T, Franzos MA, Wood JA, Nimgaonkar VL, Deshpande SN. Gender and Procreation among Patients with Schizophrenia. Schizophrenia Research (Accepted for Publication) (2004).

## Chapter 23

# Brain Banking in Aid of Neuroscience Research

*P. N. Tandon*

**N**otwithstanding the recent advances in neuroscience, the brain remains the least understood of all human organs. Yet, the number of diseases and disorders affecting it contribute to a huge burden of morbidity and mortality. At the same time, the past decades have witnessed the emergence of a number of new technologies and techniques in the field of molecular biology, genetics, biochemistry, immunology and imaging that hold immense promises for exploring the brain structure and its function in health and disease. Often, such studies are hampered by the lack of availability of brain specimens from authenticated cases of different brain disorders. The lack of animal models for many of the degenerative and psychiatric disorders make it imperative to study the human brain itself for determining morphological, biochemical or even genetic abnormalities underlying such diseases. Thus, there is no animal equivalent of schizophrenia or bipolar disorder, nor for that matter, of Down's syndrome and autism. No doubt, modern imaging techniques help to provide valuable information about the gross abnormalities at the macro level, but these fail to reveal the changes at the micro level, let alone the biochemical or functional level. It was to overcome these handicaps that led to the establishment of Brain Banks, to collect, preserve and provide specimens of brain tissue obtained during autopsy (or surgical operations) to researchers.

### Historical Background

The idea of brain banking emerged with the collection and preservation of fixed brains by C. Vogt of Germany, essentially for anatomical and pathomorphological studies. Debra Padget in the early 1940s established a unique collection of fetal brains to study the development of the vascular system, the circle of Willis, in particular. The concept and objectives of the Brain Bank have significantly been enhanced since then, to promote neurochemical and neurobiological research. Over the years, they have been established to collect the brains of patients suffering from specific neurological disorders. The Cambridge Brain Bank in the UK collects specimens from normal individuals and Parkinson's patients. Another such bank in London, concentrated on the brains of patients with Alzheimer's disease. In 1984, the Kathleen Prince Brain Bank was established at the Duke University Medical Centre, which collected a large number of brains from

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cases of Alzheimer's disease and other dementias. In the same year, Tourtellote and his colleagues established a National Neurological Research Bank at California. There are over a dozen Brain Banks in the US alone. Such banks have been established in Canada, Hungary, Switzerland and several other countries.

In addition to collecting specimens of the whole brain or parts of it, several banks also store blood, cerebrospinal fluid or even DNA from patients diagnosed to be suffering from brain disorders.<sup>1</sup> In Europe and America, a network of these centres has now been established.<sup>2</sup>

### **The Indian Experience**

In 1990, a Fetal Repository for Human Developmental studies, especially for neurogenesis, was established at the AIIMS, with the financial support from the Department of Science and Technology (DST). This functioned for nearly a decade, but had to be closed down because of practical difficulties in collecting such specimens. However, as a result of this repository—a number of valuable studies on the developing nervous system could be carried out. These included studies on the sequential development and maturation of specific neuronal systems in the spinal cord, cerebellum, hippocampus, lateral geniculate body and visual cortex.<sup>3-5</sup>

Brain Bank—A national facility was established in 1994 at NIMHANS, under Professor S.K. Shankar with the support from its Department of Science and Technology, Department of Biotechnology and the ICMR.

### ***Objectives of the project***

The Human Brain Tissue Repository was established with a view to subserve the following purposes:

1. To standardise and develop technology for the collection and storage of human brain specimens for histomorphological, cytochemical and biochemical studies. They include specimens from infective, degenerative and neoplastic diseases of the nervous system.
2. To develop a 'tissue fluid bank' for serum and Cerebrospinal Fluid (CSF) from various infectious and non-infectious neurological disorders. The material will be used to determine various parameters and basic levels in health and note the deviations in various disorders. This has great potential of being 'diagnostic markers' and also provides insight into the pathogenesis.
3. To evolve a DNA/RNA bank from the peripheral tissues in cases of neuro-degenerative disorders (and normal as controls) to develop probes for molecular biological studies.
4. The possibility of developing some cell lines from the tissues collected from cases of neuro-degenerative diseases in collaboration with the National Centre of Cell Sciences (NCCS), Pune will be actively explored and developed either there or at NIMHANS, depending on the feasibility.

This facility, which is the only one of its kind in India, continues to serve the neuroscience community in the country admirably. It has since become an integral part of NIMHANS, but its objectives remain the same. Over the years, its scope has increased. Besides the autopsy specimens of brains, from patients of neurological and psychiatric disorders, including neurotrauma and infective disorders like tuberculosis, viral encephalitis and AIDS, the bank has a repository of serum and CSF of patients with these diseases. In addition, there are specimens collected from individuals with no

known neuro-psychiatric disease or disorder. This serves to provide baseline data for comparison with the diseased brains. Between 1995 and 2000, the Bank collected 75 fresh brains during autopsy; 620 formalin fixed brains, 30 frozen tissues from surgically resected specimens, CSF (231) and serum (142) samples from a variety of neuro-psychiatric disorders. The Bank also collected blood samples for molecular biology studies from patients (and their relatives) affected with conditions of special interest like hot water epilepsy, unusually frequently seen in Karnataka, Cruetzfeldt-Jacob disease, schizophrenia and Alzheimer's disease.

### **Some Important Contributions**

It was a result of studies on the brains of patients of Parkinsonism that established a decrease in dopamine levels in the striatum that ultimately led to the development of L. Dopa therapy. Similarly, the dominant biochemical abnormality—a reduction in the levels of cholinergic acetyl transferase in the brains of patients with Alzheimer's disease—established the cholinergic hypothesis and possible therapy for this disorder. Such studies identified the role of the measles virus in the aetiology of subacute sclerosing panencephalitis, or of the Papova virus in progressive multifocal leucoencephalopathy.<sup>2</sup>

### **Summary of Some Important Studies Based on Material Obtained from the National Brain Bank**

Some of the earliest contributions based on the collection at the National Fetal Repository at the AIIMS, were those on the development of specific regions of the brain in human fetuses. Bijlani et al.<sup>4</sup> made significant contributions on the development of the human visual system (retina, optic nerves, lateral geniculate body and visual cortex), substantia nigra, cerebellum and dorsal horn of the spinal cord. These studies elucidated, some for the first time, the developmental and cellular events, temporal profile of appearance of neuro-transmitters and synaptic profile in human fetal brains. It may be pointed out that developmental defects are now known to be associated with, and probably responsible for some of the neuro-psychiatric disorders in later life, including schizophrenia. Such investigations therefore acquire great clinical significance.

These studies have highlighted the critical time periods in the development of the human spinal cord, visual pathway, cerebellar nuclei and in the autonomic innervation of human urinary bladder, during which these are susceptible to alterations in the micro-environment of the fetus that could result in related developmental abnormalities of varying degrees. It has provided baseline data for comparison with pathological material and animal experiments, and helped in the better understanding of processes involved in the development of these regions at the molecular level.<sup>6-16</sup>

The National Brain Bank at NIMHANS has proved to be a great boon for neuroscientists, not only those working at the institute but to many others across India. Some examples of contributions made with the help of the Bank are briefly described here:

1. A study of 84 normal brains of different age groups from south India revealed that the absolute number of melanised neurons in the substantia nigra were about 40% less than in the brains from UK. Surprisingly, the Indian brains failed to show statistically significant loss of these neurons with advancing age.<sup>17</sup>
2. Ageing changes in the human brain were systematically studied for the first time by Shankar and his associates.<sup>2</sup>



3. Studies on some brain enzymes in the human brain. A series of papers were published by Balijepalli et al. Cytochrome P450 and its variants as also thiol transferase in the human brain, utilising the Brain Bank facility.<sup>18</sup> The presence of the P450 mono oxygenase system was demonstrated for the first time in the human brain. This provided new insights into the xenobiotic metabolising function in the brain.

Multiple forms of cytochrome P450 and associated mono oxygenase activities were demonstrated in human brain mitochondria.<sup>19</sup> Similarly, the expression and localisation of thiol transferase was studied in human brains. These studies provided new insights on the metabolism of psycho-active drugs and environmental toxins in the brain. In addition, these elaborated the role of oxidative stress in brain damage and the functional status of the endogenous antioxidant, glutathione, with special reference to reperfusion injury following cerebral ischaemic and excitotoxic insult caused by environmental toxins and administration of some neuroleptics.<sup>18,20,21</sup> These studies revealed that the inhibition of mitochondrial complex-I in different brain regions, following the administration of a variety of neuroleptics, parallels their known propensity to generate extrapyramidal side effects. At the same time, these studies provided an explanation for the poor response to psychoactive drugs in nearly 40% of patients, in spite of adequate plasma levels.

The characterisation of 5HT<sub>2</sub> receptor mediated IP<sub>3</sub> and [Ca<sup>++</sup>] mobilisation was also studied in human brain samples provided by the Brain Bank. It was observed that there was nearly 50% decrease in the building of [3H]-Spiperone in both maniac depressive and neuroleptic syndrome patients. There was significant decrease in 5-HT-induced IP<sub>3</sub> formation in these patients. It was observed that antidepressants induce basal intracellular calcium mobilisation in a dose-dependant manner.<sup>22</sup>

The above are just a few examples to illustrate the range of studies made possible because of the establishment of a Brain Bank.<sup>2</sup> The scope and utility of such a bank are no doubt immense as tissue preserved can be accessed as new technologies and techniques are developed to study the pathology and pathogenesis of brain disorders which are not yet fully understood.

Besides specimens of whole brain, biopsy material, DNA samples and body fluids can also be preserved in a manner that can permit future biochemical, immunological and genetic studies.

A new role can be envisaged for Brain Banks: while collecting human brains in a fresh state during an autopsy, it may be possible to isolate stem cells from the hippocampus and olfactory bulb region where these are known to exist throughout life. Developing cell lines from these and manipulating them to differentiate into neurons capable of specialised function, which could then be made available for the replacement of damaged or dead neurons in patients with stroke, trauma or neuro-degenerative disorders. These neurons can be prompted to secrete deficient neurotransmitters, for example, in cases of Parkinson's disease or provide the nerve growth factor to promote neuronal regeneration.<sup>23</sup>

## Conclusion

It is generally recognised that notwithstanding immense advances, the knowledge about the structure and functions of the brain remains grossly inadequate. Brain Banks can be a valuable source of promoting neuroscience research to advance this knowledge. A fetal brain repository can be utilised to study brain development, which may lead to a better understanding of not only developmental defects, but also provide new insights about brain disorders manifesting in adult life as has been observed in cases of certain epileptic syndromes and schizophrenia. Adult brains can be studied to understand pathogenesis and pathology of brain disorders, utilising newer and more sophisticated investigations as these develop. Findings in different populations can be

compared, which may throw new light on variations in incidence and pattern of brain disorders in different population groups or regions of the world. In case of rare disorders for which no investigator can accumulate sizeable personal material, a bank can help by collecting specimens at one place and sharing it with interested scientists. Close cooperation of clinicians and pathologists is necessary to provide valuable material for the bank and in turn utilise it for advancing our knowledge of the brain in health and disease.

## References

1. Albright Jr RE, Christenson RH, Schold SC, et al. Establishment of a CSF bank. *Neurology* 1998;38:492-494.
2. Shankar SK, Mahadevan A. Relevance of human brain banking in neuroscience – A national facility. *Annals of Indian Academy of Neurology* 1999;2:59-70.
3. Damayanti N, Wadhwa S, Bijlani V. Development and maturation of lateral geniculate body in man. *Indian Journal Medical Research* 1983;77:401-408.
4. Bijlani V, Wadhwa S, Hamori J. Immunohistochemical localization of GABA-ergic cells in the developing human dorsal lateral geniculate nucleus. *Neuroscience-Letters* 1985;65:97-101.
5. Tandon PN, Gourie Devi M. Neuroscience in India : An overview. *Annals of Indian Academy of Neurology* 2000;3:3-21.
7. Rath G, Gopinath G, Bijlani V. Central canal and ependyma of developing human spinal cord. *Journal of the Anatomical Society of India* 1986;23:131-138.
8. Hayaran A, Wadhwa S, Gopinath G, Bijlani V. Developing dentate nucleus in man: A qualitative and quantitative study. *Experimental Brain Research* 1992a;89:640-648.
9. Hayaran A, Wadhwa S, Bijlani V. Cytoarchitectural development of the human dentate nucleus: A Golgi study. *Developmental Neuroscience* 1992b;14:181-194.
10. Masood F, Wadhwa S, Bijlani V. Immunohistochemical study of neurotransmitter profiles in developing human visual cortex. *International Journal of Developmental Neuroscience* 1993;11:(3):387-397.
11. Sailaja K, Gopinath G. Developing substantia nigra in human: A qualitative study. *Devl. Neurosci* 1994;16:44-52.
12. Sailaja K, Gopinath G. Ultrastructure of developing substantia nigra in humans. *International Journal of Developmental Neuroscience* 1996a;14:761-770.
13. Sailaja K, Ahuja, RK, Gopinath G. Biparietal diameter: A useful measure for determining gestational age of human abortuses. *National Medical Journal of India* 1996;9:165-167.
14. Jotwani G, Itoh K, Wadhwa S. Immunohistochemical localisation of tyrosine hydroxylase, substance P, neuropeptide Y and leucine enkephalin in the developing human retina. *Developmental Brain Research* 1994;7:285-289.
15. Nag TC, Wadhwa S. Calbindin and parvalbumin immunoreactivity in the developing and adult human retina. *Developmental Brain Research* 1996;93:23-32.
16. Nag TC, Wadhwa, S. Neurotrophin receptors (Trk A, Trk B, Trk C) in the retina of developing and adult human. *Developmental Brain Research* 1999;117:179-189.
17. Uday Muthare, Yash TC, Shankar SK. Low numbers and no loss of melanised migral neurons with increasing age in normal human brains from India. *American Neurology* 1998;283-287.
18. Bhagwat SV, Boyd MR, Ravindranath V, Multiple forms of cytochrome P-450 and associated monooxygenase activities in human brain mitochondria. *Biochemical Pharmacology* 2000;59:573-582.
19. Bhamre S, Bhagwat SV, Shankar SK, Boyd MR, Ravindranath V. Flavin containing monooxygenase mediated metabolism of psycho-active drugs by human brain microsomes. *Brain Research* 1995;672:276-280.
20. Ravindranath V, Metabolism of xenobiotics in the central nervous system : Implications and challenges. *Biochemical Pharmacology* 1998;56:547-551.
21. Balijepalli S, Boyd MR, Ravindranath V. Human brain thiol transferase: Constitutive expression and localization by fluorescent in situ hybridisation. *Molecular Brain Research* 2000;85:125-132.
22. Brain Bank Annual Report 1997-1998.
23. Tandon PN, Neural stem cell research: A revolution in the making. *Current Science* 2001;80:507-514.

## Chapter 24

# Undergraduate Psychiatric Education Reforms and Training of General Practitioners in Primary Level Mental Healthcare

*K. Srinivasan*

It is now well established that a large number of individuals in the community suffer from significant psychological distress. The WHO estimates that at least 500 million people worldwide suffer from some form of mental illness. Mental disorders rank almost as high as cardiovascular disorders<sup>1</sup> and are projected to increase to 15% of the global disease burden. In the years to come, unipolar depression could become the second leading cause in the disease burden after ischaemic heart disease.<sup>2</sup> A significant proportion of such individuals seek help for their psychological distress from non-psychiatric physicians and general practitioners in a community setting. It is also well known that general practitioners frequently fail to detect and treat the emotional distress in many of their patients. A major reason for this lacuna is the gulf that has existed between psychiatry and the rest of medicine, a gulf that has been detrimental to both disciplines. This has prompted a movement towards integrating psychiatry with the mainstream health system, which clearly mandates that future doctors be better equipped, both in terms of knowledge and skills, to deal with common psychiatric problems. Exposure to psychiatry and behavioural sciences can contribute to a greater understanding of doctor-patient relationships, treatment resistance and poor treatment compliance and other related issues that are important for all doctors. Many national and international health organisations have called for a greater emphasis on undergraduate medical education in psychiatry.<sup>3-7</sup> Reforms in undergraduate medical education that include a greater emphasis on preventive and promotional aspects of health and the use of newer teaching methodologies in the form of integrative teaching modules have received considerable support.<sup>8,9</sup> These changes have prompted the World Psychiatric Association and others to develop a core curriculum in psychiatry for future doctors.<sup>4,7</sup>

In India, since the time of the Bhore Committee (1946) the need to emphasise social aspects in medical education has been realised. This committee also recommended that a department of psychiatry be set up in every general hospital. No significant progress was made in this regard till 1965, when the first seminar on undergraduate teaching in psychiatry, organised by the WHO and the Directorate General of Health Services, took place in the Central Institute of Psychiatry in Ranchi.

During this seminar, one of the salient findings was that most of the undergraduate teaching in psychiatry took place in psychiatric institutions, rather than in general hospitals. However, the post-1960 period saw an exponential growth in GHPUs in India. In addition, there was also a greater recognition for the need to integrate mental health services with the general health delivery system and for methods to provide mental healthcare at the primary health centre level.<sup>10-12</sup> This was more clearly formulated at a policy level in the National Mental Health Programme in 1982. A major objective of this plan was to enhance mental health training in undergraduate medical education. The National Health Policy 1983, which, was later adopted by the parliament, recognised the need for basic doctors to be equipped with appropriate behavioural attributes. These positive developments brought the focus back on strengthening psychiatric training in undergraduate medical education. A national workshop on undergraduate medical education in mental health was held in Pondicherry in 1983.<sup>3</sup> The recommendations of this workshop set out in detail a curriculum in both behavioural sciences and psychiatry, for undergraduate medical students. The report also suggested four to six weeks of clinical posting in psychiatry and integrated teaching in concert with other departments especially in the field of psychosomatic medicine. This workshop also recommended that psychiatry should be made a compulsory examination subject. Similar suggestions were made in a subsequent meeting held in 1992, under the aegis of the Medical Council of India.<sup>13</sup>

In parallel with the increasing interest to training in psychiatry in undergraduate medical education, it was felt that the social and behavioural science input in the training of medical doctors needed to be strengthened. In 1971, the University Grants Commission and the Indian Council for Social Sciences Research jointly appointed a committee to consider and specify the role of social sciences in the programmes of education for professionals in agriculture, engineering and medicine.<sup>14</sup> The committee felt that the inclusion of social sciences in medical curriculum could help doctors to be socially more aware and responsive to the needs of the community. The specific objective of social science in medicine was to shift the emphasis in training from a disease-centric approach to a more holistic community-oriented approach. However, a disappointing conclusion in one of the subsequent meetings organised at the Maulana Azad Medical College in Delhi in collaboration with the International Medical Sciences Academy on the role of social science in medicine was that medical students did not take social science seriously. Notwithstanding this, it was universally recognised that social and behavioural sciences are salient to psychiatry, in the same way as physiology and biochemistry are to medicine.<sup>6</sup> Considering the importance of providing adequate socio-behavioural orientation in the training of medical doctors, a national workshop was organised at AIIMS, New Delhi in 1994. During this workshop, one of the major objectives was to develop a consensus on the scope, strategies and the technology for strengthening the social and behavioural component in the training of medical doctors. The inclusion of behavioural sciences in the undergraduate medical curriculum would help foster a better patient-doctor relationship, improve communication skills such as breaking bad news, and facilitate a greater appreciation and sensitivity to the impact of illness on people.<sup>6</sup>

## **Training General Practitioners in Psychiatry**

In India, general practitioners, unlike their Western counterparts, receive little by way of training once they complete their undergraduate medical education. They are often considered a 'finished product', ready to practise clinical medicine and offer services to the community, once they leave the portal of medical school. Many studies in this country have shown that general

practitioners are inadequately equipped to deal with the emotional and psychiatric problems that they encounter in patients in their daily practice. Hence, there have been many attempts at providing general practitioners with the necessary psychiatric skills to identify, diagnose and treat common psychiatric disorders.<sup>15-20</sup> Although the various training programmes differ in terms of duration and content of training, the outcome of these orientation programmes in terms of attitudinal change and skills has been consistently positive. This encouraged the ICMR to launch a multi-centre study concerning the various aspects of training general practitioners in psychiatry.<sup>15</sup> This study showed that, prior to training, general practitioners obtained the lowest score on identifying and treating common psychiatric problems. However, with training, there was a significant change in their ability to detect and treat common psychiatric problems. The general practitioners themselves felt that in training programmes there must be a greater emphasis on practical demonstration of clinical features. There have also been successful attempts at teaching specific skills such as psychotherapy to general practitioners.<sup>17</sup>

### **Current Scenario**

Despite the felt need of medical students, health administrators and non-psychiatric physicians,<sup>21-26</sup> many authors have commented that our record in undergraduate psychiatric training has been dismal.<sup>27-31</sup> The reasons for this are manifold. First, in many institutions, undergraduate medical students are still sent for their clinical posting to psychiatric institutions rather than a department of psychiatry in a teaching general hospital propagating the negative stereotyped image of psychiatry. Second, psychiatry is often taught in the final clinical years completely divorced from the rest of medicine.<sup>7</sup> This tends to endorse the already existing impression that psychiatry as a subject, is in some way distinct and unique and continues to pose a hindrance to integrating psychiatry with the rest of the medicine. Many educators have commented on the need for a vertical integration of psychiatry training in the undergraduate medical curriculum, with initial exposure in socio-behavioural sciences to be followed by clinical psychiatry.<sup>33</sup> Third, undergraduate training in psychiatry tends to be still largely driven by traditional didactic methods of teaching. Mental health professionals, in general, have been slow to adopt newer teaching methods such as integrated teaching, problem focused teaching and the use of objectives, although these measures have been shown to improve the effectiveness and quality of undergraduate medical teaching.<sup>27</sup> Fourth, the content of curriculum and clinical training often does not reflect the clinical reality that a future general practitioner is likely to encounter in his or her daily practice. Undergraduate psychiatric curriculum often tends to ignore the 'common cold' of psychiatry, such as depression, anxiety and somatoform disorders, with an inordinate amount of time being spent on archetypal psychiatric conditions such as schizophrenia and bipolar disorders, which a general practitioner is less likely to encounter. Fifth, many authors have stressed the need for the evaluation and assessment of psychiatric training and that psychiatry ought to be made an examination subject.<sup>3,28</sup> Finally, there is a considerable variation in the content of curriculum, duration of didactic teaching and clinical training across various medical institutions in India.<sup>5,24,29,30</sup>

### **Future Directions**

It is abundantly clear that mental health professionals alone cannot meet the mental health needs of this country. In addition, many individuals with psychiatric conditions tend to visit their general practitioners, who are often ill equipped to identify and treat such patients. Many national

and international organisations involved in medical education have recognised the importance of imparting adequate training in psychiatry to undergraduate medical students who will be future doctors. The World Federation of Mental Health and the World Psychiatric Association have developed a core curriculum in psychiatry that can be used as a template by various countries for developing curriculum so as to meet their local needs. The Indian Psychiatric Association can emulate some of their peers, such as the American Psychiatric Association in the US and the Royal College of Psychiatry in the UK, who have taken a lead in the development of undergraduate psychiatric curriculum. It is also important that mental health professionals in India appraise their non-psychiatric colleagues and administrators about the sound scientific basis of modern psychiatry. Mental health professionals must also more actively engage in developing medical curriculum. Greater attention ought also to be paid to the aspects of psychiatry that need to be included in the curricula so as to make the learning process relevant to the needs of the doctors and the society. However, in doing so, one must avoid adopting a minimalist approach to the development of curriculum that undermines the very purpose of raising the status of undergraduate psychiatric training. There is an urgent need for the inclusion of psychiatry as an examination subject. Integrative teaching with other pre-clinical and clinical branches of medicine and problem-based learning modules would help to narrow the schism between psychiatry and medicine. A greater emphasis on clinical training in psychiatry during internship is necessary as, for future general practitioners, this would present the final opportunity to learn psychiatric skills.

The benefits of strengthening the psychiatric component in undergraduate medical education extends far beyond the primary objective of equipping our future doctors with better psychiatric skills. It will help to reduce the stigma that afflicts the mental health system. It would also help to reorient medicine and its practitioners, who have become too disease centric, in adopting a more humane and holistic approach to health and disease. If one considers that about 13,000 students enter the portals of Indian medical schools every year, a great and challenging opportunity beckons our educators and health administrators.

## References

1. World Health Organization. *The World Health 1999-Making a Difference*. Geneva: WHO, 1999
2. Ustun TBC. The global burden of mental disorders. *American Journal of Public Health* 1999;89(9): 1315-1318.
3. Trivedi S, Srinivasa DK. Report of National Workshop on Undergraduate Medical Education in Mental Health, Pondicherry: JIPMER 1983.
4. General Medical Council. *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*. London: General Medical Council, 1991.  
Government of India. *National Mental Health Programme for India*. New Delhi: Ministry of Health and Family Welfare, 1982.
5. Medical Council of India. *Recommendations on Graduate Medical Education*, 1983.
6. *National Workshop on Social and Behavioural Sciences in Medical Undergraduate Training*. New Delhi: Resource Book, AIIMS, 1994.
7. Walton H, Gelder M. Core curriculum in psychiatry for medical students. *Medical Education* 1999;33: 204-211.
8. World Federation for Medical Education. *Report of the World Conference on Medical Education*. Edinburgh: World Federation for Medical Education, 1988.

9. World Federation for Medical Education. Proceedings of the World Summit on Medical Education, Walton H, ed. *Medical Education* 1993;28:Suppl-1.
10. Alma Ata. Primary health care: Report of the International Conference on Primary Health Care, Alma Ata, USSR, Jointly sponsored by UNICEF/WHO, WHO, 1978.
11. Wig NN, Murthy RS, Harding TW. A model for rural psychiatric services-Raipur Rani experience. *Indian Journal of Psychiatry* 1981;23:275-290.
12. Isaac MK, Kapur RL, Chandrashekar CR, Kapur M, Parthasarathy R. Mental health delivery through primary health care. Development and evaluation of a training programme. *Indian Journal of Psychiatry* 1982;24:237-241.
13. Sharma SD. Subject sub-committee on psychiatry as a part of committee revision of undergraduate medical curriculum. Medical Council of India, 1992.
14. Social Sciences in Professional Education. *Agriculture, Engineering and Medicine*. New Delhi: Indian Council of Social Science Research. Allied Publishing Pvt. Ltd., 1975.
15. Shamsundar C. An exercise in exposing general practitioner to psychotherapeutic orientation. *Indian Journal of Psychiatry* 1987;29:97-106.
16. Gautam S, Kapur RL Shamsundar C. Psychiatric morbidity and referral in general practice. *Indian Journal of Psychiatry* 1980;22:295-297.
17. Shamsundar C, Kapur RL, Isaac MK, Sundaram UK. Orientation course in psychiatry for the general practitioners. *Indian Journal of Psychiatry* 1983;25:298-305.
18. Shamsundar C, Sundaram UK, Kalyanasundaram S, Pai S, Kapur RL. Training of general practitioners – a 2 years experience. *Indian Journal of Psychological Medicine* 1983;85-89.
19. Bhattacharya D, Choudhry JR, Mondal D, Boral A. Psychological crisis and general practitioners. *Indian Journal of Psychiatry* 1993;35:103-105.
20. Devi S. Short term training of medical officers in mental health. *Indian Journal of Psychiatry* 1993;35:107-110.
21. Prabha R. Social science teaching in undergraduate medical education in India. *Indian Journal of Medical Education* 1987;26:57-64.
22. Prabhakaran PR, Murugappan M, Devar JV. Undergraduate psychiatric education and attitudes of medical students towards psychiatry. *Indian Journal of Psychological Medicine* 1989;12:37-48.
23. Alexander PJ, Kumaraswamy N. Senior medical student's attitude towards psychiatry. *Indian Journal of Psychiatry* 1993;35:221-224.
24. Praveenlal K, Prabhavathy KS, Krishnamurthy K, Innah JM. Undergraduate medical education in psychiatry. Are we meeting the demands? *Indian Journal of Psychiatry* 1988;30:427-429.
25. Rao TSS, Rao N, Rudrappa DA, Reddy DER. Medical student's attitudes to psychiatry-interest to specialize in psychiatry. *Indian Journal of Psychological Medicine* 1989;12:23-28.
26. Tharayan A, Dutta S, Kuruvilla K. Undergraduate training in psychiatry and evaluation. *Indian Journal of Psychiatry* 1992;34:370-372.
27. Bhaskaran K. Undergraduate training in psychiatry and behavioural sciences-the need to train the trainers. *Indian Journal of Psychiatry* 1993;32:1-3.
28. Channabasavanna SM. Psychiatric education. *Indian Journal of Psychiatry* 1986;28:261-262.
29. Kuruvilla K. Coping with the reluctance to face reality. *Indian Journal of Psychiatry* 1995;37:1-3.
30. Trivedi JK. Importance of undergraduate psychiatric training. *Indian Journal of Psychiatry* 1998;40:101-102.
31. Wig NN. World Health Day 2001. *Indian Journal of Psychiatry* 2001;43:1-4.
32. Carr VJ, Hazell PL, Williams. Teaching psychiatry in an integrated medical curriculum. *Australian & New Zealand Journal of Psychiatry* 1996;30:210-219.
33. Sharma SD. General hospital psychiatry and undergraduate medical education. *Indian Journal of Psychiatry* 1984;26:259-263.

## Chapter 25

# Current Status and Future Directions

*Parmanand Kulhara • S. Chakraborti*

Psychiatry, like other branches of medicine, has to establish, maintain and monitor the standards of excellence and competence in its practice. The need to do so keeps increasing with the advances made in basic sciences, the advent of new technologies and the burgeoning of subspecialties in psychiatry. As in other countries, the growth of postgraduate psychiatric training in India has been intimately linked with the growth and development of psychiatry as an independent speciality in this country.

### Consolidation and Growth

In 1946, the Bhole Committee outlined its agenda for the modernisation of mental health services in India along scientific lines.<sup>1</sup> The recommendations of the committee laid particular emphasis on 'training in mental health work for medical men in India and abroad and for ancillary personnel in India'. A major outcome of these recommendations was the setting up of the All India Institute of Mental Health in 1954 at Bangalore, which later became the National Institute of Mental Health and Neuro Sciences (NIMHANS). This became the first postgraduate psychiatric training centre in India, when a Diploma in Psychological Medicine was introduced a year later. In 1962, the Mudaliar Committee considered the launch of such a centre as an important and positive development and suggested that each region or state should become self-sufficient in meeting the training requirements of its mental health personnel.<sup>2</sup> The other major development that had a significant impact on mental health training was the formation of General Hospital Psychiatry Units (GHPUs). Though such units were started as early as 1933, the 1960s saw a major spurt in their growth. These units have eventually emerged as key contributors to psychiatric training and research in India.<sup>3,4</sup> The Indian Psychiatric Society (IPS) has also played a leading role in the growth and expansion of psychiatric teaching in India. Psychiatric education, both undergraduate and postgraduate, has received particular attention of different subcommittees constituted by the IPS, and has been the subject of various workshops organised by it.<sup>5</sup> The NMHP, formulated in 1982, also took note of the lacunae in training for mental health professionals in India. National level workshops on the subject were also held under the auspices of this programme. Important recommendations, such as the setting up of task forces to monitor and improve the quality of education, or setting minimum standards for the number of teaching staff in GHPUs, were made as part of the NMHP.<sup>2</sup>

All these developments resulted in a substantial proliferation of postgraduate teaching centres, beginning from the 1960s. In the 1970s, there were about 15 centres that offered such training, and



about a 100 psychiatrists qualified each year.<sup>6</sup> By the 1980s, the number of centres had increased to more than two dozen, and over 150 psychiatrists were being trained annually.<sup>7,8</sup> An even greater expansion seems to have taken place since then. Currently, there are 51 centres offering MD courses in psychiatry, and diploma courses (DPM) are conducted in 28 centres. Overall, there are about 250 or more training posts in India at present.<sup>9</sup>

### **Quality Assurance**

In contrast to undergraduate teaching, postgraduate psychiatric training appears to be better organised and expanding. However, uniform guidelines and consistency in standards are sorely lacking.<sup>10</sup> This disparity in training standards was brought to the fore by a seminal survey carried out in 1983–1984.<sup>8</sup> In this survey, using a postal questionnaire, the author attempted to collect information about various medical institutions engaged in postgraduate psychiatric training with regard to their organisation, structure and teaching facilities. Of the 25 centres identified, 19 returned the questionnaire after completion. The findings revealed that 75% of these centres were in the setting of GHPUs. It was evident that despite an increase in the number of postgraduate teaching centres, the number of psychiatric beds was very low and constituted only 4% of the total beds in general hospitals. Though there was some uniformity in the time spent in teaching and the methods employed, psychiatric subspecialties were relatively neglected. Moreover, in about half the centres, trainees had no opportunity of exposure to mental hospitals. About 65% of these centres did not have any association or liaison with a rural clinic, which severely hampered training in community psychiatry. The level of medical staffing was inadequate in a majority of centres. The state of non-medical personnel (psychiatric nurses, psychologists, social workers, occupational therapists, etc.) was even worse. The authors felt that the situation in most centres was not conducive to comprehensive teaching at the postgraduate level, which meant that trainees were ill-equipped to take up the challenging roles of leaders and planners, as envisaged by the NMHP. Although such surveys have not been repeated, several other authors have also rued the absence of common minimum standards in postgraduate psychiatric education. The variability in duration of courses, in the content of curricula, in clinical postings and in research requirements, has been pointed out by some.<sup>10</sup> Others have drawn attention to relative neglect of areas, such as psychotherapy,<sup>11</sup> subspeciality training<sup>12</sup> or research methodology.<sup>13</sup>

### **Where do We Go from here?**

Although postgraduate psychiatric teaching in India appears to have flourished over the years, problems such as the lack of uniform standards, inadequate staffing and wide variations in course content are far too evident. For the quality of teaching to improve, these issues will need to be addressed. In this regard, there appears to be some consensus that the present requirement is for two (if not more) grades of psychiatrists: 'primary care' ones, adept at handling psychiatric problems at this level, and 'tertiary-level' psychiatrists, with the added responsibilities of teaching and research.<sup>2,5,12</sup> Despite concerns about producing a 'lesser' breed of psychiatrists, the need for two separate courses, the three-year MD and the two-year DPM, is still a felt need. It is envisaged that course content and methods of teaching in both courses will continue to be largely similar, only the emphasis on certain areas, for example, research requirements, will differ. The basic minimum with regard to structure and organisation of postgraduate teaching centres has been clearly spelt out on various occasions.<sup>4,10,12</sup> Ensuring these are adhered to appear to be the much bigger challenge.<sup>8</sup> Having standardised curricula can easily do away with disparities in what is taught, clinical postings, subspeciality training and ensure greater emphasis on areas such as

psychotherapy or research methodology. This process has been recently initiated by the Medical Council of India and can be expected to yield good results. Continuous monitoring in the form of audits, surveys and feedback from students is also required to maintain standards as well as enhance the quality of teaching. The post of a clinical tutor for in-house monitoring, coordination and implementation of teaching programmes, and the supervision of trainees has also been suggested.<sup>12</sup> Such tutors are regular features of postgraduate training programmes abroad, where they play an important part. Finally, a lot more needs to be done to motivate medical students to choose a career in psychiatry. Low recruitment to psychiatry is not exclusively an Indian phenomenon. However, studies have shown that for Indian medical students, this is more likely to be related to inadequate exposure to the subject and the perception of psychiatry as an unrewarding career, rather than unfavourable attitudes towards psychiatry.<sup>14,15</sup> Thus, improving the quality of undergraduate teaching in psychiatry, in particular, and the image of psychiatry in general, may enhance the quality of postgraduate psychiatric training.

## References

1. Health Survey and Development Committee Report. Govt. of India Press, 1946; II:374
2. Ministry of Health and Family Welfare. National Mental Health Programme for India. Progress report, 1982-1988. New Delhi: Govt. of India, 1989.
3. Wig NN Psychiatric units in general hospitals: right time for evaluation (editorial). *Indian Journal of Psychiatry* 1978;20(1):1-5.
4. Kulhara P. General hospitals in postgraduate psychiatric training and research. *Indian Journal of Psychiatry*. 1984;26:281-285.
5. Neki JS. Report of the sub-committee of the Indian Psychiatric Society on public education in psychiatry and teaching standards in psychiatry in India. *Indian Journal of Psychiatry* 1964;6:72-76.
6. Mahal AS. Psychiatry in India (presidential address). *Indian Journal of Psychiatry* 1975;17:77-86.
7. Sethi BB. A plea for a National Institute of Psychiatry (editorial). *Indian Journal of Psychiatry* 1980;22:215.
8. Kulhara P. Postgraduate psychiatric teaching centres: findings of a survey. *Indian Journal of Psychiatry* 1985;27:221-226.
9. Medical Council of India. www.mciindia.org
10. Chanabasavanna SM Psychiatric education (editorial). *Indian Journal of Psychiatry* 1986;28:261.
11. Shamasundar, C. The need for a national forum for psychotherapy (Letter). *Indian Journal of Psychiatry* 1997;39:215.
12. Master RS. Psychiatric education in India. In: Desousa, 2A ed. *Psychiatry in India*. Bombay: Bhavani Book Depot, 1984;491-518.
13. Patel V. Research in India: not good enough? (Letter). *Indian Journal of Psychiatry* 2001;43:375.
14. John-Alexander P, Kumaraswamy N. Senior medical students' attitudes towards psychiatry: relationship with career interest. *Indian Journal of Psychiatry* 1993;35:221-224.
15. John-Alexander P, Kumaraswamy N. Impact of medical school experiences on senior medical students' interest in psychiatry. *Indian Journal of Psychiatry* 1995;37:31-34.

## Suggested Reading

1. A good guide to the history of psychiatry in India can be found in the book by Alan DeSousa *Psychiatry in India* Bombay: Bhavani Book Depot, 1984.
2. The status of undergraduate psychiatric education in India has been the subject of several articles. For a comprehensive overview the articles by Dr Kumar and Dr Bhaskaran are recommended. Bhaskaran K Undergraduate psychiatric education. *Indian Journal of Psychological Medicine* 1988; 11:51-55; Kumar K.A Undergraduate psychiatric education. *Indian Journal of Psychological Medicine* 1988;11:169-173.
3. Objectives of the NMHP are clearly spelt out in the document—National Mental Health Programme for India. New Delhi: Govt of India 1982.

## Chapter 26

# Status of Psychiatric Education at Postgraduate Level

*A. K. Agarwal • Madhukar Katiyar*

Psychiatry and postgraduate psychiatric education have made rapid progress over the last half century in India, as mirrored elsewhere in the world. Earlier, psychiatry was an unexplored 'medical' territory, with postgraduate psychiatric education being almost non-existent. The little material that was present, was overwhelmingly based on psychoanalytic theories and dynamic symptoms interpretations. There were only a handful of effective psychopharmacological agents and Electro-Convulsive Therapy (ECT). Therefore, psychiatric education (largely graduate and very little postgraduate) revolved around overcrowded, dehumanised mental asylums.

The milestones of psychiatry and psychiatric education over the last 50 years have been:

1. The Bhole Committee Report 1946: emphasising the improvement of the existing 17 mental hospitals, the provision of psychiatric education for doctors in India and abroad, and for ancillary personnel in India (Appendix A).
2. The Mudaliar Committee Report 1962: emphasising the education of mental health professionals and the sensitisation of all health personnel, nurses, school teachers and doctors, along with mental health training under the Community Health Volunteer Scheme (Appendix B).
3. The WHO Conference 1978: at Alma Ata, declaring 'Health for all by year 2000'.
4. The National Health Policy 1983: emphasising community participation and empowerment in mental health.
5. The National Mental Health Programme 1982: envisaged education and training of mental health professionals, namely, psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses, as well as training programmes in undergraduate psychiatry.
6. The District Mental Health Programme 1996: emphasising training of trainers.
7. The Mental Health Act 1987: which replaced the archaic Indian Lunacy Act 1912.
8. The Persons with Disabilities Act 1995: that includes mental disorders as one of the disabilities.
9. The World Health Day 2001: devoted to mental illnesses.

10. The World Health Report 2001: devoted entirely to mental illnesses.
11. The National Human Rights Commission Reports and various Public Interest Litigations against the poor quality of care in state-run 'asylums'.

On the eve of the independence of India, there were just a few qualified psychiatrists and no systematic, organised structure or facility that produced qualified psychiatrists in the country. Parallel to the above developments, an outstanding achievement in postgraduate psychiatric training in India occurred. With the formation of the All India Institute of Mental Health, now NIMHANS at Bangalore in 1954 and the Central Institute of Psychiatry at Ranchi, the first stream of the postgraduate Diploma in Psychological Medicine (DPM) began, followed by the MD course. Along with the establishment of the DPM and MD courses, a few decades later Diploma National Board (DNB) (formerly MNAMS) certification was started to make up for the shortfall in training colleges. In this third stream, a student trains in National Board 'approved' institutions and later appears in an examination conducted by the Board, obtaining an MD-equivalent postgraduate qualification. Since then, about 45 psychiatry postgraduate education centres have evolved all over the country, from which a meagre 100-120 MD, DPM, DNB trained psychiatrists graduate per annum.

With regard to the current status of psychiatry postgraduate education in India, it is heartening to realise that in some centres across the country, the quality of education imparted is near world class level, in the vast majority of postgraduate centres, owing to a multitude of causes, the standard is alarmingly low, disparate and haphazard. The main reason for this was that quality development was left to individual institutions which developed these postgraduate programmes and the resultant quality depended solely on the local resources and leadership. This should not be allowed to continue any longer, especially since its rectification would not be very expensive or time consuming.

Education, training and practice in psychiatry does not require the import and use of expensive equipment or other paraphernalia. What it requires is the judicious use of existing resources.

A conglomerate of existing centres of excellence needs to be formed, which should take up the following tasks in collaboration with the Medical Council of India:

- The formation of well-defined curricula and syllabi for a three-year MD degree in psychiatry.
- The formation of well-defined curricula and syllabi for one-year post-MD specialisations in psychiatry, such as child and adolescent psychiatry, geriatric psychiatry, substance abuse psychiatry, sexual medicine and forensic psychiatry.
- Compressing a two-year diploma course into one year, and reserving these for practising general MS physicians and non-psychiatric postgraduates, such as paediatricians.
- The formation of a core group of postgraduate psychiatry teachers and examiners with a centralised examination and accreditation body.
- The formation of basic modules of postgraduate teaching, which should be field-tested, periodically revised and universally employed in training.
- The full utilisation of modern, inexpensive and efficient tools and techniques of medical and psychiatric education, such as case and psychopathology videotapes, teleconferencing and telepsychiatry. Distances become meaningless while using off-line and online telepsychiatry in educating, training as well as examining postgraduate trainees.

- The introduction of the concept of visiting guest faculty and short inter-institutional trainee exchanges, to impart specific education aspects that are presently lacking at parent institutions.

### **The Status of Psychiatric Education at Undergraduate Level**

It is interesting as well as highly distressing to note that of the 150 medical colleges in India, nearly 25% do not have a department of psychiatry and provide a bare modicum of clinical psychiatric care and grossly insufficient undergraduate psychiatry education. For example, this is currently the scenario in all the government medical colleges (except one) in Uttar Pradesh, the most populous state in India, despite there having been established 30-50 years ago.

Further, the Medical Council of India, despite repeated representations to enhance the time allotted for undergraduate psychiatry training and to make psychiatry at least a minor medical subject, is still adhering to its half-century-old requirement of only a two-week undergraduate psychiatric education. This leads to the psychiatric non-sensitisation of a colossal number of new *doctors*, who harbour half-baked concepts of modern psychiatry and are, consequently, severely handicapped in adequately diagnosing, triaging and treating the simplest of psychiatric disorders in their patients. However, due to vagaries and 'requirements' of practice they are doomed to 'treat' these patients lifelong. In this process, they also unwillingly and unfortunately contribute to the further stigmatisation and mystification of the science of psychiatry. Also in this process, many 'potential future psychiatrists' fail to understand and appreciate psychiatry in its true form, and do not choose it as a career.

### **Non-Psychiatric Education at Postgraduate and Allied Super-Speciality Levels**

The second academic disaster occurs at the stage of non-psychiatric postgraduate education and super-speciality education, such as MD medicine, paediatrics and DM neurology, where once again, the basic/essential psychiatry training is glaringly absent. However, these specialists and super-specialists are 'forced' to 'see' and 'treat' a large proportion of psychiatric patients in their future professional lives. This regression and stagnation in psychiatric education at all levels stands out in stark contrast to the relative improvements in psychiatric postgraduate education.

A third but far more serious medical disaster that is waiting to make its presence felt nationwide, is the entry of private medical colleges and institutions, where, more often than not, sheer commercial considerations dilute the already weak and sub-standard academic standards. Stringent quality control and assurance/monitoring mechanisms have to be evolved for them.

We are at the threshold of a great opportunity and it is up to us how we handle it. There is no reason why India cannot become a world leader in the field of psychiatry, especially when it has become one in computer software. After all, only the application of mind and intellect are involved in both, with minimal requirement of expensive infrastructure.

## Chapter 27

# General Hospital-Based Psychiatric Training: The All India Institute of Medical Sciences Experience

*D. Mohan*

The All India Institute of Medical Sciences (AIIMS) was set up by an Act of Parliament, based on the recommendations of the Bhore Committee made in 1946, when India was administered by the British as a unitary state. At that time, there were many specialised all-India services like the Indian Education Service (IES), the Indian Forest Service (IFS) and the Indian Medical Services (IMS), in addition to the generalist Indian Civil Services (ICS) and the Indian Police (IP). When India became a republic in 1950, the unitary structure yielded place to a federal entity. Thus, many important subjects such as health, education and law and order passed into the state list, rendering services such as the IES and IMS redundant. Only two services, the Indian Administrative Services (IAS) and the Indian Police Service (IPS), successors to the erstwhile ICS and IP, respectively, survived. This significant development had the twin effects of reducing the status of the Civil Surgeon who, in earlier times, together with the Collector and Superintendent of Police (SP), was part of the troika which administered the district. The second and perhaps, more far reaching effect was that entry to the new state services became limited to those domiciled within the state. This eventually led to a parochial, 'sons of the soil' environment, which in many ways, undermined the very basis of the pan-Indian spirit behind the creation of institutions such as the AIIMS.

In the aforesaid context, it is essential to flag an unfortunate, though unintended and perhaps unforeseen, consequence. Those who were trained at the AIIMS, undergraduates as well as postgraduates, virtually lost their right to join the state medical services. This limited their employment options to the central medical services, including the Armed Forces, private practice and jobs abroad. Many chose the last option. Initially, some states exercised the prerogative of nominating serving state medical service doctors for postgraduate training at the AIIMS. Such sponsored candidates returned to their respective states and many rose to occupy the top positions. This practice gradually died down as the states developed their own training facilities and, now, few AIIMS alumni opt for service in their home states. This has led to accusations of elitism and of producing doctors for the affluent West. It has also diluted the primary mandate of the Institute—capacity-building in respect of highly trained manpower; development of new curricula and techniques of undergraduate and postgraduate education; and evolving viable models for rural healthcare.

## Psychiatric Training

At the time the AIIMS was founded, there were approximately 35 medical colleges in India. Postgraduate training in psychiatry was available only at two places in the country, Ranchi and Bangalore. One of the members of the Bhore Committee was a psychiatrist, who carried out a survey of all existing mental asylums in India. He was aware that the world had, even then, moved on from asylum psychiatry and that mental healthcare, with the advent of psychotherapy, Electro-Convulsive Therapy (ECT) and pharmacotherapy over the preceding decade, was well on its way to join mainstream medicare. It was, therefore, only appropriate that training in the speciality should also move out of the custodial asylum environment to the stimulating, multidisciplinary general hospital setting.

These winds of change were not, however, welcomed by all. Well-meaning pillars of the psychiatric establishment felt strongly then, as some die-hards continue to do even to this day, that no worthwhile training in psychiatry was possible except in mental hospital-based centres such as the ones at Ranchi and Bangalore. The pioneering experiment at the AIIMS demolished this myth for ever. It was clearly demonstrated that psychiatry was another medical speciality, and that training in it could be imparted in a general hospital setting, at par with other basic and clinical specialities. This was, perhaps, the single-most important lesson from the AIIMS experiment and it changed the course of psychiatry in India for good. Other institutions followed suit in quick succession and strong postgraduate training centres emerged at the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh; King George's Medical College, Lucknow; Sawai Mansingh Medical College, Jaipur; B.J. Medical College, Pune and a host of others. In this context, one interesting fact needs to be highlighted: training for MD (Psychiatry) at the AIIMS began and was sustained for several years with just 10 in-patient beds. General hospital psychiatry had finally come into its own, belying the dark forebodings of the prophets of doom.

The second major contribution relates to undergraduate training in psychiatry. Going beyond the 10 hours prescribed for the purpose by the Medical Council of India, training at the AIIMS was started during the pre-clinical phase of the MBBS course. It was hoped that this innovative measure would eventually lead to psychiatry being recognised as an independent subject, on the lines of medicine and surgery, in the undergraduate curriculum. This promise was, however, belied and expectations in this regard have remained unfulfilled even to this date. The reason is not far to seek: the other medical disciplines were not willing to share the teaching and clinical time with psychiatry. The failure of the AIIMS faculty to appreciate this vital need helped perpetuate the status quo. Had a more enlightened and generous attitude prevailed, the future course of undergraduate medical education in India would have, perhaps, taken a different course and we would not have been bemoaning the lack of even basic mental health skills among our medical graduates. Even though the subject continues to be taught at the AIIMS more extensively than in any other medical institution, it has failed to gain full acceptance at the undergraduate level and initial expectations have remained unfulfilled.

Another path-breaking contribution of the Department of Psychiatry at the AIIMS was the attempt to develop rural mental health services, through the Indian Council of Medical Research (ICMR)-funded mental health project at the Ballabgarh Community Centre during 1964. Perhaps, for the first time anywhere in the world, individual/group psychotherapy and pharmacotherapy were used concurrently in a rural, community-based setting. This bold experiment yielded robust results, which were duly documented. The moving spirit behind this pioneering initiative was Professor D. Satyanand, the first Head of the Department of Psychiatry at the AIIMS. Unfortunately,

due to his retirement midway through the project and subsequent demise, the endeavour lost its momentum and eventually withered away. Even more unfortunately, the documentation related to the project, which had been submitted to the ICMR, is now untraceable. It is, however, gratifying to note that it is still part of the undergraduate rural health training programme, though in a modified form. It may be noted here that this rural mental health programme had been introduced at the AIIMS in the early 1960s, almost 15 years before PGIMER, Chandigarh reintroduced it.

The postgraduate training programme was launched in 1962, with the first batch of three trainees, who obtained their MD (Psychiatry) in 1964. In this early period, the programme attracted a number of students from several state medical services, notably Andhra Pradesh, Kerala, Himachal Pradesh, Rajasthan and the Northeastern states. A substantial number of Armed Forces doctors were also trained. Initially, there were separate examinations in neurology and psychiatry, and each had to be cleared separately to qualify for the MD. This practice was subsequently discontinued, as it was felt that instead of having neurology as a full subject, the candidates should be examined only in respect of those elements of neurology which were relevant to the practice of psychiatry. A posting in neurology during residency training, however, continued to be mandatory. The core feature of academic as well as clinical training was the stress on the self-learning model, similar to other clinical disciplines. Didactic teaching was not favoured at the AIIMS. Tutorials, seminars, journal clubs and case-conferences remained the backbone of training. Strong OPD training, including compulsory attendance at specialised clinics like the epilepsy clinic, child guidance clinic and neurology clinic, combined with regular ward-rounds in psychiatry and neurosciences, provided a balanced clinical orientation. In the clinical area, apart from an exposure to rural health, two other features remained an integral part of training. Psychiatric emergency services in the casualty department were started from the very inception of the institute and continue till the present day. In fact, the AIIMS is the only hospital in Delhi to provide such services. In addition to this, in order to respond to the needs of interdepartmental OPD referrals, a *walk-in clinic* was introduced in the mid-1970s. This innovation, which antedated the formal advent of consultation-liaison psychiatry, became immensely popular. Over the years, it has expanded its catchment area to include fresh patients, who are directly routed to this clinic from the registration counter. In fact, the walk-in clinic now functions as a screening OPD for psychiatry.

The other firsts achieved by the psychiatry department at the AIIMS included the first *child-guidance clinic* in Delhi, started in 1964 and the *substance-abuse* unit in 1976. The posting of trainee residents was compulsory in both.

Training in psychiatric research forms an integral part of the MD course. Candidates have to work in a specified area under the close supervision of the faculty research guide, and write a thesis which, after internal assessment, is evaluated by external examiners. High quality research papers have resulted from such MD theses. In this respect, three distinct phases can be identified. The initial decade was dominated by dynamically oriented MD thesis topics, while in the next two decades, the focus shifted to biological psychiatry. In the subsequent decades, much of the work was phenomenologically oriented. Child and adolescent psychiatry, geriatric psychiatry and substance abuse also attracted greater attention. Funded research at the AIIMS focused mainly on epidemiology of substance abuse, interspersed with general population/community-based surveys.

Psychiatric training to para-professionals remained a strong part of academic activities at the AIIMS. It was provided to B.Sc. (Hons) nursing students as well as to speech therapy and audiology trainees. Interestingly, more psychiatry and psychology are taught to nurses, for whom these are examination subjects, than to undergraduate medical students. A new course in human biology



was also introduced. The essential purpose of the course was to train students who would constitute the second tier of researchers and technicians. This course had a very heavy component of behavioural sciences, which was a compulsory subject of examination. A number of other basic science disciplines also formed a part of the curriculum. Upgradation of the course to the Master's level in human biology was also contemplated. This did not take place, and eventually the course became a dead-end academic activity, as little thought was given to career planning and the graduates had few employment opportunities.

Thus, psychiatry and psychology at the AIIMS passed through many travails over the past 50 years, with many ups and downs and several course corrections, both at the undergraduate and postgraduate levels. Undergraduate psychiatry did not take firm root, despite the early head start, mainly because it was not accorded the status of an independent subject, without which little could be achieved.

The concept of postgraduate psychiatry training in a general hospital setting, however, became well-established and was a pace-setter for the rest of the country. In fact, this could be called a defining moment in the history of mental health in India. The established dogma that such training was possible only in a mental hospital setting was demolished. This provided a major impetus to the development of additional mental health manpower training centres across India. It will not be incorrect to say that were it not for the AIIMS success story, the subsequent course of the development of mental health services in India would have been completely different. There was, however, lack of uniformity in respect of standards of training and examination in the large number of postgraduate training centres that followed the AIIMS. The state medical colleges were affiliated to various universities, under the overall control and guidance of the University Grants Commission and the Medical Council of India, with their own curricula and board of examiners. These were subjects to local preference and pressures, which often played a negative role. This was one of the reasons for the creation of the National Board of Medical Examiners, which awards its own diploma, the DNB (Diploma National Board) and has maintained uniformly high standards. It might be worthwhile examining the possibility of extending the jurisdiction of the National Board to include the conduct and superintendence of MD and DPM examinations.

## **Conclusion**

The AIIMS story is, thus, a mixed bag of many successes and some failures. It did, however, provide a vibrant model for several reasons. Psychiatric training moved out of the custodial mental hospital domain into the highly competitive and stimulating general teaching hospital environment. Postgraduate trainees acquired broad-based clinical skills as well as competence in consultation-liaison psychiatry. They became used to working in a proactive mode where brief hospitalisation was a necessity due to the heavy pressure on the limited number of beds available for in-patient care. This promoted the culture of out-patient treatment for most mental disorders, including major depressions and psychoses. The excellent results of such community-based, family-centred mental healthcare contributed in no small measures to the eventual evolution of the national mental health programme in India.

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**Section IV**  
**Special Groups**

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## Chapter 28

# Child and Adolescent Psychiatry in India: Slow Beginnings and Rapid Growth

*Savita Malhotra*

Child and Adolescent Psychiatry (CAP) came into existence as an independent discipline in Europe and America around the beginning of the twentieth century. The first child guidance clinic started in America in 1909 in Chicago. It soon grew into a child guidance movement in the USA. As a step towards providing continuing education and professional identity in the field of child psychiatry and child mental healthcare, the American Orthopsychiatric Association was founded in 1924. The *Journal of American Orthopsychiatric Association* was started in 1930. Further developments occurred more rapidly with the establishment of American Association of Psychiatric Clinics for Children in 1945 and American Academy of Child Psychiatry in 1952, which approved standards of training in child psychiatry. At present, the American Academy of Child and Adolescent Psychiatry has about 6,000 members and has its own journal. The American Board of Psychiatry and Neurology recognised child psychiatry as a subspeciality of psychiatry in 1957 and established an independent subspeciality board as the accreditation body.

Similarly, the discipline of child and adolescent psychiatry is acknowledged as a medical speciality in almost all European countries. Professional organisations and national societies of child and adolescent psychiatry came into existence in France in 1937; in Germany in 1940 and subsequently in most other European countries over the years. The Union of European Pedopsychiatrists (UEP), later changed its name to the European Society for Child and Adolescent Psychiatry (ESCAP) was formally inaugurated in Paris in 1960 at the first European Congress. In the UK, a national enquiry recommended in 1939 that psychiatric services for children, earlier provided in psychiatry hospitals, should be separated from adult services.

CAP now is recognised as an academic super-speciality of psychiatry with an independent status in most developed parts of the world. The level of development of a country as a society, can be judged by the adequacy of mental healthcare provided to its children and adolescents. The levels of linkage between CAP and adult general psychiatry varies across countries.

Interestingly, CAP in the USA did not emerge from adult psychiatry or paediatrics (as could be expected), but from social psychological sciences and the judicial system. In Europe, both biological as well as psychodynamic-psychoanalytic streams of psychiatry exercised significant influence in the evolution of CAP. These influences are still visible.

At the global level, the International Committee for Child Psychiatry was founded in 1935. Later, in 1947, it was incorporated into a professional organisation called the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) with the purpose to promote the study, treatment, care and prevention of mental and emotional disorders and difficulties of children, adolescents and their families. Members of IACAPAP comprise national organisations/societies of child and adolescent psychiatrists and other mental health professionals all over the world. At present, there are about 50 national organisations that are members of the IACAPAP. It emphasises on the effective collaboration among child psychiatrists of the allied professions and psychology, public health, nursing, child development, social sciences and other professionals for their contributions to research and practice in CAP.

### **The Beginnings (1950–1980)**

In India, developments in child and adolescent psychiatry have been slower. The first ever child guidance clinic in the country was started in Mumbai by the Tata Institute of Social Sciences in 1937. The Indian Council for Mental Hygiene was established in Mumbai, giving impetus to the establishment of child guidance clinics, with some programmes there and in other big cities in the 1940s.

However, the movement did not gain credence in the rest of India until the establishment of departments of psychiatry in medical colleges/institutes in the 1950s. Some hospitals started child guidance clinics, but many teaching institutions were not as progressive. The first school for mentally retarded children was started by the Society for the Care, Prevention and Rehabilitation of Mentally Retarded Children in Mumbai. Even today, not all departments of psychiatry in teaching hospitals provide services for child mental health.

Until the 1980s, there was a very gradual increase in the number of child psychiatry clinics till it grew to a figure of 120 clinics in India, which were mostly located in large metropolitan cities, managed by a total professional staff of about 400. Services offered by these centres vary a great deal in scope and coverage. There were 286 institutions for the mentally handicapped, with approximately 2,000 qualified professional staff for about 12,200 mentally handicapped persons enrolled in these institutions.

There are about 25,000 psychiatrists and approximately an equal number of qualified psychologists, psychiatric social workers and psychiatric nurses in India. Only about half a dozen academic departments and institutions of psychiatry are engaged in significant research and teaching of child psychiatry and no more than 20 offer specialised child mental healthcare. Considering that 47% of the country's population is below the age of 19 years (about 24% below 10 and 23% between 10 and 19 years), there would be about 470 million children and adolescents. Of these, about 10–15% are estimated to suffer from psychiatric disorders and 3% from mental retardation; the number requiring psychiatric care is a staggering figure. It is evident that the facilities for psychiatric care of children and adolescents in the country are meagre and highly deficient.

There are only a handful of psychiatrists, most of whom are general adult psychiatrists, practising in large institutions or hospitals, who provide care to children in need of psychiatric help. Paediatricians take care of the neurological development and disorders in infancy and early childhood. They are unable to deal with psychiatric disorders, developmental disabilities and other mental health problems due to their heavy workload and also because of lack of training and exposure to child psychiatry in postgraduate training programme, attributable largely to the absence of such facilities and departments.

Untreated mental illness, mental disability and developmental disabilities in children have major consequences for their mental health outcomes in terms of personality development and mental disorders in adult life. Longitudinal research in recent years has shown that about one-half of mental morbidity in childhood continues in adulthood and contributes to the development of personality disorders such as antisocial, affective disorders, somatisation disorders, alcohol and drug abuse, poor job performance, unstable interpersonal relationships, accident proneness and low academic achievement. Research on psychiatric disorders commonly seen in adulthood has shown that there is an aetiological link with childhood experiences; for example, the neurodevelopmental hypothesis for schizophrenia and early maternal loss and depression in adulthood. There is robust research evidence in support of the significance of a healthy early childhood for adult mental health. Rootedness of personality development and adult psychopathology in early development through infancy and childhood as was propounded by the psychoanalytic theory has been reconfirmed. The psychoanalytical theory was earlier criticised for being retrospective in its reconstruction. However, contemporary research in child and adolescent psychiatry has been largely prospective. It can be said that research in CAP has contributed a great deal to understand adult psychiatric disorders and therefore, provides tremendous scope for primary prevention. If there was one single recommendation needed for primary prevention of psychiatric disorders, it would be the provision of adequate child mental health services.

In India, development of CAP has not kept pace with the developments in general adult psychiatry. The reasons are not difficult to understand. Of course, general psychiatry has been trying to find its own place and identity as a medical speciality and still needs to cover a lot of ground in the undergraduate medical education; starting recognised postgraduate training courses at more centres and starting centres of excellence for research and teaching in the country. The lack of teaching of the new knowledge in child psychiatry due to the absence of facilities for training in CAP in a majority of psychiatry departments adds to the failure to see the potential. The lack of recognition and administrative support of CAP, such as the absence of jobs and dedicated departments and poor career prospects, leads to a feeling of hopelessness among psychiatrists.

### **The Growth (1980-2000)**

The resurgence of the child psychiatry movement in India can be traced back to the 1980s when the first national level workshop was organised at the Department of Psychiatry, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh in 1988. Many leaders in general psychiatry, including those who were keenly interested in and already practising child psychiatry, participated in order to define the needs and priorities in child mental health at the national level. The proceedings of the workshop and recommendations were published in the form of a book. Inadequacy of resources, patchiness of planning, absence of training and research facilities, and the lack of trained professional manpower were emphasised. One of the recommendations was to start a professional organisation dedicated to research and growth of child psychiatry in India. The Indian Association of Child and Adolescent Mental Health (IACAM) was formed and registered in 1991. It is a multidisciplinary professional organisation with psychiatrists, psychologists, social workers, paediatricians, child development experts, speech and occupational therapists and special educators as its members. It has grown into a strong body in the span of 10-12 years. The IACAM holds national conferences and Continuing Medical Education (CME) programmes once in two years has a biannual newsletter; and is affiliated to the

IACAPAP and the Asian Society for Child and Adolescent Psychiatry as a full member. The IACAM has provided a forum to all professionals interested in child and adolescent mental health in India with a lot of qualitative research presented at their conferences. There are a growing number of young psychiatrists who are showing interest in the subject.

The Indian Psychiatric Society (IPS) which is the main body of psychiatrists in India, started a section on CAP in the mid-1980s and began to hold CMEs and dedicate a session to CAP at its annual conferences on a regular basis. Indian psychiatrists started organising CMEs, workshops and training seminars at local and regional levels under the aegis of the CAP section of the IPS. At a national workshop on Postgraduate Education in Psychiatry, organised by the Psychiatric Education Committee of the IPS on 26 September 1988 at Mumbai, it was recommended that child and adolescent psychiatry should be recognised as a super-speciality of psychiatry and that postgraduate training courses should be established in India. The IPS approved the DM (a post-doctoral qualification—internationally used term like MD) course in CAP in India in 2000.

The Indian Council of Medical Research (ICMR) recognised child psychiatry as one of the thrust areas for research in India in 1980 and constituted a task force on the psychological problems of children. A major multi-centred task force project in child psychiatry studying the clinic-based epidemiology of childhood psychiatric disorders was initiated as a result of their deliberations. The ICMR reaffirmed it in the Eighth Plan as well as in the subsequent five year plans.

Continuing the focus on research in child psychiatry, another multi-centred task force project was carried out during 1992–1995 on the community-based prevalence study of psychiatric disorders in children and adolescents. Several ad hoc projects have been funded by the Council in the last 20 years.

The Standing Committee on CME of the National Academy of Medical Sciences under the chairmanship of Dr J.S. Bajaj on 4 June 1992, identified child psychiatry as a speciality in which CMEs should be held nationwide. Structural guidelines for CMEs were prepared by the committee constituted for this purpose at its meeting held on 13 July 1992. The Speciality Board in Psychiatry of the National Academy of Medical Sciences, at its meeting held on 15 April 2002 at New Delhi, recommended the inclusion of a fellowship programme in child and adolescent psychiatry in the National Board's (of Medical Examiners) super-speciality courses.

A bilateral collaboration in child mental health between the Department of Psychiatry, PGIMER, Chandigarh and Guy's Hospital, London was established under the Higher Education Link Scheme of the British Council during 1991–1995, which provided an excellent training opportunity for the staff at PGI and gave importance to the service and research there.

A proposal to start post-doctoral DM courses in CAP at PGI was mooted in 1995, which was followed up by other centres such as NIMHANS, Bangalore. It is heartening to note that NIMHANS is almost through with all the formalities and is ready to start the first DM course in India.

It is evident that over the past 25 years, child psychiatry in India has assumed respectability and recognition as a subspeciality of psychiatry. An increasing amount of research and publications in the field bear testimony to this. A general psychiatrist who earlier (because of lack of knowledge) treated a child as nothing more than an 'immature adult' now has the opportunity to learn about the unique individuality, developmental dimension and qualitative aspects of the life and mind of a child in a life span perspective. Studies on neurodevelopment, through foetal life, infancy and childhood periods; the neurological basis of mental phenomena like perception, thinking and emotions; the neurological basis of social phenomena like social smiles, social relationships, theory of the mind, studies on the neurological basis of empathy and the concept of beauty now constitute

the frontiers of research in neurobiology and molecular biology. Psychopharmacology of childhood psychiatric disorders has also gained ascendance in recent years.

In India, research in child psychiatry so far has focused on clinical description. The reasons are not difficult to understand. Ethnocentrism in child psychiatry is well known. Therefore, child psychiatry research in India had to begin with the description of clinical conditions, definition and delineation of phenomena, identification of aetiological factors and correlated dimensions, the assessment of treatment needs, the adaptation and evaluation of known treatment methods, the development of service models and programmes and so on. The necessary infrastructure in the form of relevant instruments and tools for measurements, research methodology appropriate and applicable to local conditions also had to be developed.

Since then, there have been rather rapid strides and developments in child psychiatry in India. What can be termed a slow beginning through the 1980s gained momentum evident at several levels through the 1990s; it appears set for big strides in the twenty-first century.

### **The Reckoning (2000 onwards)**

The IACAM, since its inception in 1991, has been making significant steady progress and it had organised the International Congress of Child and Adolescent Psychiatry and Allied Professions (ICCAPAP) in New Delhi in 2002, which was attended by about 650 delegates from 45 countries.

This Congress increased the visibility of the discipline of child psychiatry with public and in government circles. It also helped to raise its profile among mental health professionals who now see tremendous opportunity and potential for treatment and research in this field in India. The Child Psychiatry Section as well as the zonal and state branches of the IPS have become very active and organise seminars, workshops and CMEs on a regular basis. A greater number of psychiatry departments in institutions/medical colleges, both in government and the private sector have established separate facilities for the mental healthcare of children. The number of postgraduates showing special interest in child psychiatry by taking up research or optional posting has also increased tremendously.

A few excellent centres for training and research in child psychiatry have been established in India. Notable among these are NIMHANS (Bangalore), King George's Medical College (KGMC) (Lucknow), PGIMER (Chandigarh). While NIMHANS and KGMC provide exclusive in-patient and out-patient services, the services at PGIMER are more integrated with general psychiatric and paediatric services.

NIMHANS is the premier institute and occupies a place of pride for psychiatry as a whole. They have a separate unit of child psychiatry with its own independent building and staff within the department of psychiatry, providing the best resources and facility in the country. Multidisciplinary CAP units have also been established at the AIIMS, New Delhi; Niloufer Hospital, Hyderabad; CMC, Vellore; at Chennai, and CIP, Ranchi. At most of the places, except at NIMHANS and Niloufer Hospital the staff who look after adults as well is only part-time. Due to the resource crunch, research and training suffer the most. So, we may find very active service units, but little published research output. In this manner, there exists in India a group of highly experienced and competent child psychiatrists and psychologists who can take the leadership role in starting academic programmes and super-specialisation in child psychiatry at several places in the country.

Major research projects sponsored by ICMR and other agencies have yielded a rich harvest of research papers, books and other publications.



## **The Future**

With regard to the future directions for child psychiatry in India, it has clearly arrived on the national agenda, become visible to the public eye and is seen as an important speciality of psychiatry, much in demand for service and training. The situation is ripe and all that is needed is a concrete and focused effort in this direction. An action plan to meet this growing need requires to be put in place and the steps required at various levels are as follows:

1. Accord the status of medical super-speciality to CAP (paralleling the distinction between paediatrics and internal medicine), by NAMS, MCI and start post-doctoral training courses, for example, DM in CAP and Fellowship of the NAMS.
2. Start dedicated and specialised mental health service for children and adolescents at all departments of psychiatry and paediatrics that have postgraduate courses in India.
3. Make training in CAP mandatory for MD paediatrics and MD general psychiatry courses.
4. Develop centres of excellence for training and research in CAP in India.
5. Have a national policy on child mental health that has a holistic and integrated perspective.
6. Child mental health issues should figure in all development related policy and planning in India.
7. Stimulate research in the field in India to create the necessary database, need and evaluation programmes, developing models of care and intervention that are relevant, appropriate and cost-effective.

## Chapter 29

# The Mental Health of Women: Years of Neglect and a Ray of Hope

*R. Thara*

India is a land of contradictions. While we worship the cow as a sacred animal, most of us drive past a cow or a bull that is being mercilessly beaten while struggling to pull heavy cartloads up a steep road. The same holds true for women. Many religions worship women deities and goddesses, but this reverence for the female gender is seldom translated into real life. The daily newspapers carry news of female infanticide, rape of young female children, wives tortured for not bringing enough dowry, the abuse of women at home and at work, discrimination against women, denial of their basic rights and even the glorification of the medieval practice *sati*, where the woman is deified for jumping into the funeral pyre of her husband. They are all sordid tales of apathy, neglect and indifference to women's woes. Apart from tainting Indian society, all of these carry immense implications for the mental health of women.

This chapter provides an overview of women's mental health issues, but does not cover the subject of violence against women.

'No society treats its women as well as its men'.

*UNDP Report<sup>1</sup>*

'Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination'.

*World Health Report<sup>2</sup>*

### The Relationship between Female Illiteracy and Mental Health

Alex Cohen in a recent publication has clearly described the association between female illiteracy and poor mental health.<sup>3</sup> Women belonging to a rural community in Himachal Pradesh had significantly more symptoms of somatic disorders and anxiety than men, and this was strongly associated with the lack of education, poverty and low caste.<sup>4</sup> A community psychiatric survey by Carstairs and Kapur determined that women had higher rates of psychiatric symptoms and that higher levels of education had a positive effect on the well-being of both genders.<sup>5</sup> While low levels of education did not seem to have a deleterious influence on the mental well-being of those in the age group of 15-20 years, lack of education did have a deleterious effect on the age

group 21–40 years, a finding that led Carstairs and Kapur to speculate that low levels of education restricted life opportunities and, therefore, resulted in mental distress at that time of life when individuals were seeking to establish themselves in their worlds. These effects seemed to be particularly strong among women.

The burden of disease and DALYs (Disability Adjusted Life Years) which have now been extensively studied show the importance of mental health of women in terms of role performance, productivity and health economics.

- For women, neuro-psychiatric conditions were the second leading cause of disease burden, following infections and parasitic diseases worldwide.
- For women between the age of 15 and 44 years, unipolar depression was the leading cause of disease burden in both developed and developing countries.
- Schizophrenia, bipolar disorder and obsessive-compulsive disorders also ranked in the top ten leading causes of burden for women aged 15–44 years.
- Projections till the year 2020 still foresee that the major impact of these six mental disorders will overwhelmingly affect women in this age group. The ageing effect of this population will not change the profile of the impact of these disorders.<sup>6</sup>

## Women and Common Mental Disorders (CMD)

Indian women suffer from CMD much more than men do. Both community-based studies and studies of treatment seekers indicate that women are, on average, two to three times, at greater risk to be affected by CMD.<sup>7,8</sup> There are a number of potential factors, which increase vulnerability of women to CMD. The reproductive roles of women, such as her expected role of bearing children, the consequences of infertility and the failure to produce a male child, have been linked to wife battering and female suicide.<sup>9,10</sup>

The areas of intersection of reproductive and mental health are considerable in scope and include, for example, psychological issues related to childbirth, violence, rape, adverse maternal outcomes such as stillbirths and abortions, reproductive tract surgeries, sterilisation, premarital pregnancies in adolescents, HIV/AIDS and the impact of caring, menopause and infertility.<sup>11</sup>

Rates of depression are high in women attending gynaecological clinics and qualitative studies demonstrate a strong relationship between vaginal discharge, weakness, psychosomatic symptoms and psycho-social stress.<sup>12</sup> Part of the aetiology of 'medically unexplained' vaginal discharge may be that it is a somatic idiom for depression and psycho-social distress.

Research in Asian countries has demonstrated a wide range of prevalence of Post Natal Depression (PND) from 3–36% of mothers after childbirth.<sup>13,14</sup> The majority of PNDs are self-limiting though, if untreated, this process of resolution may take up to 6–12 months.

Furthermore, the negative effects of globalisation and economic reform on public health are likely to hit women harder than men; for example, since the economic reforms and subsequent crisis in Southeast Asia, there has been a rise in reported domestic violence, rape and alcohol abuse.<sup>15</sup>

Indeed, 'it is not surprising that the health of so many women is compromised from time to time, rather, what is more surprising is that stress-related health problems do not affect more women'.<sup>6</sup>

## **Chronic Mental Illness**

Although the prevalence of chronic psychotic illnesses such as schizophrenia and bipolar disorders in women may be less than that of depression, anxiety and related conditions, they pose an immense problem in management and rehabilitation. Their propensity to be chronic, sometimes unresponsive to treatment, the resultant disability in various spheres of functioning, and above all the stigma attached to these illnesses and the social sequelae make it a public health issue.

While men and women are equally affected by schizophrenia, there have been some differences in their manifestation, course and outcome. A consistent finding has been a higher mean age at onset and first hospitalisation for women suffering from schizophrenia. Women have also been found to have more paranoid and affective symptoms, more atypical symptoms and more frequently an insidious onset with passivity and social withdrawal.

The most robust research finding has probably been the better course and outcome of schizophrenia in women as reported by Thara and Rajkumar and many others in the developing world.<sup>16</sup> Various hypotheses including the protective effects of oestrogen have been put forward to explain this difference.

Social consequences, such as homelessness, vulnerability to sexual abuse and exposure to HIV and other infections, contribute to the difficulties of rehabilitation of women. The absence of any clear welfare policies in this part of the world for this group of women, and the social stigma further compound the problem. Stigma has been reported to be more in women than men. Women caregivers also reported more stigmas and many felt depression and sorrow, which was greater if the patient was a woman.<sup>17</sup> These feelings probably become even more severe when they have to deal with their daughters with uncertain futures, broken marriages and lack of social support.

### **Sequelae of mental disorders**

Unwanted pregnancies	High risk for sexual abuse	Higher sexual activity
Lack of awareness about contraception	Serious risk of HIV infection	Lack of skills for risk reduction

## **Rehabilitation of Women**

This throws up a number of challenges which are different from those concerned with men. It is not unusual that women brought for rehabilitation are more often accompanied by their parents than their spouses, even if they are married. These parents are often quite elderly and burdened by ill-health, as well as the additional stress of having to care for a mentally ill daughter and sometimes her children as well. The focus of rehabilitation has to be on Activities of Daily Living (ADL), performance of domestic chores, parenting skills and interpersonal relations within the family. Married women admitted into rehabilitation centres are much more concerned about early discharge so that they can join their husbands and children at an early date. Unmarried women very often suffer spells of depression on account of their single status. The hormonal side-effects of psychotropic medication such as weight gain, amenorrhoea and galactorrhoea do little to improve their state.

## **The National Council of Women – Schizophrenia Research Foundation (NCW-SCARF) Study**

### ***Mentally ill women and their marriages***

The Schizophrenia Research Foundation at Chennai, carried out an ethnographic, qualitative study of 75 mentally ill women who were separated or divorced, sponsored by the National Commission for Women.<sup>18</sup> This was primarily a qualitative study, although some instruments were also used to measure and quantify burden. The sample was largely of Hindu women, aged 30–40 years, with a mean duration of illness of 12 years.

There were 32 women (42%) who had been mentally ill before their marriage. Most of them had got married between the ages of 21 and 30. Of these marriages 95% were arranged by the families, as is still largely the norm in this part of the world. Also, 14 marriages had been consanguineous while four women had been married twice and separated.

It was found that all but eight of these separated women lived in their parental homes with the onus of care being borne by their elderly parents. Legal separation had occurred only in 16 cases, all of them being educated women. None of them remarried, while of 34 the husbands had done so. The fathers looked after only six of the 26 children.

The stigma of being separated/divorced was often more acutely felt both by families and patients than that of mental illness per se. This is exemplified by the fact that many women, even after decades of separation from their husbands, continued to wear traditional symbols of marriage (for example, *mangalsutra*). This seemed to give them a sense of security and status in a society where marriage is particularly revered.

Finally, the issue of legal redressal was one about which families were largely ignorant. This was partly due to lack of awareness, but also because of the tedious and complicated nature of the legal processes themselves and the cost associated with them. So, many families took no efforts to initiate legal action and had resigned themselves to their fate. Partly because of this, almost none of the women received any maintenance either for themselves or for their children.

This has also highlighted the diminishing resources of care for such women from both the families (break-up of joint families, non-availability/reluctance of alternate carers). Community-based resources such as half-way homes, day-care facilities and rehabilitation centres in both the government and private sectors are meagre to say the least, and concentrated in the southern part of India.

Interviews were also conducted on 75 primary caregivers of these women to understand their attitudes, assess the burden of caregiving and determine the status of children born out of the broken marriages.

An overarching theme, which emerged from these interviews was, 'How long do I have to support her? What after me?' The fact that many of the ill women held no jobs, were not financially independent and did not receive any alimony from the husbands, only added to their distress and uncertainties. The children born to these women suffered considerable neglect. In most cases their fathers either refused to acknowledge them as their children or, as is most often the case, did not contribute any financial support for the care and upbringing of the child. The burden of care inevitably falls on the patients and her parents, further compounding their problems.

Comprehensive care for this group of patients requires the collaborative effort of families, professionals, the state and NGOs, policy planners and philanthropists. It would be worthwhile to offer these women some training in employment skills, which might help them acquire some

skills and thereby generate some employment. It is also necessary to offer some kind of support for the children who are often victims of such circumstances beyond their control.

### ***Suicide and self-harm***

Studies of suicide and deliberate self-harm have revealed a universally common trend of more female attempters and more male completers of suicide. A spate of studies from India in the nineties has reiterated this finding. Biswas et al. found girls from nuclear families and women married at a very young age, to be at a higher risk for attempted suicide and self-harm.<sup>19</sup> It may also be noted that terrorist groups train many women as human bombs.

However, the women in many of these studies were not referred to psychiatric services. This could be due to a variety of reasons, such as the need to downplay such behaviours in an attempt not to reinforce them and because of the stigma attached to seeking psychiatric help.

### ***Healthcare utilisation***

Evaluations of services for women with long-term mental health problems have underscored the need to set right the unevenness in the access and utilisation of mental health services among the genders.<sup>20</sup> Services should be made attractive to women and agencies, and facilities outside mainstream mental health services should be supported to accommodate women with long-term mental health problems.

The unevenness in healthcare utilisation is well mirrored by the following data: The allotment of beds in government and mental hospitals is 73% for men and 27% for women. In private psychiatric centres, it is 60% and 40% for men and women, respectively. Male to female utilisation ratios of facilities for mentally handicapped children range from 6:1 to 3:1.<sup>9</sup> A study conducted at SCARF residential centres also showed similar trends in out-patient and admission figures.

#### **Other psychoses**

- *Post-partum psychosis* (1-2/1,000 births)  
Sudden onset, shifting picture, close watch, aggression to self and child, suicidal ideas and breast feeding.
- *Hysterical psychosis*  
Sudden onset, quick progression, closely mimics schizophrenia and gives good response to treatment and family counselling.

### **Future Directions**

Women's mental health is increasingly recognised as a major public health concern, with a critical impact on the well-being of individuals, families and society. It is also recognised that this field is in its infancy, calling for more research and the development of policies and programmes consistent with the broader definitions of health.

The last two decades have witnessed a growth of self-help movements in women's groups, and some local groups have been outstanding in their efforts. Example of this is the spearheading of the anti-alcohol movement by women in the South Indian state of Andhra Pradesh. There is an urgency to strongly reinforce such movements since they are all measures which will

strengthen self-esteem, enhance problem-solving abilities, and reinforce autonomy and assertiveness skills.

It is equally important for treating clinicians to be sensitive to the mental health impact that various disorders and their interventions can produce.

Stigma and misconceptions about mental illness can be tackled only by extensive and intense public education efforts. While NGOs can do this in their limited catchment areas, it warrants a national effort by the government to initiate a programme as was done in the case of leprosy and tuberculosis.

Policy planners also play a critical role, since any comprehensive strategy to improve the mental health of women necessitates coordinated action. This involves the improvement of policies and legislation, better access and availability of healthcare facilities, better health education and determination of safety at the places where women live and work. An enhanced gender sensitivity in all walks of life will certainly augur a better future for the mental health of women.

## References

1. United Nations Development Programme. *Human Development Report*. New York: Oxford University Press, 1997.
2. World Health Organisation. *The World Health Report*. Geneva: WHO, 1998.
3. Alex Cohen. Our lives were covered in darkness. In: Cohen A, Kleinman A, Saraceno B, eds. *The Work of the National Literacy Mission in Northern India, Chapter 5, World Mental Health Case Book*. New York: Kluwer Academic/Plenum Publishers, 2002.
4. Shirala KA, Kanwar S. Mental illness and hill women: A demographic study. *Journal of Personality and Clinical Studies* 1987;3(2):103-108.
5. Carstairs GM, Kapur RL. *The Great Universe of Kota: Stress, Change and Mental Disorder in an Indian Village*. Berkeley: University of California Press, 1976.
6. Murray JL, Lopez AD. *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020. Summary*. Boston: Harvard School of Public Health, World Health Organisation, 1996.
7. Patel V, Araya R, Lima MS, Ludermir A, Todd C. Women, poverty and common mental disorders in four restructuring societies. *Social Science and Medicine* 1999;49:1461-1471.
8. Mumford DB, Saeed K, Ahmad I, Latif S, Mubbashar M. Stress and psychiatric disorder in rural Punjab. A community survey. *British Journal of Psychiatry* 1997;170:473-478.
9. Davar B. *The Mental Health of Indian Women: A Feminist Agenda*. New Delhi: Sage, 1999.
10. Dennerstein L, Astbury J, Morse C. *Psychosocial and Mental Health Aspects of Women's Health*. WHO/FHE/MNH/93.1. Geneva: World Health Organisation, 1993.
11. Thara R, Patel V. *Women's Mental Health: A Public Health Concern-Regional Health Forum*. Geneva: World Health Organisation, 2001;24-33.
12. Bang R, Bang A. Women's perceptions of white vaginal discharge: Ethnographic data from rural Maharashtra. In: Gittelsohn J, Bentley ME, Pelto PJ, Nag M, Pachauri S, Harrison A, eds. *Listening to Women Talk about their Health: Issues and Evidence from India*. New Delhi: Ford Foundation, 1996;79-94.
13. Gautam S, Nijhawan M, Gehlot P. Post-partum psychiatric syndromes: an analysis of 100 cases. *Indian Journal of Psychiatry* 1982;24:383-386.
14. Kit LK, Janet G, Jegasothy R. Incidence of postnatal depression in Malaysian women. *Journal of Obstetrics and Gynaecology Research* 1997;23:85-89.
15. Subramaniam V. The impact of globalisation on women's reproductive health and rights: A regional perspective. *Development* 1999;42:145-149.

16. Thara R, Rajkumar S. Gender differences in schizophrenia, Results of a follow-up study from India. *Schizophrenia Research* 1992;7:65-70.
17. Thara R, Srinivasan TN. How stigmatising is schizophrenia in India? *The International Journal of Social Psychiatry* Summer 2000;46(2):135-141.
18. Thara R, Kamath S, Kumar S. Women with schizophrenia and broken marriages – doubly disadvantaged? Part I: Patient perspective. *International Journal of Social Psychiatry* 2003;49(3):225-232.
19. Biswas S, Roy S, Debnath C, Sengupta SB. A study of attempted suicide in adolescents in West Bengal. *Indian Journal Of Psychiatry* 1997;39:54-55.
20. Adityanjee DM, Wig NN. Determinants of emergency room visits for psychological problems in a general hospital. *International Journal of Social Psychiatry* 1988;34:25-30.



## Chapter 30

# The Graying of India: Mental Health Perspective

*Mathew Varghese • Vikram Patel*

Projections indicate that by the year 2020, there will be 470 million people aged 65 and older in developing countries, more than double the number in developed countries. The three countries that are projected to have the largest number of old people in the year 2025 are China, India and Indonesia.<sup>1</sup> In India, the past century has witnessed a decline in the birth rate and an improvement in life expectancy, with a substantial reduction in mortality amongst older persons. As a result of this demographic transition, India's elderly population has increased from 12 million in 1901 to 57 million in 1990 and is expected to cross a 100 million in 2013. From a mere 5.1% of the population in 1901, the elderly will become 21% of the population by the year 2050. The elderly population itself is getting older, with people over 80 years of age forming the fastest growing sub-group of the population in many countries.<sup>2</sup>

A nationwide survey conducted by the National Sample Survey Organisation,<sup>3</sup> reported that 45% of the elderly suffered from chronic illnesses. Elderly people in India suffer from the dual medical problems of both communicable as well as degenerative diseases. This is further compounded by impairments of special sensory functions, like vision and hearing. Nearly 70% of the elderly in urban areas and 34% in rural areas were economically dependent on their families. The percentage of the elderly living alone was 6 and 8, respectively, for the urban and rural areas. This proportion is, however, expected to increase in the coming years, necessitating appropriate measures for the support of the elderly. This chapter will describe mental health problems that affect the elderly focusing on the two commonest conditions: depression and dementia. The chapter will review the epidemiology of these disorders in India and consider the implications for care and future research.

### **Epidemiology of Mental Disorders**

Epidemiological studies have been conducted in a variety of populations in India and these are briefly reviewed hereunder:

#### ***Community studies***

Some community-based studies of adult populations have included a geriatric sub-group in their samples. However, these reported widely varying rates of psychiatric morbidity for the elderly.<sup>4,5</sup> For example, while Dube<sup>4</sup> found a rate of 2.2%, Nandi et al.<sup>5</sup> reported a prevalence rate

of 33.3%. These studies had methodological weaknesses, including small, unrepresentative samples of the geriatric sub-group, and could not offer conclusive information about the prevalence of psychiatric disorders in the elderly. The earliest published community study of a geriatric population found a remarkably high prevalence of 34.9%.<sup>6</sup> Depression was the most common disorder (24.1% above 50 years age group) followed by dementia (3.2%). Another study in a sample aged above 60 years found similar prevalence figures for mental illnesses (33.7%).<sup>7</sup> In contrast, Venkoba Rao, and Madhavan reported psychiatric morbidity of 8.9% in a sample aged over 60 years.<sup>8</sup> Consistent with earlier evidence, rates of depression were the highest (6%). In an elderly rural population of West Bengal, 61% were found to have psychiatric illness with females having significantly higher rates than males.<sup>9</sup> Consonant with earlier studies, depression was most frequently reported (52.2%), while the prevalence of dementia was 1.6%. A study in a representative rural geographical area in northern India indicated a prevalence of psychiatric morbidity of 43.3%; neurotic depression, Manic Depressive Psychosis (MDP) depression, and anxiety state were the commonest diagnoses in descending order of frequency.<sup>10</sup> Thus, there is a wide variation of rates of mental disorders in elders, with median rates being in the range of one out of three elders. Depressive disorders are the commonest mental disorders in the elderly.

There have been a number of studies on the epidemiology of dementia in India. Prevalence rates of 3.39% and 3.5% were reported in two rural population studies in elders.<sup>11,12</sup> Rajkumar et al. reported that prevalence rates increased with age and negligible male/female differences.<sup>12</sup> An Indo-US study in the rural setting of Ballabgarh, found a strikingly low prevalence of dementia at 1%.<sup>13</sup> This study had the most rigorously developed culture and education-fair dementia diagnostic procedures. A recent study of dementia in urban Mumbai reported a prevalence rate for dementia in those aged 40 years and over as 0.43%, and for persons aged 65 and above, it was 2.44%.<sup>14</sup> Alzheimer's disease was the most common type of dementia, followed by vascular dementia, and its prevalence was higher in women than in men. Some of the special issues relating to these differences in epidemiological studies in developing countries have been discussed by the 10/66 Dementia Research Group.<sup>15</sup>

### ***Treatment seeker studies***

Data from one of the first speciality geriatric clinics in India found that the number of patients diagnosed increased over a four-year period.<sup>16</sup> The gender ratio was skewed towards males, with the most common disorder being depression (39.9%) followed by organic brain syndrome (34.3%), paranoid illness and neuroses. Data from geriatric patients attending a general hospital psychiatry clinic indicated that a majority of cases had functional psychosis (43.7%), while 19.8% had a neurotic illness.<sup>17</sup> A retrospective analysis of case records of geriatric patients presenting to psychiatric out-patient departments of NIMHANS found a predominance of non-organic psychosis (43%) followed by organic psychosis (22%) and neurosis (17%).<sup>18</sup> Khurana et al. screened geriatric in-patients in a general hospital medical setting and found the prevalence rate of delirium to be 27%.<sup>19</sup>

A recent prospective study of 1,586 patients from a speciality geriatric clinic at the AIIMS, New Delhi, provides information about the health and functional status of older Indians seeking health services.<sup>20</sup> Results revealed that 95% of the subjects were above the age of 80 and that 87% of them sought medical attention for an acute illness. About one-third of a subset of 209 subjects had a psychiatric illness, while depression accounted for 50% of all psychiatric illnesses. There is only one prospective outcome study of mental disorders in elders in India, which described the outcome of late onset depression in 50 elders attending psychiatric services. Only a quarter of subjects showed full recovery in 12 months.<sup>21</sup>

### **Risk factors**

A study in northern India indicated a much higher prevalence in the geriatric group (43.3%) than in the non-geriatric group (4.6%).<sup>10</sup> The risk of mental disorders with rising age has been replicated in a number of other studies. Most community studies have found that socio-economically and educationally disadvantaged subjects are at greater risk to suffer mental disorders. For example, a community study of depressive disorders in North India found that older age and illiteracy were risk factors.<sup>22</sup> Among the illiterate, there was no gender difference, while among the literate, higher depressive scores were found among women. Cognitive impairment and functional disability were independently associated with higher depressive scores after adjustment for age, gender and literacy.

Several groups of elders may be especially vulnerable to suffer mental disorders. Older women face a triple jeopardy: that of being old, of being women and of being poor. Most women perceive themselves as 'old' by the time they are 50 years of age. This is based on the presence of grandchildren, widowhood, shrinkage of social roles and post-menopausal status.<sup>23</sup> With lower levels of literacy and increased likelihood of being homemakers, this lowers the women's socio-economic status further and increases the dependency on their family. Older women report more psychological distress and may need specific intervention strategies to empower them.<sup>23</sup>

Elders living in rural areas may represent another risk group, because rural areas lack resources, and with agriculture being the main occupation, there is neither income security nor any systematic provision for old age. Older people in urban slums grapple with the twin problems of poverty and ill health. The lack of social integration rather than social isolation per se and the lack of occupation are related to morbidity.<sup>8</sup> Research indicating higher rates of psychiatric illnesses among those from nuclear families/living alone, highlights the need for family cohesion and support.<sup>7</sup> Older people are also at high risk of self-destructive behaviour, often associated with incurable or painful physical disorders, or economic stressors. The rate of suicide in the 50+ group is around 12/100,000, a figure higher than 7/100,000 for the general population. Although, ethical, religious and familial deterrents may hold back the person from attempting suicide, old age is an important risk factor.<sup>24</sup>

Biological factors play an important role in determining the risk to some mental disorders, in particular, dementia. The APOE\*E4 allele of the gene for apolipoprotein E (APOE) has been reported as a risk factor for Alzheimer's disease (AD) to varying degrees in different ethnic groups. A cross-national study compared APOE\*E4-AD epidemiological associations in India and the US. The frequency of APOE\*E4 was significantly lower ( $p < 0.001$ ) in India vs the US samples (0.07 vs 0.11). The frequency of probable or possible AD, in the Indian vs US samples, was as follows: 70-79 years, 0.7% vs 3.1%; 80 years or older, 4.0% vs 15.7%. Among those aged 70 years or older, adjusted odds ratios (95% confidence interval) for AD amongst carriers of APOE\*E4 vs non-carriers, were 3.4 (1.2-9.3) and 2.3 (1.3-4.0) in the Indian and US samples, respectively, and not significantly different between cohorts ( $P = 0.20$ ). This study showed that though there was a very low prevalence of AD in Ballabgarh, India, the association of APOE\*E4 with AD was of similar strength in Indian and US samples.

Psychiatric illness is seldom an isolated event amongst elderly people. A minimum of two or three other clinical diagnoses is the rule.<sup>25</sup> Geriatric mental illnesses are often associated with physical illness, disability or handicap; indeed, physical ill health and disabilities may be risk factors for depressive disorders. Both community and clinic-based epidemiological studies reported the presence of physical illnesses in over 40% of their samples.<sup>8,9,16,17</sup> Undiagnosed physical illnesses were found to be more common among mentally ill geriatric patients and elderly depressed patients.<sup>26,27</sup> There are two clinic-based studies<sup>18,20</sup> that reported even higher rates of 96% and 70%,

respectively. The most common problems included deficits of vision and hearing, hypertension, diabetes mellitus, cardiovascular disorders and osteoarthritis.

## **Mental Health Interventions in Old Age**

### ***Assessment and identification***

A challenge for the diagnosis of mental disorders, which relies heavily on interview-based examination, are the cultural and educational factors such as illiteracy, which are relevant in the Indian context. A number of investigators have evaluated instruments for the detection and diagnosis of mental disorders in community settings, taking into account these factors. Screening questionnaires such as the Mini-mental State Examination for the detection of dementia have been translated and validated for use in a North Indian population.<sup>28</sup> A scale for activities of daily living has also been developed by the same investigators.<sup>29</sup> In an epidemiological survey with a largely illiterate sample of 5,126 individuals aged 55 and older in the rural community of Ballabgarh in North India, participants were administered a general mental status test, the Hindi Mental State Examination (HMSE) and a brief battery of neuropsychological tests. Their informants answered a questionnaire assessing functional ability, the Everyday Abilities Scale for India (EASI). In participants who could be tested cognitively, the HMSE, the neuropsychological battery, and the EASI had sensitivities of 81.3%, 81.3%, and 62.5%, respectively, with specificities of 60.2%, 74.5%, and 89.7%, respectively. A combination of all three was 93.8% sensitive and 41.8% specific.<sup>30</sup> An advantage of the EASI was that it could also be administered to informants of subjects who were cognitively not testable. In this largely illiterate community, with a low prevalence of dementia, the combination of cognitive tests and a functional ability questionnaire had substantial value for population screening.

The 10/66 Dementia Research Group interviewed 2,885 persons aged 60 and over in 25 centres in India, China, Southeast Asia, Latin America, the Caribbean and Africa. The sample included 729 people with dementia, and three groups free of dementia; 702 with depression, 694 normals with high education and 760 normals with low education. Experienced local clinicians diagnosed dementia and depression. The Geriatric Mental State, the Community Screening Instrument for Dementia and the modified CERAD 10 wordlist-learning task were then administered by an interviewer, masked to case status. Each measure independently predicted dementia diagnosis. An algorithm derived from all three performed better than any individually and identified 94% of dementia cases with false positive rates of 15%, 3% and 6% in the depression, high education and low education groups, respectively. The algorithm developed and tested in this study provides a sound basis for culture and education-fair dementia diagnosis in clinical and population-based research in India.<sup>31</sup>

Given the low awareness of mental disorders in elders, there is a need to develop culturally sensitive methods for identification of probable cases. Shaji et al. have described a simple, cost-effective, method of training community health workers to identify dementia in Kerala.<sup>32</sup> After two and a half hours of formal training, local community health workers in rural Kerala were asked to identify possible cases of dementia from the community they served. Diagnoses were then verified by a senior local psychiatrist with clinical and research interests in old age psychiatry. This method was found to have a positive predictive value of 64.7%.<sup>32</sup>

Other methods of assessment, such as neuroimaging techniques like CT and MRI scans, have been used by investigators in tertiary care institutions.<sup>33</sup> However, these techniques have limited relevance in the diagnosis of mental disorders in clinical settings.

### **Care arrangements**

Ancient Indian scriptures advocate the preparation for old age by adopting the disengagement theory. This stage of *Vanaprastha* in a man's life requires him to give up his authority over family and property, and devote his time to self-realisation. Therefore, old age was never seen as a social problem in ancient India. Respect towards elders and the concept of obligation towards parents (*pitra rina*) forms part of the cultural value system.<sup>34</sup> In contemporary Indian society, however, the position and status of the elderly and the care and protection they traditionally enjoyed have been undermined by several factors. Urbanisation, migration, the break-up of the joint family system, growing individualism, the change in the role of women from being full-time carers and the increased dependency status of the elderly are some of the prominent factors. There have been changes in terms of education, aspirations and values, and the allocation of resources to different members of the family. Often, the family is unable to meet the financial, social, psychological, medical, recreational and welfare needs of the elderly, and needs help from supporting services. Elders often feared being abandoned and neglected, and experienced 'dependency anxiety'.<sup>35</sup> A recent report on elder abuse in India found that 'maltreatment', 'neglect' and 'disrespect' was attributed to changing value systems.<sup>36</sup> Older couples being separated to live with different children was identified as a significant problem. Discussions with primary healthcare workers revealed that elder abuse is not considered a health issue that warrants intervention, although psychosomatic problems were identified as being related to psychological abuse.

A study in Goa analysed the attitudes towards mental health problems in elders amongst healthcare providers and family caregivers.<sup>37</sup> Vignettes of depression and dementia were widely recognised. However, neither condition was thought to constitute a health condition. Dementia was construed as a normal part of ageing and was not perceived as requiring medical care. Thus, primary health physicians rarely saw this condition in their clinical work, but community health workers frequently recognised individuals with dementia. Depression was a common presentation in primary care, but infrequently diagnosed. Both late-life mental disorders were attributed to abuse, neglect or lack of love on the part of children towards a parent. There was evidence that the system of family care and support for older persons was less reliable than has been claimed. Care was often conditional upon the child's expectation of inheriting the parent's property. Care for those with dependency needs was almost entirely family-based with little or no formal services. Not surprisingly, fear for the future and, in particular, 'dependency anxiety' was commonplace among older persons.

Studies by the 10/66 Dementia Research Network in Goa and Chennai examined the impact of caregiving for elders. Carers of people with dementia spent a significantly longer time providing care than did carers and co-residents of depressed persons and controls. The highest proportion of time was spent in communicating, supervising and helping with eating and going to the bathroom. Levels of carer strain were notably higher amongst carers of people with dementia. They were 16 times more likely to have a common mental disorder than carers or co-residents of controls and twice as likely as carers or co-residents of people with depression. Economic strain was indicated by the high proportion of caregivers of people with dementia, who had given up work to provide care, coupled with the increased likelihood that the family had to meet relatively high healthcare costs. This was explained by the increased propensity for people with dementia to use expensive private medical care services, rather than free or low-cost government services.

Formal care arrangements for elders, for example, in the public health sector, are scarce. Indeed, geriatric medicine as a special area of healthcare is not available in most medical colleges or hospitals in India. As compared to the West, the number of residential places for elders with

severe mental disorders such as dementia is very low. The reported number of old age homes in India was only 354 in 1997 and this continues to be a low priority.<sup>38</sup> The South Indian states of Kerala and Tamil Nadu have together more than half of all the old age homes in India. These states have witnessed the emigration of young people in large numbers to Middle Eastern and Gulf countries and are amongst the economically better off states. Urban centres have seen the promotion of senior housing projects with medical and recreational facilities. Another study has shown that elders living in institutions have lower life satisfaction than those living in their family homes.<sup>39</sup> However, the family is still the primary source of care and support for the vast majority of elders in India.

## Conclusion

The evidence presented earlier demonstrates that mental disorders in elders in India are a major public health issue for four main reasons. First, due to demographic ageing, the population of elders and therefore, the numbers with mental disorders, are rising rapidly. Second, there is very poor awareness about these disorders. Third, traditional family and social support systems for elders are rapidly changing. Fourth, there are virtually no health services geared for the special needs of elders in India.

In 1998, HelpAge India conducted a series of seminars in the four regions of the country. From each region, existing regional data were compiled and eventually presented at a national conference held in New Delhi. This conference recommended that a National Institute on Ageing should be established in order to:

- undertake, promote and supervise cross-regional multidisciplinary research on all basic issues related to ageing;
- issue guidelines for training different levels of gerontological workers and to evaluate such training programmes;
- monitor the work of old age homes and NGOs involved in gerontological work;
- initiate and maintain networking among institutions and individuals involved in gerontological work.

These four principles form the cornerstone of the policy initiatives needed to meet the mental health needs of elders.

It has been argued that solutions to the problems of the elders should be sought outside the healthcare system and the state, within the society and community.<sup>40</sup> Involvement of NGOs and catalysing the community is essential for proactive steps in designing and delivering appropriate services. However, the role of the state is also crucial, in particular, to strengthen the economic security for elders, for example, by extending the coverage of and the support given by the National Old Age Pension Scheme. The existing pensions need to be enhanced, and steps taken to assure their appropriate disbursement.<sup>39</sup> The promotion of savings, pre-retirement counselling and legislation to protect parents' right to be supported by children are some other proposals of the National Policy for Older Persons 1999. Schemes to allow the elderly to remain economically active have been mooted and NGOs have been encouraged to provide income-generating activities.<sup>41</sup> Other proposed measures include economic strengthening of family support for the elderly, for example, tax incentives, rebates for medical expenses, giving preference in housing, provision of respite care, health insurance coverage and other support services for caregivers. The Ministry of Social Justice and Empowerment makes financial assistance available to voluntary

agencies to run day-care centres and other centres. There is a need for these centres to expand both quantitatively and qualitatively to reach out to the vast majority of elders who need such care. The combination of growing needs of the geriatric population and India's limited resources calls for a well-orchestrated, multisectoral response based on systematic planning.<sup>42</sup>

There is a need to raise the awareness about mental disorders in late-life in the community and amongst health professionals, and to improve the access to appropriate healthcare for the elderly with mental illness. Health education should aim to educate health workers and the community, to recognise the common symptoms of mental disorders and, in particular, to stress that depression and dementia are real disorders and not just the natural consequences of ageing. The promotion of geriatric medicine within Indian medical schools is an important agenda. A workshop on the public health implications of ageing in India was organised in 1993 by the ICMR. Its recommendations included introducing the concept of geriatric care into hospital services, developing rehabilitation services for the disabled elderly, introducing principles of geriatric medicine in the undergraduate medical curriculum and organising facilities for postgraduate training in gerontology at some institutions. Many of these recommendations are still far from being implemented.

Caregiver strain has not been acknowledged; instead, a near mythical strength is attributed to the abilities of families to cope. This distracts from the need for a rational debate regarding the future balance between informal family support and formal care services, and hinders evidence-based policy making. We suggest prioritising home-based support for elderly persons with serious mental disorders and their carers. Removing stigma may require integrating the subject of mental disorders of elders into community and general health programmes. Collaboration is required with NGOs (such as the Alzheimer's and Related Disorders Society of India) that are pioneering programmes to empower the elderly, support families with a mentally ill elder and provide healthcare sensitive to their needs. Working with the existing manpower and health and social service infrastructure is likely to be more successful in meeting the mental health needs of elders in India than developing specialised psychogeriatric services throughout the country.

Earlier research in India has led to the development of a number of culture and education-fair measures for mental disorders in elders. These include screening questionnaires, cognitive tests and diagnostic interviews. While there are now substantive epidemiological studies from rural and urban settings in India, there is a need for incidence studies which also explore associated physical illnesses, bio-psychosocial risk factors and care arrangements.<sup>43</sup> Future research should focus on the evaluation of the efficacy and cost-effectiveness of community interventions and the treatment of depression in general healthcare settings. Such research has already been initiated in a number of Indian centres. For example, the 10/66 Dementia Research Group has developed a basic level home-based intervention suitable for administration by generic primary care health workers. This will be evaluated in many centres in a randomised controlled trial. The findings of these studies will hopefully form the basis to guide health policy for community care for elders with dementia and other illnesses in India.

## References

1. Siegel JS, Hoover SL. Demographic aspects of the health of the elderly to the year 2000 and beyond. *World Health Statistical Quarterly* 1982;35:132-202.
2. WHO, Fact Sheet No.135 (Revised September 1998). Population Ageing—A Public Health Challenge.
3. National Sample Survey Organisation. Socioeconomic profile of aged persons. *Sarvekshana* 1991;15:1-2.

4. Dube KC. A study of prevalence and biosocial variables in mental illness in a rural and an urban community in Uttar Pradesh—India. *Acta Psychiatrica Scandinavica* 1970;46:327–332.
5. Nandi DN, Ajmany S, Ganguli H, Banerjee G, Boral GC, Ghosh A, Sarkar S. Psychiatric disorders in a rural community in West Bengal—an epidemiological study. *Indian Journal of Psychiatry* 1975;17:87–99.
6. Ramachandran V, Sarada Menon M. Epidemiological study of depression in old age. In: Venkoba Rao A, Parvati Devi S, eds. *Depressive Illness*. Madurai: Vaigai Achagaum, 1980.
7. Ramachandran V, Sarada Menon M, Ramamurthy B. Family structure and mental illness in old age. *Indian Journal of Psychiatry* 1981;23:21–26. Sanjay Kumar N, Vissar PJ. Structural MRI neuroimaging in dementia and related disorders. *NIMHANS Journal* 1997;15:367–378.
8. Venkoba Rao A, Madhavan T. Geropsychiatric morbidity survey in a semi-urban area near Madurai. *Indian Journal of Psychiatry* 1982;24:258–267.
9. Nandi PS, Banerjee G, Mukherjee SP, Nandi S, Nandi DN. A study of psychiatric morbidity of the elderly population of a rural community in West Bengal. *Indian Journal of Psychiatry* 1997;39:122–129.
10. Tiwari SC. Geriatric psychiatric morbidity in rural northern India: implications for the future. *International Psychogeriatrics* 2000;12:35–48.
11. Shaji S, Promodu K, Abraham T, Roy KJ, Verghese A. An epidemiological study of dementia in a rural community in Kerala, India. *British Journal of Psychiatry* 1996;168:745–749.
12. Rajkumar S, Kumar S, Thara R. Prevalence of dementia in a rural setting: A report from India. *International Journal of Geriatric Psychiatry* 1997;12:702–707.
13. Chandra V, Ganguli M, Pandav R, Johnston J. Prevalence of Alzheimer's disease and other dementias in rural India: The Indo-US study. *Neurology* 1998;51:1000–1008.
14. Vas CJ, Pinto C, Panikker D, Noronha S, Deshpande N, Kulkarni L, Sachdeva S. Prevalence of dementia in an urban Indian population. *International Psychogeriatrics* 2001;13(4):439–450.
15. The 10/66 Dementia Research Group. Methodological issues for population-based research into dementia in developing countries. *International Journal of Geriatric Psychiatry* 2000b;15:21–30.
16. Venkoba Rao A. Mental health and ageing in India. *Indian Journal of Psychiatry* 1981;23:11–20.
17. Bhogale GS, Sudarshan CY. Geriatric patients attending a general hospital psychiatry clinic. *Indian Journal of Psychiatry* 1993;35:203–205.
18. Prasad KMR, Sreenivas KN, Ashok MV, Bagchi D. Psychogeriatric patients: A sociodemographic and clinical profile. *Indian Journal of Psychiatry* 1996;38:178–181.
19. Khurana PS, Sharma PSVN, Avasthi A. Prevalence of delirium in geriatric hospitalised general medical population. *Indian Journal of Psychiatry* 2002;44:41–46.
20. Dey AB, Soneja S, Nagarkar KM, Jhingan HP. Evaluation of the health and functional status of older Indians as a prelude to the development of a health programme. *National Medical Journal of India* 2001; 14:135–138.
21. Jhingan HP, Sagar R, Pandey RM. Prognosis of late-onset depression in the elderly: a study from India. *International Psychogeriatrics* 2001;13:51–61.
22. Ganguli M, Chandra V, Kamboh MI, Johnston JM, Dodge HH, Thelma BK, Juyal RC, Pandav R, Belle SH, DeKosky ST. Apolipoprotein E polymorphism and Alzheimer disease: The Indo-US cross-national dementia study. *Archives of Neurology* 2000;57:824–830.
23. Jaiprakash I. Women and ageing. *Indian Journal of Medical Research* 1997;106:396–408.
24. Venkoba Rao A. Suicide in the elderly. *Indian Journal of Social Psychiatry* 1985;1:3–10.
25. Venkoba Rao A. Psychiatric morbidity in the aged. *Indian Journal of Medical Research* 1997;106:361–369.
26. Praveenlal K, Dube S, Mohan D, Sundaram KR. Aged seeking psychiatric help: A study of associated physical diseases and disabilities. *Indian Journal of Psychiatry* 1996;19:70–74.
27. Satapathy R, Kar N, Das I, Kar GC, Pati T. A study of major physical disorders among the elderly depressives. *Indian Journal of Psychiatry* 1997;39:278–281.
28. Ganguli M, Dube S, Johnston JM, Pandav R, Chandra V, Dodge HH. Depressive symptoms, cognitive impairment and functional impairment in a rural elderly population in India: A Hindi version of the



- Geriatric Depression Scale (GDS-H). *International Journal of Geriatric Psychiatry* 1999;14:807–820.
- Ganguli, M, Ratcliff G, Chandra V, Sharma S, Gilby J, Pandav R, Belle S, Ryan C, Baker, C, Seaberg E, Dekosky S. A Hindi version of the MMSE: the development of a cognitive screening instrument for a largely illiterate rural elderly population in India. *International Journal of Geriatric Psychiatry* 1995;10:367–377.
- Government of India, The National Policy on Older Persons, Ministry of Social Justice and Empowerment, Shastri Bhawan, New Delhi, 1999.
29. Fillenbaum GG, Chandra V, Ganguli M, Pandav R, Gilby J, Seaberg E, Belle S, Baker C, Echement DA, Nath L. Development of activities of daily living scale to screen for dementia in an illiterate rural population in India. *Age and Ageing* 1999;28:161–168.
  30. Pandav R, Fillenbaum G, Ratcliff G, Dodge H, Ganguli M. Sensitivity and specificity of cognitive and functional screening instruments for dementia: the Indo-US dementia epidemiology study. *Journal of the American Geriatric Society* 2002;50:554–556.
  31. Prince M, Acosta D, Chiu H, Scazufca M, Varghese M and the 10/66 Dementia Research Group. Dementia diagnosis in developing countries. *Lancet* (in press 2003).
  32. Shaji KS, Arun Kishore NR, Lal KP, Prince M. Revealing a hidden problem. An evaluation of a community dementia case-finding programme from the Indian 10/66 dementia research network. *International Journal of Geriatric Psychiatry* 2002;17:222–225.
  33. Suresh KP, Sreenivas KN, Arya BYT, Ashok MV, Rajesh Mohan. C.T. Scan in psychogeriatrics. *NIMHANS Journal* 1995;13:43–46.
  34. Venkoba Rao A. Psychiatry of old age in India. *International Review of Psychiatry* 1993;5:165–170.
  35. Vatuk S. 'To be a burden on others': dependency anxiety among the elderly in India. In: OM Lynch, ed. *Divine Passions: The Social Construction of Emotion in India*. Berkeley, CA: University of California Press, 1990.
  36. Soneja S. *Elder Abuse in India: Country Report for World Health Organisation*. Geneva: World Health Organisation, 2001.
  37. Patel V, Prince M. Ageing and mental health in a developing country: who cares? Qualitative studies from Goa, India. *Psychological Medicine* 2001;31:29–38.
  38. Jaiprakash I. *Ageing in India*. Geneva: World Health Organisation, 1999.
  39. Mathew S. Life satisfaction and some of its correlates among institutionalised and non-institutionalised elderly. *NIMHANS Journal* 1997;15:215–218. Mathew S. Elderly's attitude towards death and the concept of euthanasia. *NIMHANS Journal* 1998;16:43–46.
  40. Sathyanarayana K, Medappa N. Editorial: Care of the aged – a long haul ahead. *Indian Journal of Medical Research* 1997;106:i–ii.
  41. Chanana HB, Talwar PP. Ageing in India: Its socioeconomic and health implications. *Asia-Pacific Population Journal* 1987;2(3):23–38.
  42. Kalache A, Sen K. Ageing in developing countries. In: Pathy, ed. *Principles and Practice of Geriatric Medicine*. New York: John Wiley & Sons, 1998.
  43. The 10/66 Dementia Research Group. Dementia in developing countries: A consensus statement from the 10/66 Dementia Research Group. *International Journal of Geriatric Psychiatry* 2000a;15:14–20.

## Chapter 31

# Mental Health of Indians in the UK

*Dinesh Bhugra • Ranjith Gopinath • Rahul Bhintade*

Indians have migrated to other parts of the world since time immemorial. The reasons for this phenomenon have been similar to those of other such migrants—economic and social upliftment, education and occasionally, political causes. The Indian diaspora can be found across all parts of the globe. There is no doubt that the process of migration and mental ill health are linked together and several studies have shown that migrants have higher than expected rates of mental illness.<sup>1-3</sup> The variation of these rates is dramatic across different periods and different cultures.

In this chapter, we look at some of the epidemiological findings among Indians in the UK and discuss the reasons for such variations. The largest migration of Indians to the UK occurred initially in the fifties, when economic migrants moved to the UK after the Second World War. The second wave of migration was after the Asians from east Africa were expelled by their political masters and sought refuge in the UK. The reasons for the two sets of migration were quite different—economic and political. Furthermore, the first group had largely males as primary migrants—their wives and families joined them later. The second group had families escaping en masse. In considering the main factors which affect migration, it is useful to conceptualise it in two ways—push factors and pull factors. The pull factors in the UK were gaps in the labour market, especially in manual jobs and shift work. Both positive active recruitment and chain migration helped in this process. Taylor suggests that a rubber vulcanising plant's, operating a positive recruitment drive among members of the Indian Army, led to Southall becoming a focus for the settlement of Sikhs.<sup>4</sup> She argues that the settlement patterns of Pakistanis reflected a post-war job vacancy vacuum in textile industries in the North of England. The push factor from the Indian subcontinent included Mirpuri Pakistanis being forced to move to enable the construction of a dam. They were given priority for migration.

In the nineteenth century, a considerable number of Indians were recruited as indentured labour by the British and taken to Fiji, Mauritius, Trinidad, Guyana and other parts of the world, to provide cheap labour for sugarcane plantations. These migrants had to face a different set of problems compared with those who migrated voluntarily.

In this chapter, we aim to provide an overview of British influence on Indian psychiatry and a discussion of psychiatric morbidity among Indians in the UK. We conclude by comparing and contrasting some of the observations.

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## British Influence on Indian Psychiatry

The British influence in India began in the seventeenth century with the East India Company on 31 December 1600. Although the Portuguese had reached India in 1498 along with other Europeans at different times, including the French, the Dutch and Danes, it was the British who were destined to leave a lasting imprint. It was a British doctor who treated the Mughal Emperor Shah Jahan's daughter and won the East India Company its trading rights. The development and import of Western medical systems into India, led to not simply ignoring the traditional ayurvedic systems by the British, but positively denigrating them. This had a number of effects. The ruling classes, including Indians who were supporting the British in the colonial system, allowed the ayurvedic systems to wither. The coexistence of this new system in conjunction with the old lasted only a short time, when the former supplanted the latter. The main tenets of revivalist ideology evolved early in the nineteenth century in a conflict between British orientalist and anglicists. The former were cultural pluralists and advocated reforms which utilised indigenous systems, whereas the latter believed in the supremacy of the English language and the British as a race and recommended establishing an English language school system with the practical purpose of training Indian men for jobs in British enterprises. They won the argument<sup>5</sup> and the aim of the colonial rule became to seek every practicable means of effecting the gradual diffusion of European knowledge. As part of this deliberate process, the traditional systems of medicine like *ayurveda* were slowly pushed into the background and by the nineteenth century, the teaching of European systems of medicine had begun. A considerable number of European doctors, including the French, the Dutch and the Portuguese, were appointed in the medical services. The appointment of natives of India (i.e. a male-child of parents, of whom one or both were pure unmixed natives) as commissioned officers in the Indian Medical Services was strictly forbidden, and it was only in 1855 that the service was opened to Indians. The subordinate medical services thus incorporated the natives.

The influence of the British on the development of psychiatry can be divided into three areas – the development of the Indian Medical Services (1764), the development of the asylums (1826) and the influence of the Royal Medico-Psychological Association. The asylums developed in parallel with the historical turmoil in India. These were cited in the first instance in three cities in presidency areas. The mentally ill Europeans were segregated from the natives and whenever possible, they were transferred back to the UK.<sup>6,1</sup> In 1889, institutions responsible for the insane numbered 21 and had 3,668 places with 3,246 patients.<sup>7</sup> Natives were not admitted to the Ranchi hospital in the early twentieth century. The alienists were exclusively male and the adverse publicity generated by the appalling state of asylums in the early twentieth century had led to some major changes. Specialists in psychiatry were recognised as full-time officers in hospitals and all asylums were brought under one central supervisory system.<sup>8</sup>

Clinical lunatics in India were classified into three categories: those unable to stand trial; those who committed the act due to a mental illness and those who became mentally ill after having been sentenced. Indian hemp insanity and child marriage were seen as two significant factors in the aetiology of mental illness. The constitution of asylums followed the rules of Victorian architecture rather than making allowances for the local climate.

The establishment of various societies on the lives of British associates had a varied influence in India largely due to the vastness of the country and conflicting interests of Indians and their British masters. The mental hospitals in India still reflect the European influence and the English designs, attitudes, training and aspirations still permeate the practice of psychiatry in modern India. The mental health programmes also owe their origins to the British and bear the stamp of the British Raj.

## **Psychiatric Morbidity among Indians in the UK**

Indians are not evenly distributed in the UK. They settled in different cities as labour was required in different industries in different parts of the country. Racial prejudice, unemployment and poor quality housing, all contributed to the problems faced by Indians. Their children, however, have consistently outperformed not only other migrant groups but also the British white children. This has led to an increase in Indian students in several medical schools where they form significant proportions of students.

In some surveys, the psychiatric morbidity among Indians has been lower, compared with the local indigenous populations. However, there are several methodological problems. Cochrane demonstrated that Indian males and females were less likely to be admitted, with percentages being 85 and 79 of their British counterparts—a similar figure was reported by Hitch from Bradford.<sup>9,10</sup> Local differences in pathways into care may contribute to some of the differences and Rack argues that overall, there are no clear differences in psychological morbidity in Indians and their white indigenous counterparts.<sup>11</sup> The admission rates, of course, do not reflect the time prevalence or incidence rates. They simply reflect the pattern of utilisation and the admission policies followed in such services. It may be that the accessibility of services, language or communication problems and stigma, all play a role in help-seeking. It is helpful to look at the data from population studies. In the UK, there have been a number of other epidemiological studies, looking at the rates of various psychiatric disorders amongst ethnic minorities. Some of the studies have lumped together various ethnic groups from the Indian subcontinent, whereas others have used cultural groupings, for example, Punjabis and, therefore, by definition involved those from the Northeastern parts of Pakistan as well. This mixture adds another layer to the problems of epidemiological studies. In addition, some of the studies have collected samples from General Practitioner (GP) surgeries among those attending the surgery, whereas others have included only those who have been registered with the surgery.

Yet another set of studies have relied purely on admission data from psychiatric hospitals, whereas there has been at least one population-based study in the UK looking at the prevalence of psychiatric disorders in ethnic minorities. In this section, we will present some of the findings to give the reader an indication about the extent of psychopathology. This is not a comprehensive review of the field and we do not propose to cover every psychiatric diagnosis either. As in all epidemiological studies using ethnicity as a variable, their definitions of ethnicity, the definition and understanding of distress, and explanatory models for distress and illness must be taken into account.

In one of the earliest studies, Murray and Williams reported from their sample of 5,904 subjects from GP surgeries that among 144 Asian men and 115 Asian-born women, on self-assessment, Asians were less likely to rate their own health as good and yet, more were less likely to have long-standing illness or disability; and Asians were also more likely to have contacted their GPs (but this was statistically significant only for men).<sup>12</sup> There is a possibility that this sense of being unwell may reflect underlying depressive schema or it may represent a form of somatisation. Gillam et al. using retrospective data analysis for consultations over a two-year period (1979–1981), observed that in primary care, Asians had the highest rates of consultation and yet migrants had the lowest rate of consultation for mental disorders.<sup>13</sup> Asians were much more likely to present with upper respiratory tract infection and non-specific symptoms. Yet, they were less likely than their white counterparts to leave the surgery with a prescription, sick note or follow-up appointments. From a British general household survey of 1983–1985 of a sample of 63 people, 966 aged 0–64 years, Balarajan et al. used logistic regression analysts to study consultation rates

along with other related factors, which may possibly contribute to the process of consultation in primary care.<sup>14</sup> The general household survey covered some 25,000 people from 10,000 households and data were collected on a wide range of economic and social variables, such as population, housing, employment, education and health. The respondents were asked to clarify themselves into nine groups. The authors analysed the responses to the consultations rated with GPs within the previous fortnight of the interview. The study was also confined to respondents under the age of 65 for practical reasons. By grouping the ages into different decades and using social class clarification, they calculated adjusted odds ratios on various parameters. The age structure of the Indian subjects was broadly similar to that of whites though there were some non-significant variations across the age spectrum. Significantly higher consultation rates were reported among men from ethnic minorities. Pakistani men were nearly three times (2.82, CI 1.86–4.28) more likely to consult, whereas West Indian men were 1.53 more likely to consult when compared with white subjects. Ethnic differences were greatest between the age of 45 and 64, when all ethnic minority groups were more likely to be seeking consultations. Pakistanis were also more likely to show higher consultation rates for boys aged 0–15. The authors suggest that a number of explanations are possible for the increase and variation in consultation rates. To what extent these reflect time, psychological morbidity, varying thresholds and perceptions of illness is difficult to ascertain from their data.

Furthermore, in another study it was observed that Asians were more likely to have been registered with Asian GPs and their higher consultation rates reflected a genuine physical need. Johnson et al. also observed that Asians tended to bypass their GPs and used hospital out-patients or casualty services.<sup>15</sup> As chronic conditions like hypertension, heart disease and diabetes are more common among Asians, the high rates of consultation may well reflect this increase.

Carr-Hill et al. studied 100 consecutive Asian females attending a survey in west London.<sup>16</sup> They included only those women who were over the age of 16, had been residing in the UK for at least one year and had originated from the Indian subcontinent. Exclusion criteria included schizophrenia, chronic psychosis, organic mental states and learning disability. Using clinical interviews for diagnosis they found that nearly half (48%) were cases according to GHQ-12 (General Health Questionnaire) criteria and 21% had depression, 7% had neurasthenia and 2% had mixed anxiety and depression disorder. The 'cases' consulted 9.3 times per year—a highly significant difference. This difference persisted after adjustment for chronic physical illness, age, marital status, religion, education and occupation. GPs picked up only 37% of the cases and their recognition rate had a sensitivity of 17% and a specificity of 91%. It was interesting to note that all non-cases reported discussing their problems with the GPs and only half the cases reported doing so. In addition, those who did not disclose all their problems to the GPs believed that depression and somatisation were not medical problems. This was in line with the previous findings of Bhugra et al., who found in a series of focus groups that Punjabi women (these were largely middle-aged women who had migrated from the Indian subcontinent) believed that depression was caused by what sociologists and clinicians term as life events, but their manner of dealing with these symptoms was to seek help from religious healers rather than general practitioners.<sup>17</sup> They confirmed the terms previously identified by Fenton and Sadiq that Asian women saw depression as sorrow, with symptoms including weakness, listlessness, tearfulness, inability to sleep and cope, loss of self-confidence and the loss of meaning of life.<sup>18</sup> This was a qualitative study where hardly any of the women used the word depression and more were probably unaware of it. Bhugra et al. found that using focus groups allowed them to gather rich qualitative data.<sup>17</sup>

The focus groups were conducted in Punjabi and the vignette for depression was introduced without using the word depression. The subjects ranged between 40 and 69 years and had been in the UK for around 15–30 years. The younger women in the group used the word depression whereas the older ones used terms such as ‘weight on my mind’ ‘excessive thinking (leading to pressure on the brain),’ and ‘pressure on the brain’. The symptoms identified as a result of this were poor concentration, insufficient and poor sleep, forgetfulness, unwanted, intrusive and bad thoughts, tiredness, too much sleep, giddiness, too much thinking, restlessness, sweating, palpitations, sadness, feeling of heat, inability to focus in the mind, poor appetite, shame and lack of self-esteem. The frequently reported symptom of ‘*vayu-badi*’ (flatulence and dyspepsia) was not mentioned as such, but the illness was often attributed to ‘gas’. Gas is a term often used among North Indians to denote a mobile entity in the body which affects the body in various ways. There is little doubt that the respondents were describing milder or less severe forms of depression. Among the causes which were identified included bereavement, family conflict, unemployment, financial problems and receiving sudden bad news.

Interestingly, the women blamed the symptoms on children not fulfilling parental expectations, especially in terms of material success and changes in family set-up. They saw the family as extremely important in providing support and dealing with shame. This group’s expectations of their children in material success and the close-knit nature of the family on the one hand, reflects kinship or collectivist views being carried forward. On the other hand, pressures on their children lead to discrepancy in expectations and to culture conflicts. When identifying managing such individuals, this group saw the first line of treatment as talking to family or friends. As one respondent suggested, ‘because letting off steam lightens the mind’.

Religious activities such as going to the *gurdwara* to talk to the *Granthi* or to the temple to talk and listen to scriptures were seen as useful coping strategies. In addition, ‘not taking things to heart’, ‘listening with one ear and out of the other’, ‘courage’ and tolerance were important factors. One respondent mentioned that because doctors did not have a cure for life’s ills and yet wanted to dish out pills, she did not think that there was any point at all in seeking help from doctors. Further, since everyone in the surgery knew everyone else’s business, the family problems which caused the distress would become public knowledge and bring shame to the family. The respondents felt that trouble within the household needed to be kept within the four walls of the house and only family and friends were likely to keep this information confidential. They also suggested that mental tensions could be diverted by reading the scriptures or attending religious gatherings. In addition, the general attitude towards managing depression was a preference for non-medical self-reliant models for getting better (especially for milder forms of depression). Talking and giving off steam was preferred, but confidentiality was a major issue. Despite problems with the study design, it raised some very pertinent and useful observations.

Bhui et al. reported that among 252 Punjabis living in Southeast London who were compared with 251 English subjects, both groups having been recruited from GP surgeries, Punjabis were more likely to be screened positive using standardised clinical diagnosis.<sup>19</sup> Bhui found that those Punjabis who were born in Kenya, Uganda (but not Tanzania) and in Pakistan were more likely cases, although by ethnicity Asian Indians were more likely to be so.<sup>20</sup> Those who spoke Urdu were more likely to be diagnosed as cases. Surprisingly, somatisation was not as common as expected. Although Punjabis were more likely to worry about physical health and had relatively poor concentration and memory, they were marginally more likely to have depressive ideas and depression. Interestingly, GPs were able to identify only 13% of cases among Punjabis (compared

with 21% of English subjects), 8.8% of non-cases among Punjabis and 4.7% of cases among the English as significant psychiatric disorders.

In the fourth national ethnic minority survey, Nazroo demonstrated that 1.9% of males and 2.9% of females of Indian or African-Asian origin considered life was not worth living.<sup>21</sup> The annual prevalence of non-affective psychosis was six per 1,000 for both men and women. Age and gender standardised rates of non-psychosis were similar among Indians and British samples. Those who scored less than two on the clinical interview schedule (i.e. they did not reach caseness) were not surprisingly less likely to visit their GPs 36%, compared with 60%, respectively. Those Indians who scored high were six times more likely to speak to their GP about being anxious, depressed or having a mental or nervous problem.

The Indian sample, 8% of males and 11% of females (9% age and gender standardised) were diagnosed as having anxiety and 2.5% males and 3.2% females were noted to have a weekly prevalence of depressive neurosis. This suggests that having the symptoms per se does not lead to help-seeking, whereas if the level of psychiatric morbidity is high, then individuals are likely to convey their symptoms to the GP.

## Diagnostic Pitfalls

Many Indian patients show their depression or anxiety in physical terms which has sometimes been referred to as somatisation, suggesting that somatisers are somewhat less psychologically sophisticated in expressing their distress. English patients too, often use terms like 'I feel gutted', which are clearly somatised symptoms. In addition, etymologically, both the depression and anxiety terms, are derived from physical roots. However, many patients who have somatised their symptoms or present with physical symptoms, may be diagnosed or the diagnosis missed altogether. In the migrant groups, additional physical factors related to diet and religious taboos may well contribute to confusion regarding the diagnosis. When depression or diagnosis is suspected and direct questions are asked about mood, clinicians must be careful in training the question and also focusing too narrowly on emotional terms which patients may not wish to discuss.

The rates of schizophrenia and its misdiagnosis has led to a number of problems. Possession states or trance states being misdiagnosed is one set of problems—another is the likelihood of confusing brief reactive psychoses with schizophrenia. The studies funded by the Indian Council of Medical Research have contributed tremendously to this end. However, further cross-cultural work is essential to try and understand these aspects of diagnoses. Hysterical psychoses too need to be addressed. These are not seen very commonly in the UK or reported. Managing Indian patients with psychiatric problems in the UK is no different than managing them in India. However, there are key differences such as family members who may be too busy or uninterested in getting involved in treatment. The patients may be more interested in finding out why something is wrong and dietary taboos may be enquired into. The clinician, therefore, must aim to provide multi-axial and multimodel explanations and treatments.

Providing psychotherapy to patients in the Western mode of psychotherapy may not work in older patients who may benefit from Neki's models of *sahaja* therapy or *guru-chela* relationship.<sup>20,22</sup> Alternative models of therapy must be utilised. Similarly, for providing pharmacotherapy, clinicians must be aware of dietary habits, religious taboos and the possibility that Indian patients may be using pluralistic approaches in treatment. The additional non-biological factors such as fasting, incompatibility of models of illness and other factors may play a role in non-compliance. Psychiatrists in the UK have much to learn from their counterparts in India with regard to their approaches in managing patients with psychiatric illnesses.

## Conclusion

A complex interaction between culture, migration, racism and mental health (determined by cultural identity, migratory events, racial life events and the prevalence of mental illness) exists and it is only recently that this has been studied. The presentation of psychological and physical distress in atypical ways may be affected by language, culture and religion. More work is required to bring culture into the core, to establish culturally sensitive and culturally appropriate interventions. Using indigenous therapies in psychotherapy may be the first key step to move the agenda forward.

## References

1. Bhugra D. Migration and schizophrenia. *Acta Psychiatrica Scandinavica* 2000; Suppl 450.
2. Bhugra D. Depression and Migration. *Acta Psychiatrica Scandinavica* 2003; Suppl (in press).
3. Bhugra D, Jones. Migration and mental illness. *Advances in Psychiatric Treatment* 2001;7:216–223.
4. Taylor C. Asians in Britain—origins and lifestyles. In: BR Mc Avoy, L Donaldson, eds. *Health Care for Asians*. Oxford: Oxford University Press, 1990;3:16.
5. Leslie C. The ambiguities of medical revivalism in modern India. In: C Leslie, ed. *Asian Medical Systems*. Berkeley, CA: University of California Press, 1976.
6. Ernst W. *Mad Tales from the Raj*. London: Routledge, 2000.
7. Burdett H. *Hospitals and Asylums Around the World*. London: J & A Churchill, 1891.
8. Shaw WS. The alienist department of India. *Journal of Mental Science* 1932;78:331–341.
9. Cochrane Review: Mental illness in immigrants to England and Wales. *Social Psychology* 1977;12:25–35.
10. Hitch PJ. *Migration and mental illness in a northern city* (Ph.D. thesis). University of Bradford, 1975.
11. Rack P. Psychological and psychiatric disorders. In: BR Mc Avoy, L Donaldson, eds. *Health Care for Asians*. Oxford: Oxford University Press, 1990;290–303.
12. Murray J, Williams P. Self-reported illness and GP consultation in Asian and British born residents of west London. *Social Psychiatry* 1986;21:139–145.
13. Gillam S, Jarman B, White O, Law R. Ethnic differences in consultation rates in urban general practice. *British Medical Journal* 1989;299:953–957.
14. Balarajan R, Yuen P, Soni Raleigh V. Ethnic differences in general practitioner consultations. *British Medical Journal* 1989;299(6705):958–960.
15. Johnson M, Cross M, Cardew. Inner city residents, ethnic minorities and primary healthcare. *Postgraduate Medical Journal* 1983;59:664–667.
16. Carr-Hill R, Dixon P, Thomson A. Too simple for words. *Health Survey Journal* 1989;99 (5155): 728–729.
17. Bhugra D, Baldwin D, Desai M. Focus groups: implications for primary and cross-cultural psychiatry. *Primary Care Psychiatry* 1997a;3:45–50.
18. Fenton S, Sadiq A. *Sorrow in my Heart*. London: CRE, 1993.
19. Bhui KS, Bhugra D, Goldberg D, Dunn G, Desai M. Cultural influences on the prevalence of common mental disorders. *Psychological Medicine* 2001;31:815–825.
20. Bhui KS. *Common mental disorders among Punjabi Asians: prevalence, explanatory models and GP assessments*. (M.D. thesis). University of London, 1999.
21. Nazroo J. *Ethnicity and Mental Health*. London: PSI, 1997.
22. Bhugra D. The colonized psyche. In: D Bhugra, R Littlewood, eds. *Colonialism and Psychiatry*. New Delhi: Oxford University Press, 2001.



## Chapter 32

# Understanding the Militant Mind: Can Psychiatry Help?

*D. S. Goel • D. Saldhana*

The manifestations of militant violence are protean. They have become an almost inalienable part of the human situation today. The Indian subcontinent has a bewildering variety of militant hues, politically and otherwise. From the godless Naxalities of Telangana to the religious fundamentalists of Tarn Taran; from the *Trishul* to the AK-47, the spectrum ranges far and wide. Public consciousness has become immune to the mounting senseless slaughter and the victims and witnesses of violence seem to have gradually acquiesced to it.<sup>1,2</sup>

The battle against militancy appears to have reached a stalemate. Bullets have failed to stop the bullets. Even massive military operations like Rakshak, Bajrang and Rhino have not helped beyond a point, and may even prove to be counterproductive in the long run unless systematic attempts are made to understand the psychological substrate of militancy. This is, however, an almost uncharted area and few guidelines are available for those planning psychological operations. Can psychiatry help?

### Psychiatry and Violence

In a world frightened by highly disruptive episodes of collective violence, psychiatrists are often asked to explain such deviant behaviour. In developed countries, society also expects them to predict violence and to help prevent or contain it.<sup>3</sup> In clinical situations, the failure to anticipate such violence may lead to legal complications.<sup>4</sup> Apart from the frequent requirement of dealing with violent behaviour in clinical practice, the theoretical aspects of such behaviour raises important conceptual issues that are relevant to current psychiatric thinking. It has become imperative for psychiatrists to construct a model of militant violence as a manifestation of underlying emotional disorder.<sup>5,6</sup>

Clinical observations indicate that most violent behaviour is maladaptive for the perpetrator. At the macro level, however, this view appears to be oversimplistic. Violence is multi-determined. Biological, psychological and environmental (including socio-political) factors play a key role in the genesis of violent behaviour. Biological research has focused the attention on a number of relevant parameters, which include aberrant cortical activity, carbohydrate metabolism (with special reference to high dietary intake of refined sugars), 17-ketosteroid levels and endogenous opiates. Social and learning theories of violence which attempt to trace its roots to childhood

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**Note :** The initial part of this study was published in the *Combat Journal* 1992;19(4):38-50.

experiences offer interesting possibilities for prophylactic interventions.<sup>7,8</sup> At the other end of the spectrum is the specious argument that almost any form of violence may be viewed as a political act, and that an attempt to attribute the same to an underlying emotional disorder tends to negate the political meaning of such violence.<sup>9,10</sup> Throughout history, violence has been employed to attain political goals. It is difficult to be judgmental in this politicised context. One country's terrorist is another's freedom fighter. Notably, most Western historians still classify our venerated national heroes like Shivaji, Rani Laxmibai, Bhagat Singh and Netaji Subhash Chandra Bose as terrorists. A frequent and honoured visitor to our shores, Yasser Arafat, continues to be bad news in the West. The leaders of the American revolution were anathema to the British, and some of the present-day world statesmen were, till not long ago, branded as terrorists.

These conceptual and methodological problems probably motivated Freud's pessimistic observation that he saw 'no likelihood of our being able to suppress humanity's aggressive tendencies'.<sup>11</sup> Earlier in 1939, however, a group of several hundred psychiatrists from 30 nations had signed a noble manifesto on the prevention of the war: 'We psychiatrists declare that our science is sufficiently advanced for us to distinguish between real, pretended and unconscious motives, even in statesmen'.<sup>12</sup> Hitler's holocaust soon belied their optimism, and psychiatry retreated into the consulting chamber. The United States Office of Strategic Studies (OSS) under the dynamic leadership of Allen Dulles was probably the only allied organisation to use psychiatry in aid of the war prevention efforts. The brilliant psychiatric study of Hitler conducted by an eminent American psychiatrist helped guide Roosevelt and Churchill in dealing with the Nazi Supremo, and accurately predicted his violent end. This top secret study was later published (*The Mind of Adolf Hitler: The Secret Wartime Report* by Walter Charles Langer) in 1972, and became a best-seller. An analogous study conducted in India still remains classified.

## Conceptual Model of Violence

No single theoretical framework can suffice to explain this complex phenomenon, or rather, group of phenomena. A simple economic principle postulates that, 'violence is likely to result when the perceived benefits of a violent action are greater than the perceived risks of a violent action'.<sup>3</sup> While in deliberate professional crime, the risk-benefit ratio may be evaluated at the conscious level, unconscious mechanisms appear to be operating in many violent acts. The perpetrator of violence is not always a rational person, and quite often violence does not serve the interests of the violent person who may be unable to make an accurate or adequate assessment of the risk-benefit factor, owing to impaired perception. Impairment of the reality function of the ego is, perhaps, the single-most significant determinant in such a situation. This aspect will be elaborated further a little later.

The benefits of violence, real or perceived are the following: (a) gratification of emotional needs;<sup>13,14</sup> (b) power and control over others;<sup>15,16</sup> (c) territory and wealth;<sup>17</sup> (d) relief from oppression or the threat of oppression and (e) increased self-esteem.<sup>18</sup> Biological factors, like higher levels of androgen, appear to be associated with increased rates of violence.<sup>19</sup> Impaired cerebral function resulting from organic brain syndromes<sup>20</sup> and drug intoxication<sup>21</sup> often interferes with the individual's capacity to assess external reality and to evaluate the benefits of violence. Paranoid elaboration of environmental factors, such as economic inequality, felt that socio-political injustice and urban overcrowding, are significant contributors to rising homicide rates among substance abusers in the US.<sup>22</sup> The high correlation between alcoholic intoxication and violent behaviour is probably due in large part to poor risk perception.<sup>23</sup> This factor also operates in impulse control disorders and episodic dyscontrol syndrome.<sup>23,24</sup> Thus, impairment of the reality function appears to play a significant role in the genesis of violence.

## The Ego Revisited

Freud defined the principal characteristics of the ego thus, “in consequence of the preestablished connection between sense and perception and muscular action, the ego has muscular movement at its command. It has the task of self-preservation. With regard to external events, it performs the task by becoming aware of stimuli, by avoiding excessively strong stimuli (through flight), by dealing with mild stimuli (through adaptation) and finally by learning to bring about expedient changes in the external world to its own advantage (through activity). As regards internal events, in relation to the id, it performs the task of self-preservation by gaining control over the demands of the instincts, and deciding whether they are to be allowed satisfaction or to be postponed to times and circumstances favourable to the external world or by suppressing their excitations entirely”.<sup>25</sup> This remarkable formulation has survived psychoanalysis. Even now, when Freud is no longer fashionable, the essential ego functions (control of motility, perception and contact with reality) remain core issues in any deliberations on the neuropsychological basis of personality.

The reality function of the ego comprises three basic components—reality sensing, reality testing and reality adaptation. Empirical evidence suggests that each of these components operate in three modes: executive, litigative and ethical. This concept involves dynamic interfacing of psychological, social and philosophical aspects of the human situation. The conceptual model along with its colloquial counterparts is depicted in Table 32.1.

**Table 32.1: Reality Function of the Ego: Proposed Paradigm**

Reality function component	Executive mode	Litigative mode	Ethical mode
Reality sensing	Assessing the situation with regard to the practicability of the proposed activity <i>Can it be done?</i>	Assessing the legality of the proposed activity <i>Can it be done legally?</i>	Evaluating the morality of the proposed activity <i>Is it morally right?</i>
Reality testing	Probing moves to assess reaction to the proposed activity <i>Let me try an experiment</i>	Assessing legal reactions to the hypothetical model of the proposed activity <i>Can I get away with it without getting caught?</i>	Exploring avenues to justify the morality of the proposed activity <i>Can I find a moral loophole to justify myself?</i>
Reality adaptation	Compromise solution: activity modified to accord with situational requirements <i>Let me be pragmatic</i>	Activity modified in form rather than content to accord with legal requirements <i>At least it should not appear that the law has been broken</i>	Ethical compromise to accord moral sanction for the activity <i>Situational ethics</i>
Management jargon	Doing the practical thing	Doing things right	Doing the right thing

The precedence, hierarchical as well as chronological, of these modes appears to mirror the ethico-moral state of the society. In simple terms, the social ethos may range from an absolutist belief in the transcendence of absolute standards of morality, ethics and justice to a relativistic one, where these values are viewed as the product of complex historical, political, social, economic and cultural determinants.<sup>26</sup> In the Indian context today, executive and litigative modes appear to have eclipsed the ethical mode insofar as the reality function of the ego is concerned. If an act can be accomplished without falling foul of the law, its moral status hardly ever acts as a deterrent. Lawyers and income tax consultants thrive on the basis of their ability to discover legal ways of doing illegal things.

## Materials and Methods

This chapter is based on studies conducted in Punjab (1991–1992) and Jammu and Kashmir (J&K) (1992–1996). The material comprised 19 captured militants in the Punjab and 89 militants in J&K. Their informed consent to the study was duly obtained. Accordingly, the psychometric evaluation of willing subjects was carried out in the J&K group using Cassel’s Somatic Inkblot Series-I (SIS-I) and SIS-II (video version). Detailed interviews of the militants were also carried out. In addition, inputs from intelligence agencies and police/military officials with real-time experience in combating terrorism in both states were obtained to complete the picture.

<b>Sample profile</b> (Jammu & Kashmir)	
Total number of militants in custody	89
Number of militants volunteered for study	36
Psychometric test completed	31
Mean age	35 years (Range: 28 years–48 years)
Mean duration of custody	149 days (Range: 26 days–341 days)

<b>Group affiliation (n=31)</b>	
Hizbul Mujahideen (HM)*	12 (38.76%)
Jammu & Kashmir Liberation Front (JKLF)	05 (16.15%)
Al Jihad (AJ)	03 (9.69%)
Lashkar-e-Tayyeba (LeT)	03 (9.69%)
Harkat-ul-Ansar (HA)	01 (3.23%)
Jamait-e-Islami (JI)	01 (3.23%)
Al Umar (AU)	01 (3.23%)
Others/non-affiliated	05 (16.13%)

\*Hizbul Mujahideen (HM) has since split into:

- (a) the residual HM
- (b) a larger faction led by Maulana Masood Azhar and renamed Jaish-e-Muhammad (JeM). After 9/11, this was again renamed Tehrik-al-Farquan to escape US sanctions.  
Maulana Masood Azhar was released at Kandahar in exchange for the passengers of IC 814, the Indian Airlines flight hijacked to Afghanistan.

**Psycho-social stratification of militants (n=31)**

Medulla ('Hard core')	21 (67.83%)
Cortex ('Middle' level)	07 (22.61%)
Epicortex ('Peripheral' zone)	03 (9.69%)

**Age profile (n=31)**

Age group	Medulla	Cortex	Epicortex	Total
30 years or less	16	05	02	23 (73.96%)
31 years or less	05	02	01	08 (26.04%)
Mean age (years)	28.6	27.85	35.66	

**Educational status (n=31)**

Education Level	Medulla	Cortex	Epicortex	Total
Illiterate	-	-	-	-
Non-matriculate	13	02	02	17 (54.84%)
Matriculates	06	05	01	12 (38.71%)
Graduates	02	-	-	02 (6.46%)

**Group affiliation and strata (n=31)**

Group	Medulla	Cortex	Epicortex
HM	09	03	-
JKLF	04	-	01
AJ	03	-	-
Let	03	-	-
HA	-	01	-
JI	-	-	01
AU	01	-	-
Others	01	03	01

<b>Self-reported mode of recruitment (n=31)</b>		
<b>Group</b>	<b>Volunteers</b>	<b>Non-volunteers</b>
HM	11	-
JKLF	04	01
AJ	03	01
Others	05	06
Total	23 (74.19%)	08 (25.84%)

<b>Self-reported substance abuse (n=31)</b>	
Medulla	04
Cortex	01
Epicortex	0

<b>Psychometric profile (n=31) (Cassel's SIS-I &amp; SIS-II Video)</b>			
<b>Rejection profile</b>	<b>Medulla</b>	<b>Cortex</b>	<b>Epicortex</b>
10 or more cards rejected in SIS-I	15	03	-
15 or more images rejected in SIS- II (V)			
5-9 cards rejected in SIS-I	04	04	01
10-14 cards rejected in SIS-II (V)			
4 or less cards rejected in SIS-I	02	01	01
9 or less images rejected in SIS-II (V)			

<b>Family size (n=31)</b>				
<b>No. of siblings</b>	<b>Medulla</b>	<b>Cortex</b>	<b>Epicortex</b>	<b>Total</b>
Four siblings or less	02	02	01	05 (16.13%)
Five siblings or more	19	05	02	26 (83.89%)

<b>Marital status (n=31)</b>				
<b>Marital status</b>	<b>Medulla</b>	<b>Cortex</b>	<b>Epicortex</b>	<b>Total</b>
Unmarried	14	03	02	19 (61.37%)
Married	07	04	01	12 (38.76%)

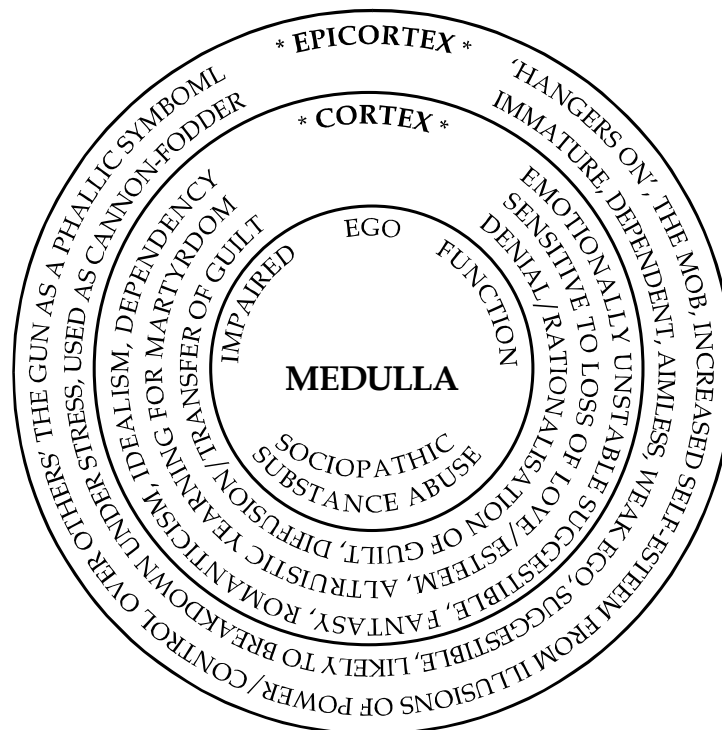
Level	Hostility and aggression (n=31)			Total
	Medulla	Cortex	Epicortex	
Moderate (03-05)	06	02	02	10 (32.30 %)
High (06-10)	15	05	01	21 (67.70 %)

### Militant Organisation: Psycho-Social Profile

The hypothesis advanced in this section is derived from empirical data analysed in the conceptual context of sociopathic personality traits coupled with impaired reality-testing being associated with insensate violence, regardless of the possible consequences for the perpetrator as well as the social group as a whole. Situational exigencies were a limiting factor in field observations, but a great deal of valuable material accrued from detailed interviews with those who had real-time experience in combating terrorism in the Punjab and J&K. Gradually, the psycho-social profile of the militant organisation emerged from this mass of complex and at times confusing information. This is diagrammatically depicted in the Figure 32.1.

The inner core or the **medulla** of the militant organisation comprises individuals with sociopathic traits and marked impairment of the reality function in all its modalities. Their actions

Figure 32.1: Militant Organisation: Psycho-Social Profile



appear to be completely divorced from environmental realities and they appear immune to external reactions. This autistic attitude insulates them from corrective situational cues as well as from emotional remorse. Substance and alcohol abuse is frequent, and many of them show pronounced sadistic traits. Sexual sadism is often encountered, along with impulse control disorders of various hues. In terms of forensic terminology, they would be classified as criminal psychopaths. Serial killers like the Boston strangler probably belonged to the same genre. The prototype subject cooperated in the interview situation with surprising willingness, but he did not know that the interviewer was a psychiatrist. The absence of feeling of guilt coexist with paucity of emotions and bland resistance to even subtle attempts at reasoning. Ideologic delusions were sustained by a paleologic process of internal validation. Simple schizophrenia could perhaps be considered as a possible diagnosis in some of these cases. The usual corrective or penal measures are unlikely to have any effect on these militants. Most of them would eventually meet a violent end.

The next hierarchical level, the **cortex**, arouses greater interest. The constituents are better educated (many are graduates or students of professional colleges), emotionally unstable, suggestible and rather dependent in outlook. They are sensitive to the loss of love and esteem of others, suffer from feelings of guilt and self-doubt, particularly when involved in insensate violence. These self-condemnatory responses are dealt with in three ways: (a) by diffusion of responsibility within the militant group;<sup>27</sup> (b) by dependent transfer of responsibility for the act to persons they perceive as powerful,<sup>28</sup> i.e. the core group in the medulla and (c) projection of their own socially unacceptable impulses (greed, exploitation, sexual aggression), the 'foreign otherness' of Erikson's concept,<sup>29</sup> on a minority group, which then becomes the target of justified retaliation. It is interesting to note in this context that militant ideologies in the Punjab as well as in J&K accuse the 'Brahminical regime' in New Delhi of the same 'evil' exploitativeness, greed and avarice which has characterised their own state-level political leaders in the past. In simple terms, militants in the cortex level could perhaps be viewed as romantic idealists whose neurotic dependency needs are fulfilled by an apparently powerful leadership, which then exploits their potential in the pursuit of sociopathic aims. Hitler's use of youth power in the Nazi movement in Germany is an analogous model of this phenomenon.

There is, however, reason for guarded optimism in respect of the aforesaid cortical group as the reality function is only partly or temporarily impaired. Contact with reality is not lost and return to reason is possible if they can be made to realise the true nature of their sociopathic leadership. In fact, particularly in J&K, some of these misguided idealists have already, on their own, realised the true face of their erstwhile alter-egos. The resulting disillusionment has been a painful process and many of them have left the valley in disgust. This group must be targeted in any attempt to win back hearts and minds. The cortex is also the level at which any information or disinformation (depending on which side of the fence one is) endeavour must focus.

At the periphery of the militant organisation lies another hierarchical level, **epicortex**, an amorphous mass of the curious and the credulous, of drifters and petty offenders who try to find some meaning in the movement for their otherwise shallow and aimless lives. This is the crowd which gives a transient, albeit spurious, sense of power to its constituents. There is no real commitment, and the militant leadership employs them merely as window-dressing, as expendable cannon-fodder. The epicortex level seldom survives the demise or decimation of the medulla and the cortex. At worst, it creates a temporary law and order problem which may be utilised by more serious militants either to execute an act of terrorist violence or to escape the security dragnet. When the medullar 'leadership' is eventually discredited and the cortical component disillusioned, the epicortex will rapidly melt away.



Before turning away from this topic, one must consider the role of certain types of learning behaviour at the macro level in promoting violent behaviour. Inaccurate or distorted risk-benefit assessment may be the product of a social milieu, where unethical, illegal or even violent acts are not attendant by external punitive sanctions.<sup>30</sup> Indian society today is characterised by transcendental ethico-legal degeneration. Political leaders, senior civil and military bureaucrats, and even members of the higher judiciary vie with each other in grave transgressions of the law of the land. The consequent climate of cynicism erodes ethical and moral values which could have been effective deterrents to violence.

## Prejudice and Militancy

Allport defines prejudice in very simple terms: 'thinking ill of others without sufficient warrant'.<sup>31</sup> Racial or sectarian prejudice may be viewed as a 'conscious adaptive mechanism by which members of a dominant group exploit members of a vulnerable group in order to meet their own perceived social, psychological and economic needs'.<sup>32</sup> While the potential for such prejudice is rooted in personal anxiety and feelings of insecurity, at the group level it is utilised as a defense mechanism to deal with collective socio-psychological insecurities.<sup>33</sup> These may in turn be traced to a perceived or real sense of hurt and injustice—economic, political or historical. It is interesting to note that sexual fears and anxieties are often associated with ethnic prejudice.<sup>34</sup> The ideological matrix underlying militancy in the Punjab as well as in J&K conforms uncannily with this theoretical formulation, and 'Hindu chauvinism' is projected as the common enemy. This commonality of collective paranoia probably accounts for the tactical alliance between militant groups in the two states. In this context, the frequent allegations of 'mass rape' against the security force, and the retaliatory molestation of minority women become more understandable as manifestations of sectarian psychopathology.

## Psychiatric Treatment

Racism and related violence have been eloquently described as an 'infectious disease, a perceptual disease and a lethal disease'.<sup>35</sup> Psychiatric intervention is most useful when dealing with individuals rather than groups and while confronting violence which results from distorted perceptions rather than conscious benefit-motivated considerations (for example, organised crime). The individual who (a) gains little from violent acts; (b) who ultimately harms both himself and the victim; (c) who cannot define a clear purpose in being violent; and (d) who experiences a feeling of sincere remorse after the act, may be likely to benefit from therapy. Prima facie the last two criteria appear to exclude militancy from the scope of psychiatric treatment. Closer scrutiny, however, indicates that subjects belonging to the medullary and cortical zones of the militant organisation are analogous with psychiatric patients in respect of certain parameters. This view opens up the avenues of therapeutic intervention.

Psychopharmacology has made phenomenal advances in recent decades and its application in frontier areas, such as borderline personality disorders, episodic dyscontrol syndromes and atypical paranoid conditions, offer intriguing possibilities for therapy with some types of militant psychopathology. Most of the patients suitable for such therapeutic intervention would be located in the medullary zone. Among the drugs which may be considered for possible use are carbamazepine, propranolol, lithium and more speculatively pimozide.<sup>36,37</sup> It must, however, be emphasised that few guidelines exist for the use of such psychotropic drugs. It is believed that these have been used by security agencies in the former USSR and perhaps even in some Western

countries. Published work is scant and important ethical issues are involved. The World Psychiatric Association in its 'Declaration of Hawaii', issued at the annual conference held at Hawaii in 1977 opposed the misuse of psychiatric skills, knowledge and facilities for the suppression of dissent.<sup>38</sup>

It is, however, a moot point whether insensate militant violence earlier in the Punjab and currently in J&K and elsewhere can qualify for the label of permissible or even authentic political dissent. The escalating level of mass murder of soft targets can be defined only in terms of a sociopathic quest for power and control over others. The cortical militants would be amenable to psychotherapeutic intervention, though few subject-specific models for such social engineering exist. Directed towards changing pathological patterns of thinking and feeling that may be associated with a flawed appreciation of perceived oppression, risk-benefit ratio and a romanticised/factitious image of the essentially sociopathic leadership, therapy aims also at teaching alternative response patterns to violence. As has been emphasised earlier, unmasking the true nature of the medullary leadership could be the single-most effective means of including insight and consequent remorse/reform in the cortical group. However, a word of caution needs to be sounded at this stage. As part of their suggestible-idealistic mental outlook, these subjects often show an altruistic yearning of martyrdom ('*Shahadat*'), the romantic mystique of which overrides the normal fear of death. In combat, therefore, they may prefer to die in a hail of bullets rather than suffer the ignominy of surrender. In this regard, they may be tougher adversaries than even the medullary leadership.

The amorphous and unstable nature of the epicortical group has been discussed earlier. No specific corrective measures are required and they may be expected to melt away once the inner hierarchy is successfully dealt with. Finally, it needs to be emphasised that these hierarchical levels are not entirely watertight or mutually exclusive. Each derives sustenance from the other, and there may be considerable overlap or interflow between them. Such classification is, however, helpful in planning psychological operations against militants. It also provides useful inputs while dealing with captured terrorists.

### **Psychiatrist as Reality Tester/Interpreter**

The role of the psychiatrist in the field of international relations and public affairs has been shrouded in controversy, largely owing to the complexity of a large number of interdependent variables which go into the making of a modern nation state. A series of operational propositions derived from an analysis of diplomatic case studies<sup>39</sup> is relevant to decision makers confronted with the problem of militancy:

- decision makers often perceive what they expect, and information inputs are distorted (subconsciously or otherwise) to fit preconceived notions;
- incomplete or minimal data inputs are used to ratify perceptual expectations;
- preconceived images of the adversary can be modified more easily if evidence to that effect is received in piecemeal rather than in one lot;
- decision makers tend to project their own political beliefs, previous life experiences and historical interpretation while conceptualising the problem or phenomenon and its various components;
- misunderstandings often arise because of parallax in communication;
- lack of clarity in explaining operational plans leads to inadequate comprehension and consequent confusion in those who have to execute the plans;

- decision-makers tend to see the adversaries as more hostile than they actually are, resulting in overreaction to a given threat or situation;
- overestimation of the adversary's potential may lead to erosion of self-confidence among own forces;
- unrealistic expectations from peace initiatives, which the adversary may not regard as credible, often resulting in recriminatory disillusionment.

The present dilemma of a well-meaning but 'soft-headed' (according to his critics) Chief Minister in J&K illustrates this paradigm.

The psychiatrist, with his greater insight into human behaviour, can help to correct the distortions outlined above. The most vital aspect undoubtedly is the pernicious tendency on the part of official agencies to distort data inputs, internal as well as external, to accord with preconceived politico-ideological conceptions or considerations of motivated sectarian self-interests of the ruling or the dominant political groups. The epiphenomena of intelligence agencies feeding doctored data (depending on their concepts of what will please the political masters) is a tragically frequent corollary of this pathological constellation. The reality tester-interpreter can play a significant therapeutic role in this scenario.

In the West, the psychiatrist is often called upon to play the role of crisis manager.<sup>40</sup> Elite counter-terrorist combat units like the Strategic Air Service (SAS) in the UK routinely function with two psychiatrists. While one is at the actual scene of operations giving concurrent evaluation of terrorist intents and possible courses of action, the other remains behind at headquarters where he can make a more detached strategic appreciation of the situation. Unfortunately, however, our thinking in this area is still governed by outmoded notions of a colonial administration, where the show of force or its quantum was taken as an index of effectiveness. Such facile knee-jerk responses to modern militancy have been repeatedly found wanting, and a more scientific approach is required. The situation is compounded by the inability or unwillingness of decision makers at the highest level to act decisively in a crisis situation because of the all-pervasive 'fear of failure' syndrome. The resultant delay in taking decisions renders even a good decision irrelevant and often has disastrous consequences. The hijacking of the Indian Airline IC 814 to Kandahar was a classic example where such procrastination led to avoidable national humiliation. Viable options to tackle the hijackers while the aircraft was at the Amritsar airport were available and could have been activated at short notice, had the decision makers not lacked the courage to decide.

Finally, the role of psychological warfare in the context of militant activity needs to be considered. The terrorist, above all, deals in terror. His main aim is to terrorise the populace, discredit the system and eventually destroy it through internal subversion. By the skilful use of discrete violence, he achieves a multiplier effect. Empirical evidence suggests that the most effective long-term countermeasures lie in the psychological sphere. In this context, it is interesting to note that the screening in Srinagar of a Libyan film, *Umar Makhtar* in 1985, is believed to have ignited the people's fury against the Farooq Abdullah regime. The film, dealing with an episode in the freedom struggle of Libya, depicts the corruption and decadence of the erstwhile leadership once they had tasted the fruits of power. The people of Kashmir immediately identified their ruling dynasty as the 'betrayers of people' as portrayed in the Libyan film, and viewers streamed out of cinema halls shouting anti-Sheikh Abdullah slogans. Such a thing would have been unimaginable a few years earlier. It is now difficult to state whether the screening of this movie was an unfortunate coincidence or a matter of deliberate design. In any case, it remains a major event in the chronology of the growth of militancy in J&K.

Psychological countermeasures have to be designed around authentic data inputs, and must conform to ground realities. In this regard, one possible avenue involves the funding of militant organisations by hostile foreign powers. The almost accidental unmasking in 1986 of a foreign cheque made out in favour of a non-existent 'madrasa' in Bandipora, resulted in a lot of negative publicity for militants who had been trying to impress the local population with their supposedly selfless commitment to the cause. There are embarrassing rumours about some militants who are alleged to have stashed away large sums of money in foreign banks, just as there are insinuations of some corrupt elements in the security forces who are rumoured to have made money by colluding with militants. Such clandestine money laundering operations should not be very difficult to unmask and then debunk. This offers a possible avenue for psychological countermeasures.

At the macro level, certain generally accepted principles are relevant:

- more equitable distribution of power and wealth will diminish violence;
- alleviation of social oppression will reduce levels of violence;
- violence begets violence; hence the need for diminished quantum of violence in national and international affairs;
- development of skills for resolving conflicts by non-violent means will result in less violence;
- the capacity to communicate and empathise at the group level helps in resolving unrealistic feelings of oppression;
- reduction in availability of weapons helps in containing violence.

## Can Psychiatry Help?

The answer is both yes and no. Yes, if one takes an innovative and unconventional view and approaches the problem with an open mind. No, if a clinically constricted concept of psychiatry is allowed to prevail. The material adduced above offers a glimmer of hope. Whether this glimmer will eventually become a guiding and illuminating beacon for effective action depends on the intellectual integrity with which we approach the problem. There are few landmarks in this area of darkness. This communication is a very small attempt to arouse the interest of the politico-military establishment, as well as mental health professionals in this vital, yet neglected, field. The bullet for bullet policy lies in shambles. Can the mind triumph where the gun has failed?

## References

1. Pasnau RO, Fawgy FI. Stress and Psychiatry. In Kaplan HI, Sadock BJ, eds. *Comprehensive Textbook of Psychiatry*. Baltimore: Williams & Wilkins, 1989:1232.
2. Shore JH, Tatum EL, Vollmer VM. Relationship of perception and mediating variables to the psychiatric consequences of disaster. In Shore JH, ed. *Disaster Stress Studies: New Methods and Findings*. Washington DC: American Psychiatric Press, 1986:49.
3. Halleck S. Social violence and aggression. In: Kaplan HI, Freedman AM, Sadock BJ, eds. *Comprehensive Text Book of Psychiatry*. Baltimore: Williams & Wilkins, 1980:3149-3154.
4. Gurevitz H. Protective privilege versus public peril. *American Journal of Psychiatry* 1977:134-292.
5. Zitrin A, Hardesty AS, Burdock EL. Crime and violence among mental patients. *American Journal of Psychiatry* 1976:133-149.
6. Sosowsky L. Crime and violence among mental patients reconsidered. *American Journal of Psychiatry* 1978; 135:33-42.

7. Berkowitz L. *Aggression: A Social Psychological Analysis*. New York: Mc Graw Hill, 1962.
8. Bandura A. *Aggression: A Social Learning Analysis*. Englewood Cliffs, New Jersey: Prentice-Hall, 1973.
9. Cleaver E, *Soul on Ice*. New York: Mc Graw Hill, 1968.
10. Halleck SL, *Politics of Therapy*. New York: Science House, 1971.
11. Freud S. *Collected Papers*, Vol 5. London: Hogarth Press, 1950.
12. Wedge B. Psychiatry and international affairs. *Science* 1967;157:281–285.
13. Mc Cord W, Mc Cord D. *Psychopathy and Delinquency*. New York: Grune & Stratton, 1956.
14. Meninger KA, *The Vital Balance*. New York: Viking Press, 1963.
15. Abel GC, Barlaw DH, Blanchard EB, Gulid D. The components of rapist's sexual arousal. *Archives of General Psychiatry* 1977;34:895–903.
16. Mac Donald J. *Psychiatry and the Criminal*. Springfield, Illinois: Charles C Thomas, 1968.
17. Sullivan RF. The economics of crime: An introduction to literature. *Crime and Delinquency* 1970;23–138.
18. Wolfgang ME, Ferracuti F. *The Subculture of Violence* Chicago. Aldine Publishing Co. 1961.
19. Fields WS, Sweet WH. *Neutral Basis of Violence and Aggression*. St. Louis. Warren & Green, 1975.
20. Elliot FA. Neurological factors in violent behaviour. In: Sadoff R, ed. *Violence and Responsibility*. New York: Spectrum 1978.
21. Rinklenberg A, Stillmen W. Drug users and violence. In: Daniel D, Gilula M, Ochberg F, eds. *Violence and the Struggle for Existence*. Boston: Little, Brown & Co. 1970: 55.
22. Tardiff K. Patterns and major, determinants of homicide in the United States. *Hospital Community Psychiatry* 1985;36:632–639.
23. Toch H. *Violent Men: An Enquiry into the Psychology of Violence*. Chicago. Aldine Publishing Co. 1961.
24. Hollis WS. On the etiology of criminal homicides: The alcohol factor: *Journal of Political Science and Administration* 1974;2:50.
25. Freud S. An outline of psychoanalysis. In: *Standard Edition of the Complete Psychological Works of Sigmund Freud*. London: Hogarth Press, 1953–1966.
26. Freedman AM. Ethics in psychiatry: A question of allegiance. *Annals of Psychiatry* 1978;85.
27. Bandura A, Underwood B, Fromson ME, Disinhibition aggression through diffusion of responsibility and dehumanisation of victims. *Journal of Research* 1975;9–253.
28. Milgram S. Some conditions of obedience and disobedience to authority. *Human Relations* 1965;18–57.
29. Erikson EH. *The Roots of Virtue*. In: Huxely J, ed. *The Humanist Frame*. New York: Harper, 1961.
30. Kohiberg L. Moral stages and moralisation: The cognitive development approach. In: Lichona T, ed. *Moral Development and Behaviour*. New York: Rinehart & Winston, 1976.
31. Allport GW. *The Nature of Prejudice*. Cambridge, Massachusetts: Addison-Wesley, 1954.
32. Thomas CS, Comer JP. Racism and Mental Health. In: Willie CV, Kramer BM, Brown BS, ed. Pittsburgh University of Pittsburgh Press, 1973:165.
33. Thomas A, Sillen S. *Racism and Psychiatry*. New York: Brunner/Mazel, 1972.
34. Poussaint AF. Interracial relations and prejudice. In: Kaplan HI, Freedman AM, Sadock BJ, eds. *Comprehensive Textbook of Psychiatry*. Baltimore: Williams & Wilkins, 1980;3155–3161.
35. Pierce CM. Psychiatric problems of the black minority. In: Arieti S, ed. *American Handbook of Psychiatry*. Vol 2. New York: Basic Books, 1974.
36. Kaplan PM, Boggiano WE, Anticonvulsants, nor-adrenergic drugs and other organic therapies. In: Kaplan HI, Sadock, BJ, eds. *Comprehensive Textbook of Psychiatry*. Baltimore: Williams & Wilkins, 1989:1681–1687.
37. Jeferrson JW, Greist JH. Lithium therapy. In: Kaplan HI, Sadock BJ, eds. *Comprehensive Textbook of Psychiatry*. Baltimore: Williams & Wilkins, 1989:1656–1662.
38. Delrio VBY. Psychiatric ethics. In: Kaplan HI, Freedman AM, Sadock BJ, eds. *Comprehensive Textbook of Psychiatry*. Baltimore: Williams & Wilkins, 1989;3216–3231.
39. Pieczenik SR. Psychological dimensons of international dependency. *American Journal of Psychiatry* 1975: 132–134.
40. Halleck SL. *Politics of Therapy*. New York: Science House, 1971.

## Chapter 33

# Psychological Aspects of Counter-Insurgency Operations

*D. S. Goel*

The Indian Army has been almost continuously engaged in Counter-Insurgency Operations (CI Ops) since 1948, when it was called upon to deal with the communist-led insurrection in Telangana. The level and complexity of such operations has risen steeply since 1984. A new and more dangerous dimension was added in 1989, when Pakistan stepped up its proxy war in Jammu and Kashmir (J&K).<sup>1</sup> Thus, while the nation has been technically at peace, the army has been at war and has suffered more casualties in such 'low intensity' operations than in the three major conflicts with Pakistan. A major and unfortunately unpublicised consequence of these escalating commitments has been a skewed pattern of deployment, wherein 'peace' tenures in the real sense of the term have virtually ceased to exist. Units returning from a strenuous tour of duty in Sri Lanka or the North East had to be inducted post haste into J&K, and soldiers whose units had just moved to their peace-time locations found themselves deputed to the Rashtriya Rifles, which were in the middle of CI Ops. The resultant psychological stresses cannot but extract their toll.

The problem of combat-related stress has received considerable attention in the West, particularly the US.<sup>2-7</sup> The Indian scene is, however, surprisingly sterile. While a number of authors have focused on the politico-military aspects of such conflicts in the Indian context, few have touched upon the psychological issues involved.<sup>8-11</sup> The first and perhaps the only formal psychiatric study of the problem was carried out in the Northern Command, and the results have been accordingly reported.<sup>12,13</sup> The present study was conducted between June and July 1997, among troops belonging to specialised battalions engaged in high intensity CI Ops. While a major part of the said study remains unavailable, some of the general findings are being reported in this communication.

### Materials and Methods

A multidimensional approach was adopted to acquire the following data for the study:

- Self-administered questionnaire consisting of 83 structured and nine subject-generated items, administered to officers serving in these units.
- Observer-assisted questionnaire consisting of 42 structured and four subject-generated items, administered to Junior Commissioned Officers (JCOs) and Other Ranks (ORs) serving in these units.

- Structured and semi-structured interviews with formation commanders at various levels within the theatre of operations.
- Visits to adjoining areas to assess ground realities and to interact with troops deployed there.
- Complete psychological workup of individuals involved in aberrant acts with a view to build up a holistic profile of such incidents.

Confidentiality was assured by not asking for identifying personal details (number, name and unit) from the respondents. Data were tabulated and subjected to computer analysis, using a programme especially developed for the study.

## Observations and Analysis

The response rate among officers, most of whom had sent in the completed questionnaire by post, was gratifying (92.5%). Even more satisfying was the lack of equivocation among JCOs/ORs with only 18.8% (mean figure) giving 'don't know' responses. The demographic profile of the sample is reflected in Table 33.1.

**Table 33.1: Demographic Profile**

Rank	Percentage of total sample (%)	Average age (years)	Average length of service (years)	Average length of stay in CI Ops area (months)
Officers	14.7	34.68	15.14	15.53
JCOs	18.2	39.52	22.15	21.20
ORs	67.1	28.25	10.70	18.70

Not surprisingly, a majority of the subjects were initially unhappy at being inducted into counter-insurgency operations, but their attitude became more positive as time went on. Motivational levels tended to decline when the tenure was prolonged for more than 24 months. Most of the respondents felt that two years should be the optimal duration of the tour of duty in CI Ops. There were small but significant determinants of motivation and morale, depicted in Table 33.2. Feelings of insecurity with regard to families back home, the lack of societal support, adverse publicity in the media, hostile attitude of human rights groups, the lack of cooperation/hostility on the part of the local population, dissatisfaction with regard to financial compensation in respect of additional risks/hardships involved in CI Ops, difficulties encountered in rail travel while proceeding home on leave/posting and a sense of disgust towards a corrupt polity were some of the factors affecting morale. Contrary to general belief, however, leave was not a problem area.

In the operational context, the factors exercising a negative impact included ambiguity with regard to aim, feelings of uncertainty, fear of ever present danger/attack from unexpected quarters, feeling of anger/frustration at fighting with 'one arm tied behind the back' and anger/bitterness at not being able to deal with the unarmed but vicious ideologues/motivators/financiers of militants—the '*jamayatis*' who blatantly misused religious institutions such as *madrasas*, in their anti-national activities (Table 33.3).

**Table 33.2: Determinants of Motivation/Morale**

S. No.	Parameter (negative determinant)	Officers (%)	JCOs (%)	ORs (%)
1.	Feeling of insecurity regarding families back home	14.5	42.2	62.5
2.	Lack of societal support	72.5	38.6	58.6
3.	Adverse publicity in the media	84.1	30.2	52.4
4.	Hostile attitude of human rights groups	86.6	24.4	23.8
5.	Lack of cooperation/hostility from the local population	76.4	68.5	66.4
6.	Financial dissatisfaction	90.2	78.6	89.4
7.	Difficulties in rail travel (including bribes demanded by railway staff)	40.4	82.4	91.6
8.	Disgust at a corrupt polity	91.5	36.8	61.4

**Table 33.3: Operational Factors Affecting Morale**

S. No.	Negative OP factor	Officers (%)	JCOs (%)	ORs (%)
1.	Ambiguity regarding aim	31.6	28.6	42.4
2.	Feeling of uncertainty	30.6	40.4	66.4
3.	Fear of ever present danger/unexpected attack	28.4	42.4	61.6
4.	Anger at fighting with constraints	76.4	82.4	84.5
5.	Bitterness at inability to deal with <i>jamayatis</i>	91.5	60.6	66.4

These negative factors were counterbalanced by a widely held perception among the men that their officers were fair, just and competent. Regimental spirit, group cohesiveness and the feeling of organisational support in spite of deficiencies in some areas, also contributed to high morale, despite the dangers and hardships involved in CI Ops (Table 33.4).

**Table 33.4: Reinforcers of Morale**

S. No.	Positive factor	Officers (%)	JCOs (%)	ORs (%)
1.	Regimental spirit	88.5	78.2	81.6
2.	Group cohesiveness	89.0	71.6	84.5
3.	Organisational support	91.0	68.5	72.4
4.	Fear of letting down family prestige	31.4	54.5	42.4

## Discussion

Low Intensity Conflicts (LICs) involve unconventional politico-military operations, overt as well as covert (including subversion psychological tactics such as the use of terror to destroy morale, economic sabotage), carried out by a vicious, highly motivated and well-funded militant group.<sup>14</sup>



In fact, considering the level of ruthlessness/violence encountered in such operations, the use of the prefix 'Low' appears to be rather paradoxical. Troops are thus exposed to significantly greater stresses as compared to conventional warfare. The contributory factors include:

- **Ambiguity** of aim, politico-moral justification and societal support.
- **Apprehension** of ever present danger, the source of which is largely unknown, unrecognisable and unexpected.
- **Insecurity** resulting from the operational requirement of operating in small sub-units, often cut off from each other, in a hostile environment where the insurgent is virtually indistinguishable from and frequently sustained by support (directly or indirectly, willingly or under fear of reprisals), from the local populace who suffer casualties/privation in the crossfire and who tend to blame the troops rather than terrorists, for their travails.
- **Fatigue** and eventual exhaustion as a consequence of continuing tension over prolonged periods, lots of worries, irregular mail, problems relating to leave/railway reservations at short notice, inability to relax even in secure bases due to fear of unexpected attacks/sabotage and an all pervading feeling of uncertainty.
- **Frustration** at the perceived failure of their superior officers, the organisation and the state, to deal firmly with and eliminate the *jamayatis*, who, though unarmed, are the real ideological motivators and material sustainers of militancy in J&K. This leads to the erosion of confidence in themselves, their leaders, the organisation and even the future course of operations. The Americans experienced this with a vengeance in Vietnam, as exemplified in this doggerel:

*We are the unwilling, led by the unqualified,  
doing the unnecessary, for the ungrateful.*

In conventional operations of war, on the other hand, the battle lines are clearly drawn, the enemy is clearly identifiable and aggression can be unequivocally channelised in this direction. Organisational as well as national goals are clear and unambiguous, public support is ensured and the soldier comes to regard himself as a living symbol of patriotic pride, and the unit operates from a firm base, where relaxation in a relatively secure environment is readily accessible.

Limited periods of intense stress followed by adequate recovery phases do not significantly sap the psychological resources of the soldier in such formal, structured combat scenarios, unless the operations are unduly prolonged or are attended by repeated reverses. The situation in LICs is diametrically opposite. Prolonged spells of stress punctuated by quantitatively and qualitatively inadequate opportunities for relaxation/recovery impose immense and often, unbearable demands on even otherwise robust subjects. This may result in combat stress reaction (transient, reversible psychological malfunction leading to temporary combat unworthiness); combat stress disorder (more severe/global psychological disturbance requiring psychiatric treatment, preferably in the same corps zone); or post-traumatic stress disorder (severe, disabling psychiatric disorder, usually manifesting after a variable latent period and requiring intensive/prolonged psychiatric treatment.<sup>13</sup>

The findings of this study have highlighted the negative impact on the morale of socio-political factors such as lack of societal support, adverse propaganda by the media/human rights activists, uncooperative/hostile attitude of the local population and a sense of disgust at the rampant corruption and moral degradation.<sup>1,12,15</sup> The almost universal grievance relating to exploitation by corrupt railway

men is but one facet of this hydra-headed monster. The soldier also looks askance at being equated to an unskilled worker in matters of pay and what is even more important, *izzat*.<sup>16</sup>

The element of ambiguity and uncertainty is inherent in the very nature of counter-insurgency operations as the Americans learnt at the cost of defeat and humiliation in Vietnam.<sup>1,4,7,9,12</sup> The Indian *jawan* has, however, transcended the negative impact of this factor and the success achieved in containing insurgency in J&K is an amazing example of sheer willpower triumphing over unbelievable levels of military and environmental adversity. Time honoured but currently unfashionable concepts, such as regimental spirit, group cohesiveness, identification with the organisation and loyalty to family/clan/tradition are even today potent motivations of men going into battle.

This should not, however, lull the nation into a state of self-congratulatory complacency. The soldier, even the redoubtable Indian *jawan*, cannot remain perpetually immune to the prevalent climate of a rapacious self-serving 'marketing' society, where almost everything and everyone is up for sale to the highest bidder.

## Conclusion

Soldiering in an LIC scenario thus involves significant additional stress. Officering troops in these complex operations demand dedication, courage and professional skills of a high order. It also requires sensitisation to problems and issues which are peculiar to such operations, training programmes, which incorporate training in these skills and are likely to produce the desired results. This does not, however, detract from time honoured requirements of promoting cohesiveness, motivation and morale among soldiers who are expected to face extra danger as individuals and as a team.

Finally, it needs to be noted that the problem has a wider, deeper macro-dimension. In the current climate of socio-political degeneration, institutions as well as their keepers have lost credibility. Trust is tarnished, faith has fallen prey to deceit and patriotism has been reduced to a mere platitude. It would not be an easy task to sustain motivation and morale in such infertile soil. This is the challenge.

## References

1. Prasad BA. Holocaust in Kashmir: A review. *Combat Journal* 1992;19:10-20.
2. Driskell J. Effects of stress on military performance. In: *Handbook of Military Psychology*. Gal R, Mangelsdorf AD, eds. New York: John Wiley, 1991:84-88.
3. Matus J. Fear and motivation on AWS battle study. *Marine Corps Gazette* 1988:65.
4. Hendin H, Haas AP. *Wounds of War: The Psychological Aftermath of Combat in Vietnam*. New York: Basic Books, 1984:28-32.
5. Ford JD. Psychosocial debriefing after operation desert storm: Marital and family assessment and intervention. *Journal of Social Issue* 1993;49:73-102.
6. Sutker PB. War-zone trauma and stress-related symptoms in operation desert Shied/Storm (ODS) returnees. *Journal of Social Issue* 1993;49:33-49.
7. Mc Mohan BF. Low intensity conflict: the Pentagon's foible. *Orbis* 1990;34:3-16.
8. Grewal SS, Khanna BK. Low intensity conflict in the Indian context. *USI Journal* 1992;72:205-223.
9. Raza M. Beyond guerilla warfare: a new dimension. *Combat Journal* 1992;19(2): 3-13.
10. Sardeshpande SC. Military and national security. *Combat Journal* 1992;19(4):3-9.
11. Kharb KS. Joint civil military response to terrorism. *Combat Journal* 1992;19(2):14-22.

12. Goel DS. Low intensity conflicts: psychological aspects. Paper presented at CME (Military Psychiatry), Kirkee, September 1997.
13. Saldanha D, Goel DS, Kapoor S, Garg A, Kochhar HK. Post-traumatic stress disorder in polytrauma cases *Medical Journal Armed Forces of India* 1996;7-10.
14. Shultz RH. The low intensity conflict environment of the 1990s. In: Lambert RD, Heston AW, eds. *The Annals of the American Academy of Political and Social Science*. Newbury Park: Sage, 1991:12-134.
15. Goel DS. Understanding the militant mind: Can psychiatry help: *Combat Journal* 1992;19(4):38-50.
16. Joshi M. In the hot seat. *India Today*, 6 October 1997;58-59.



**Section V**

**Issue-Related Studies**





# Chapter 34

## Suicidology: The Indian Context

*A. Venkoba Rao*

“Suicide is characterised as the final common pathway of diverse circumstances, of an interdependent network rather than an isolated cause, a web of circumstances tightening around a single time and space”.

Haven, 1965

**T**he term suicidology has been coined by Edwin Shneidman, a leading American suicidologist. In this chapter, some features of suicidological interest will be discussed in relation to the Indian context.

### Database

India does not appear in the 50 to 60 countries (from the list of 192 member countries of WHO) that report suicide mortality statistics regularly to the WHO. The annual statistics for India are collected by the National Crime Records of the government. The figure available for the year 1990 was 8.9 per 100,000, a rise of more than 40% from 1978.<sup>1</sup> However, in India there are large variations between the states. The mortality rate was 26.3/100,000 for Kerala, 117/100,000 for Bihar, and 50/100,000 for the Union Territory of Pondicherry.<sup>1,2</sup> These discrepancies are possibly due to local reporting methods by the institutions. On the other hand, the field researches by independent workers provide more reliable figures. For example, the rate for the city of Jhansi was reported as 29/100,000;<sup>3</sup> for a rural area in West Bengal, the mortality rate was 43.4/100,000.<sup>4</sup> and for Madurai and surrounding areas,<sup>5</sup> it was 43/100,000. Earlier, in 1961, the estimate for Bangalore, based on police records was around 10/100,000.<sup>6</sup> Recent epidemiological study in Bangalore yielded a figure varying from 33 to 35/100,000.<sup>7</sup> These rates are five to six times higher than the national rate. However, Indian data from the national sources fail to conform to the WHO format. For example, the data are not collected for the age groups below 18 and over 55. The certification of suicide and assigning its causes is carried out by coroners, which may not always be reliable. However, these are all the numbers that are available until improvements are effected in data collection.

The official data on non-fatal suicidal behaviour are difficult to obtain. It is generally believed that there are 10 to 20 suicidal attempts for every completed suicide in the USA. In the elderly, more suicide attempts result in death, yielding the ratio of 7:1 to 6:1.<sup>8</sup>

## Gender and Suicide

In contrast to the data from many other countries, except China which records the highest female suicide rate, women outnumber men in completed suicides in India, although the gap between them is narrow. The relatively higher mortality due to suicide among women was observed in Gujarat more than 50 years ago.<sup>9</sup> The gender paradox in suicide has been extensively debated and the consensus is that non-fatal suicidal behaviour is more common in females than males, while completed suicide is more common in males.<sup>10</sup> As of now, however, there is no plausible explanation for the gender discrepancy. As the seminal studies of Emile Durkheim had so vividly demonstrated over a century ago, socio-cultural factors are significant determinants of suicide behaviour and perhaps these impact men and women differently. This also flags the point that what might be true for the Western nations like the USA and Western Europe, may not apply to India. The suicide rate by age for India reveals that the suicide rates peak for both men and women between the age 18 and 29, while in the age group 10–17, the rate for the female exceeded the male figure (5.5 and 7.1, respectively), a rare example of women having a higher figure than men. However, in the age groups 18–29; 30–49 and above 50, male rates have exceeded the rates for the females: M.18.2, 15.9 and 10.7 and F.16.8, 8.5 and 4.8, respectively.<sup>11</sup> It is interesting to note that the suicide rate of Indian immigrants to other nations was invariant in rate and gender-wise, as against the figures in their home country. India—total suicide rate: 8.9 for 1990; male 10.2 and female 7.6, m/f ratio being 1:34.<sup>11</sup> The suicide rate among Indian immigrants in the UK is 16:4, for males being 23:1 and females 10, with the m/f ratio of 2:31. This invariant finding is obvious, that is, the suicidal behaviour of the immigrants differs from that prevalent in their home country. More work on epidemiological data collection reliably and accurately has been suggested in this regard. However, the gender ratio in certain places in India differs from the national ratio. In Jhansi, where there were 103 females as against 84 male suicides (m/f ratio 0:8) and for a village near Kolkata there were three female suicides as compared with one male suicide. It is difficult to ascertain data for non-fatal suicidal acts. A study from Chennai reported 48 men and 38 women hospitalised for such behavioural condition.<sup>12</sup>

The notion that ‘para-suicide’ (attempted suicide) and suicide involve different populations has been challenged to be inaccurate. A meta-analysis shows, a history of attempted suicide enhanced the risk of its completion to 40 times that of the general population.<sup>13</sup> Past history of attempted suicide in patients predicts a high risk for a second attempt, even higher than that associated with relatively serious mental disorders like major depression, personality disorder, substance abuse or dependence on alcohol. The presence of the latter adds to the suicidal risk in patients who have attempted suicide earlier. Contrary to the earlier belief that suicidal risk declines following an attempt, it has been reported that the risk may persist for years. Cases of completed suicide after an attempted suicide 22 years earlier have been reported.<sup>14,15</sup> Venkoba Rao reported 114 cases of attempted suicides, hospitalised in Madurai during the first six months of 1964.<sup>16</sup> Some Indian studies have reported a low incidence of repeat suicidal attempts but the follow-up period was shorter.<sup>16</sup> There are no official data for non-fatal suicidal attempts even in the USA. The spectrum of suicidal behaviour ranges from suicidal ideas, to suicidal gestures and, subsequently, suicidal acts.

## Sociological and Economic Theories

The three important social theories of suicide, Durkheim’s, Ginsberg’s and Henry and Short’s, emphasise, respectively, social integration and social regulation, the discrepancy between aspirations and reward and the issue of ranking in the social hierarchy.

The study of suicidology has to consider the convergence of three factors, namely, the individual's psychology, social institutions and the economic climate. It has been observed that the relation between suicide rate and the individual's economic situation is not linear. Poverty, illiteracy and unemployment figure prominently in this context in India. Durkheim extended the sociological concepts to religious groups, family, marital bonds and so on.<sup>17</sup>

Regarding religion and suicide, it has been recognised that Muslim nations report lower rates throughout the world, including the Muslim majority in Kashmir (0.9/100,000). Bangladesh shows a rise from 0.8 to 2.5 during the period 1986 to 1993. For Pakistan (from Karachi), the rate varies from 0.72 to 1.24 during the period 1959 to 1978. Among the Malays in Malaysia, the rate is 1.1, lower than the rate among Indians (23.3) and the Chinese (8.1). The low rate among the Malays has been attributed to their Muslim religion.<sup>11</sup>

Durkheim postulated that egoistic suicide results when society fails to integrate the individual into its fold, while anomic suicide is the consequence of the failure of society to *regulate* and maintain *integration* of the individual, leading to normlessness and a sense of alienation. Durkheim also described the altruistic type of suicide occurring in traditional societies such as the Japanese, though he later extended it to non-traditional ones. Egoistic suicide ensues when the individual finds life to be meaningless, while altruistic suicide occurs when death appears meaningful.

Among many factors, improved physical and mental healthcare has been advanced as a protective factor against suicide. In this connection, it has been pointed out that Kerala, with a well-organised network of health services, has the highest literacy rate, highest life expectancy, lowest infant mortality in India, but has high rates of suicide, divorce and alcoholism. The state continues to be poor economically, with little development.<sup>18</sup> There is a message here, organising health services and literacy drives does not ensure positive mental health. There is a debate in India on whether the media reports exaggerate the occurrence of dowry deaths, sensationalising the issue. A discrepancy has been observed between the police reports and the researcher's data.<sup>2,19</sup> Suicide pacts involving mutual arrangements are rare in India, accounting for less than 1% of all suicides. They are related to anticipatory dowry problems. Such suicides have been reported from Tamil Nadu, Bangalore, Agra and Kerala.<sup>20,21</sup>

### **Self-Immolation as Surrender of Self to Self**

There is a class of suicide which is distinct from others, which is the voluntary giving up of one's life, where individuals sacrifice themselves as a mark of self-dedication to a higher level of existence. They give up their lives gladly, oblivious to the weariness of life, frustration, depression or the need to avoid any conflicts. Most importantly, these individuals are totally free from stigma, as their sacrifice is considered praiseworthy and they are commended, revered and venerated by generations of men and women. Unlike the places or sites of suicide, which are generally considered haunted, the places of such deaths by self-immolation become centres of pilgrimage and worship. There are hundreds of such deaths that have occurred in both the young and the old. Examples of this kind of suicide are Kumarila Bhatta, a great Mimamsa philosopher who lit his own funeral pyre and entered it; Adi Sankara entered a cave in Kashmir in a yogic state and a disciple of his sealed it; Dnyaneswar entered a samadhi designed by him and his brother Nivrutti covered it with a slab; Chaitanya Mahaprabhu jumped into the blue waters of the Bay of Bengal at Puri when he saw a vision of Lord Shyam; Eknath entered the waters of the river Godavari; Tukaram leapt into the Indriyani river. These are considered blessed, who through their mortality attained immortality. Some of them, for example, Tukaram, have even left behind lines, which may serve as suicide notes.<sup>22</sup>



## Prevention of Suicide

The prevention of suicide is the ultimate objective of the art and science of suicidology. That religious beliefs and spiritual disposition play a protective role against suicidal behaviour has been recognised. In all world religions, suicide is not a recommended choice for the resolution of problems. Some of these are to be cultivated in the vulnerable population and should be a part of counselling procedures. In India's multi-religious and multi-ethnic mosaic of groups it is difficult to practise these techniques uniformly.

Applying public health concepts, primary prevention (leading to the reduction of a number of new cases) is the ideal target and requires addressing the social, economic, psychiatric and biological conditions to prevent people having suicidal thoughts.<sup>23</sup> Some of these measures include the reduction of poverty, unemployment, divorce rates, illiteracy, family violence and promoting the empowerment of women, greater physical health, adequate exercise, diet and sleep.<sup>24</sup> The early diagnosis and effective treatment of psychiatric disorders is called for, to prevent suicidal ideas.

The precipitants for suicide, according to Indian government statistics, are as follows: among women compared to men, dowry disputes (2.9% versus 0.2%); love affairs (15.4% versus 10.9%); illegitimate pregnancies (10.3 versus 8.2) and quarrels with spouse or parents-in-law (10.3% versus 8.2%). Failure in examinations was the common precipitant among males in the age group 10–12 (11.4 versus 7.5%). The most common method of suicide in India in 1990 was poisoning (33%), followed by hanging (24%) and drowning (11%). Official Indian reports put all these cases under 'insanity', an all-inclusive term, at 3%. The common causes for suicide in India are disturbed interpersonal relationships, followed by psychiatric disorders and physical illnesses. Mental illness, especially depression, does not play an important role, and disturbed personal relationships take precedence over it.<sup>19</sup> In a report on 100 consecutive instances of female burn cases, dowry-related deaths accounted for a small percentage.<sup>17</sup> However, the low incidence of dowry-related suicides has not been confirmed in the statistics published by the Indian Parliament. The number of dowry-related deaths more than doubled during 1988–1990. Out of 11,259 dowry-related deaths during this period, 4,038 were counted as suicides.<sup>23a</sup> This aspect demands serious public debate and proper action. The Dowry Prohibition Act 1961 was meant to prevent the exploitation and harassment of women and thus to prevent the dowry-related deaths, including suicides.

Depression is a long-term illness characterised by recurrence and chronicity. Hence, long-term illness requires long-term treatment. Higher doses of antidepressants for the treatment of depression are known to prevent suicides. The role of family doctors is significant in treating depression. Besides depression, alcohol and substance abuse, borderline personalities and cases of earlier suicide attempts must be diagnosed and treatment undertaken. However, the available evidence does not support the hypothesis that effective treatment had a protective or preventive effect on suicidal behaviour, especially in females.<sup>10</sup> It is to be noted that medicines: Selective Serotonin Reuptake Inhibitors (SSRIs) provoke suicidal ideation and pose problems, though they are less prone to cause side-effects and rarely fatal if overdosed. On the other hand, tricyclics, for example, amitriptyline, do not induce suicidal ideation but may be fatal in overdoses. ECT has an antidepressant and anti-suicidal function, but is underutilised. Anxiety and severe agitation may mask expression of suicide in depressed subjects. Such patients, while not verbalising suicide thoughts, do commit suicide. This is an important risk factor to be identified.<sup>25</sup>

Beck et al. have reported that those who ultimately commit suicide are those who are in a state of total hopelessness.<sup>26</sup> According to Beck et al., hopelessness correlates better with suicidality

than the psychiatric diagnosis of depression. The trait hopelessness is associated with depression, while the state of hopelessness correlates with suicide. The suicidal hopelessness reflects a cognitive inflexibility, in believing that there are no options other than suicide. The relation between persistent hopelessness in the face of remission of depression symptoms and low melatonin levels with risk relapse and suicide has been reported by Venkoba Rao and Parvathi Devi.<sup>27</sup> Many studies have shown that 50% of people who committed suicide had few close friends. At least one important person – therapist, spouse or another person, for example, a befriender – being present with the suicidal individual becomes crucial.<sup>24</sup>

As indicated in the opening quotation, suicide is a multidimensionally determined act, and the management of the suicidal patient involves many treatment modalities. The use of pharmacological agents, especially one of the SSRIs may be considered to raise the serotonin concentration, which is invariably low in suicidal individuals. These often need to be combined with anxiolytics, mood-stabilising agents like lithium and sodium valproate and atypical antipsychotics.

There are several positive factors, internal as well as external to the individual, which counter the suicidal impulse.<sup>28</sup> These relate to moral, ethical, religious and social values. Besides a sense of obligation towards spouse, children and parents, economic and social support systems do act as counters. The treatment approach consists of strengthening these positive factors to offset suicidal impulses.

## **A Critique of Contemporary Preventive Measures and Suggestions for New Approaches**

It has been recognised that the suicide prevention measures hitherto employed have not met with any degree of success. ‘The land of suicide prevention is one of hopes and promises and not of certainties.’<sup>29</sup> Although data are available in profusion, none of them measure up to rigorous standards, and much confusion has followed.<sup>30</sup> Several reasons have been advanced for this non-contributory nature of research findings, such as the predominantly unidimensional nature of research, simplistic models employed for understanding a complex problem like suicide, lack of long-term follow-up, poor concordance between researchers and inadequate multidisciplinary teamwork. The paucity of robust data has hampered the development of effective preventive strategies. Other factors include methodological problems in applying the findings from one culture to another. For instance, suicides among the wives of alcoholics unable to tolerate their husbands’ delusional allegations of marital infidelity are common in India and other low-income countries, contrary to the scenario in the West.<sup>31</sup> Another example is belief in the law of “karma” in India. The doctrine of karma implies that an individual’s actions, good or bad in a given life, determine the quality of the next life. The cutting short of one’s life by unnatural death like suicide or euthanasia compels one to reincarnate and live out the unexhausted karma. Hence, suicide or euthanasia provides only a temporary solution for current problems but the remaining part of one’s karma has to be experienced in the forthcoming life. Such a contingency may be worse than the present one! Thus one finds, albeit rarely, instances of persons going through pain and suffering patiently as determined by past karma to burn away all traces of their karmas. This indicates the need for a philosophical and spiritual dimension to counselling.

Additionally, uncritical acceptance of certain data without concrete proof of their validity, particularly those related to community programmes devoid of research input, also contribute to ineffective preventive measures. There is yet another factor, namely, the lack of interest among

psychiatrists in the area of suicidology, in spite of the fact that psychiatric disorders contribute importantly to the phenomenon of suicide.<sup>29</sup>

There are many crisis intervention centres in India offering excellent services. However, there is no evaluation of their effectiveness. Many individuals prone to suicide do not make calls to these centres owing to their inherent withdrawal tendencies. The need to reach such high-risk individuals through outreach programmes should be a high priority.

A multidimensional approach to suicide prevention is needed. Greater use of antidepressant drugs in doses larger than those prescribed to control and prevent mood disorders, functional neuro-imaging (to visualise brain structures in suicidal ideators), genetic studies and psychometric approaches to screen impulsive behaviour at an early stage, as well as suicide proneness, seem to hold promise for better suicide prevention in the future.<sup>29</sup> Maris and colleagues have listed 15 risk factors as predictors of suicide. The difficulty has been that many of them turn out to be false positives. The most reliable risk factors seem to be major depression, schizophrenia in the post-psychotic phase, substance abuse, chronic alcoholism and borderline personality. An earlier non-fatal suicidal attempt is the single-most important risk factor as has been mentioned earlier. Suicide can be completed even two decades after the first attempt.<sup>14</sup> Hence, a long-term follow-up of non-fatal suicide attempters is required, accompanied by adequate treatment.

Presently, attempted suicide is a legally punishable offence in India. However, this does not serve as a deterrent for suicide. On the contrary, it prevents people from seeking treatment as this would lead to medico-legal entanglements. Therefore, the law needs rethinking and appropriate revision. Suicide and attempted suicide carry social stigma, which needs to be addressed along with destigmatising measures against mental illness in general.

## References

1. Desjarlais R, Eisenberg L, Good B, Kleinman A. *Suicide. World Mental Health: Problems and Priorities in Low-income Countries*. New York: Oxford University Press, 1995.
2. Aleem S. *The Suicide: Problems and Remedies*. New Delhi: Ashish, 1994.
3. Shukla GD, Verma BL, Mishra DN. Attempted suicides in Jhansi. *Indian Journal of Psychiatry* 1986;28:59-62.
4. Banerjee G, Nandi DN, Nandi S, Sarkar S, Boral GC, Ghosh A. The vulnerability of Indian women to suicide: a field study. *Indian Journal of Psychiatry* 1990;32:305-308.
5. Ganapathy MN, Venkoba Rao A. A study of suicide in Madurai. *Journal of the Indian Medical Association* 1971;46:18-23.
6. Satyavathi K, Murti Rao DLN. A study of suicide in Bangalore. *Transactions of the All India Institute of Mental Health* 1961;2:1.
7. Gururaj G, Mohan Isaac. *An Epidemiological Study of Suicide in Bangalore*. Bangalore: NIMHANS Publication, 2001.
8. Venkoba Rao A. Depression in the aged. In: Venkoba Rao A, ed. *Depressive Disease*. New Delhi: Indian Council of Medical Research, 1986:152-163.
9. Thakur U. *The History of Suicide in India*. Delhi: Munshi Ram Manohar Lal, 1963.
10. Canetto, Silvia Sara, Sakinofsky, Isaac. The gender paradox in suicide. *Suicide and Life-threatening Behaviour* 1998;28:1-23.
11. Lester D. Suicide in emigrants from the Indian sub-continent. *Transcultural Psychiatry* 2000a;37(2):243-254.
12. Ponnudurai R, Jeyakar J, Saraswathy M. Attempted suicides in Madras. *Indian Journal of Psychiatry* 1986;32:44-51.

13. Shneidman ES. Introduction: Current overview of suicide. In: Shneidman, ed. *Suicidology: Contemporary Developments*. New York: Grune and Stratton, Inc., 1976:1–22.
14. Runeson Bo S. Suicide after parasuicide. *British Medical Journal (South Asian Edition)* 2003;18:1070–1071.
15. Jenkins GR, Hale R, Papanatassiou, Crawford MJ, Tyrer P. Suicide rates 22 years after parasuicide: cohort study. *British Medical Journal* 2002;325:1155.
16. Venkoba Rao A. suicide attempters in madurai. *Journal of Indian Medical Association* 1971;57:278.
17. Durkheim E (1897). *Suicide: A study in sociology* (translated by Spalding J.A. and Simpson G). London: Routledge & Kegan Paul, 1952.
18. Sen A. *Poverty and Famine*. Oxford: Oxford University Press, 1981.
19. Venkoba Rao A. One hundred burn cases in young women: A study in suicidology. *Indian Journal of Psychiatry* 1989;31:43–50.
20. Vijayakumar L, Thilothammal N. Suicide pacts. *Crisis* 1993;14:43–46.
21. John CJ. Family murder suicides in Kerala. *Crisis* 2000;21(3):105–107.
22. Savarkar VD. Self-immolation and self-dedication. *Bhavan's Journal* 2001;47:27–34.
23. Maris RW, Berman AL, Silverman MM. *Comprehensive Textbook of Suicidology*. New York: Guilford, 1992.
- 23a. Pitchford R. India reports 11,000 'dowry deaths' in three years. *Reuter Library Report*, 1991.
24. Maris RW. Suicide. *Lancet* 2002;360:319–326.
25. Mattsberger JT. Letter across the Pacific. *Crisis* 2000;21:154–156.
26. Beck AT. Cognitive approaches to suicide. In: Goldsmith, ed. *Suicide Prevention and Intervention*. Washington DC: National Academy Press, 2001;10–12.
27. Venkoba Rao A, Parvathi Devi S. Psychobiology of suicide behaviour. *Indian Journal of Psychiatry* 1987; 29:299–305.
28. Venkoba Rao A, Nammalvar N. Death orientation in depression (a phenomenological, cultural and endocrine study). *Indian Journal of Psychiatry* 1979;21:199.
29. Leo D. Why are we not getting any closer to preventing suicide? *British Journal of Psychiatry* 2003;181: 372–374.
30. Lester D. The end of suicidology. *Crisis* 2000b;21:158–159.
31. Venkoba Rao A. Marriage, parenthood, sex and suicidal behaviour. *Indian Journal of Psychiatry* 1974;16:9.

## Chapter 35

# Substance Abuse and the Growth of De-Addiction Centres: The Challenge of Our Times

*Rajat Roy*

India has had a long history of drug and alcohol use, with cannabis and opium being the traditional drugs of abuse. In recent times, however, reports suggest the abuse of newer intoxicants like heroin, synthetic products and pharmaceutical compounds. This chapter discusses the response of the government towards containment of the problem as well as future challenges.

### **Earlier Period (1960s to mid-1980s)**

By the mid-1960s, many people were concerned about the rising magnitude of drug abuse in India. Several research reports published in this period, suggested the abuse of drugs by students, the general public and clinical subjects. Alarmed by this increased use, in 1977 the Ministry of Health and Family Welfare (henceforth the Ministry of Health), Government of India appointed an expert committee (the Committee). The Committee had experts from various disciplines/organisations, namely, the University, Excise and Customs Department, the Narcotics Commissioner, the Drugs Controller of India, the Indian Council of Medical Research and the Ministry of Social Justice and Empowerment (earlier Social Welfare). This was one of the first major national efforts to assess the contemporary drug scene. The Committee reviewed the available literature extensively and concluded that though a large number of students were abstainers, there were sufficient numbers of college students as well as the general population who were habitual drug abusers. Abuse of alcohol and cannabis was most often reported among both these groups. Additionally, the abuse of other drugs like amphetamines, pethidine, barbiturates and tranquillisers by some was also reported. The Committee noted that (special) facilities to treat drug-dependent individuals were very few at that time and most were being treated in the psychiatric hospital or psychiatric department of some medical colleges. The Committee suggested several means to control drug abuse. Heroin abuse was reported from treatment centres in 1981 for the first time and during subsequent years, it was perceived by many experts that drug abuse, including the abuse of heroin was on the rise. In 1985, the Narcotic Drugs and Psychotropic Substances (NDPS) Act was enacted and it provides the current framework for drug abuse control in India. Essentially, the NDPS Act deals with law enforcement activities related to the availability of drugs of abuse. There are, however, certain

provisions in this Act for the treatment of drug-dependent individuals. The necessary measures for identification, treatment, aftercare and rehabilitation of drug abusers, in addition to preventive education, have been suggested. It urged the government to establish, maintain and regulate treatment centres. Following the enactment of the NDPS Act, the Ministry of Health appointed another expert committee in 1986 to suggest schemes to control drug abuse.

### **Current Scenario (the mid-1980s to the present)**

The current initiative of the Ministry of Health really emanates from the recommendations of the expert committee formed in 1986. The committee recommended the following measures:

- The development of a National Centre under the Ministry of Health and equivalent centres in various states.
- The strengthening of existing general hospitals to provide de-addiction services.
- The treatment of patients as the responsibility of the state health departments.
- Manpower development was to receive high priority.

Several long-term and short-term treatment modalities were suggested. An opiate maintenance programme for certain patients (satisfying the qualifying criteria) with heroin dependence was also proposed. It was proposed that the data from treatment centres should be collected periodically and analysed centrally to generate the profile of patients seeking treatment. The expert committee suggested that the treatment of alcohol and drug-dependent patients should have a clear visibility in India's overall health system.

An action plan for the augmentation of services was proposed. Subsequently, a cabinet subcommittee was formed in 1988. On the basis of recommendations made by the expert committee in 1986 and the cabinet subcommittee in 1988, de-addiction centres in five central government institutes and two regional centres in two state capitals (Kolkata and Mumbai) were established. These seven centres initiated several activities towards the treatment of patients. In addition to the effort by the Ministry of Health, the Ministry of Social Justice and Empowerment (henceforth the Ministry of Social Justice) also became active. While the Ministry of Health carried out its functions through Government Organisations (GOs), the Ministry of Social Justice funded Non-Governmental Organisations (NGOs).

### **Centres Established**

From mid-1992, the Ministry of Health began to provide construction grants (one time) to establish de-addiction centres, in various state health departments. Some of the centres in the North-eastern states received token recurring grants as well for the purchase of medicines, supplementary diets to patients, etc. By 1994, a total of 34 GOs were established. In 1997, the established centres increased to 72 and in 2001, their number stood at 114. Most of these centres are either at the state medical colleges or the district hospitals. A few have been set up at the community health centres as well. These centres have been chosen in consultation with the state health department. Formal and informal reviews show that many of these centres are not optimally functional due to the lack of financial support and other resources required for treatment. Very few state health departments have earmarked any money for these centres and for de-addiction activities per se in the states. Many do not even have trained staff, medicines and other assets to carry out the task.

The Ministry of Social Justice supported a study in 1989, where secondary data and opinion of experts were collected from 33 cities in India. The programme outline was based on this report and several discussions were held in the Ministry. The Ministry also directed its effort to carry out public awareness campaign, media publicity and community-based treatment. It operates primarily through the NGOs and provides financial assistance to these voluntary organisations. The programme emphasises the mobilisation of community resources, community participation, awareness building, counselling of affected individuals and follow-up assistance to recovering persons. The programme supports drug awareness, counselling and assistance centres, treatment-cum-rehabilitation centres, de-addiction camps and a workplace prevention programme. The treatment-cum-rehabilitation centre usually has 15 beds, though some have 30 beds and in rare instances, there are 50-bed facilities as well. The state government (welfare department) is actively involved in the screening, and inspection of NGOs and the grant is released based on the recommendations of the state governments. In early 1990s, the centres based upon their activities, were categorised as:

- Counselling centres.
- De-addiction centres.
- Aftercare centres.

Financial support was received in 1992 from the Ministry of Social Justice for 143 counselling centres, 86 de-addiction centres and 14 aftercare centres. In 1997, there were altogether 341 centres and in 2002, these centres were re-categorised as:

- De-addiction centres.
- Counselling centres.

At present, there are 369 de-addiction centres and 90 counselling centres which receive financial assistance from the Ministry.

Both the ministries (Health and Social Justice), from time to time, have attempted for the convergence of activities. Inter-ministerial committees have been formed and they have recommended that the government treatment centres and the non-government treatment centres should act in unison and supplement each other. However, this effort has not been very successful. Most recently, the Ministry of Health has requested the Ministry of Social Justice to establish NGO centres in the premises of the district hospital in certain states.

## **Other Significant Events**

A National Master Plan (NMP) to control drug abuse was formulated in 1994. The team, with representatives from all the key ministries/departments (Narcotics Control Bureau, Ministry of Health and Ministry of Social Justice), held extensive consultations with key stakeholders, state governments and proposed a comprehensive sector-wise plan for the years 1994 through 2000, for both demand and supply reduction activities. The NMP team recommended specific activities for the two ministries engaged in carrying out the prevention, treatment and rehabilitation of drug-dependent individuals. It was noted that there was some degree of overlap of activities of the two ministries that was possibly unavoidable. It proposed synergy rather than two parallel programmes. During the same year (1994), a training master plan was also formulated. This plan addressed issues regarding the training of medical doctors, paramedical staff, social scientists

and counsellors attached to the GO and NGO centres. Several of these activities, namely, the development of the NMP and the training master plan, and assistance to the treatment centres (GO and NGOs) was possible through the support of the United Nations International Drug Control Programme (UNDCP). The activities initiated by the two ministries were re-examined in late 1996. The evaluation showed that:

- The course curriculum for general duty medical officers, nursing personnel and laboratory staff has been developed and the training programmes have been commenced.
- Several treatment centres have been established and are functional, though not optimally.
- Several research studies on epidemiology, treatment outcome and other clinical issues have been carried out.
- Several national/regional workshops to critically examine the then ongoing programmes were held.
- Certain innovative projects, for example, community-based pilot projects, district-based surveys and ethnographic studies of the drug using population have been carried out.

The WHO (India fund) supported some of the projects. Several shortfalls were also noticed. Through a formal in-house review carried out in 1996, it was noticed that many government treatment centres were not functional from their inception (1992–1993). Yet another effort is being made to evaluate the functioning of these centres. The Ministry of Health in 2002, has initiated a study to examine and assess:

- The functioning of these centres.
- The number of patients.
- The quality of treatment being provided.
- The utilisation of equipment.
- The staff available.

Further, on-site interviews with the officer-in-charge of the centres and the review of records are also being carried out as a part of this exercise.

## **Challenges Ahead**

Recently (2000), a study titled, National Survey on Extent, Pattern and Trends of Drug Abuse in India, jointly sponsored by the UNDCP and Ministry of Social Justice was completed. The major components of this national study are a national household survey, rapid assessment survey, drug abuse monitoring system and focused thematic studies on drug abuse among women, the burden on women due to drug abuse in the family, drug abuse in rural subjects, drug abuse in border areas and drug abuse in prisons. A comprehensive national report will be available soon and will provide a greater understanding of drug abuse in India and thus, help to formulate appropriate strategies for intervention. Its component, Rapid Assessment Survey (RAS) of drug abusers has also been carried out in 15 Indian cities. Meanwhile, the RAS report is available and it states that *Cannabis*, heroin and pharmaceutical drugs were the major drugs of abuse currently in urban India. Many were poly drug users and a large number were Injecting Drug Users (IDU). Most have not been treated and those who did approach treatment centres, felt that the service



facilities were inadequate and staff were often insensitive to their needs. Thus IDU, abuse of pharmaceutical drugs and the associated risk of spread of communicable diseases like hepatitis and HIV/AIDS are the major areas of concern. Many drug abusers are sexually active and have had unprotected sex with multiple sexual partners, including commercial sex workers. Thus, the additional risk of acquiring sexually transmitted diseases along with HIV/AIDS is immense. Most users reported that they were able to procure the pharmaceutical drugs (being abused) easily from the pharmacy without prescription. A judicious balance is required between the availability of these compounds (medicinal compounds with abuse liability) to genuine users for legitimate reasons, as against stringent measures restricting their illicit availability to abusers.

### **Needs of Users and Service Requirements**

Service utilisation by those who require it is dependent on several factors like location and proximity of the centre, and the capacity of service providers. Studies have revealed that some drug users in India felt so stigmatised that they had no clear expectation from treatment centres and were hesitant to approach them for treatment. It has been stated earlier that many treatment centres in India are understaffed, receive very little funding and the skills of the service providers are low. Many have no facilities for proper follow-up and aftercare. It can safely be assumed that the overall efficacy of treatment programmes provided by these centres is low. Recently, the Ministry of Social Justice prepared a manual on the minimum standard of care of services by NGOs. The manual delineates job responsibility, details of activities, steps to organise de-addiction camps, activities for workplace prevention, code of ethics for staff and rights of clients. The Ministry of Health also needs to prepare such a document for government de-addiction centres.

Treatment should be modified depending upon changing needs. It is important to record the proportion of drug abusers currently in treatment and the profile of treatment seekers. It appears that a large number of drug abusers in India require treatment urgently though very few of these however, are actually undergoing treatment. Thus, efforts should be directed towards encouraging people to be treated and to create greater awareness about the availability of services. The efficiency of the service providers should be enhanced and an effort should be made to converge drug de-addiction programmes with other health programmes. Finally, treatment centres need to be sensitive towards the needs and expectations of the users. In a recent (2002) review carried out by the World Bank, *Better Health Systems for India's Poor – Findings, Analysis and Options*, it was noted by the authors, that India is at a crossroad with regard to its health system and delivery of care. Shifting population demography and altered health behaviour is going to cause changes in the distribution of diseases. The management of certain psychiatric diseases, alcoholism and drug abuse, along with HIV/AIDS would acquire prominence and would require urgent attention. The capacity of the existing health system to respond to the changing needs would amount to stretching its capacity to the maximum. There are additional problems, too. The public remains badly informed about much of the health system; it knows little about the services available or the quality. The delivery is further handicapped by the poor level of training and knowledge of the health workers. Thus, rather than accepting help from the public health utility, many often spend good amount of money to seek help privately. Though the private health sector has grown, its performance has rarely been assessed. This World Bank report recommends that the reforms need to emerge through continuing analysis, public discourse and experimentation. These criticisms are equally applicable to the services for patients with alcoholism and/or drug abuse and their care within the system.

## **Suggested Reading**

1. Kumar MS. *Rapid Assessment Survey of Drug Abuse in India*. In: R Ray R, ed. A Publication of Ministry of Social Justice and Empowerment and United Nations International Drug Control Programme, Regional Office for South Asia, 2002 .
- 2.. Ministry of Health and Family Welfare, Government of India. *Drug Abuse in India, Report of the Committee, 1977*.
3. Ministry of Health and Family Welfare, Government of India. *Expert Committee Report on Drug Dependence Services, 1986*.
4. National Master Plan for Drug Abuse Control – (Draft) Report submitted to the Government of India, 1994.
5. Peters DH, Yazbeck AS, Sharma RR, Ramana GNV, Pritchett LH, Wagstaff AW. *Better Health Systems for India's Poor – Findings, Analysis, and Options*. Washington DC: World Bank, 2002.
6. Ray R, ed. *Drug Demand Reduction Report*. United Nations International Drug Control Programme, Regional office for South Asia, 1998.
7. Ray R, ed. *Substance Use Disorder – A Manual for Physicians*. A Publication of Drug Dependence Treatment Centre and Department of Psychiatry, All India Institute of Medical Sciences, 2000.

## Chapter 36

# Child and Adolescent Mental Health: A Pragmatic Perspective

*S. P. Agarwal*

**E**xcept for man, the most highly evolved species on this planet, no other member of the animal kingdom seems to require training in parenting skills. What comes naturally or intuitively to other animals, appears to be an increasingly rare commodity in our complex and sophisticated society. This curious paradox merits examination. Is it an essential price we have to pay for development and material progress? Or, is it an artifact of mindless consumerism untempered with wisdom? Mental health professionals must be urged to seek answers to these basic questions. Therein might lie the key to some of the solutions in the field of child and adolescent mental health.

The magnitude of the problem is perhaps, best summarised in the World Health Report 2001:

“Contrary to popular belief, mental and behavioural disorders are common during childhood and adolescence. Inadequate attention is paid to this area of mental health. In a recent report, the Surgeon General of the United States (DHHS 2001) has said that the United States is facing a public crisis in mental health of infants, children and adolescents. According to the report, one in ten young people suffers from mental illness severe enough to cause some level of impairment, yet fewer than one in five receives the needed treatment. The situation in large parts of the developing world is likely to be even more unsatisfactory”.<sup>1</sup>

Estimated prevalence figures across the world vary from a low of 12.8% in India to a high of 21.0% in the US, 21.7% in Spain and 22.5% in Switzerland.<sup>1</sup> This indicates that material prosperity alone might not be an effective antidote. It is of course possible that the relatively low and widely varying prevalence data reported in Indian studies<sup>2-6</sup> may reflect methodological issues rather than actual ground realities, given the vulnerability of children to socio-economic stressors such as poverty, deprivation and malnutrition.<sup>7</sup> The profound consequences of the widespread employment of child labour in the organised as well as the much larger unorganised sector and the resultant loss of childhood are yet to be quantified or even comprehended in empirical terms.<sup>8</sup> Societal violence in the form of wars, ethnic or religious strife, other forms of armed conflict and natural disasters, and pandemics such as HIV/AIDS affect children more than any other segment of the population.<sup>7</sup> Terrorism in many parts of the world continues to orphan, maim and warp the lives of thousands of children, who will carry these deep psychological scars into adulthood.

These challenges are far too complex and their magnitude much too vast to be confronted by mental health professionals alone, or for that matter by any single agency or organisation. All sections of the civil society, governments and international bodies, such as the WHO, UNICEF and the UN itself, have to come together and join hands to make the world a safer and happier place for our children.

One of the most disturbing developments in recent decades has been the emergence of delinquency, lawlessness and insensate violence among young people who have not experienced want, deprivation or trauma in the conventional sense. These are children and adolescents from apparently 'good' homes with law-abiding parents and adequate educational opportunities. A number of well-designed studies from the West, including the classic 1981 ongoing Swedish prospective longitudinal child psychiatric study, have tried to identify the causative factors.<sup>9</sup> These findings may not be entirely appropriate or applicable to our socio-cultural context. We must generate good quality data in this area and formulate innovative strategies. Blind, ex-cathedra acceptance of Western solutions is likely to prove wasteful and even counterproductive.

The genesis of deviant behaviour in children and adolescents can be traced back to, more than any other single factor, the decay of parenting, which in turn is a direct consequence of the decline of the family, the basic building block of civilised society. The institution of the traditional family rests on four pillars: shared values, shared goals, shared emotional concerns and shared activities, cemented together by communication, vertical as well as horizontal. Sharing was the key word in that uniquely Indian institution, the joint family in which each individual willingly surrendered a part of his or her autonomy and privacy for the greater good and accepted the authority of a patriarch, or sometimes a matriarch. The decline and near extinction of the joint family was perhaps inevitable in the face of rapid socio-economic change, but its successor, the unitary small family appears to have found itself equally helpless and inadequate. This is a matter of deep concern. In large metropolitan cities, next door neighbours have become strangers to each other. It now seems that within unitary families even individual members have become strangers, living mutually isolated lives without any meaningful communication. It may be that our mindless aping of the Western model of individual autonomy and privacy has contributed to the erosion of the family matrix. It is sad to hear parents complain that they have no influence or even interaction with their children. It is sadder still to see children viewing their parents as distant, even hostile adversaries in an 'us and them' paradigm. This erosion of the institution of the family must be halted and reversed if we are to attain the goal of positive mental health for children and adolescents.

In this context, a word of caution – the tendency to medicalise all problems of the youth must be resisted. Over-enthusiastic commitment to their calling often leads mental health professionals to try to diagnose and treat what is essentially a socio-cultural malaise. Trees are often mistaken for the woods, and mere palliatives frequently masquerade as radical cures. This pitfall needs to be avoided. Strategy formulation should be informed by the fundamental need to renew and reinforce the family as a vital asset and instrument in the quest for our goal of health for all.

At the macro level, the need for a vibrant and universal school mental health programme aimed at early identification and management of syndromic mental disorders, as well as undesirable risk-taking behaviour patterns which contribute to major public health problems like smoking, substance abuse and sexual promiscuity, HIV/AIDS, life skills training and promotion of mental health awareness, is now well recognised. The NMHP has received a massive thrust during the Tenth Five Year Plan, with an outlay of Rs 19 billion, an up from Rs 2.8 billion during the Ninth Five Year Plan. The reoriented NMHP comprises five major areas of activity:

- expansion of the DMHP to cover 100 districts across India, with the provision to extend it to 100 more districts in the second phase;
- strengthening of medical college departments of psychiatry;
- upgradation and streamlining of the 37 government-run mental hospitals;
- energising of state mental health authorities for effective supervision and monitoring of programmes at the state level;
- IEC, training and relevant research.

Considering the wide reach of the expanded DMHP network, this Directorate is examining the possibility of integrating a school mental health module with the proposed district level mental health programme, using the same technical support infrastructure with the additional involvement of the district education officer. It is hoped that this intersectoral linkage will result in value addition to the NMHP, and will impart a quantum thrust to child and adolescent mental health activities at the grass roots level across India. The basic requirements for this include simple but holistic training modules and manuals, which can be used in the field for training educators, teachers and parents in essential skills.

## References

1. World Health Report 2001. Geneva: WHO, 2001:36.
2. Jiloha RC, Murthy RS. An epidemiological study of psychiatric problems in school children, *Child Psychiatry Quarterly* 14 April 1981.
3. Naik US, Menon S, Ahmed A. Culture and Psychiatry: An Indian Overview of Issues in Women and Children, Clinical Methods. In: Okpaku S, ed. *Transcultural Psychiatry*. American Psychiatric Press, 1998.
4. Rozario, Kapur M, Kaliaperumal VG. An epidemiological survey of prevalence and pattern of psychological disturbance in school going adolescents. *Journal of Personality and Clinical Studies* 5.2.1990;165-169.
5. Kapur M. *Mental Health of Indian Children*. Sage, 1995.
6. Srinath S, Srikala B, Girimaji S. Characteristics of a child inpatient population. *Journal of the American Academy of Child and Adolescent Psychiatry* 1993;32.
7. Left J. The state of the evidence: Mental health services and barriers to implementation. In: *Mental Health – A Call For Action by World Health Ministers*. Geneva: WHO, 2001;33-35.
8. Nikapota A. Poverty and children. In: Young JG, et al., eds. *Brain, Culture and Development*. Delhi: Macmillan, 2003:141-147.
9. Rydelius PA. Children at Risk for Delinquency. In: Young JG, et al., eds. *Brain, Culture and Development*. Delhi: Macmillan, 2003:148-159.

## Chapter 37

# Private Sector Psychiatry: The Need for an Ethical Approach

*S. P. Agarwal*

For centuries people have gone to the city of Kashi seeking spiritual solace. In an increasingly tension-ridden world, the search for mental peace goes on, but perhaps on a different plane. Varanasi is no longer the favoured destination. The benzodiazepines and alprazolam provide convenient pharmacological short-cuts to oblivion, providing temporary escape from the anxieties of everyday living. The adverse long-term consequences of these instant solutions arouse little concern among users and prescribers alike. Aggressive, attractively packaged marketing gimmicks employed by a profit-driven pharmaceutical industry, further fuel this pernicious quest which carries within itself the seeds of eventual destruction. Occasional warnings by the likes of David Healey, highlighting the danger of the commercialisation of medical practice, pass largely unheeded.

Commercialisation also threatens to distort the growth of psychotherapy and other counselling modalities. The bandwagon effect has drawn a large number of inadequately trained opportunists who style themselves as counsellors or therapists with the sole aim of cashing in on the need for quick-fix solutions. At the other end of the spectrum, are the modern day *gurus* who seek to promote the quest for spiritual peace as a marketable commodity, complete with best-selling do-it-yourself manuals, guaranteed to improve the disciple's quality of life. It is an index of the age of insecurity we live in that these self-proclaimed *gurus* often command huge followings, despite their all too obvious feet of clay.

In this scenario, a special responsibility devolves on mental health professionals. Hitherto the main focus in clinical practice has been on major mental disorders, though a shift towards what are termed as Common Mental Disorders (CMDs) is slowly becoming discernible. Apart from being more common, CMDs affect peoples' day-to-day lives to a much greater degree. The temptation to provide quick symptomatic relief without addressing the underlying psycho-social issues needs to be resisted. Maladaptive patterns of behaviour and, at a deeper level, negative modes of thinking, need to be modified to bring about greater harmony in interpersonal relations as well in the individual's inner world. There is an imperative requirement to evolve an indigenous model of brief cognitive behaviour therapy, field test it in actual clinical situations and then incorporate it in the training curricula for various categories of mental health professionals.

These training programmes themselves need to be regulated and monitored with regard to quality assurance. Counselling services should be employed effectively in implementing school mental health programmes aimed at early identification of mental disorders among children and adolescents, focused intervention and life skills training to augment their coping capabilities. Psychiatrists in private practice can adopt this as part of their social agenda. If each one of them could 'adopt' a few schools and provide them with technical support and guidance in this regard, a small but significant beginning will have been made.

It is gratifying to learn that a majority of psychiatrists in private practice are located not in the larger metros but in smaller cities and *mofussil* towns. This gives them a wide reach, perhaps wider than that of the government sector in some areas. Viewed in the context of the declining share of public spending in the health sector, this assumes even greater significance. The National Health Policy 2002 acknowledges the fact that 83% of healthcare expenditure is in the private sector, and much of it is out-of-pocket expenditure as the reach of health insurance cover is still very limited. This places a great responsibility on the shoulders of psychiatrists. Keeping in view the limited financial resources of the average Indian, it is imperative that the costs of private sector Medicare should be kept as low as possible. Fortunately, the commonly used psychiatric drugs are relatively cheap, perhaps the cheapest anywhere in the world. The temptation to use costlier brands when much cheaper generic medications are available should be resisted. There is no scientific evidence to suggest that costlier brands are more effective than cheaper ones. Unnecessary investigations, specially high cost ones such as CT scan and MRI, significantly add to treatment costs. In a clinically oriented speciality like psychiatry, there is little rationale for putting the patient to such avoidable expense. This gives rise to allegations of kick-backs and other malpractices. Hospitalisation is largely redundant and even counterproductive in the treatment of mental disorders. Community-based out-patient psychiatric treatment can help keep the costs at an affordable level. These are sensitive issues which impact on the credibility and public image of the medical profession. Ethical considerations and enlightened self-interest, rather than myopic greed should inform the conduct of medical practice. This will serve the mutual interests of the providers as well as the consumers of medical care, and will strengthen mutual bonding rather than the 'us and them' paradigm which promotes adversarial posturing.

## Chapter 38

# Delivery of Epilepsy Care to the Community: Towards the National Epilepsy Control Programme

*M. Gourie Devi • P. Satishchandra • G. Gururaj*

In the context of epidemiological transition and the paradigm shift from communicable to non-communicable disorders in India, neurological disorders have emerged as major public health problems in the last decade. Epilepsy is a common neurological disorder, accounting for a third of these.<sup>1</sup> Based on community surveys, it is estimated that there are approximately 6–10 million people with epilepsy in India: a matter of serious concern is that the burden of epilepsy in India accounts for 20% of the global burden (of epilepsy of 50 million people). Further, every year about 500,000 new cases will be added to the existing number of people with epilepsy in India. Apart from the issues involved in its diagnosis, management and prevention, epilepsy poses sad problems of social ostracisation due to stigma, myths and superstitions associated with the illness, and limited opportunities in education, employment, marriage and quality of life.

The recognition of epilepsy as a public health problem, increasing the awareness among the public, providing care for people with epilepsy in terms of diagnosis, treatment, counselling, and rehabilitation and developing preventive strategies should be an urgent driving concern in the country for healthcare professionals, neurologists, health planners, and health managers in government and private sectors, supported by firm political commitment.

### Global Campaign against Epilepsy

In view of the magnitude of epilepsy in the community, and the burden of the epilepsy on the individual, family and society being far greater than what was expected the Global Campaign against Epilepsy, a collaborative effort of the WHO, the International League Against Epilepsy (ILAE) and the International Bureau for Epilepsy (IBE) to bring epilepsy out of the shadows was launched on 19 June 1997 in Geneva, with the following objectives:<sup>2</sup>

1. To increase public and professional awareness of epilepsy as a universal and treatable brain disorder;
2. To raise epilepsy to a new plane of acceptability in the public domain;
3. To promote public and professional education about epilepsy;



4. To identify the needs of people with epilepsy at national and regional levels;
5. To encourage governments and departments of health to address the needs of people with epilepsy including awareness, education, diagnosis, treatment, care, services and prevention.

The strategy of the global campaign has two parallel tracks of (a) raising general awareness and understanding of epilepsy; and (b) supporting departments of health in identifying needs and promoting education, training, treatment, services, research and prevention. The campaign envisages active interaction between international, regional and national components. The campaign structure and activities have recently been further elaborated and activities well defined.<sup>3</sup> The global campaign also envisages close interaction between the regional offices of the WHO and the Ministry of Health and initiates research in (a) assessment of knowledge and attitudes followed by education; (b) epidemiological assessment; (c) service delivery, including social and educational intervention; and (d) analysis and outcome. This is to be followed by an implementation phase for educational and social intervention; service delivery and intervention and development of a National Programme on Epilepsy.

## Important Facts About Epilepsy

- **What is epilepsy**  
Epilepsy, a recurrent paroxysmal disorder, due to cerebral dysrhythmia, is well recognised in its generalised tonic-clonic type, simple partial seizures and complex partial seizures. Apart from these common types, special types of epilepsies in childhood or epileptic syndromes have to be identified, since the choice of anti-epileptic drug depends on the type of the seizure disorder.
- **Prevalence and incidence of epilepsy**  
Community-based epidemiological surveys in the last four decades have shown prevalence ranging from 2.2 and 11.9 per 1,000 population.<sup>4-13</sup> The prevalence is higher in the rural compared to the urban population (Table 38.1). The regional differences in the prevalence rate may be due to variation in case definition, case ascertainment and differences in survey methodology. It is estimated that there are 6-10 million people with epilepsy in India, with approximately two-thirds (4-6 million) in the rural areas.
- **Incidence rates**  
Although no incidence studies have been carried out in India, based on global studies in developing countries, it is estimated that 50 new cases per 100,000 population occur annually, adding 500,000 cases to the existing burden. Lifetime prevalence has been estimated to be 2,000 per 100,000 of the population, suggesting that 2% of the population suffer from epilepsy.
- **Burden of epilepsy**  
Using Disability Adjusted Life Years (DALYs) it has been estimated that epilepsy accounts for 1% of the total burden of disease in the world and is higher among children at 1.6%, DALYs do not include the burden due to social stigma, social isolation and its effect on family members and these issues are very important in India. Hence, the total burden of epilepsy is likely to be higher than the estimated figure.<sup>14</sup>
- **Economic aspects of burden**  
Costs of epilepsy are direct costs, which include out-patient care, drugs, emergency admissions and in-patient care.<sup>15</sup> Indirect costs are unemployment, under-employment

**Table 38.1: Prevalence of Epilepsy in India (Rate per 1,000)**

Author	Year	Place	Population		Rate
Surya	1964	Pondicherry	2731	Urban	2.2
Mathai	1969	Vellore	45778	Rural, urban	9.0
Dube	1970	Agra	29468	Rural, urban	2.3
Sethi	1972	Lucknow	2691	Rural	2.2
Nandi	1975	West Bengal	1060	Rural	10.4
Issac	1980	Bangalore	4209	Rural	10.4
Gourie Devi	1987	Gouribidanur	57660	Rural	4.6
Bharucha	1988	Bombay	14010	Parsis	4.7
Kaul	1988	Kashmir	63615	Rural	2.5
Kapoor	1989	Ballabgarh	48798	Rural	4.0
Das	1995	Malda	37286	Rural	3.0
Gourie Devi	1995	Bangalore	102557	Rural, urban	8.8 11.9; 5.7
Mani	1997	Yelandur	64963	Rural	4.6

World Bank, 1993

and excess mortality. Intangible costs usually not accounted for are stigma, social isolation, poor quality of life, burden on the patient and family members. These costs can be significantly reduced by the proper control of seizures with cheap and effective drugs like phenobarbitone and phenytoin with the annual cost a mere Rs 1,000 per patient.

- **Aetiology**

Epilepsy can be the result of brain damage due to a variety of causes including birth injuries, malformations, traumatic brain injury, infections (viral, bacterial, parasitic), vascular lesions and tumours. The relative risk of developing epilepsy due to various factors needs to be emphasised so that appropriate preventive measures can be planned and implemented.<sup>16</sup>

Causative factors	Relative risk
Genetic factor	0.7-5.6
Brain injury	1.4-12.7
Febrile convulsions	3.0-14.2
Pyogenic meningitis	7.0-40.0
(Risk in general population is taken as 1)	

- **Neurocysticercosis and epilepsy**

Single Small Enhancing CT Lesions (SSECTL), many of them confirmed to be neurocysticercosis (other tuberculomas), are a frequent cause of epilepsy in India. Studies from different regions of the country show that in 4.6-5.6% of epileptic patients, SSECTL was found. Cysticidal drugs (albendazole, praziquantel) along with anti-epileptic drugs yield very satisfactory results in the large majority and the overall prognosis is benign. In the Indian context, recognition of neurocysticercosis is of prime importance in therapeutic implications.

- **Epilepsy is treatable**  
The myths and superstitions surrounding epilepsy can be easily dispelled by widely propagating the well-accepted observations that in 70–80% of people with epilepsy, seizures can be controlled satisfactorily and that the affected person can lead an active normal life. Further, it has been shown that this target is achievable by using first-line anti-epileptic drugs, viz., phenobarbitone, phenytoin, carbamazepine and valproate.<sup>17</sup>
- **Treatment gap**  
The treatment gap is large in developing countries (60–90%) and in India it varies from 38% to 80%, the lowest figure of 38% being from Kerala, which has a high rate of literacy and awareness of health problems.<sup>18,19</sup> It is estimated that about 3–6 million people with epilepsy would never have been treated in India. The wide treatment gap is multifactorial, a result of the failure of patients seeking medical consultation due to lack of awareness of the disorder, associated stigma, a reluctance to accept the diagnosis, the lack of knowledge that epilepsy can be treated, the lack of medical practitioners in rural and remote areas and finally, the acceptability, availability and affordability of anti-epileptic drugs.
- **Intractable epilepsy**  
Despite optimal treatment with anti-epileptic drugs, in 20–30% of patients, seizures remain uncontrolled, necessitating detailed investigations including electroencephalography, imaging and drug monitoring. Newer anti-epileptic drugs may be required for seizure control and in selected patients surgery may be indicated. Major advances in drug development, imaging technologies, surgical techniques and non-surgical interventions (vagal nerve stimulation) have made considerable impact in the management of intractable epilepsy.

## Who Provides Epilepsy Care

In the developed countries, there is one neurologist per 20,000–100,000 people, while in India the ratio is dismally low at approximately one neurologist for 1,500,000 people.<sup>20,21</sup> An analysis of epilepsy care providers has shown that 60–70% of epileptic patients in India are being treated by primary care physicians, general practitioners, internists, paediatricians and psychiatrists.<sup>16</sup> It is obvious that in India and other developing countries with scarce neurologists, alternative approaches need to be developed.

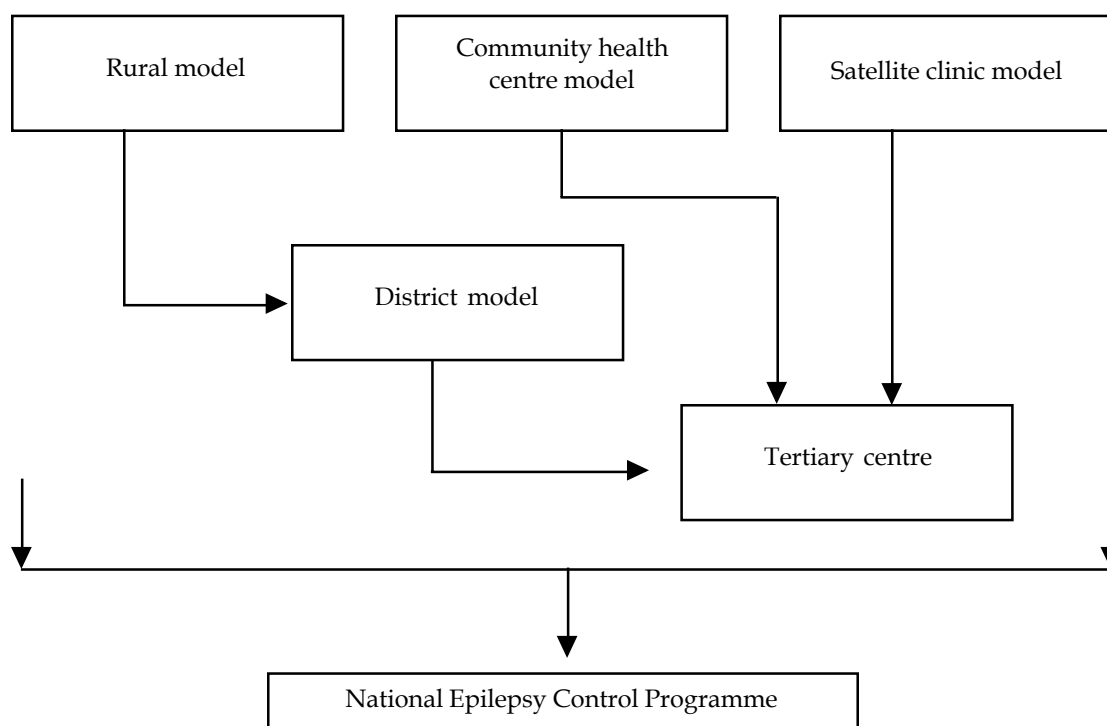
## Models for Delivery of Epilepsy Care

The structure of the healthcare system in India would influence the pattern of medical practice and consequently the care of the person with epilepsy. Certain general guidelines will help in formulating the models such as (Figure 38.1).

1. The stated policy on epilepsy in India, for example, to develop the National Epilepsy Control Programme.
2. The decentralisation of care and development of resources and skills at the primary level.
3. The close interaction between general practitioner/physician and specialist to ensure continuity of care.
4. Training in diagnosis, treatment and counselling to health providers in the healthcare pyramid.
5. Ensuring continuity of care by adequate documentation in medical records. Providing patient held epilepsy cards is a reasonable alternative.
6. The adequate and regular supply of first-line anti-epileptic drugs and ensuring quality control.

7. The partnership between governmental and non-governmental agencies with focused goals of providing comprehensive epilepsy care.
8. Spreading awareness about epilepsy through communication media, posters, flash cards, advertisements, radio/TV programmes and street plays.
9. Integrating it with existing health programmes.

**Figure 38.1: Models for Epilepsy Control**



### **The Rural Epilepsy Model**

The prevalence of epilepsy in rural areas is almost twice that of urban area and since 70% of India's population lives in rural areas, of the estimated 6-10 million people with epilepsy in India, about 4-7 million are likely to be found in rural regions. Instead of patients trying to reach cities/towns for medical care, epilepsy care needs to be provided in the villages itself. Demonstration projects of the rural epilepsy care model in Karnataka have successfully shown that it is possible to control epilepsy in 80% of people with phenobarbitone/phenytoin without taking recourse to investigations (EEG/CT/MRI). The control programmes had incorporated the following strategies:<sup>22</sup>

1. Collaborative effort of neurologists, non-governmental agencies and government.
2. Training of primary care physicians in diagnosis of common seizure types, treatment with anti-epileptic drugs, how to ensure drug compliance and counselling. They should also be trained to identify the patients to be referred to district hospital or a tertiary centre.

3. Training of paramedical workers in identifying people with epilepsy, and encouraging them to attend primary care clinics.
4. Providing free and regular supply of first-line anti-epileptic drugs (phenobarbitone, phenytoin).
5. Regular periodic follow-up ensured by monthly home visits by paramedical workers.
6. Home distribution of drugs.
7. Intensive health education.

A similar success has been observed in the rural areas of West Bengal, Malawi, Kenya and Ecuador experience.<sup>23-26</sup> It is thus feasible and practicable, with enduring commitment, adequate planning and minimal resources, to control epilepsy in rural areas.

### ***Community Health Centre Model***

There are nearly 200 medical colleges and institutions in India and many of them have peripheral Community Health Centres (CHC) providing general healthcare and immunisation. The epilepsy control programme can be integrated with general healthcare. Usually, the CHCs cover a population ranging from 50,000 to 100,000 and some of them work in close liaison with Primary Health Centres (PHCs). Residents and postgraduates who help to provide healthcare can be trained to diagnose and treat epilepsy. First-line anti-epileptic drugs should be made available and their regular supply ensured. Education about epilepsy can be dovetailed with education about general hygiene, nutrition and prevention of common disorders. Regular follow-up is possible, since health records are maintained and paramedical staff carry out home visits. The neurologists in the medical college/institution can be made responsible for training and for consultation in uncontrolled epilepsy or those requiring detailed investigation. In addition to daily out-patient services at the centre, the CHCs also conduct mobile healthcare reaching out to interior villages, thus expanding the area of coverage. It has been shown in this CHC model that a significant proportion of patients became seizure free.<sup>27</sup>

### ***Satellite Clinic Model***

NIMHANS, Bangalore, developed a Satellite Clinic Model (SCM) which was initiated in 1982 and has continued to successfully function for more than two decades in the delivery of neurologic and psychiatry services to the rural community.<sup>28</sup> Experts from NIMHANS, local government agencies at the *Taluk* level, non-governmental agencies (Lions Club Rotary) through a joint venture, provide neuro-psychiatry care to five peripheral centres located within 50-100 km.<sup>28</sup> The services are offered through monthly camps with fixed days, time and places and the same senior members of team visit a centre. Epilepsy constituted 30-50% of all neuro-psychiatric disorders. First-line anti-epileptic drugs are provided free on a monthly basis and simple medical records are maintained. Awareness about epilepsy and other neuro-psychiatric disorders was disseminated through talks and the media. The regular follow-up of patients was ensured through confidence building and demonstration that epilepsy can be treated.

### ***District Model***

The district has advantages of being used as a model for healthcare delivery, since it is (a) an independent administrative unit; (b) district health officer has powers of planning activities;

(c) implementation and monitoring of national health programmes occur at the district level; (d) intersectoral coordination is possible at the district level; and (e) all health programmes at primary health centres and *taluks* are under the jurisdiction of the district.

To implement the NMHP, the Bellary district model was developed by the NIMHANS in 1984–1985. This model was demonstrated to be a feasible proposition, since it was possible to integrate mental healthcare with general health services and was cost-effective. In the last two decades this district model of mental healthcare delivery has been extended to 25 districts.

Since the lessons learnt from this model are encouraging, the district model of epilepsy care was developed by the authors' team at NIMHANS with the support of WHO.<sup>1,16</sup> There are 593 districts with an average population of 1.5–2 million people and based on prevalence data it is estimated that there would be 16,000–20,000 people with epilepsy in a district.

The strategy included the following:

#### *A. Nodal Neurologist*

1. Identification of one to two nodal neurologists in each state.
2. Status paper presentation by neurologists on epilepsy care in their respective states.
3. Plan of action for district epilepsy control programme.

#### *B. Training of District Medical Officers*

1. State health departments to depute district medical officers—physicians, paediatricians or psychiatrists.
2. Training focused on the following issues:
  - Identification of epilepsy
  - Diagnosis
  - Treatment
  - Counselling
  - Psycho-social aspects
  - Educating patients
  - Improving the quality of life.
3. Training modules:
  - Lectures (clinical, drugs, side-effects)
  - Video demonstration of common seizure types
  - Visit to out-patient and in-patient services
  - Training manual was prepared.
4. Evaluation of training:
  - Structured questionnaire developed to conduct pre- and post-training evaluation.
5. Follow-up:
  - Periodic contact through post/e-mail
  - Follow-up workshop.

#### *C. Measures to Ensure Adequate Control of Epilepsy*

The District Medical Officers were sensitised to issues related to ensuring the control of seizures. The importance of the following was emphasised:

1. To ensure uninterrupted supply of first-line anti-epileptic drugs (phenobarbitone, phenytoin, and if possible, carbamazepine, valproate).
2. Simple medical records.
3. Epilepsy diary to be maintained and kept by the patient.
4. Free during distribution on a monthly basis.
5. Regular follow-up.

### **Tertiary Care**

Expertise and facilities for electroencephalography, video EEG, imaging should be available at least at one centre in every state. Patients with intractable epilepsy would require intensive investigations trial with newer anti-epileptic drugs and in selected patients surgical intervention like lesionectomy and medial temporal lobectomy may be required. Through a network, communication should be established between different models of epilepsy care and a tertiary centre for the referral of patients.

### **National Epilepsy Control Programme**

The various models of epilepsy care including the rural model, community health centre model, satellite clinic model and district model are not mutually exclusive but complementary, with the unified goal to provide care to every patient with epilepsy, control seizures and provide an improved quality of life. In consonance with the global programme, a National Epilepsy Control Programme should be implemented in India with the following broad objectives.<sup>1,16</sup> Thinking globally and acting locally is critical in epilepsy control.

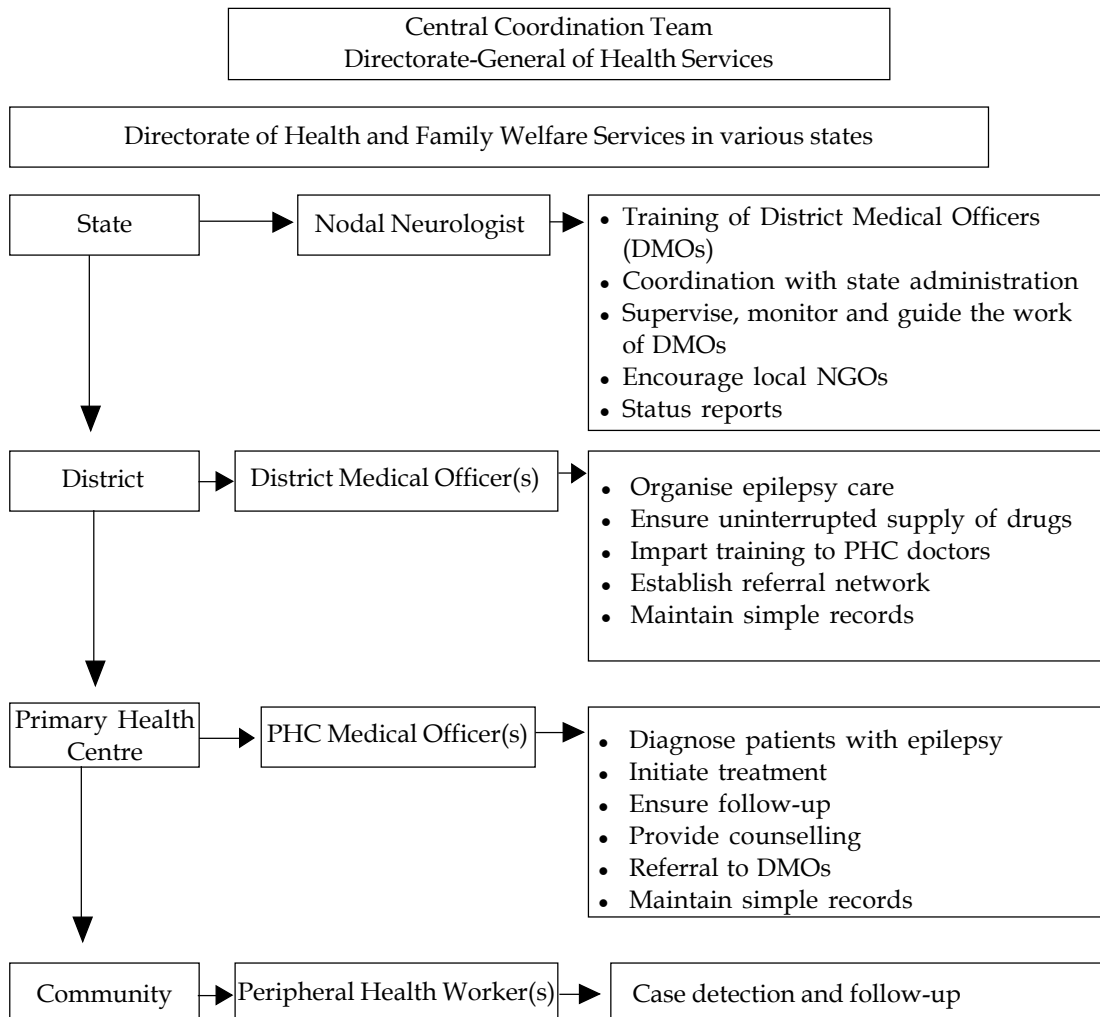
1. To make healthcare available and accessible to all with epilepsy, with particular emphasis on the rural population, the underprivileged and other vulnerable sections of the population.
2. To promote participation by community and non-governmental agencies in delivery of comprehensive care to people with epilepsy.
3. To ensure integration of people with epilepsy in various spheres of activity through psycho-social and vocational rehabilitation.
4. Preventive measure to reduce the prevalence of epilepsy in the community by reducing birth injuries, and control of parasitic diseases (cysticercosis) and neuroinfections.

The framework of action envisaged is outlined below (Figure 38.2).

1. Establish a National Epilepsy Control Programme with political and operational support.
2. Prepare a programme manual for case definition, treatment guidelines, counselling and psycho-social aspects.
3. Establish a recording and reporting system using standardised material.
4. Develop training programmes for medical and paramedical health professionals at various levels of the health structure.
5. Establish treatment services within existing health services.
6. Ensure regular and adequate supply of anti-epileptic drugs.

7. Develop a monitoring system with regular feedback in respect of specified performance parameters and online course correction where required.
8. Built-in mechanisms for the prevention of common risk factors associated with epilepsy such as birth injuries, infections and parasitic diseases of the nervous system and traumatic head injuries.
9. Make the programme sustainable for long-term care.
10. Deal with issues related to education, employment, marriage and perinatal care, to improve the overall quality of life.
11. Examine the knowledge, attitude and practices, and provide the appropriate education.

**Figure 38.2: National Epilepsy Control Programme: Action Plan**





## Conclusion

Epilepsy needs to be recognised as a public health problem in view of the magnitude of the problem, the associated social stigma and social ostracisation. Awareness must be created that in 80% of epileptics, seizures can be controlled with available and affordable anti-epileptic drugs. There is an urgent need to reach epilepsy care to rural areas and integrate into general healthcare. Different models of epilepsy care can be integrated into the National Epilepsy Control Programme and India also can be an active partner in the Global Campaign Against Epilepsy.

## References

1. Gourie Devi M, Satishchandra P, Gururaj G. Epilepsy on primary care. Epilepsy control programme in India: A district model. *Epilepsia* 2003;44(Suppl 1):58–62. ILAE/IBE/WHO Global Campaign against Epilepsy, 2000.
2. ILAE/IBE/WHO Global Campaign against Epilepsy, 2000.
3. ILAE/IBE/WHO Global campaign against epilepsy, 2003.
4. Mathai KV. Investigation into methods for rehabilitation of persons disabled by convulsive disorders. SRS Project No. 19-P-58113 Fol. HEW Washington DC and ICMR 1969.
5. Dube KC. A study of prevalence and biosocial variables in mental illness in a rural and urban community in Uttar Pradesh—India. *Acta Psychiatrica Scandinavica* 1970;46:327–359.
6. Sethi BB, Gupta SC, Kumar R, Kumari PA. Psychiatric survey of 500 rural families. *Indian Journal of Psychiatry* 1972;14:183–196.
7. Gourie Devi M, Rao VN, Prakshi R. Neuroepidemiological study in semiurban and rural areas in South India: Pattern of neurological disorders including motor neuron disease. In: Gourie Devi M, ed. *Motor Neuron disease: Global Clinical Patterns and International Research*. New Delhi: Oxford and IBH, 1987:11–21.
8. Bharucha NE, Bharucha EP, Bharucha AE, Bhise AV, Schoenberg BS. Prevalence of epilepsy in the Parsi community of Bombay. *Epilepsia* 1988;29:111–115.
9. Koul RL, Razdan S, Motta A. Prevalence and pattern of epilepsy (Lath/ Mirgi/ Laran) in rural Kashmir, India. *Epilepsia* 1988;29:116–122.
10. Kapoor SK, Chandra V, Banerjee AK, et al. Pilot study of the prevalence of major neurologic disorders in a rural population of India. *Neuroepidemiology* 1990;9:287–295.
11. Das SK, Sanyal K. Neuroepidemiology of major neurological disorders in rural Bengal. *Neurology India* 1996;44:47–58.
12. Gourie Devi M, Gururaj G, Satishchandra P. Neuroepidemiology: Present insights and future prospects. *NIMHANS Journal* 1999;17:423–437.
13. Mani KS, Geeta R, Srinivas HV, et al. The Yelandur study: A community based approach to epilepsy in rural South India: epidemiological aspects. *Seizure* 1998;7:281–288.
14. World development report 1993; *Investing in Health*. New York: Oxford University Press for The World Bank, 1993.
15. Begley CE, Beghi E, Beran RG, et al. ILAE commission on the burden of epilepsy, sub-commission on the economic burden of epilepsy: final report 1998–2001. *Epilepsia* 2002;43:668–673.
16. Gourie Devi M, Satishchandra P, Gururaj G. National workshop on public health aspects of epilepsy for senior personnel of state health departments in India. *Ann Indian Acad Neurol* 1999;2:43–48.
17. Mattson RH, Cramer JA, Collins JF, et al. Comparison of carbamazepine, phenobarbital, phenytoin and primidone in partial and secondarily generalised tonic-clonic seizures. *New England Journal of Medicine* 1985;313:145–151.
18. Meinardi H, et al. The treatment gap in epilepsy. *Epilepsia* 2001;42:136–149.
19. Radhakrishnan K, Pandian JF, Santoshkumar T, Nayak SD, Sarma PS. Prevalence, knowledge, attitude and

- practice of epilepsy in Kerala, south India. *Epilepsia* 2000;41:1027-1035.
20. Aarli JA, Neurology and WHO: Challenges and issues – A report. *World Neurology* 2002;17:10-11.
  21. Gourie Devi M. Medical technologies for neurological sciences. In: Mathew L, ed. *Technology Management in Healthcare*. Bangalore: Defence Bio-engineering and Electro-medical Laboratory 1998;62-67.
  22. Mani KS, Geeta R, Srinivas HV, Kalyansundaram S, Narendran S, Reddy AK. Epilepsy control with phenobarbital or phenytoin in rural South India: The Yelandur study. *Lancet* 2001;357:1316-1320.
  23. Pal DK, Das T, Chaudhury G, Johnson AL, Neville BGR. Randomised controlled trial to assess acceptability of phenobarbital for childhood epilepsy in rural India. *Lancet* 1998;351:19-23.
  24. Watts AE. A model for managing epilepsy in a rural community in Africa. *British Medical Journal* 1989; 298:805-807.
  25. Feksi AT, Kaamugisha J, Sanders JWAS, Gatiti S, Shorvon SD. Comprehensive primary healthcare: anti-epileptic drug treatment programme in rural and semi-urban Kenya. *Lancet* 1991;337:406-409.
  26. Placencia M, Sander JWAS, Shorvon SD, Paredes V, Suarez J, Cascante SM. Anti-epileptic drug treatment in a community healthcare setting in Northern Ecuador: a prospective 12-month assessment. *Epilepsy Research* 1993;14:237-244.
  27. Sriram TG, Chandrashekar CR, Moily S. Epilepsy in primary care: A study of follow-up profile and response to treatment. *NIMHANS Journal* 1999;8:133-137.
  28. Reddy GNN, Channabasavanna SM, Gourie Devi M. Extension of mental health services by satellite clinics as a model. *NIMHANS Journal* 1986;4:71-75.

# Chapter 39

## Head Injuries and Psychiatric Disturbances

*P. Sarat Chandra • V. S. Mehta • S. P. Agarwal*

### Epidemiology

Traumatic Brain Injury (TBI) may well be termed a disease of development, related to the growth of civilisation. It is a matter of grave concern for individuals, institutions and governments. It constitutes a major source of disability not only for the patients, but also for the family members and society in terms of emotional burden, loss of workforce and financial drain. It is an ongoing pandemic with an annual incidence of 2 million cases per year, even in developed countries like the US.<sup>1</sup>

In India, the incidence of head injuries is steadily rising, with rapid urbanisation and an exponential increase in the number of vehicles, most of which are poorly maintained and inexpertly driven. A 1991 study showed that while India has only 1% of the world's vehicles, the number of deaths related to Road Traffic from Accidents (RTAs) accounted for 6% of the world total, making Indian roads the unsafest across the globe.<sup>2</sup> A recent study showed that about 1.5–2 million persons are injured and 1 million die every year in India due to traumatic brain injuries. Road traffic injuries are the leading cause (60%) of TBIs, followed by falls (20–25%) and violence (10%). Alcohol contributes to about 15–20% of these injuries.<sup>3</sup> India and other developing countries face major challenges in the areas of prevention, pre-hospital care, specialised trauma centres and rehabilitation to reduce the burden of mortality and morbidity related to TBIs. Delhi itself presents a grim picture, with about 500 vehicles being added to its already clogged roads every day, while having one of the highest RTA rates in the world.<sup>2,3</sup>

Psychiatric/functional/behavioural disturbances following TBI are quite common. Many patients suffer varying periods of behavioural disturbances, even after mild head injuries. Surprisingly, however, very little literature about the epidemiology, pathophysiology and management of such disorders is available. A few random controlled studies regarding the treatment of these psychiatric sequelae have been conducted despite the obvious clinical and public health implications, especially in the Indian high risk context.

This chapter reviews the common psychiatric conditions associated with head injury, highlighting the link between psychiatry and neurosurgery, as well as the public health implications of this highly disabling disorder.

### ***Psychiatric sequelae of brain injury***

Recovery from brain injury is a complex and dynamic process that continues for a prolonged period from the time of the injury. Little information is available on the exact duration of recovery, the factors influencing recovery, or the relationship between the severity of the injury and the duration and nature of recovery.

Animal studies suggest that, because of the plasticity of the brain, neuronal and axonal recovery occur within a few months after injury.<sup>4</sup> Researchers have hypothesised similar mechanisms of recovery in the human brain; however, this information cannot be applied directly to humans because of differences existing in the pathophysiology of the injury.

In humans, recovery after focal brain injury differs from recovery after diffuse brain injury. The location, size, site and other pathophysiologic features, such as haemorrhage, oedema and mass effect determine the course of recovery in patients with focal lesions. The recovery phase may be broadly divided into three phases: (a) an acute phase lasting from a few seconds to hours, during which the patient is frankly confused; (b) a subacute phase, lasting two to several days, characterised by the gradual clearing of confusion but with persistence of several cognitive sequelae (common symptoms include headache, dizziness, anxiety, depression, inattention and memory lapses); and (c) a chronic phase, lasting for weeks to months and characterised by gradual improvement in symptoms. In a small percentage of patients with focal TBI, some symptoms persist for months or even years after the injury. The reason for this is unclear but is probably a combination of biological or psycho-social factors and premorbid personality traits.<sup>6,21</sup> The stages of recovery after such injury have been described using the Rancho Los Amigos scale of cognitive functioning.<sup>5,6</sup>

### ***Classification***

TBI is associated with several psychiatric disturbances that are not always easy to classify. A review of the literature also reveals a lack of uniformity in classifying the psychiatric sequelae. Similar psychiatric disturbances have been classified differently by various researchers. For example, impulsivity, aggressiveness, disinhibition, or cognitive deficits occurring together have been classified by some as frontal or temporal lobe syndromes, depending on the anatomic site of damage, while others classify them,<sup>7</sup> according to their clinical presentation as 'personality changes'<sup>8</sup> or 'aggressive disorder',<sup>9</sup> or according to the time of occurrence, duration and functional dependency, as 'delirium'<sup>8</sup> or 'dementia'.<sup>10</sup>

It is, however, preferable to classify the neuro-psychiatric disturbances associated with TBI according to their phenomenology as follows:<sup>11-16</sup>

1. Cognitive deficits (most common—20–80% of patients)
2. Mood disorders:
  - Major depression
  - Mania
3. Anxiety disorders (also common—11–70% of patients)
4. Apathy
5. Psychosis
6. Behavioural dyscontrol disorder
  - Major variant
  - Minor variant.

(The term *behavioural dyscontrol disorder*<sup>17</sup> has been used to describe a constellation of cognitive,

physical and emotional signs and symptoms that can occur together. It has been sub-classified into major and minor variants, based on the severity of the signs and symptoms).

### ***Aetiology and risk factors for neuro-psychiatry disorders***

The aetiology of the psychiatric disturbances after TBI involves the presence of post-injury biological changes, premorbid personality traits, and psycho-social and environmental factors. There is little information about the correlation between the different personality traits and post-TBI psychiatric sequelae. Risk factors<sup>18,19</sup> for the development of psychiatric sequelae described above include: pre-injury history of psychiatric illness, pre-injury poor social functioning, increased age, alcoholism, arteriosclerosis, lower Glasgow Coma Scale Score, lower Mini Mental State Examination (MMSE) Score; marital discord, financial instability, poor interpersonal relationships, pre-injury levels of education, and finally, compensation claims.

### ***Epidemiology of the neuro-psychiatry sequelae***

About 10–80% of people who sustain a TBI suffer from a psychiatric disturbance at some point in their recovery period.<sup>20</sup> This wide variation in estimates is probably the result of subjective differences in defining various syndromes, the lack of standardised diagnostic criteria, and selection bias related to community, rehabilitation facilities, acute trauma centres and psychiatric clinics.

## **Clinical Diagnosis**

The psychiatric evaluation of an individual with brain injury should be comprehensive and include:

- I. History.
  - A. Demographic information.
  - B. Family history of psychiatric illness.
  - C. Personal history.
    1. Birth and development.
    2. Childhood health and behaviour history.
    3. Education.
    4. Pre- and post-injury employment.
    5. Pre- and post-injury marital status.
    6. Pre- and post-injury living situation.
  - D. Drug and alcohol history.
  - E. Pre- and post-injury legal history.
  - F. Medical history.
  - G. Current medication.
  - H. Past psychiatric history.
    1. History of hospitalisation.
    2. History of out-patient treatment.
    3. History of self-injurious behaviour/suicide attempt.
    4. History of treatment with psychotropics.
  - I. Details regarding premorbid personality for collateral informants.

- J. History of patient illness.
  - 1. Details of head injury:
    - (i) Open versus closed.
    - (ii) Mechanism of injury.
    - (iii) Glasgow Coma Scale at the time of injury.
    - (iv) Duration of Loss Of Consciousness (LOC).
    - (v) Duration of Past Traumatic Amnesia (PTA).
    - (vi) Hospitalisation vs out-patient treatment.
    - (vii) Treatment of surgical or medical complications.
  - 2. Details regarding current psychiatric illness.
  - 3. Review of old medical records.
- II. Mental status examination.
- III. Neurologic examination.
- IV. Brief cognitive assessment MMSE.
- V. Neuroimaging studies.
- VI. Neuropsychological tests.
- VII. Occupational therapy assessment of functional skills and safety.

The key components include obtaining a detailed history from the patient, information from relatives, and review of old medical records, performing a mental status, physical, and neurologic examination and conducting a brief test of global cognitive functioning, such as the MMSE.<sup>21</sup>

## Management

This section provides an overview of the psychiatric disturbances associated with TBI, because it is beyond the scope of this chapter to discuss in detail all the different psychiatric sequelae. The reader is referred to the textbook *Neuropsychiatry of Traumatic Brain Injury*, edited by Silver et al.<sup>22</sup> for more information.

### *General guidelines on the management of psychiatric sequelae*

Management of the psychiatric disorders of TBI is both complex and challenging. Approach to care should be multifaceted and interdisciplinary, with the psychiatrist working in close collaboration with the neurosurgeon. The treatment plan should be practical and should include: (a) pharmacotherapy, (b) psychotherapy, and (c) caregiver and family education and support.<sup>23</sup>

#### *Pharmacotherapy*

In general, TBI patients are very sensitive to medication; hence, one should follow the golden rule of 'start low and go slow'.<sup>24</sup> Other rules include: (a) minimise medication; (b) avoid medication that may have a deleterious effect on the central nervous system, such as phenytoin, haloperidol, barbiturates and benzodiazepines;<sup>25</sup> (c) monitor serum levels if necessary; and (d) always discuss indications, risks and benefits with patient and family members. Arciniegas et al.<sup>26</sup> have provided an extensive literature review on the medication useful for the treatment of various psychiatric disorders following TBI, which the reader is encouraged to read.

### *Psychotherapy*

Psychotherapy is as important as pharmacotherapy in the rehabilitation of patients with psychiatric disorders secondary to TBI. In addition to education and hope, supportive psychotherapy should include recommendations on nutrition, regular exercise, the importance of maintaining routine and scheduling daily activities. Patients should be encouraged to attend brain injury support groups available in their area and to maintain contact with the local and national brain injury associations.

Psychotherapy may be individual, group, or family therapy, or a combination. The different types of therapies include occupational therapy, physical therapy, behaviour therapy, cognitive rehabilitation, reality orientation, speech therapy, social skills training, recreation therapy, vocational training and substance abuse counselling. Even though some of these interventions have been useful for some patients, their use is largely empiric, with a lack of scientific validation.

Cicerone et al.<sup>27</sup> conducted an extensive literature review on the effectiveness of the different forms of cognitive rehabilitation for people with TBI and stroke and have found an overall effectiveness.

### *Caregiver support and education*

A caregiver may be the spouse, parents, family member, a friend, or even a professional care provider. Whoever they may be, addressing their needs is important, because they often experience intense stress, depression and anxiety as a result of caring for a person with TBI.<sup>28</sup> Often, these adverse effects are present for years after the TBI. The frequency of psychiatric illness, such as anxiety and major depression, among care providers of TBI patients ranges from 16% to 51%.<sup>29</sup> In addition, other problems, such as financial difficulties, role changes, social isolation and impaired family functioning<sup>28</sup> are common. Hence, support of the family and of the caregivers is an essential component of treatment of their brain-injured patient. Each family is unique, and so are their problems, and their needs should be addressed individually. The general approach to caregiver support includes: (a) providing education; (b) instilling hope; (c) providing emotional support; (d) if symptoms of anxiety or low mood are persistent, recommending professional help; and (e) encouraging the use of available resources, such as local and national brain injury association centres.

## **Summary**

TBI is a complex heterogeneous disease that can produce a variety of psychiatric disturbances, ranging from subtle deficits in cognition, mood and behaviour to severe disturbances that cause impairment in social, occupational and interpersonal functioning. With improvement and sophistication in acute trauma care, a number of individuals are able to survive the trauma, but are left with several psychiatric sequelae. This has major public health implications. It is important for psychiatrists and neurosurgeons alike to be aware of this entity because an increasing number of physicians will be involved in the care of these patients. Treatment should be interdisciplinary and multifaceted, with the psychiatrist working in collaboration with the patient, caregivers, the family, other physicians and therapists. The goal of treatment should be to stabilise the residual symptoms, maximise potential, minimise disability and increase productivity in the social, occupational and interpersonal domains.

## References

1. Frankowski RF. Descriptive epidemiologic studies of head injury in the United States. *Advances in Psychosomatic Medicine* 1986;16:153-172.
2. Editorial: Head injuries: a neglected field in India. *National Medical Journal* 1991;4:53-44
3. Gururaj G. Epidemiology of traumatic brain injuries: Indian scenario. *Neurological Research* 2002 Jan;24(1): 24-28.
4. Erb DE, Povlishock JT. Neuro-plasticity following traumatic brain injury: A study of GABAergic terminal loss and recovery in the cat dorsal lateral vestibular nucleus. *Experimental Brain Research* 1991;83:253-267.
5. Katz DI. Neuropathology and neurobehavioral recovery from closed head injury. *Journal of Head Trauma Rehabilitation* 1992;7:1-15.
6. Katz DI. Traumatic brain injury. In: Mills VM, Cassidy JW, Katz DI, eds. *Neurological Rehabilitation: A Guide to Diagnosis, Prognosis and Treatment Planning*. Boston: Blackwell Science Publishers, 1997: 105-143.
7. Kraus MF, Maki P. The combined use of amantadine and L-dopa/carbidopa in the treatment of chronic brain injury. *Brain Injury* 1997;11:455-460.
8. Kwentus JA, Hart RP, Peck ET, et al. Psychiatric complications of closed head trauma. *Psychosomatics* 1985;26:8-15.
9. Levin HS: Neurobehavioural sequelae of head injury. In: Cooper PR, ed. *Head Injury*. Baltimore: William & Wilkins, 1987.
10. Capruso DX, Levin HS. Neuropsychiatric aspects of head trauma. In: Kaplan HI, Saddock BJ, eds. *Comprehensive Textbook of Psychiatry*. vol 1. Baltimore: Williams & Wilkins, 1995;207-220.
11. Kraus MF. Neuropsychiatric sequelae of stroke and traumatic brain injury: The role of psychostimulants. *International Journal of Psychiatry in Medicine* 1995;25:39-51.
12. Kraus MF. Neuropsychiatric sequelae: Assessment and pharmacologic interventions. *Traumatic Brain Injury* 1999;14:173-185.
13. Lishman WA. Psychiatric sequelae of head injury: A review. *Psychological Medicine* 1973;3:304-318.
14. McAllister TW. Neuropsychiatric sequelae of head injuries. *Psychiatric Clinics of North America* 1992;15: 395-413.
15. McLean A, Temkin NR, Dikmen S, et al. The behaviour sequelae of head injury. *Journal of Clinical Neuropsychology* 1983;5:361-376.
16. O'Shanick GJ, O'Shanick AM. Personality and intellectual changes. In: Silver JM, Yudofsky SC, Hales RE eds. *Neuropsychiatry of Traumatic Brain Injury*. Washington DC: American Psychiatric Press, 1994; 163-168.
17. Rao V, Lyketsos C. Neuropsychiatric sequelae of traumatic brain injury. *Psychosomatics* 2000;41:95-103.
18. Fedoroff JP, Starkstein SE, Forrester AW, et al. Depression inpatients with acute traumatic brain injury. *American Journal of Psychiatry* 1992;149:918-923.
19. Deb S, Lyons I, Koutzoukis C, et al. Rate of psychiatric illness 1 year after traumatic brain injury. *American Journal of Psychiatry* 1999;156:374-378.
20. Van Reekum R, Bolago I, Finlayson MAJ, et al. Psychiatric disorders after traumatic brain injury. *Brain Injury* 1996;10:319-327.
21. Katz DI, Alexander MP. Traumatic brain injury. In: Good DC, Couch JR, eds. *Handbook of Neurorehabilitation*. New York: Marcel Dekker, 1994;493-549.
22. Silver JM, Yudofsky SC, Hales RE. *Neuropsychiatry of Traumatic Brain Injury*. Washington, DC: American Psychiatric Press, 1994.
23. Rabins PV, Lyketsos CG, Steele CD. Overview of dementia care. In: Rabins PV, Lyketsos CG, Steele CD, eds. *Practical Dementia Care*. New York: Oxford University Press, 1999;79-91.



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24. Levin H, Kraus MF. The frontal lobes and traumatic brain injury. *Journal of Neuropsychiatry Clinical Neuroscience* 1994;6:443-454.
25. Preston GC, Ward CE, Broks P, et al. Effects of lorazepam on memory, attention and sedation in attention. *Psychopharmacology* 1989;97:222-227.
26. Arciniegas DB, Topkoff F, Silver JM. Neuropsychiatric aspects of traumatic brain injury. *Current Treatment Options in Neurology* 2000;2:160-186.
27. Cicerone KD, Dahlberg C, Kalmar K, et al. Evidence-based cognitive rehabilitation: Recommendations for clinical practice. *Archives of Physical Medicine and Rehabilitation* 2000;81:1596-1615.
28. Mateer CA. The rehabilitation of executive function. In: Stuss DT, Winocour G, Robertson IH, eds. *Cognitive Rehabilitation*. Cambridge, UK: Cambridge University Press, 1999;314-322.
29. Robinson RG, Boston JD, Starkstein SE, et al. Comparison of mania with depression following brain injury: Causal factors. *American Journal of Psychiatry* 1988;145:172-178.

# Chapter 40

## Functional Neurosurgery for Psychiatric Disorders

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Functional neurosurgery became possible with the introduction of human stereotactic frames in 1948, by Spiegel and Wycis. It aims at specific desirable alterations in brain functions, as a result of ablation, interruption or stimulation of certain tracts, foci or nuclei within the brain tissue. Functional neurosurgery has been defined as 'that aspect of neurosurgery that acts to change neurophysiologic function by surgical means'. This is in contrast to general neurosurgery, wherein the desirable results mostly emerge by achieving certain anatomic endpoints of tissue resection.

In the preceding two decades, there has been a resurgence of functional neurosurgical procedures worldwide. This is primarily due to the realisation of the limitations of medical therapy for these conditions, coupled with rapid advancements in radiological and localisation techniques. There have been simultaneous developments in microelectrode monitoring and stereotaxic techniques, which have further enhanced the accuracy of surgical procedures utilising such techniques to sub-millimetre levels.

The other notable paradigm shift in functional procedures has been towards the stimulation of neural tissue to achieve the desired effect, rather than the older techniques utilising lesion generation or ablation. For example, electrical stimulation at certain frequencies and amplitude has a well-documented inhibitory effect at the stimulation site. For psychiatric disorders, however, the emphasis still remains on ablative or lesioning procedures.

Radiosurgery is an additional tool available for functional neurosurgical procedures, with the significant added advantage of avoiding open surgery and its complications, however, small. However, the main disadvantage is the inability to have biofeedback, and physiologic localisation of the desired target prior to executing the brain lesion. Furthermore, relatively high radiation doses are required, the long-term sequelae of which are yet to be understood.

It is also prudent to realise that, with the exception of neural transplantation, all functional neurosurgical procedures are 'palliative' in nature, as they do not have any impact on the natural history of the diseases treated per se.

The principal problem with functional neurosurgery is the optimisation of techniques to produce brain lesions of the 'correct' site, size and configuration. Furthermore, there is a lack of homogeneity in case selection, targets, localisation and evaluation of results with these procedures. Finally, there is continuing controversy regarding the benefit compared to other conventional therapies.

## Major Indications for Functional Procedures

A wide variety of neurologic and psychiatric disorders are currently being treated with functional neurosurgical procedures. The major categories of such diseases are listed here:

- Movement disorders: Parkinson's disease, various dyskinesias, athetoses and other variants;
- Spasticity;
- Intractable pain;
- Psychiatric illness: 'psychosurgery'.

## Psychosurgery

### *Introduction and historical aspects*

Psychosurgery was defined in 1976 by the WHO as 'the selective surgical removal or destruction of nerve pathways for the purposes of influencing behaviour'<sup>1</sup> has a long and chequered past. Beginning probably even in the Stone Age, psychosurgery attained public recognition with Egas Moniz winning the Nobel Prize in 1949. In the 1950s, with psychopharmacological advances (the availability of chlorpromazine) and growing public awareness, surgical treatment of psychiatric diseases began to fall out of favour. Many prefer to now call this speciality as 'functional' or 'limbic system' surgery. It has always been recognised as a potential candidate to become a more acceptable treatment for psychiatric diseases.

The first 'psychosurgical' procedure performed on a human patient probably occurred during the Stone Age. Records of trephining for the 'relief of unexplained and unbearable pain ... melancholia ... or to release demons' have been dated as early as 1500 BC. The earliest physical evidence, however, of trephining in human skulls, has been dated to the Neolithic Period of the Stone Age, approximately 3,500 years earlier.<sup>2</sup>

Gottlieb Burckhardt performed the first psychosurgical procedure in the human brain in 1888.<sup>3</sup> He was strongly influenced by the popular localisationist and associationist trends in neuroscience, as well as the empirical data reported by specific authors of that time.<sup>3,4</sup> Many of their neuroscientific theories were derived from observations of accidents. Clinical sequelae in survivors of brain injuries resulting from accidents or war were documented in newspapers and hospital journals, and many neuroscientists were interested in the inferences regarding brain function and anatomic features that could be drawn from these injuries. On 29 December 1888, Gottlieb Burckhardt, who is considered by some to be the father of modern psychosurgery, performed the first experimental topectomy (the selective removal of parts of the cerebral cortex). In 1891, Burckhardt published his report on six patients with intractable psychiatric illnesses whom he described as demented and aggressive.<sup>4</sup>

An interesting anecdote is that of Phineas Gage, a 25-year-old railroad worker. On 13 September 1848, while working on a railroad line in Vermont (US), an accidental explosion drove a steel rod up into his left cheek, through his frontal lobes, and out through his cranium near the sagittal suture. After being taken to a local physician, Gage recovered and lived for 13 more years. After Gage's death, Harlow described the case in a letter to the *New England Journal of Medicine* in December 1848. The striking personality changes described are now well-known.<sup>5</sup> Various authors demonstrated that the brain areas injured were in the left anterior orbitofrontal cortex (Brodmann Areas 11 and 12), the polar and anterior mesial frontal cortices (Areas 8, 9, 10 and 32), and the anterior cingulate gyrus (Area 24). To summarise, the processing of emotion and the ability to make rational decisions in personal and social matters were severely impaired, but attention and

the ability to handle abstract logic and calculate were spared.<sup>6</sup>

Fulton and Jacobsen in 1935, presented their experience with animal experiments in this regard and placed the entire subject in scientific perspective.<sup>7</sup> This interested Antonio Egas Moniz to start similar efforts on patients. On 12 November 1935, Egas Moniz directed his neurosurgical colleague Almeida Lima, to perform a prefrontal leukotomy on a 63-year-old woman with melancholia, acute anxiety and paranoid delusions. The procedures initially performed by Lima, under the direction of Moniz, involved the injection of absolute alcohol into the centrum ovale of both frontal lobes via trephine holes in the lateral surfaces of the cranium. Moniz chose the centrum ovale for the initial lesions because of the high density of fibres connecting the anterior frontal cortex with the thalamus and other cortical areas, as well as the relative lack of major vessels in this area. Moniz won the 1949 Nobel Prize in Medicine and Physiology.

In 1942, Freeman and Watts reported the results for their first 200 lobotomy cases; they claimed that 63% of patients exhibited improvement, 23% were in unchanged condition, and 14% were in worsened conditions (including deaths).<sup>8</sup> Apart from the suboptimal results, there were often serious side-effects, such as seizures, apathy, confusion, poor attention and an inability to maintain socially appropriate behaviour.

In India, Govindaswamy and Rao published the first experience with leucotomies, in 1944.<sup>9</sup>

Subsequently, psychosurgery fell into disrepute primarily because of severe criticism from various organisations, as well as advances in the efficacy and availability of a variety of good antipsychotic agents.

The modern understanding of functional neuroanatomy and neurobiology, psychophysiology, and deficiencies of psychopharmacology combined with advances in stereotactic technology and functional imaging is leading to a situation in which neurosurgery may offer a minimally invasive and highly selective potentially beneficial treatment for a variety of psychiatric illnesses.

Functional neurosurgical procedures are presently being used for carefully selected patients with major categories of illnesses that are intractable to medical and psychological therapies. These include major affective disorders, obsessive-compulsive disorders and schizophrenia.

### ***Anatomic and physiologic basis***

The proposal of an anatomic basis of emotions in 1937 by Papez laid the scientific foundations for selection of lesion sites in psychiatric disorders.<sup>10</sup> Papez theorised that emotional stimuli passed, via the cingulate gyrus, from the septum to the hippocampus and then, via the fornix, to the hypothalamus (mammillary bodies), from the hypothalamus to anterior thalamic nuclei, and from thalamic radiations back to the cingulate gyrus (the 'Papez circuit'). This, therefore, formed a reverberating circuit, which he felt played a role in emotion, memory, as well as anxiety. At the same time, MacLean and others asserted the importance of structures comprising the phylogenetically older cortex around the brainstem and their connections with the limbic system, and emphasised the association of this system with emotion and visceral functions.<sup>11,12</sup> These general theories subsequently went on to win the support of a general nature from various experiments and observations.

The precise neuroanatomic and neurochemical basis of emotions in health and disease is still elusive, but there seems to be evidence supporting the role of the limbic system and its interconnections with the basal ganglia and the basal forebrain in the genesis of psychiatric disorders. Electrical stimulation of certain brain areas in humans causes alteration in anxiety levels and autonomic responses.<sup>13</sup> Recently, Position Emission Tomography (PET) studies have shown hypermetabolism localised to caudate nucleus, anterior cingulum, midfrontal cortex and thalamus during obsessive states.<sup>14</sup>

Each of the currently performed surgical procedures aims at targeting a part of the Papez circuit directly (anterior cingulotomy), connections between the frontal cortex and the limbic system (subcaudate tractotomy and capsulotomy), or both (limbic leukotomy).

### ***Indications***

Even at present, there is no unanimity regarding which cases should be subjected to psychosurgery. This is because of the non-uniformity of nomenclature, varied medical protocols, individual preferences and diverse opinions, even among highly experienced psychiatrists.

In general, only patients with severe, chronic, disabling, and refractory psychiatric illnesses are considered. The severity of the illness is usually measured in terms of the subjective distress, as well as the impairment of psycho-social functioning. Chronicity in conjunction with treatment-refractory illness implies few other avenues open to the patient.

The usual practice is:

- Referral by the treating psychiatrist.
- Review by a multidisciplinary group that includes a psychiatrist, a neurologist, and a neurosurgeon.
- Documented DSM III-R disease that interferes significantly with normal functioning.

The disease categories usually included are treatment-refractory unipolar depression, bipolar depression, Obsessive-Compulsive Disorder (OCD) and generalised anxiety disorder. Schizophrenia is not currently considered a viable indication for psychosurgery. However, Ballantine and Giriunas feel that carefully selected schizophrenic patients with predominant anxiety, depression or obsessions could be considered.<sup>15</sup> There are also a few reports of self-mutilation being treated with psychosurgery.

All patients should undergo detailed psychiatric evaluation, to assess Axis I and Axis II disorders, and complete neurological evaluation, including MRI and electroencephalography, to rule out organic causes of mental disease. Substance abuse and Axis II disorders (i.e. personality disorders, especially borderline personality) were considered contraindications to surgery. Every patient should have demonstrated resistance to an exhaustive array of conventional medical therapies, including pharmacotherapy, psychotherapy, behaviour therapy and electro-convulsive therapy trials. Symptoms should be severe and unremitting for at least one year, but generally exist for several years before surgery is contemplated.

### ***Targets and procedures***

#### *Anterior cingulotomy*

The anterior cingulum was first suggested as a feasible target by Fulton in 1947. Fulton quoted experiments in which stimulation of the anterior cingulum in monkeys led to autonomic responses associated with emotion and that lesions in this region resulted in less fearful and aggressive animals.<sup>16,17</sup> Sir Hugh Cairns at Oxford introduced the bilateral open cingulectomy in 1948. Cingulectomy was noted to be effective in reducing emotional and obsessional symptoms. Additionally, the adverse effects on personality and behaviour were fewer compared to the lobotomies.<sup>18</sup> Subsequent developments led to ventriculographic techniques in the localisation of the cingulum, which led to cingulum ablation without the need for craniotomy. Modern-day

stereotactic techniques are a further advancement on this technique. A relatively standard procedure was developed by Ballantine, using thermocoagulation to produce lesions of predictable size.<sup>19</sup>

The primary indication for anterior cingulotomy is intractable OCD, but some patients with treatment-refractory chronic anxiety and major affective disorders may also merit this procedure. Since this procedure reduces the affective and unpleasant component of pain perception, the other indication includes refractory unremitting pain.

Ballantine has published one of the largest experiences of cingulotomy of 198 patients who underwent anterior cingulotomy over a 24-year period. Around 123 of 198 patients (62%) demonstrated sustained benefit.<sup>20</sup> The efficacy was greatest for affective and anxiety disorders, moderate for OCD, and the least for schizophrenia and personality disorders. The procedure was demonstrated to be safe, as there were no surgery-related deaths, and post-operative complications were limited to seizures (1%), hemiplegia (0.3%) and suicide (9%). There are two recent studies that have reported outcomes, in addition to concerns of mild cognitive decline after cingulotomy.<sup>21,22</sup>

#### *Subcaudate tractotomy*

This procedure was first stereotactically performed in 1964 by Geoffrey Knight,<sup>23</sup> evolving from 'restricted orbital undercutting'. The aim was to interrupt white matter tracts between the orbitofrontal cortex and subcortical limbic structures forming the limbic circuit.

The surgical indications include treatment-resistant major affective disorders (unipolar or bipolar), OCD and chronic anxiety states. Like cingulotomy, usually the greatest efficacy is observed for affective disorders (unipolar or bipolar depression) and the least for psychosis.

In an early review, Goktepe et al.<sup>24</sup> reported results for 208 patients, with a mean follow-up period of 2.5 years. Using a categorical outcome scale, those authors observed significant improvement in 68% of cases with depression, 62.5% with anxiety, and 50% with OCD. From India, Ramamurthi et al. presented their results of 42 cases undergoing subcaudate ('frontobasal') tractotomy, of which 72% demonstrated improvement.<sup>25</sup> More recent articles regarding the outcomes of patients undergoing this procedure<sup>26,27</sup> indicate that 40–60% of patients may begin to lead 'normal or near-normal lives' after surgery. Like cingulotomy, subcaudate tractotomy is also largely free of major complications. The specific short-term complication is transient post-operative disorientation, which may be seen in around 10% of patients. This complication is thought to be related to post-operative oedema (visible on MRI scans), which may last as long as one month. The major long-term complications are seizures, which are observed in a minute percentage of patients. The first prospective study of the neuropsychological effects of this operation was reported in 1991.<sup>28</sup> The authors showed that subcaudate tractotomy did not produce any significant long-term cognitive decline. However, patients showed transient deterioration in recognition memory tests and in card-sorting tests aimed at assessing frontal lobe dysfunction. Both of these deficits were well correlated with the signal changes visible on postoperative MRI scans. Over a six-month period, both the signal changes and the cognitive dysfunction resolved completely.

#### *Limbic leukotomy*

This procedure aims at ablation of parts of the limbic cortex as well as its connections with frontal lobes. It was introduced by Kelly et al.<sup>29</sup> It essentially combines bilateral cingulotomy with subcaudate tractotomy. The underlying hypothesis was that since the Papez circuit was a reverberating circuit with multiple connections and projections, a dual lesion would produce a better effect. The ventromedial frontal lesion was aimed at interrupting frontal lobe connections (as with subcaudate tractotomy), whereas the cingulum lesion was aimed at interrupting the Papez circuit directly.<sup>30</sup>

Surgical indications for limbic leucotomy include OCD, anxiety states and depression as well as some other psychiatric disorders including self-mutilation.<sup>29-31</sup>

In 1976, Kelly reported on 66 patients undergoing leucotomy, with a mean follow-up of 16 months after surgery. They devised a rating scale, according to which the authors noted improvement for 89% of patients with OCD, 66% of patients with chronic anxiety and 78% of patients with depression.<sup>32</sup> Apart from these usual indications, few reports have explored the use for other indications, such as treatment of Tourette's syndrome,<sup>33,34</sup> as for patients with OCD complicated by Tourette's syndrome.<sup>35,36</sup> The neuropsychological profiles of patients undergoing limbic leucotomy have also been reported.<sup>37</sup> The authors found that the surgically treated and control groups did not differ significantly in intellectual or memory functioning, but the surgically treated group performed more poorly than the control group on a version of the Wisconsin Card Sort Test. Recent reports have documented the role of limbic leucotomy in self-mutilation,<sup>38</sup> the cerebral blood flow changes taking place after this procedure<sup>39</sup> and the prospect of MRI-guided performance of this procedure.<sup>40</sup>

#### *Anterior capsulotomy*

Talairach and his team<sup>41</sup> first selectively lesioned the anterior limb of the internal capsule for the treatment of psychiatric disorders. The pioneer neurosurgeon Lars Leksell, developed a procedure to produce radiofrequency thermocoagulative lesions in the internal capsule ('stereotactic capsulotomy').<sup>42,43</sup>

The scientific basis for targeting the internal capsule was that fibres that connect the frontobasal cortex to the limbic system pass through the anterior limb of the internal capsule. A more recent hypothesis by Modell et al.<sup>44</sup> proposes that overactivity in a fronto-striatal-pallido-thalamic-frontal loop may underlie the pathophysiological features of OCD. This theory has been lent support by data from at least one functional imaging report.<sup>45</sup>

Like the other operations, it has also been observed for capsulotomy that the results are poor for patients with schizophrenia or other psychoses, but better for patients with affective disorders. The usual inclusion criteria for capsulotomy include intractable generalised anxiety disorder, OCD and panic disorder of a more than five-year duration. The other inclusion and exclusion criteria are broadly the same as mentioned previously.

Mindus and Jenike have described the surgical technique initially pioneered by Leksell. The procedure is performed under local anaesthesia.<sup>46</sup> Coordinates of the target area in the anterior limb of the internal capsule are determined by preoperative MRI with special tailored sequences. Monopolar electrodes are inserted through small burr holes and thermolesioning is performed by heating the tip of the electrode to 75° C for 75 seconds, producing a lesion 4 mm wide. Radiosurgical lesioning (gamma capsulotomy) has also been used by Leksell's team for this purpose.<sup>47</sup> The efficacy of radiosurgery seems to be similar to that of the radiofrequency thermolesioning procedure.<sup>48,49</sup> In the context of treating psychiatric patients and disorders, there are distinct advantages of radiosurgery: the procedure becomes logistically easier, and less demanding as the need for a craniotomy is eliminated; the procedure can be performed for medically unfit cases; the procedure is relatively safe; 'sham' procedures can be performed, and the results seem to be comparable.

The initial results with use of anterior capsulotomy were not good. For example, Herner reported response rates in the region of 20-27% for schizophrenia and anxiety disorders.<sup>50-52</sup> The efficacy for OCD seem to be clearly better, at almost 50-70%. More important is the observation that many incapacitated patients are able to lead much better lives, with much less need for support.

A few potential adverse effects of capsulotomy are a cause for concern. A fraction of patients show transient postoperative cognitive and affective deficits, manifested as decrease in initiative and mental drive. There have been studies showing that as for limbic leukotomy, this dysfunction was correlated with postoperative oedema visible on MRI scans and disappeared with resolution of the oedema. The heartening aspect is that again, as for leucotomy, these effects are probably self-limited, and disappear over the long term. In fact, another study totally negated any such adverse effects, and instead found improvements in anxiety levels.<sup>53</sup> Overall, therefore, there is a strong suggestion regarding the efficacy and safety of anterior capsulotomy, especially for OCD.

### ***Choice and comparison of procedures***

Very few studies have attempted to compare different procedures, and these mostly aim to compare cingulotomy against capsulotomy. Of these, two such reports indicated that anterior capsulotomy was more efficacious, but the latter of these studies also indicated a higher incidence of cognitive and affective undesirable effects.<sup>54,55</sup> In a subsequent study by Vasko and Kullberg,<sup>56</sup> the authors observed no postoperative changes in general intelligence. However, there was a tendency for capsulotomy to interfere with verbal memory, whereas cingulotomy tended to interfere with spatial tasks for some patients. An overall estimation indicated that 67% of patients exhibited significant improvement after surgery. Another recent study also reported continuing concerns regarding the choice of procedure for patients with OCD.<sup>57</sup>

Several factors make the analysis of efficacy difficult. First, until recently, all psychosurgical outcome reports described long-term retrospective studies, and diagnostic criteria, patient populations and outcome assessments were not necessarily constant for the course of each study. Most recent outcome reports describe shorter-term prospective studies of more well-defined patient populations. Second, the clinicians or centre responsible for selecting the patients and performing the surgical procedures, also performed the clinical outcome assessment, introducing potential rating bias. Only a few critical evaluations by independent investigators have been published. Third, estimates of outcome (even using categorical rating scales) are difficult to compare between studies. Fourth and most difficult is the issue of appropriate control groups. A randomised, double-blind, prospective study of surgical vs non-surgical treatments is definitely needed. Factors that undermine the ability to perform such a study include the ethics of withholding treatment in the patient population selected for surgery, the practical difficulty of identifying control patients with a severe disease who are not surgical candidates and the ethics of 'sham' open neurosurgical procedures, with the attendant risks. The lack of 'sham' operations in a control group creates two problems. First, a placebo effect of the operation cannot be ruled out; second, outcome assessment cannot be completely double-blind. In this regard, the development of the gamma knife technique may more easily allow for control 'sham' procedures. In the absence of double-blind prospective studies, the best current evidence of efficacy is derived from pre- and postoperative evaluation in individual patients.

There also remains the logistics of action for physicians contemplating surgical intervention for their patients. Referring psychiatrists must be familiar with:

1. Selection criteria;
2. Indications (surgery is indicated for treatment-resistant affective disorders, OCD and anxiety; whereas personality disorders and psychotic disorders are relative contraindications);



3. Procedures available and their rationale, relative efficacy, and potential side-effects;
4. Preoperative workup and postoperative evaluation and rehabilitation.

In addition, it is important that literature available to primary care psychiatrists reflects the availability of surgical therapy for patients refractory to other treatment modalities.

There are numerous excellent reviews recently available for ready reference, regarding most of the above issues addressed in this chapter.<sup>58-62</sup> Future developments also promising, the above limitations notwithstanding. An emerging advance is the application of the stimulation paradigm to psychosurgery which has recently been reported.<sup>63</sup>

## References

1. World Health Organization. *Health Aspects of Human Rights*. Geneva: World Health Organization, 1976.
2. Horrax G. *Neurosurgery: An Historical Sketch*. Springfield: Charles C Thomas, 1952;6-7.
3. Joannette Y, Stemmer B, Assal G, Whitaker H. From theory to practice. *Brain and Language* 1993;45:572-587.
4. Burckhardt G. Uber Rindenexcisionen, als Beitrag zur operativen Therapie der Psychosen. *Allgemeine Z Psychiatrie psychisch-gerichtliche Medizin* 1891;47:463-548.
5. Harlow JM. Recovery from the passage of an iron bar through the head. *Proc Mass Med Soc* 1868;2:327-346, (original report published, *New England Journal of Psychiatry* 1848;39:389-392).
6. Demasio H, Grabowski T, Frank R, Galaburda A, Damasio A. The return of Phineas Gage. *Science* 1994; 264:1102-1105.
7. Fulton JF, Jacobsen CF. *The Functions of the Frontal Lobes: A Comparative Study in Monkeys, Chimpanzees, and Man*. London: Abstracts of the Second International Neurological Congress, 1935;70-71.
8. Freeman W, Watts J. *Psychosurgery: Intelligence, Emotion and Social Behavior Following Prefrontal Lobotomy for Mental Disorders*. Springfield: Charles C Thomas, 1942.
9. Govindaswamy MV, Rao BNB. Bilateral prefrontal leucotomy in Indian patients. *Lancet* 1944;1:466.
10. Papez JW. A proposed mechanism of emotion. *Arch Neurol Psychiatry* 1937;38:725-743.
11. MacLean PD. Some psychiatric implications of physiological studies on the frontotemporal portion of the limbic system (visceral brain). *Electroencephalography and Clinical Neurophysiology* 1952;4:407-418.
12. MacLean PD. Contrasting functions of limbic and neocortical systems of the brain and their relevance to psychophysiological aspects of medicine. *American Journal of Medicine* 1958;25:611-626.
13. Kelley D. The limbic system, sex and emotions. In: *Anxiety and Emotions: Physiological basis and Treatment*. Springfield, IL: Charles C Thomas, 1980;197-300.
14. Rauch SL, Jenike MA, Alpert NM, et al. Regional cerebral blood flow measured during symptom provocation in obsessive-compulsive disorder using 15-O-labelled CO<sub>2</sub> and positron emission tomography. *Archives of General Psychiatry* 1994;51:62-70.
15. Ballantine H, Giriunas I. Treatment of intractable psychiatric illness and chronic pain by stereotactic cingulotomy. In: Schmidek H, Sweet WH, eds. *Operative Neurosurgical Techniques*, Vol. II. New York: Grune & Stratton, 1988;1069-1075.
16. Smith WK. Functional significance of the rostral cingular cortex as revealed by its responses to electrical excitation. *Journal of Neurophysiology* 1945;8:241-255.
17. Ward AA. The cingular gyrus, Area 24. *Journal of Neurophysiology* 1948;11:13-23.
18. Whitty CWM, Duffield JE, Tow PM, Cairns H. Anterior cingulectomy in the treatment of mental disease. *Lancet* 1952;1:475-481.
19. Cosgrove GR, Ballantine HT. Cingulotomy in psychosurgery. In: Gildenberg PL, Tasker RR, eds. *Textbook of Stereotactic and Functional Neurosurgery*. New York: McGraw-Hill, 1998;1965-1970.
20. Ballantine HT Jr, Bouckoms AJ, Thomas EK, Giriunas IE. Treatment of psychiatric illness by stereotactic cingulotomy. *Biological Psychiatry* 1987;22:807-819.

21. Cohen RA, Kaplan RF, Moser DJ, Jenkins MA, Wilkinson H. Impairments of attention after cingulotomy. *Neurology* 1999;53:819-824.
22. Kim CH, Chang JW, Koo MS, Kim JW, Suh HS, Park IH, Lee HS. Anterior cingulotomy for refractory obsessive-compulsive disorder. *Acta Psychiatrica Scandinavica* 2003 April;107(4):283-290.
23. Knight GC. The orbital cortex as an objective in the surgical treatment of mental illness: The development of the stereotactic approach. *British Journal of Surgery* 1964;51:114-124.
24. Goktepe EO, Young LB, Bridges PK. A further review of the results of stereotactic subcaudate tractotomy. *British Journal of Psychiatry* 1975;126:270-280.
25. Ramamurthi B, Ravi R, Narayanan R. Long term follow up of functional neurosurgery in psychiatric disorders. Experience of 30 cases. *Applied Neurophysiology* 1982;45:538.
26. Bridges PK, Bartlett JR, Hale AS, Poynton AM, Malizia AL, Hodgkiss AD. Psychosurgery: Stereotactic subcaudate tractotomy, an indispensable treatment. *British Journal of Psychiatry* 1994;165:599-613.
27. Hodgkiss AD, Malizia AL, Bartlett JR, Bridges PK. Outcome after the psychosurgical operation of stereotactic subcaudate tractotomy, 1979-1991. *Journal of Neuropsychiatry and Clinical Neurosciences* 1995;7:230-234.
28. Kartsounis LD, Poynton A, Bridges PK, Bartlett JR. Neuropsychological correlates of stereotactic subcaudate tractotomy: A prospective study. *Brain* 1991;114:2657-2673.
29. Kelly D, Richardson A, Mitchell-Heggs N, Greenup J, Chen C, Hafner RJ. Stereotactic limbic leucotomy: A preliminary report on forty patients. *British Journal of Psychiatry* 1973;123:141-148.
30. Kelly D, Richardson A, Mitchell-Heggs N. Stereotactic limbic leucotomy: Neurophysiologic aspects and operative technique. *British Journal of Psychiatry* 1973;115:257-266.
31. Kelly D, Mitchell-Heggs N. Stereotactic limbic leucotomy: A follow-up study of thirty patients. *Postgraduate Medical Journal* 1973;49:865-882.
32. Mitchell-Heggs N, Kelly D, Richardson A. Stereotactic limbic leucotomy: A follow-up at 16 months. *British Journal of Psychiatry* 1976;128:226-240.
33. Rauch SL, Baer L, Cosgrove GR, Jenike MA. Neurosurgical treatment of Tourette's syndrome: A critical review. *Comprehensive Psychiatry* 1995;36:141-156.
34. Robertson M, Doran M, Trimble M, Lees AJ. The treatment of Gilles de la Tourette syndrome by limbic leucotomy. *Journal of Neuropsychiatry and Clinical Neurosciences* 1990;53:691-694.
35. Baer L, Rauch SL, Jenike MA, Cassem NH, Ballantine HT, Manzo PA, Martuza RL. Cingulotomy in a case of concomitant obsessive-compulsive disorder and Tourette's syndrome. *Archives of General Psychiatry* 1994;51:73-74.
36. Kurlan R, Kersun J, Ballantine HT Jr, Caine ED. Neurosurgical treatment of severe obsessive-compulsive disorder associated with Tourette's syndrome. *Movement Disorders* 1990;5:152-155.
37. Cumming S, Hay P, Lee T, Sachdev P. Neuropsychological outcome from psychosurgery for obsessive-compulsive disorder. *Australian and New Zealand Journal of Psychiatry* 1995;29:293-298.
38. Dean CE. Limbic leucotomy in self-mutilation. *Journal of Clinical Psychiatry* 2002 Dec;63(12):1181.
39. Kim MC, Lee TK, Son BC, Choi CR, Lee C. Regional cerebral blood flow changes in patients with intractable obsessive compulsive disorders treated by limbic leucotomy. *Stereotactic Functional Neurosurgery* 2001; 76(3-4):249-255.
40. Montoya A, Weiss AP, Price BH, Cassem EH, Dougherty DD, Nierenberg AA, Rauch SL, Cosgrove GR. Magnetic resonance imaging-guided stereotactic limbic leucotomy for treatment of intractable psychiatric disease. *Neurosurgery* 2002 May;50(5):1043-1049; discussion 1049-1052.
41. Talairach J, Hecaen H, David M. Lobotomie préfrontal limitée par électrocoagulation des fibres thalamo-frontales à leur émergence du bras antérieur de la capsule interne, in *Congress Neurologique International*. Paris, Masson, 1949;1412 (abstr).
42. Leksell L. A stereotaxic apparatus for intracerebral surgery. *Acta Chirurgica Scandinavica* 1949;99:229-233.
43. Leksell L. *Stereotaxis and Radiosurgery: An Operative System*. Springfield: Charles C Thomas, 1971.

44. Modell JG, Mountz JM, Curtis GC, Greden JF. Neurophysiologic dysfunction in basal ganglia/limbic striatal and thalamocortical circuits as a pathogenetic mechanism of obsessive-compulsive disorder. *Journal of Neuropsychiatry and Clinical Neurosciences* 1989;1:27–36.
45. Trivedi MH. Functional neuroanatomy of obsessive-compulsive disorder. *Journal of Clinical Psychiatry* 1996; 57:26–36.
46. Mindus P, Jenike MA. Neurosurgical treatment of malignant obsessive-compulsive disorder. *Psychiatry Clinics of North America* 1992;15:921–938.
47. Leksell L, Backlund EO. Stereotactic gamma capsulotomy, In: Hitchcock ER, Ballantine HT Jr, Meyerson BA, eds. *Modern Concepts in Psychiatric Surgery*. New York: Elsevier/North Holland Biomedical Press, 1979; 213–216.
48. Mindus P, Bergstrom K, Thuomas KA, Hindmarsh T. Magnetic resonance imaging of stereotactic radiosurgical lesions in the internal capsule. *Acta Radiologica Supplementum* 1986;369:614–617.
49. Lippitz Bodo E, Mindus P, Meyerson BA, Kihlström L, Lindquist C. Lesion topography and outcome after thermocapsulotomy or gamma knife capsulotomy for obsessive-compulsive disorder: relevance of the right hemisphere. *Neurosurgery* 1999;44:452–460.
50. Herner T. Treatment of mental disorders with frontal stereotactic thermo-lesions: A follow-up of 116 cases. *Acta Psychiatrica Scandinavica Supplementum* 1961;158:36.
51. Bingley T, Leksell L, Meyerson BA, Rylander G. Long-term results of stereotactic capsulotomy in chronic obsessive-compulsive neurosis, In: Sweet WH, Obrador S, Martin-Rodriguez JG, eds. *Neurosurgical Treatment in Psychiatry, Pain and Epilepsy*. Baltimore: University Park Press, 1977;287–299.
52. Burzaco J. Stereotactic surgery in the treatment of obsessive-compulsive neurosis, In: Perris C, Struwe G, Jansson B, eds. *Biological Psychiatry*. Amsterdam Elsevier, 1981;1103–1109.
53. Mindus P, Nyman H. Normalization of personality characteristics in patients with incapacitating anxiety disorders after capsulotomy. *Acta Psychiatrica Scandinavica* 1991;83:283–291.
54. Fodstad H, Strandman E, Karlsson B, West KA. Treatment of chronic obsessive compulsive states with stereotactic anterior capsulotomy or cingulotomy. *Acta Neurochirurgica (Wien)* 1982;62:1–23.
55. Kullberg G. Differences in effect of capsulotomy and cingulotomy. In: Sweet WH, Obrador S, Martin-Rodriguez JG, eds. *Neurosurgical Treatment in Psychiatry, Pain, and Epilepsy*. Baltimore: University Park Press, 1977;301–308.
56. Vasko T, Kullberg G. Results of psychological testing of cognitive functions in patients undergoing stereotactic psychiatric surgery, In: Hitchcock ER, Ballantine HT Jr, Meyerson BA, eds. *Modern Concepts in Psychiatric Surgery*. New York: Elsevier/North Holland Biomedical Press, 1979;303–310.
57. Bejerot S. Psychosurgery for obsessive-compulsive disorder – concerns remain. *Acta Psychiatrica Scandinavica* 2003 April;107(4):241–243.
58. Crossley D, Freeman C. Should neurosurgery for mental disorder be allowed to die out? Against. *British Journal of Psychiatry*. 2003 September;183:196.
59. Persaud R. Should neurosurgery for mental disorder be allowed to die out? For. *British Journal of Psychiatry* 2003 September;183:195–196.
60. Pedrosa-Sanchez M, Sola RG. Modern-day psychosurgery: a new approach to neurosurgery in psychiatric disease. *Revista of Neurology* 2003 May 1–15;36(9):887–897.
61. Laitinen LV. Psychosurgery. *Stereotactic and Functional Neurosurgery* 2001; 76(3–4):239–242.
62. Feldman RP, Alterman RL, Goodrich JT. Contemporary psychosurgery and a look to the future. *Journal of Neurosurgery* 2001 December;95(6):944–956.
63. Gabriels L, Cosyns P, Nuttin B, Demeulemeester H, Gybels J. Deep brain stimulation for treatment-refractory obsessive-compulsive disorder: psychopathological and neuropsychological outcome in three cases. *Acta Psychiatrica Scandinavica* 2003 Apr;107(4):275–282.

## Chapter 41

# Advances in the Management of Intracranial Mass Lesion Presenting with Psychiatric Symptoms

*Sushil Kumar • S. P. Agarwal*

Psychiatric symptoms are not uncommon in patients with brain tumours.<sup>1</sup> Brain tumours can produce a variety of psychiatric symptoms and can occur without neurological symptoms or focal neurological signs. Occasionally, the early manifestations of brain tumours may consist mainly, or even only, of psychiatric symptoms where the patient may come to the attention of the psychiatrist. Psychological symptoms occur in the majority of patients with brain tumours at some time during the illness. Binder reported three patients with psychiatric symptoms but without any neurological changes.<sup>2</sup> The psychiatric symptoms are of three main types:

1. Confusional states and progressive cognitive deterioration occurs in one-third of patients. Disorientation with variable clouding of consciousness, euphoria or indifference and loss of insight are prominent in those with confusional states. Progressive mental impairment, loss of initiative or bradyphrenia are common in those with a more protracted course and often coexists with signs of raised intracranial pressure.
2. Behavioural and mood disturbances occur in 20% of patients. Irritability, euphoria, depression and less frequently, psychotic symptoms are part of picture. Wellisch et al. reported 28% incidence of major depressive disorder using DSM IV criteria.<sup>3</sup>
3. Paroxysmal disturbances such as poorly formed visual hallucinations and automatisms indicating temporal lobe involvement are less common.

Brain tumours have been associated with the entire spectrum of behaviour disorders, which are determined by location, size and the histological nature of the lesion. The tumours produce behaviour disturbances by directly affecting brain functions, by destroying or compressing brain parenchyma from mass effect or oedema or through obstructive hydrocephalus, or by disrupting brain vasculature. Normal pressure hydrocephalus and chronic subdural haematoma can also present with dementia.

Fast-growing tumours are more likely to cause psychiatric symptoms. The prevalence of intracranial tumours in American psychiatric hospitals was 1.3–2.6 %, a third of which were

frontal and had long-standing psychosis.<sup>4</sup> Larson et al. scanned 123 psychiatric patients and found tumours in three cases and subdural haematoma in three cases.<sup>5</sup> Roberts and Lishman subjected 323 psychiatric patients to CT scanning and found one patient with parieto-occipital astrocytoma.<sup>6</sup> Marsden and Harrison, in an investigation on 106 patients of dementia, found eight patients with brain tumours.<sup>7</sup> Victorates et al. found similar incidence of brain tumours on pneumoencephalography.<sup>8</sup> Jacoby and Levy in a review of 40 cases of dementia found one case of corpus callosum glioma and another case of frontal subdural hematoma.<sup>9</sup> Jacoby and Levy<sup>10</sup> did not find any tumour in 40 elderly depressive patients who underwent CT scan and a similar experience was found by Dolan et al.<sup>11</sup>

The following review of literature describes the characteristic mental pictures of tumours in the different parts of the brain. The prevalence of mental symptoms in brain tumours ranges between 47% and 94%. The incidence of primary brain tumours amongst elderly persons is on the increase. Given the early diagnosis and treatment of brain tumours, thanks to the wide availability of modern non-invasive imaging techniques, formal studies of psychiatric symptoms of brain tumours are difficult to carry out and the prevalence difficult to estimate.

### **Frontal Lobe Tumours**

Symptoms of these may lead to the mistaken diagnosis of primary dementia due to paucity of neurological signs. The impairment of consciousness and intellectual deterioration are common. Sachs and Chee et al. have reported frontal meningiomas presenting with dementia before any symptoms indicative of tumours appeared.<sup>12,13</sup>

Tumours of the left frontal lobe appear to be associated with greater cognitive disturbances than tumours of the right, and bilateral involvement produces more disturbances than when a single lobe is implicated. Spontaneity, slowing and inertia may be the striking features. Affective symptoms like irritability, depression, euphoria and apathy are often characteristic, especially in slow growing meningiomas. Patients may have severe depression unresponsive to electroconvulsive therapy.

Symptoms such as irresponsibility and childishness may occur before any evidence of intellectual deterioration become evident. Disinhibition leads to social lapses, sexual excitation and erotic behaviour. Lack of insight is characteristic and the patient may be completely indifferent about his illness and denial of illness may also be seen. Hallucinations may occur from tumours located in the neighbourhood of the temporal lobe, and obesity, stupor or narcoleptic fits from pressure on the hypothalamus.

Maurice-Williams and Dunwoody reported two cases of frontal meningiomas who presented to psychiatrists.<sup>14</sup> Of these, one was diagnosed after prolonged psychiatric treatment and in the other, diagnosis was made at autopsy. Hunter et al. reported on three patients who had been similarly symptomatic for periods ranging from 3 to 43 years before the diagnosis of brain tumour was made.<sup>15</sup> Suspicion should arise in the presence of gradual non-remitting symptoms, such as irritability, memory loss and self-neglect, or a previous history of psychiatric disease.

Attention deficit, impulsiveness of thought and affect and vulnerable behaviour are the hallmark of prefrontal lesions. Orbitofrontal and anteromedial lesions produce predominantly affective symptoms, while impaired reasoning is produced by dorsolateral lesions. A family history of mood disorders or atrophy in frontal and diencephalic regions predispose to secondary mania.

## **Temporal Lobe Tumours**

Temporal lobe tumours produce mental disturbances quite frequently. Early onset and rapid progression of dementia is characteristic. Tumours on the dominant side produce impairment of intellect both verbal and non-verbal.<sup>16</sup> There may be slowing and asynchronicity of speech and movement. Euphoria is as common as in frontal lobe tumours. Depression, anxiety, panic disorder and irritability are all common with tumours on the dominant side. Ghadirian et al. reported anxiety and panic attacks in a case of right temporal meningioma, which responded to surgery.<sup>17</sup>

Childish behaviour may be seen as frontal lobe tumours. Psychopathic and paranoid traits, hypochondriasis and irritability have been reported by Strobos.<sup>18</sup> Occasionally, the resultant psychosis may resemble schizophrenia. This may even be the initial manifestation of a temporal lobe tumour.<sup>19,20</sup> Owing to the disruption of limbic structures including components of the Papez circuit, which comprises the hippocampus, fornix, mammillary bodies, mamilothalamic tract, anterior thalamic nucleus, cingulate gyrus and parahippocampal gyrus. Visual and auditory hallucination may be mistakenly attributed to a psychotic illness. Olfactory and gustatory hallucinations may arise from the uncinate region.

## **Parietal Tumours**

As they produce motor and sensory signs along with psychotic disturbances, an erroneous diagnosis of primary psychiatric disorder is less likely, though depression and personality changes may be there. Kinesthetic hallucinations are confined to contralateral limbs. Cognitive disturbances may be mistaken for dementia or hysteria. Disturbances of body image or its neglect may be so bizarre as to suggest a non-organic psychiatric disorder. Panic attacks associated with parietal lobe tumour have been reported by Alemeyehu et al. (1995). These cleared up after surgical resection.

## **Occipital Tumours**

Allen<sup>21</sup> noted neurotic manifestations early in the course of disease in 40 cases of occipital tumours, along with pronounced defects of attention and memory in one-third. Amnesia was rarely found though dementia may be profound.

## **Diencephalic Tumours**

Amnesia is a typical feature of tumours in the vicinity of the third ventricle. There may be marked inability to register current events. Impairment of new learning occurs, while remote memory and cognitive functions remain intact. Confabulations may be present. Memory defect is also more frequent in craniopharyngiomas involving the posterior part of the hypothalamus and the third ventricle. The clinical features of a failing intellect and memory without neurological deficit may be seen in cases of adult craniopharyngiomas.<sup>22</sup> Thalamic tumours may present relatively early in the disease, with severe dementia, which progresses rapidly due to the involvement of the medial thalamocortical fibres.<sup>23</sup> Somnolence and hypersomnia are common with diencephalic tumours. Sleep disorders occur due to lesions involving the posterior hypothalamus and contiguous upper midbrain. Akinetic mutism may be seen with lesion of the posterior diencephalon or upper midbrain. Mood alterations from depression to exuberance or defective emotional control leading to outbursts of temper on minor provocation may be also seen. Dementia with hyperphagia and outburst of rage have been reported with hamartoma of hypothalamus.<sup>24</sup> Fluctuating and progressive dementias have been reported in third ventricular

colloid cysts,<sup>25-28</sup> which were relieved by removal of the cyst. Lajara-Nanson reported personality changes and mild paranoia with colloid cyst.<sup>29</sup> Neuropathologically, the behaviour disturbance associated with colloid cyst may be secondary to dysfunction of diencephalic structures.

### **Pituitary Tumours**

Pituitary tumours account for about 13% of cerebral tumours found in psychiatric patients.<sup>30</sup> The psychiatric features may be attributable to endocrine disturbances, for example, acromegaly and Cushing's disease, or directly to extensions of the tumour beyond the sella resulting in the compression of the diencephalon, frontal or temporal lobes.<sup>31</sup> Dullness, apathy, mental slowing, emotional instability, irritability, sudden rage and schizophrenia have been reported.<sup>19</sup> Prolactinoma may be accompanied by depression, and psychological distress has been reported with hyperprolactinaemia.<sup>32</sup> Wilcox has reported a pituitary microadenoma presenting with panic attacks, which responded to surgery.<sup>33</sup>

### **Corpus Callosum Tumours**

These may present with severe mental symptoms more frequently than tumours elsewhere. Mental changes are more common with tumours involving the rostrum and splenium than the middle portion. Fersten et al. reported a case with paranoid syndrome treated for 12 years by psychiatrists, till he was investigated for epileptic seizures, which revealed a tumour in the anterior part of corpus callosum.<sup>34</sup> Rostral tumours produce mental changes before intracranial pressure symptoms appear. Splenial tumours present with deficits of memory and visual perception. Blocking of thought and action may resemble catatonic schizophrenia. Personality changes as seen in the frontal lobe tumour may also be present. Mental disturbances are perhaps due to involvement of the adjacent structures, for example, frontal lobe anteriorly and thalamus and midbrain posteriorly. Involvement of the third ventricle and diencephalon produce somnolence, akinesia and stupor. Koro, secondary to a tumour of the genu of corpus callosum, has been reported by Durst and Rosca-Rebaudengo.<sup>35</sup> Schizophreniform catatonia secondary to hydrocephalus associated with subthalamic mesencephalic glioma was reported in five patients by Neuman et al.<sup>36</sup> They attributed it to damage to ascending DA pathways.

### **Infratentorial Tumours**

Mental disturbances are less common with infratentorial lesions, are usually mild and arise late in the course of disease. Wilson and Rupp have reported five cases of posterior fossa mass lesion, who initially had been admitted to psychiatric wards for memory impairment, confusion and emotional instability, without any evidence of raised intracranial pressure.<sup>37</sup>

Euphoria, emotional lability, apprehension, irritability may be seen in some cases.

Woodcock found mental changes in seven out of 31 cases and attributed these to vascular disturbances consequent upon brain stem herniation.<sup>38</sup> Summerfield reported a case of cerebellar hemangioblastoma with multiple psychiatric admissions for depression and psychosomatic symptoms.<sup>39</sup> In children, anxiety, withdrawal, hyperactivity, irritability, cruelty and obstinacy have been reported with pontine glioma, and these symptoms may antedate physical signs.

Approximately, a third of patients experience confusional states or progressive intellectual decline; 20% experience behaviour and mood disturbances. A few might present with paroxysmal visual hallucinations and automatisms. Psychiatric manifestations are less common with infratentorial tumours. Mental abnormalities are more frequent in gliomas than meningiomas, because of the relatively more rapid growth and destructive character of these malignant tumours.

It has been observed that patients with left hemispheric lesions are prone to depressive or catastrophic reactions, whereas patients with right hemispheric lesions often show undue cheerfulness and an attitude of indifferent emotional reactions.

## **Imaging for Psychiatric Symptoms**

Plain x-rays are now rarely employed, because of the widespread and easy availability of computed tomography and magnetic resonance imaging. Electroencephalography (EEG) usually reveals non-specific electrical abnormalities. Focal evidence in the form of delta waves, irregular in form and amplitude and often with faster waves in the vicinity, may be seen. Diffuse changes may consist of less well-developed alpha activity, or an increase of slow waves on the side of the tumour. This cannot be relied upon, however, to exclude intracranial mass lesion.

Echoencephalography was used earlier as a non-invasive procedure to demonstrate the shift of midline but often gave false positive as well as false negative results. It was used primarily as a screening procedure to be followed by angiography. Radioisotope scan was also used in the past to demonstrate vascular tumours like glioblastomas, meningiomas and secondaries. Ventriculography, pneumoencephalography and angiography were the mainstay of diagnosis in the pre-CT era but are hardly ever carried out nowadays for the diagnosis of brain tumours. At present, computed tomography is an initial non-invasive procedure for the diagnosis of brain tumours. CT scan can detect 90% of brain tumours. The scan can demonstrate the site, size, nature of the tumour and a contrast scan can give information about its vascularity. In addition, it can show brain displacements, surrounding oedema and changes in the overlying bone. Meningiomas show increased density, whereas gliomas and metastasis may be either hypodense or hyperdense. Vassallo and Allen<sup>40</sup> reported a case of gliomatosis cerebri at postmortem, in which two CT scans of brain were normal. However, smaller lesions and those near the bones will require MRI for the diagnosis.

Magnetic resonance imaging is superior to CT in producing greater anatomical detail in multiple planes and is especially useful in brain stem and posterior fossa lesions. It can demonstrate the relationship of the tumour to the intracranial vessels. Contrast enhances the sensitivity of the test, i.e. gadolinium enhancement delineates the tumour margins from the surrounding oedema. Magnetic resonance spectroscopy demonstrates the metabolism, i.e. a decrease in Nor Adrenaline Aspartase (NAA), which is a neuronal marker in tumours. Echoplanar MRI provides information on tumour perfusion and diffusion. Its increased sensitivity allows the detection of very small lesions as well. MRI and CT scan have rendered Pneumoencephalogram (PEG), isotope scan, Echo, EEG and Ventriculography virtually obsolete.

## **Problems of Misdiagnosis**

The chances of a psychiatrist overlooking a brain tumour is very small these days due to the rapid, safe and easy availability of non-invasive investigations like CT and MRI. Kraft et al. found 14 intracranial tumours in 1,000 patients admitted to psychiatric wards.<sup>41</sup> Cole reported 3% incidence of brain tumours at autopsy on psychiatric patients.<sup>42</sup> However, Klotz did not find a higher incidence of brain tumours in psychiatric hospital autopsies.<sup>43</sup> Raskin reported 3.5% incidence of brain tumours in autopsy on psychiatric patients.<sup>44</sup> Meningiomas occur more than gliomas at autopsy, because autopsy surveys deal mostly with chronically hospitalised patients. Meningiomas produce a chronic picture of mental disorder and therefore, tend to be missed. Treatable conditions like normal pressure hydrocephalus, neoplasm and subdural haematoma were likely to be found in approximately 1% of patients suffering from reversible dementia.



The lack of brain tumour consciousness is probably because of the relative rarity with which cerebral tumours are encountered, even in busy psychiatry units. Greater awareness and readiness to investigate could reduce the errors that might occur. Psychiatrists should always keep physical causes as a possible basis for mental symptoms and perform a thorough neurological examination, which may be sometimes difficult because of poor cooperation from patients. It is suggested that in patients who have no history of previous psychiatric disorders, the sudden appearance of anxiety or panic attacks associated with visual illusions or hallucinations should alert the physicians to the possibility of an underlying structural neurological cause, and to investigate it accordingly.

Most clinicians advocate CT or MRI scanning in older patients with the recent onset of neurobehavioural symptoms. Despite this, patients with brain tumours may still mistakenly carry a diagnosis of primary psychiatric disorder months or years before the tumour is discovered.

## Treatment

Surgical excision of benign tumours and decompression of malignant tumours followed by radiotherapy and/or chemotherapy are the mainstay of treatment. Residual tumours or tumours in inaccessible situation, or tumours smaller than 3 cm can be treated by gamma knife. The subsequent course is determined by the relative malignancy of the tumour, with survival ranging from months in cases of glioblastoma-multiforme to decades in meningiomas. Neuro-psychiatric symptoms after surgery may require neuroleptics, anticonvulsants, antidepressants and lithium. These drugs should be used with care in patients with brain tumours, because of their adverse effects, such as excessive sedation and a lowered seizure threshold.

## References

1. Uribe V. Psychiatric symptoms and brain tumor. *American Family Physician* 1986;34:95-98.
2. Binder RL. Neurologically silent brain tumours in psychiatric hospital admissions: three cases and a review. *Journal of Clinical Psychiatry* 1983;44:94-97.
3. Wellisch DK, Kaleila TA, Freeman D, Cloughesy T, Goldman J. Predicting major depression in brain tumour patients. *Psychooncology* 2002;11:230-238.
4. Morse ME. Brain tumour as seen in hospitals for the insane. *Archives Neurology Psychiatry* 1920;3:417-428.
5. Larson EB, Laurence MPH, Mack A, et al. Computerized tomography in patients with psychiatric illness: advantage of a rule-in approach. *Am Int Med* 1981;95:360-364.
6. Roberts JKA, Lishman WA. The use of CAT head scanner in clinical psychiatry. *British Journal of Psychiatry* 1984;145:152-158.
7. Marsden CD, Harrison MJG. Outcome of investigation of patients with presenile dementia. *British Medical Journal* 1972;2:249-252.
8. Victoratos GC, Lenman JAR, Herzberg L. Neurological investigation of dementia. *British Journal of Psychiatry* 1977;130:131-133.
9. Jacoby RJ, Levy R. Computed tomography in the elderly. Senile dementia diagnostic and functional impairment. *British Journal of Psychiatry* 1980(a);136:256-269.
10. Jacoby RJ, Levy R. Computed tomography in the elderly affective disorders. *British Journal of Psychiatry* 1980(b);136:270-275.
11. Dolan RJ, Calloway SP, Mann AH. Cerebral ventricular size in depressed patients. *Psychological Medicine* 1985;15:837-838.
12. Sachs E. Meningiomas with dementia as the first and presenting failure. *Journal of Mental Science* 1950; 96:998-1007.

13. Chee PC, David A, Galbraith S, et al. Dementia due to meningiomas: outcome after surgical removal. *Surgical Neurology* 1985;23:414-416.
14. Maurice-Williams RS, Dunwoody G. Late diagnosis of frontal meningiomas presenting with psychiatric symptoms. *British Medical Journal* 1988;296:1785-1788.
15. Hunter R, Blackwood W, Bull J. Three cases of frontal meningiomas presenting psychiatrically. *British Medical Journal* 1968;3:9-16.
16. Bingley T. Mental symptoms in temporal lobe epilepsy and temporal gliomas. *Acta Psychiatrica et Neurologica Scandinavica Supplement* 1958;120:1-151.
17. Ghadirian AM, Gauthier S, Bertrand S. Anxiety attacks in a patient with right temporal lobe meningioma. *Journal of Clinical Psychiatry* 1986;47:270-271.
18. Strobos RRJ. Tumours of temporal lobe. *Neurology* 1953;3:752-760.
19. Davison K, Bagley CR. Schizophrenia-like psychosis associated with organic disorders of the central nervous system: A review of the literature in current problems in neuropsychiatry, Harrington RN, ed. *British Journal of Psychiatry* Special publication No. 4, 1969;113-184.
20. Malamud N, Francisco: Psychiatric disorder with intracranial tumours of limbic system. *Archives of Neurology* 1967;17:113-113.
21. Allen IM. A Clinical study of tumours involving the occipital lobe. *Brain* 1930;53:194-243.
22. Carroll N, Neal LA. Diencephalic tumours presenting as behavioural problems in workplace. *Occupational Medicine* 1997;47:52-54.
23. Kumar S, Prakash B, Malik R, Puri V, Gupta S, Gupta M. Thalamic tumours. *IJRI* 1989;43:15-18.
24. Reeves AG, Plum F. Hyperphagia rage and dementia accompanying a ventromedial hypothalamic neoplasm. *Archives of Neurology* 1969;20:616-624.
25. Lobosky JM, Vangilder JC, Damasio AR. Behavioural manifestations of third ventricular colloid cysts. *Journal of Neurology Neurosurgery Psychiatry* 1984;47:1075-1080.
26. Nitta M, Symon L. Colloid cysts of the third ventricle. A review of 36 cases. *Acta Neurochirurgica* 1985;76:99-104.
27. Upadhaya AK, Sud PD. Psychiatric presentation of third ventricular colloid cyst. A case report. *British Journal of Psychiatry* 1988;152:567-569.
28. Carson BS, Weingart JD, Guarnieri M, Fisher PG. Third ventricular choroids plexus papilloma with psychosis. *Journal fo Neurosurgery* 1997;87:103-105.
29. Lajara-Nanson WA. Neuropsychiatric manifestations of third ventricular colloid cyst. *West Virginia Medical Journal* 2000;96:512-513.
30. Summer D. The diagnosis of intracranial tumours. *British Journal of Hospital Medicine* 1992;2:489-494.
31. Kelly WF. Psychiatric aspects of Cushing's syndrome. *Quarterly Journal of Medicine* 1996;89:543-551.
32. Reavley A, Fisher AD, Owen D, Creed FH, Davis JR. Psychological distress in patients with hyperprolactinaemia. *Clinical Endocrinology* 1997;47:343-348.
33. Wilcox JA. Pituitary microadenoma presenting as panic attacks. *British Journal of Psychiatry* 1991;158:426-427.
34. Fersten E, Luczywek E, Glowacki M and Czernicki Z. Paranoid syndrome in a patient with tumour in the anterior part of corpus callosum. *Neurologia Neurochirurgia Polasko* 2001;35:741-747.
35. Durst R, Rosca-Rebaudengo P. Koro secondary to a tumour of the corpus callosum. *British Journal of Psychiatry* 1988;153:251-254.
36. Neuman E, Rancurel G, Lecrubier Y, Fohanno D, Boller F. Schizophreniform catatonia in 6 cases secondary to hydrocephalus with subthalamic mesencephalic tumour associated with hypodopaminergia. *Neuropsychobiology* 1996;34:76-81.
37. Wilson G, Rupp C. Mental symptoms associated with extramedullary posterior fossa tumours. *Transactions of the American Neurological Association* 1946:104-107.

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38. Woodcock SM. Mental symptoms in patients with acoustic neuromas. *Journal of Neurology Neurosurgery and Psychiatry* 1967;30:587.
39. Summerfield DA. Psychiatric vulnerability and cerebellar haemangioblastoma. A case report. *British Journal of Psychiatry* 1987;150:858-860.
40. Vassallo M, Allen S. An unusual cause of dementia. *Postgraduate Medicine* 1995;71:483-484.
41. Kraft E, Finby N, Schillinger A. Routine skull roentgenography of psychiatric hospital admissions. *American Journal of Roentgenology* 1963;89:1212-1219.
42. Cole G. Intracranial space-occupying lesions in mental hospital patients: necropsy study. *Journal of Neurology, Neurosurgery and Psychiatry* 41:730-736.
43. Klotz M. Incidence of brain tumours in patients hospitalized for chronic mental disorders. *Psychiatric Quarterly* 1957;31:669-680.
44. Raskin N. Intracranial neoplasms in psychotic patients. *American Journal of Psychiatry* 1956;112:481-484.



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**Section VI**

**Past Experiences and Future Directions**

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## Chapter 42

# Six Decades as a Psychiatrist: The Story of Col. Kirpal Singh, IMS (Retd)

*(As told to Lt Col. P.S. Bhat,  
Associate Professor of Psychiatry, Base Hospital, Delhi Cantt.)*

Col. (Retd) Kirpal Singh was born in 1911, and obtained his Licentiate in Surgery and Medicine (LSMF) from Medical School, Amritsar and worked in Kenya for over five years to gain professional experience. He then obtained his MBBS degree from the Madras Medical College, and joined the army during the First World War. Col. Kirpal Singh served in the Southeast Asia Command, completed in-service training in psychiatry and was graded as a psychiatrist in 1944. Since then, he has never looked back and continues to practise at the age of 92 years.

When he joined the field of psychiatry, specialists dealing with mental patients were called 'mental specialists'. The centres of psychiatric activity at that time in India were mental hospitals, situated far away from cities and surrounded by high walls, with the aim of admission more for the protection of the community than the treatment of the patient. The treatment was mainly restraint, manual, mechanical or chemical. In the army, however, facilities were better and psychiatric units were located even in operational areas. Towards the end of the Second World War, a 1,000-bed psychiatric hospital was also functioning in Jalahalli, Bangalore. The first Electro-Convulsive Therapy (ECT) machine in India was brought from the UK in 1943 by Brig. E.A. Bennet, Consultant Psychiatrist to GHQ. After the war, insulin-coma therapy and psychosurgery became popular and some even used ECT as a pre-surgery anaesthesia. In the fifties, excellent psychotropic medication appeared in the form of chlorpromazine and tricyclic antidepressants. However, the stigma and myths attached to psychiatry were very high. Col. Kirpal Singh, in one of his All India Radio broadcasts in Poona mentioned an incident where an educated lady used to caution others about psychiatrists, saying, 'Never look at the eyes of psychiatrists as they can read your minds'.

He has been closely associated, as a foundation member, with Indian Psychiatric Society (IPS) since its inception in 1947 and served as its President twice (1959 and 1968). He was the recipient of the first Sandoz Award in 1967 and the D.L.N. Murthy Rao Oration Award in 1983. An award in his name was also instituted by the IPS in 1982. He was the first psychiatrist from India to be elected as a Corresponding Fellow of the Royal Medico Psychological Association of the UK, and was also trained in mental health at the Harvard School of Public Health. Col. Kirpal Singh was also given a Consultant status in the state of Victoria, Australia.

Col. Kirpal Singh was actively involved in clinical research throughout his career. His first presentation in an international forum was a paper that was read at the Conference of Army Psychiatrists at Rangoon on 11 November 1945, titled 'Psychiatric practice among Indian troops' which was later published in *The Indian Medical Gazette*, (V. 1 LXXXI, No. 10, October 1946). He has to his credit more than 70 papers in national and international journals of repute and has authored chapters in Indian Medical Association (IMA) publications and in the book, *Psychiatry in India* by Alan D'Souza. Some of his publications in Indian journals were later fully reproduced in international journals. Most of his research was problem-oriented and his co-workers were from various fields, including psychologists, physicians and venereologists. All the co-workers, including the junior-most, were given the status of co-authors in his publications. He did considerable work on the psychiatric aspects of military personnel, including prisoners of war. At the same time, he remained a devoted family man and he was strongly supported by his charming wife who always stood by him in their 63 years of married life. When he delivered the National Academy of Medical Sciences Oration on 12 December 1993, which also happened to be their sixty-first wedding anniversary, he publicly acknowledged the contributions of his wife.

The renowned Dr Erich Lindmann was deputed by the WHO to India in 1961 to study the state of undergraduate training of psychiatry. At that time in the Armed Forces Medical College (AFMC) Poona, there was no undergraduate training in this subject. However, Brig. (later Maj. Gen.) P.N. Bardhan and Kirpal Singh invited Lindmann to visit the military hospital and Department of Psychiatry in the AFMC. Later, Lindmann invited Col. Kirpal Singh to study at the Harvard School of Public Health, Boston for a period of one year in 1962, under Gerald Kaplan, famous for his Client Oriented Consultation Techniques. During Lindmann's stay in India, he was invited to the annual conference of the IPS, at Calcutta.

Col. Kirpal Singh's association with Dr. Vidya Sagar, a legend in Indian psychiatry is worth a mention here. Dr. Vidya Sagar was a colleague in the army, being posted at Jalandhar, while Col. Kirpal Singh was a district psychiatrist in the Indian Military Hospital Lahore Cantonment, as well as the British Military Hospital. He used to substitute for Col. Kirpal Singh during leave. He was a committed doctor who would see patients every day till late in the afternoon. There was no ECT machine at that time, and he used to purchase phrenzol in powder form, make a solution of the required strength and use it for convulsion therapy. In Amritsar, he successfully involved family members in the treatment by providing them with tented accommodation within the hospital premises. The Vidya Sagar Institute of Mental Health and Allied Neuro Sciences (VIMHANS) was established in Delhi in his memory.

Psychiatry as a medical discipline over the last few decades has undergone a sea change for the better. At the same time, with the radical changes taking place in the socio-cultural values of Indian society, the incidence and prevalence of psychiatric morbidity is on the increase. The WHO and the governments all over the world have recognised this and have been giving strong inputs for the development of this speciality, with a special emphasis on community mental health. With an improvement of psychiatric orientation in undergraduate training facilities, the reduction of stigma, the advent of newer psychopharmacological agents and a speedy implementation of the national mental health programme, a bright future for psychiatry in India is foreseen.

## Chapter 43

# An Extraordinary Career

*N. S. Vahia*

I had my medical training at Seth G.S. Medical College and KEM Hospital. When I was posted for clinical training at the hospital after passing my first MBBS examination, I was surprised to find that there were no appropriate cases that were sent to the Chief of the department. When I questioned the senior Resident Medical Officer (RMO) why this was so when there were 50 new cases in the OPD, he replied that the patients who had symptoms should exhibit signs which could be observed during examinations. Out of these 50-odd patients that came to the OPD, 48 or more had no signs, and therefore were not referred to the Chief and instead 'disposed of' by the RMOs. When questioned if there was *nothing wrong with them, then what was wrong with them?* He said that 'these patients did not come for your final MBBS examination; therefore they were of no significance to you. You will learn about them after passing your final examination'.

When I passed my final examination and became an RMO myself, I asked my Chief the same question. He just laughed. One of the senior RMOs told me that these patients had no physical illnesses, so they were given any one of the following mixtures: (a) carminative (sweet mixture); (b) gensionc soda (bitter mixture) or (c) salicylate (for pain relief). If the patient felt better after a week, the same mixture was continued. Otherwise these three mixtures were given in rotation, knowing fully well that they were of no therapeutic value. I also asked him if there was nothing wrong with these people, why did they come to the hospital and wait for hours for the medicine which was of no therapeutic value. I was told that they were either pretending or mentally sick. Disgusted with my questions, he told me to go to the mental hospital, but I replied that I was not interested in mental hospital patients, only why they come to the general hospital. Not satisfied with the explanations I was given, I went to the library to learn more. I found that these patients were sick, but the cause of their illnesses was not physical, but were the result of psycho-social stress. I then went to the Dean of the hospital and told him that I would like to study these patients in detail.

He told me that such a department could not be opened for anyone interested in any special subject, unless he had special postgraduate training. To the best of my knowledge, there were no facilities for such training in India, so I had to go abroad. As facilities for such training in England were temporarily suspended because of the war, I decided to go to the US. Once there, I learnt that there are two major types of mental sicknesses—partially maladjusted (psychoneurosis) and grossly maladjusted (psychosis). The first group was treated by studying intrapsychic conflicts, deeply imbedded in the unconscious and resolved unsatisfactorily by various mental mechanisms, by psychoanalysis. The second group was treated by insulin-coma and electro-convulsive therapy.



After learning about these sicknesses and the methods of the treatment, when I returned to India, I was horrified to find that nobody was interested in these illnesses or their treatment. When the psychiatry department was opened in a general hospital in Bombay in 1947, patients were reluctant to visit it and no medical graduates were willing to study psychiatry. Even though the Dean showed interest in the psychiatry department, the chiefs of other departments objected to having it in the premises of a general hospital. They feared that such patients could disturb others. Similarly, there was difficulty in admission of these patients in the hospital. Gradually, after much convincing that mental sicknesses were not an infectious disease, the department gradually grew and indoor services were also opened.

An example of a colleague's prejudice against psychiatrists is given below:

A colleague who was a good friend asked me in the Honorary Consultant's room how I felt. I said that I was alright. He said that he must correct me. I should have said, 'I am alright so far', so I corrected myself to satisfy him. Then he replied 'Sorry Vahia, you are wrong. You should have said, 'I am all right so far according to me,' because in his opinion I was not alright. He said, 'Your patients also feel that they are alright.'

The parents of one patient came to me in a very angry mood, telling me that they wanted to file a suit against their family doctor for referring their son to me. Briefly, their argument was that the family doctor should have said that there was nothing physically wrong with him, but should not have declared him mentally ill by referring him to me. They felt that to hide his ignorance regarding the diagnosis, the family doctor called their son insane.

A patient with delusions and hallucinations was brought to me by a family physician. The patient gave me a long talk on demonology. He said that seeing me was of no use, as being a doctor, I would not understand the influence of supernatural forces, which can only be treated by offering sacrifices. In fact, the mere act of having sought medical treatment was believed to anger these forces and thus result in supernatural retribution.

On the other hand, many young men and ladies came requesting me to secretly examine their partners (without disclosing the nature of my speciality) and to certify them as mentally sick so that they could get a divorce more easily.

A police officer had suspected that one of my patients had committed a crime involving a murder. The patient, however, kept denying the charges. The officer wanted to know whether I would give the patient a truth serum and permit him to be questioned regarding the crime. He was told that the patient would cooperate and be made aware of the nature of his treatment. The officer thought over it for some time, but he did not like the idea of the patient being told about the truth serum. He said that he would return with the patient, but he never came again.

Looking back into the recent past, one of the deans of KEM Hospital was consulted for the development of the psychiatry department. He refused further expansion. His argument was that the number of patients coming to the department had increased, but that did not mean that psycho-social factors were more common. An illness can be due to various factors, and if the patient was alright physically it did not mean that he was under psycho-social stress and therefore, there was no need for further expansion of the department. I told him that I agreed with him that there might be other causes also, for instance, genetic factors. We were planning to study the possibility of consistent genetic factors if any, in aetiology, to various psychiatric disorders. Recently, this has become easier due to the decoding of the human genome. By comparing the

patient's genome with a healthy genome, it might be possible to detect the abnormal gene in the patient. Subsequently, it was hoped that with genetic engineering, it might be possible to replace the abnormal gene by a normal gene and thus help in the patient's recovery. The Dean appreciated the merit of the idea, but was not convinced enough to help in the development of genetic studies in the aetiology of mental illnesses. In retrospect, it appears that if the Dean had agreed to the idea, it would have been the first such department in India.

## Chapter 44

# The Need for a Balanced Approach

*K. Bhaskaran*

**T**he Erwady tragedy that occurred on 6 August 2001, where 26 mentally ill patients were charred to death, caused a widespread sense of shock and outrage as it was reported that the patients were apparently kept chained and could not escape.

The inhuman conditions in which persons with mental disorders are treated in Indian mental hospitals were the focus of a National Human Rights Commission report.<sup>1</sup> According to the Report: "overcrowding in large hospitals was evident" (p. 34). "In hospitals at several places, the patients are expected to urinate and defecate into open drain in public view" (p. 38). "... Many hospitals have problems with running water. Leaking roofs, overflowing toilets, broken doors and windows are a common sight" (p. 44). "... Privacy was present in less than half of the hospitals. Trained psychiatric nurses were present in less than 25% of the hospitals; even routine blood and urine tests were not available in more than 20% of the hospitals." The deficiencies in the areas described so far are enough indicators that the rights of the mentally ill are grossly violated in mental hospitals.

In the more developed countries, the mental hospital as the main centre of mental health service delivery has found disfavour and an effort is being made to close down these institutions, transferring the responsibilities to GHPUs and other community-based services, in what is described as a 'de-institutionalisation' policy. Gudeman and Shore have reported that 90% of former mental hospital patients in Massachusetts, the USA, have been maintained successfully in the Massachusetts Mental Health Center without any back-up mental hospital service.<sup>2</sup> De-institutionalisation, however, has several disadvantages: (a) it poses a great strain on the relatives of patients who have to look after them, especially if there has been no previous special training; (b) de-institutionalisation often results in trans-institutionalisation; the patient gets transferred from one institution to another which is equally unsatisfactory; (c) if there are no adequate community-based supportive services, there is every chance of the patients slipping through the gaps in the mental health service net; (d) according to Anthony et al.,<sup>3</sup> 35-50% of those discharged from mental hospitals are re-admitted within one year of discharge and 65-75% within five years; and (e) it must also be recognised that five clearly identifiable groups who together constitute 6-10% of the population cannot be treated in the community-based mental health centres for want of specialised treatment facilities.

These groups are: (a) mentally retarded patients with concomitant psychiatric illness and assaultive behaviour; (b) patients with a serious loss of impulse control due to brain damage from head injury and degenerative diseases; (c) schizophrenics who are unremittingly assaultive,

suicidal and uncooperative despite the use of available treatment modalities over a period of years; and (d) chronic schizophrenics who exhibit socially unacceptable behaviour like eating garbage, disrobing in public, urinating and defaecating.

In India, we are not in a position to close down our mental hospitals, as alternative community-based services are not adequately developed. Attempts should be made to develop fully fledged psychiatric units in all general hospitals, offering a spectrum of psychiatric services. The minimum provisions required are: in-patient units of at least 20 beds, two full-time psychiatrists, one clinical psychologist and one psychiatric social worker as well as an adequate number of trained psychiatric nurses. There should be an active out-patient department and a well-developed consultation-liaison service.

Though mental hospitals may not be shut down, they may be renovated so that the ambience is pleasing. Buildings with individual cells should be demolished and replaced by blocks or dormitories. The various block housing of different services may be scattered in the spacious grounds where the patients can move about freely. These units will serve the needs of (a) psychogeriatric patients; (b) physically ill patients; (c) patients needing short-term hospitalisation for emergencies and relapses – the duration of stay not exceeding 30 days; and (d) drug dependence cases.<sup>4</sup>

Similarly, one block may be converted to a day care centre, where services like group therapy, family counselling, occupational and industrial therapy are offered. Social skills training, etc., can also be organised for both in-patients and out-patients.

Structural remodelling of the hospital alone is not adequate. As most of the ward attendants have worked in custodial care type of hospitals, it is essential to retrain them to participate in therapy-related activities. They should be taught to motivate the patients to plan for their own future and to participate in rehabilitation activities.

It is also very important to work closely with patient's relatives, to enable them to function better as caregivers.

Educational programmes should also cover the community at large, with the idea of increasing their awareness of different types of mental disorders and their management.

Educational programmes for general practitioners are an absolute necessity for many reasons. First, the number of patients going to general practitioner have unresolved psychological problems and for complete treatment these underlying problems must be assessed and rectified. Second, with adequate training, general practitioners may be able to manage common psychiatric problems themselves and thus they are in a position to offset the problem of manpower shortage in the profession.

Many NGOs are involved in training lay counsellors, who offer a helping hand to those unable to handle stressful situations. Their contribution should be welcomed and they should be offered consultation services, wherever required.

The DMHP which was launched in 1996 seems to be doing well and the service should be extended to cover more districts.

With regard to the primary prevention of mental disorders, though there are no identifiable methods of preventing major psychoses and psychoneuroses, there is a consensus that the absence of emotional security in childhood may lead to behaviour problems and adjustment difficulties in adulthood.<sup>5</sup> A significant proportion of people who are at high risk of becoming psychiatrically ill is constituted by those exposed to moderate or severe psycho-social stress. A good percentage of people exposed to civilian disasters or earthquakes succumb to post-traumatic stress disorders and the rest to major depression, panic disorders or paranoid disorders. Psychiatrists should therefore be active participants in disaster management teams.

## References

1. Quality assurance in Mental Health, National Human Rights Commission. Sardar Patel Bhavan, Sansad Marg, New Delhi, 1999.
2. Gudeman JE, Shore MF. Beyond De-institutionalization. A new class of facilities for the mentally ill. *The New England Journal of Medicine* 1984;311:832-836. National Mental Health Programme of India Director General of Health Service, Ministry of Health and Family Welfare, Government of India, New Delhi.
3. Anthony WA, Cohen MR, Vital R. The measurement of rehabilitation outcome. *Schizophrenia Bulletin* 1978;4:365-383.
4. Bhaskaran K. What shall we do with our mental hospitals (guest editorial). *Journal of Indian Psychiatric Society* 1992;OSB:3-9.
5. Bhaskaran K. Dr Murti Rao Oration: Primary psychiatric prevention: Problems and prospects. *Indian Journal of Psychiatry* 1992(34);2:7-88.

## Chapter 45

# Mainstreaming Mental Health

*N. N. Wig*

**P**redicting the future is a dangerous game, almost always, one is wrong. At the same time, it is so tempting to appear wise and try to forecast how the future will unfold in the next 20 years. I take comfort in the thought that most likely I will not be around in the year 2020 to take the blame for any wrong prediction. Furthermore, as a precaution I do not plan to make a forecast of what will happen in the field of mental health in India in the next 20 years but make a 'wish list' instead of what I would rather see taking place in India in 20 years.

### Looking Back

If a person was asked in 1950 to forecast what would happen in the field of psychiatry in India in the next 50 years, what would have been the response? As the records of the early years of the Indian Psychiatric Society would testify, our vision was rather limited at that time. We were thinking generally in terms of more and better mental hospitals, with a few centres for postgraduate training, amending the Indian Lunacy Act of 1912, and improving training in undergraduate psychiatry. Some of these things have happened and some have not, but other very dramatic additional developments have taken place, which were unforeseen and which have changed the face of psychiatry in India. First, the postgraduate training programmes moved very rapidly beyond our expectation. It quickly eliminated the need for foreign training – at least at the basic levels of DPM and MD. India now has over 50 training centres, with over a 100 psychiatrists graduating every year. The next significant thing which happened was the dramatic progress of general hospital psychiatry in the 1960s, which has now spread to cover every state, in both the government and the private sector. This development has greatly changed the practice of psychiatry in India. In the 1970s, we saw yet another major development, in the shape of community psychiatry, with the delivery of mental healthcare through the primary healthcare network, which led to the introduction of the National Mental Health Programme in 1982. The old Lunacy Act was also finally abolished and a new Mental Health Act came in 1987. The 1990s saw some very powerful judicial interventions for the human rights of the mentally ill. The last decade also saw the emergence of many NGOs as an important force in the care of the mentally ill. Another development, which is often forgotten is the rise of the Indian psycho-pharmaceutical industry. Almost every major psychotropic drug is easily available in India today.

## **Looking Ahead**

There is no doubt that our record for the first 50 years is quite impressive, a fact that any nation could be proud of. In this background, let us try to foresee what may happen in the next 20 years.

### ***The benefits of modern scientific psychiatry should be available to all sections of the population in India, rich or poor, urban or rural, male or female***

It is hoped that in the year 2020, there will be no 'wandering lunatic' or mad person on the roads of the villages and towns of India. It is a degrading sight for any civilised society to see a mentally ill person, with torn and dishevelled clothes, with nothing to eat and nowhere to live, wandering on the roads and being ridiculed by street children and passers by. I hope that by the year 2020, we will have organised our health services in such a way as to provide decent minimum care for such seriously mentally ill people.

At present, the availability of psychiatric services is confined to big cities and in some states up to district towns. It must spread further. With the limited resources available for mental healthcare, we will have to choose our priorities very carefully. The aim must remain, the greatest good of the largest number of mentally ill people. This can be better achieved through GHPUs and district-level psychiatric centres linked with primary mental healthcare services. Families will remain our main resource for the care of the mentally ill. Some mental hospitals will be needed for the care of the more serious mentally ill, who do not have sufficient social support and also for medico-legal cases, but the new mental hospitals must be small, near the community and with sufficient interaction through NGOs.

The availability of essential neuro-psychiatry drugs for epilepsy, psychosis and major depressive disorders needs to be ensured through the public health network.

### ***Psychiatry should not be seen as a peripheral discipline but must become a part of mainstream medicine***

There is enough evidence now to show that almost 15–20% cases diagnosed in primary healthcare are suffering from various types of psychological, psycho-social or psychiatric disorders. If a future physician is going to spend so much of his/her time in looking after these cases, his/her training must provide him with proper knowledge, skill and aptitude to deal with these problems. The rapid advances in neurosciences in the last two decades have greatly reduced the boundary between medical and psychiatric disorders. Dementia, schizophrenia and bipolar disorders are now as much medical disorders as diabetes or hypertension are. In short, new knowledge must replace old ignorance and prejudice. Artificial barriers between general health and mental health must be brought down. Psychiatry and mental health must become an integral part in the training curricula of doctors, nurses and all health workers.

### ***Psychiatry must remain a holistic discipline with a bio-psychosocial approach as its model***

While it is encouraging that psychiatry has come back to the fold of medicine, we must remember that more than any other speciality, psychiatry looks at the totality of a human being. No other speciality of medicine has such a special understanding of human distress as psychiatry has. This understanding of human suffering, both medically and psycho-socially is our special double heritage and we must not give up one for the sake of the other.

***Mental health services must become more relevant for Indian cultural needs***

Medicine and psychiatry do not develop in a vacuum, but they develop in a historical social context. Modern science, medicine and psychiatry have all developed during the last few centuries, in a European setting. In the case of psychiatry, the influence of European philosophy is particularly striking. Various psychiatric terms, systems of diagnosis and classifications, and approaches to management, are all based on European philosophical thoughts. This is not a very comfortable situation for a country like India, with its own rich philosophical heritage. Perhaps, no other civilisation has considered understanding the functions of the human mind, psychopathology and the management of various mental disorders, the way we have in India. Yet, we continue to blindly follow alien concepts and methods, even though these are often inappropriate in our socio-cultural context. We need to deliberate on these issues and evolve a truly indigenous approach to mental health. Operational strategies derived from such an approach will accord more closely with ground realities, particularly in respect of psycho-social therapeutic interventions.





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Section VII

**Appendices**

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## Appendix A

# Bhore Committee Report, 1946

### Chairman

Sir Joseph Bhore, K.C.S.I., K.C.I.E., C.B.E.

### Members

Dr. R.A. Amesur, President, Indian Medical Association.

Rai Bahadur Dr. A.C. Banerjea, C.I.E., Director of Public Health, United Provinces.

Khan Bahadur Dr. A.H. Butt, Director of Public Health, Punjab.

Dr. R.B. Chandrachud, F.R.C.S., Chief Medical Officer, Baroda State.

Col. E. Cotter, C.I.E., I.M.S., Public Health Commissioner with the Government of India.

Dr. (Mrs.) D.J.R. Dadabhoy, M.D., M.R.C.P. (Lond.), ex-President of the All-India Association of Medical Women, Bombay.

Dr. J.B. Grant, C.B.E., M.D., Director, All-India Institute of Hygiene and Public Health, Calcutta (1939-1945).

Khan Bahadur Dr. M.A. Hameed, M.D., M.R.C.P., Member, Medical Council of India, Professor of Pathology, Lucknow University.

Lt. Gen. J.B. Hance, K.C.I.E., C.I.E., I.M.S., Director General, Indian Medical Service.

Sir Henry Holland, C.I.E., F.R.C.S., C.M.S. Hospital, Quetta.

Sir Frederick James, O.B.E., M.L.A., Member, Central Advisory Board of Health.

N.M. Joshi, Esquire, M.L.A.

Lt. Col. (Miss) H.M. Lazarus, F.R.C.S., Chief Medical Officer, Women's Medical Service.

Pandit L.K. Maitra, M.L.A., Member, Central Advisory Board of Health.

Diwan Bahadur Dr. Sir Lakshmanaswami Mudaliar, M.D., Vice-Chancellor, Madras University.

Dr. U.B. Narayanrao, President, All-India Medical Licentiates Association (1939-1945).

Dr. Vishwa Nath, M.A., M.D., F.R.C.S., Member, Medical Council of India.

Major General W.C. Paton, C.I.E., M.C., K.P.H., I.M.S., Surgeon General with the Government of Bengal (1941-1945).

Dr. B.C. Roy, M.R.C.S., President, Medical Council of India (1939-1945).

The Hon'ble Mr. P.N. Saprú, Member, Council of State, and Member, Central Advisory Board of Health.

Lt. Col. B.Z. Shah, M.R.C.S., L.R.C.P., I.M.S. (Retd.), Superintendent, Mental Hospital, Poona.

B. Shiva Rao, Esquire.

Mrs. K. Shuffi Tyabji, J.P., K.I.H.

Dr. H.R. Wadhvani, J.P., K.I.H., Minister for Public Health, Sind, till April 1945.

### **Secretary**

Rao Bahadur Dr. K.C.K.E. Raja.

### **Joint Secretaries**

Dr. M. Ahmed, Captain A. Banerji, Dr. K.T. Jungalwalla,

Rai Bahadur Man Mohan, Rao, Bahadur Dr. S. Ramakrishnan.

## **Extracts Pertaining to Mental Health**

### **Mental Diseases and Mental Deficiency**

#### ***Introduction***

1. The physical and mental health of an individual are interrelated and no health programme can be considered complete without adequate provision for the treatment of mental ill-health and for the promotion of positive mental health. Positive mental health is characterised by discriminative self-restraint associated with consideration for others. A man in such positive health uses effectively his intelligence and talents to obtain the maximum satisfaction from life, with the minimum of discomfort to others. He will not allow himself to be overwhelmed by the stresses and strains inseparable from ordinary existence. He not only profits from experience but, under favourable circumstances, can transcend such experience. It should be the aim of every health programme to include measures meant to assist the individual to achieve mental stability and poise and develop into a useful citizen.

2. Conditions of mental ill-health may be divided into two broad groups, (i) mental disorder and (ii) mental deficiency.

Mental disorder may be either inherited or acquired, and very often it is both. No age is exempt from mental disorder although the types may be different at different age periods. A large proportion of them is amenable to modern method of treatment.

Mental deficiency is ascribed, on the other hand, to a hereditary or congenital taint or to some accident or illness occurring just before or soon after birth. There are grades of mental deficiency, and although the condition is generally regarded as incurable, yet by proper care and supervision, the majority of defectives can be made to lead useful, but segregated lives; and what is more important from the point of view of the society, they can be prevented from becoming criminals and in the case of girls, social menaces.

3. It may be of advantage at this stage to examine such evidence as is available regarding the incidence of these conditions elsewhere, and attempt to draw from it inferences applicable to the country.

In England and Wales there were at the beginning of 1937 about 129,750 patients under treatment in the mental hospitals maintained by the various local authorities, who are responsible, under the law, for making such provision. This figure gives a proportion of about 2-3 mental patients per 1,000 of the population.

In America, the annual admission rate is more than 170,000 to the public mental hospitals, in which is already resident a population of half a million patients. More hospital beds are devoted to the care of the mentally sick than to the treatment of all other patients combined. In some states, as much as one-eighth of the revenue is earmarked for expenditure on the mentally sick. There are 500,000 mental defectives, and perhaps as many epileptics. Amongst criminals, there is a very large number whose offences are attributable to diseases and defects of the mind and maladjusted personalities.

During the World War, one-sixth of all casualties were neuro-psychiatry, excluding wounds, and a peak load of one-third or more was sometimes reached by such causes. At least, one child out of every twenty-seven children born in America and one in thirty born in England is likely to become, in the course of a few years, mentally sick to such an extent as to require admission in public hospitals. This is an appalling figure, but it does not include large groups of persons in whom the essential basics of ill-health is either a defective personality or an inability to adjust themselves to a difficult environment, while they are diagnosed as cases of debility, gastritis, anaemia or rheumatism.

4. While some of the mental disorders are directly due to infections, or are associated with chemical or structural changes in the body, in most of the others, however, no such changes can be discovered. They are termed functional and include two of the largest groups of mental disorder, the more severe forms being known as psychoses and the less severe forms as psycho-neuroses.

Schizophrenia (split mind) and affective reactions (mania and melancholia) collectively termed bio-genetic psychoses, account for at least 50 per cent of the admissions to mental hospitals and for at least a third of the permanent, incurable, population of these public institutions.

5. Psycho-neuroses include a variety of forms of mental ill-health, hysterias, phobias, anxiety states, obsessional and compulsive neuroses belong to this group as well as problem children, stammerers, certain classes of delinquents and most of those who used to be diagnosed as suffering from shell shock. Psycho-neurosis also accounts for chronic ill-health in many men and women and for many so-called nervous break down. The psycho-neurotic condition is often of a mild nature and most persons suffering from it do not find their way into hospitals. Psycho-neurosis is the most important single cause for absenteeism in industry, for unemployment and for poor turn over in factories. "Dr Halliday the Glasgow Regional Medical officer of the Department of Health for Scotland under the Insurance Act discovered that out of 1,000 consecutive cases kept away from work for 12 weeks or more, 33.5 per cent were in what was primarily a psycho-neurotic condition. He showed that the majority of those were certified as suffering from organic diseases including gastritis, debility, anaemia and rheumatism. He estimated that the incidence of psycho-neurosis among the employed males was 28 per cent, while it was 37 per cent among the unemployed. Further he showed that in one enquiry of 145 consecutive cases described as rheumatic 39.3 per cent, and in another 62 consecutive cases 37 per cent were psycho-neurotic. In a close investigation of the psycho-neuroses of 21 insured persons he established a definite connection between neurosis and rheumatism. Dr Thomas M. Ling, the Medical Officer of Joseph Lucas Ltd., Birmingham, analysed the case records of 200 consecutive cases of sick employees. He concluded that 27 per cent, who were absent for two or

more weeks, were suffering from psycho-neurosis, the period during which another 32 per cent stayed away from work was prolonged by psycho-neurosis. A series of articles in the first three numbers of Vol. X of the *Human Factor*, the organ of the National Institute of Industrial Psychology, by Dr Garland, provides evidence of a similar character obtained from a factory employing between 2,000 and 3,000 girls. Sir Maurice Cassidy, a consulting cardiologist, has also attributed 29.15 per cent of the cases coming to him to psycho-neurotic causes. It is suspected too, that accident proneness is due to some form of psychological condition. The Industrial Health Research Board, for example, has discovered 75 per cent of the factory accidents generally occur among 25 per cent of the employees. Thus, there are evidently many people suffering from mental ill-health which is never diagnosed. Their health and their work often suffer and sometimes they may be even dangerous to their fellow citizens, particularly if they handle dangerous machinery or drive cars". It is clear that the number of persons suffering from mental disorders or varying degrees of intensity must be much more than those who are admitted and treated in the mental hospital in England.

6. As regards mental deficiency the Joint Committee of the Board of Education and the Board of Control on Mental Deficiency (commonly known as the Wood Committee) gave in its report, which was issued in 1929, an estimate of about 300,000 mental defectives in England and Wales or 8 per 1,000 of the population.
7. It will be seen that varying degrees of mental ill-health and mental instability affect a much larger section of the community than that which the statistics for mental patients suggest. General medical consultants in large cities in America have found not only that 40-50 per cent of their consultations concern psycho-neurotic conditions, wherein no organic pathology can be found, but also that purely psychiatric or emotional factors are estimated to cause 50-60 per cent of physical illness. Asthma, eczema, gastric ulcer, high blood pressure are a few examples. Hence has sprung a new branch of medicine—sycho-somatic medicine. The expenditure on mental hospitals in America is a billion dollar. It has been estimated that, if the time each patient stayed in hospital could be reduced by attention to the emotional factors in physical illness, the annual saving in public expenditure would be several million dollars.

### ***The Result of Treatment***

8. In connection with the general impression that the results of treatment in mental diseases are disappointing, Strecker and Ebaugh (1940) point out that "It is conservatively estimated that between 60 and 75 per cent of the psychoses which are comparable to what a general physician would designate 'acute' are recoverable. Particularly in psychiatry do we meet conditions and situations which are capable of considerable modification in favourable direction even though a complete cure may not be affected. This is particularly true in incipient and early schizophrenia, and the failing to recognise this potentiality made the outlook seem even gloomier than it really is".

In recent years, an increasing number of articles reporting a high proportion of cures, social remissions, and improvements in incurable patients have appeared. Recent progress in the understanding and treatment of mental disorder has been so spectacular that the chances of recovery of a mental patient can be said to be greater than those of a patient suffering from any other illness. The therapies deserving mention are: shock therapy by cardiazol, insulin, continuous narcosis, and exploratory therapy by sodium pentothal, surgical approach to the brain by sectioning the white matter (leucotomy), and the use of penicillin, hormones, vitamins, and direct and indirect psychotherapy.

## **The Present Position in India**

9. The position in India is extremely unsatisfactory. It has been mentioned above that in England, in 1937, the ratio of mental patients treated in hospitals was 3.2 per 1,000 of the population, and in America, the rate has varied from 5 to 8 per 1,000 in different years and in different states. These figures give only a rough indication of the extent of prevalence of mental disorder in the two countries. In India there is no reason to believe that the rate of incidence of mental disorder is in any way less than in England and the United States. While it is true that, in this country, the higher rate of infant mortality and the shorter span of life for the individual should help to produce a smaller proportion of persons liable to adolescent and senile psychoses respectively, there are other factors influencing the development of mental disorder which are operative here to a greater extent than in those two countries. Chronic starvation or under-nutrition, tropical fevers, anaemia and frequent childbirth in women who are unfit for motherhood are responsible for large numbers of mental breakdown in this country. On the other hand, purely sociological causes may not be operative in India to the same extent as in the other two countries.

In view of these considerations, even if the proportion of mental patients in India be taken as 2 per 1,000 of the population, hospital accommodation should be available for at least 800,000 mental patients. On the other hand, there are only a little over ten thousand beds for such patients. The great disparity in respect of mental hospital accommodation between England and India can be shown in another way. In India the existing number of mental hospital beds is in the ratio of one bed to about 40,000 of the population (taking the present population of the country as 400 million) while, in England, the corresponding ratio is approximately one bed to 300 of the population. Thus the provision in India for the institutional care of insane persons is about 130 times less than that existing in England, even if we estimate the rate of incidence of such cases here as about 37.5 per cent less than the rate in that country. As regards the possible number of persons suffering from varying degrees of mental disorder, who may not require hospitalization and yet should receive treatment, and of those suffering from mental deficiency, we have no information of all. It seems however, almost certain that their numbers are likely to run into some millions in this country, if the ratio of incidence in England or America can be taken as even an approximate guide for estimating the numbers of such cases in India. Psychological and medical treatments are necessary for many forms of psycho-neuroses. Mental deficiency will require provision on a wide scale, including special educational facilities and institutional care for children suffering from various forms of this condition and segregation and treatment in institutions for a considerable proportion of mentally deficient adults also. Provision for these two classes of suffering from mental diseases is almost non-existent in India.

In the previous volume of the report dealing with a review of health conditions in India we have already referred to the extremely unsatisfactory conditions of some of the existing mental hospitals which, it will be seen, are altogether too few to meet the requirements of the country. Col. M. Taylor, I.M.S., Medical Superintendent, Ranchi European Mental Hospital, who visited, at our requests, all the major mental hospitals in the country and prepared a report (Appendix 21) for us, says "Every mental hospital which I have visited is disgracefully under-staffed. They have scarcely enough professional workers to give more than cursory attention to the patients". He also states that "Seven of the largest mental hospitals in India have men appointed as superintendents at salaries that a first class mechanic in Tata Work would scorn, six of them have little or no postgraduate experience or training in psychological medicine, and yet these men have been charged with the supervision of large hospitals, and what is more important,



human lives. The deputy superintendents and subordinate medical staff are utterly untrained in psychiatry". The nursing staff and the ward attendants attached to most of those hospitals are, he points out, insufficiently trained and inadequate in numbers to do efficient service. The use of social workers and the provision of occupational and recreational therapies, which constitute important parts of a modern mental health programme, have, speaking generally received quite insufficient attention in this country.

## Our Proposals

10. In putting forward the following proposals we have had the benefit of advice from a small sub-committee, which we appointed, consisting of mental specialists from different parts of India and from Col. M. Taylor, to whose report we have already referred. In our view the most important step to be taken is the formulation of a mental health programme for the country after a preliminary investigation of the needs of individual provinces. Such a programme should aim at providing for the community, in successive stages, a modern mental health service embracing both its preventive and curative aspects. As a part of the implementation of such a programme two of the most urgent need that should be met are (1) an improvement and augmentation of existing institutional facilities for the treatment of mental ill-health and (2) provision for the training of different types of mental health workers, including doctors and ancillary personnel. With these objects in view we make the following recommendations for the short-term programme:

- (a) The creation of mental health organization as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services;
- (b) The improvement of the existing 17 mental hospitals in British India and the establishment of two new institutions during the first five years and of five more during the next five years;
- (c) The provision of facilities for training in mental health for medical men in India and abroad and for ancillary personnel in India; and
- (d) The establishment of a Department of Mental Health in the proposed All-India Medical Institute.

(a) *The creation of mental health organisations as part of the directorate of health, central and provincial*

11. The creation of mental health organisations as part of the establishments of the Director General of Health Services and of the Provincial Directors of Health Services is in our view of such great importance that we have placed it first among our recommendations. The problems of mental health have so far received very little attention in India and we believe that the appointment of officers with a wide experience of modern developments in this field at the centre and in the provinces is essential for carrying out preliminary investigations, the formulation of a sound programme of action and its effective implementation. So little information is available regarding the incidence of mental ill-health in the country and the developments in this field of health administration, even in the more progressive countries, are so recent that we feel we shall not be justified in attempting to make detailed recommendations regarding the mental health organisation which the country requires. We must leave this task to Health Departments with the guidance of the specialists, whose appointment we have suggested.

12. We realise that with the existing lack of medical men with special training in this subject in India, the appointment of separate mental specialists on the staff of the Director General of Health Services and of every Provincial Director may not be easy. We would suggest that a highly qualified person, with wide experience of the different branches of mental health work, should be appointed on the staff of the Central Directorate of Health and that his advice should be made available to the provinces in the development of their programmes. Until officers with similar qualifications become available for appointment in the provinces, we put forward certain suggestions for the interim arrangement. In a number of provinces mental hospitals exist at their headquarters. Bombay and Bengal are two notable exceptions among the major provinces. We are, however, suggesting the establishment of a 200-bed mental hospital at Bombay and Calcutta with the least practicable delay. As has already been pointed out, in most of the existing mental hospitals the superintendents are medical men without any special training in psychological medicine. We would suggest that steps should be taken, without delay, to appoint to these institutions (including the proposed new hospitals at Bombay and Calcutta) fully qualified mental specialists who can perform the dual function of being the superintendent of the mental hospital at the provincial headquarters and of acting as the adviser to the Director of Health Services on mental health administration. We suggest this arrangement only until qualified mental specialists become available in sufficient numbers to permit the appointment of separate whole-time officials on the Provincial Directorates of Health. We believe that the duties in connection with the development of mental health work in a province require the attention of a full-time officer.

*(b) An improvement of institutional facilities for the treatment of mental ill-health*

13. The existing mental hospitals, with the accommodation available in each, and the places where they are located are shown in Appendix 22. We were advised by the special sub-committee that three types of institutions are required for the treatment of mental patients, via, (i) hospitals for general mental patients, (ii) homes for mental deficient and (iii) homes for incurable and for senile cases. It has further been suggested that, normally, the accommodation provided in an institution of each of these types should be 1,000 beds. The staff required and the estimates of cost for each type of institution have been worked out for us by the sub-committee and they are given in Appendix 23. The capital outlay required on each of these types of institutions is estimated Rs 10 lakhs. The annual recurring expenditure per bed is likely to be Rs 1,000 for a mental hospital, Rs 700 for a mental deficiency home and Rs 550 for a home for senile and incurable cases, and the ratio recommended for these three types of institutions is 5:3:2.
14. We are in full agreement with the above recommendations of the sub-committee as the ultimate objectives are to be kept in view. In the meantime, we are putting forward our proposals for the short-term programme taking into consideration the existing inadequacy of training personnel and the possible insufficiency of funds. We suggest that radical improvements should be made in the existing mental hospitals in order to make them conform to modern standards. Provision should be made for all the newer methods of diagnosis and treatment. The idea, which is now widely prevalent that these institutions are asylums and serve mainly the purpose of segregating mental patients from the general community, should be replaced by the conception of a hospital, which provides them with all the medical attention and

sympathetic handling they require for the improvement of their condition. Apart from such remodelling of existing mental hospitals, we also recommend the creation of seven new institutions during the short-term programme, of which at least two should be established as early as possible during the first five-year period. These are the 200-bed hospitals in Calcutta and Bombay to which we have already referred. As will be seen from our proposals for the development of training facilities they are intended to play an important part in the creation of such facilities.

15. The existing seventeen institutions in British India are hospitals for the treatment of mental disorders. As far as we are aware, no homes of reasonable size and with adequate facilities for the reception and treatment of mental deficient and of incurables exist in the country. The need for an expansion of mental hospital accommodation is, under existing conditions, so great that we do not wish to suggest that any of the seven new institutions we propose for the establishment during the short-term programme should be homes of either of these two types. A decision on this matter can, however, be left to the Provincial Health Departments after they have had an opportunity to study carefully the requirements of their provinces and of formulating plans to meet them. As regards the size of the new institutions, we feel that this is also a matter for decision by the Provincial Health Departments. We would, at the same time, suggest for consideration the desirability of limiting their accommodation to approximately 500 beds. Considerations of cost and the need for staffing these new institutions with adequate trained personnel have led us to suggest smaller bed strength of 500 instead of the 1,000 recommended by the sub-committee. For the hospitals at Calcutta and Bombay we have proposed a figure of 200 beds in each case, mainly because of the need for ensuring all possible speed in their establishment in order to develop facilities for training mental health workers. We hope, however, that their expansion may be possible without undue delay.

*(c) The provision of training facilities for medical men in India and abroad and for other types of mental health personnel in India*

16. The urgent need for the training of a large number of medical men and of other personnel for mental health work will be realised from the remarks of Col. Taylor, which we have already quoted, regarding the unqualified staff now employed in many of the existing mental hospitals. Further, any proposals for an expansion of mental health activity can obviously be carried out only if there be a simultaneous execution of an intensive training programme.
17. As regards medical men, the ultimate aim should be to ensure that all those who are employed in mental institutions should possess a recognised Diploma in Psychological Medicine. It is also desirable that the Superintendent, the Deputy Superintendent and Senior Medical Officers in charge of different branches of work in a mental hospital should have a higher degree in Medicine or Surgery, such as M.D. or M.S. A proper clinical background in either of these specialities is of advantage to the medical officer even in the treatment of mental patients, because a differential diagnosis of the condition of many of them may often require as much knowledge of general medicine and surgery as of Psychological Medicine. The possibility of error, with serious consequences to the patient, is great in respect of all who specialize only in their narrow fields. To quote Col. Taylor's words "Every Psychiatrist has seen cases in which eye specialists have tried to correct failing vision by refraction in a patient suffering from General Paralysis of the Insane. Surgeons have frequently been guilty of operations on hysterics

and psychiatrists have called the complaints of patients somatic delusions, until they finally died of cancer”.

18. One of the purposes of the tour, which Col. Taylor undertook at our request, was to make an estimate of existing training facilities in the mental institutions in the country. In his view such facilities exist on a reasonable scale at Bangalore and at Ranchi. At the former, the mental hospital has, he says, all the essentials for treatment and that it “Is recognised as a teaching institution for M.B.B.S., B.A. (Hons.) in Psychology of the Mysore University and the L.M.P. course of the medical school. The hospital is also recognised as a school for postgraduate work and some research work is already being undertaken”. It is reported that the staff as a whole has attained a high standard of efficiency. As regards Ranchi European Mental Hospital already provides a postgraduate course of instruction which includes Psychiatry (clinical and theoretical), Forensic Psychology and Mental Hospital Administration. The instruction covers the ground in Psychiatry only, for the Diploma or M.D. in Psychological Medicine of London. This hospital is recognised as a training school for the Diploma in Psychology by the University of London, and a teaching school for nurses by the Royal Medico Psychological Association. There are no facilities for the study of advanced Anatomy, Physiology, Histology of the Central Nervous System and Experimental Psychology.
19. We understand that nowhere in this country are available all the facilities for the starting of a course for the Diploma in Psychological Medicine. We would suggest that, as early as possible, courses of training for this diploma should be developed in Bombay and Calcutta in association with the universities concerned. We have already referred to the desirability of establishing, as early as possible, a 200-bed mental hospital to help in the provision of such facilities. We understand that, in the vicinity of Calcutta, there is a small mental institution, the Lumbini Park Mental Hospital, which is being managed by the Indian Psycho-Analytical Society. The visiting physicians are reported to be all highly qualified. But owing to inadequacy of funds, the institution is at present being conducted in such a way as to afford no training facilities. Col. Taylor states that “This institution, given adequate funds to meet the cost of expansion on modern line, would in time become both a useful hospital and a good teaching school” and we recommend that this development should be assisted and advanced as early as possible. In Bombay the Child Guidance Clinic of the Sir Dorabji Tata Institute of Social Sciences is said to have made an encouraging start, although the number of children dealt with is small. Col. Taylor reports that “This institution will be of great help in the training of both undergraduates and postgraduates in the study of problem children and child psychology”. Advanced training in such subjects as Anatomy, Physiology and Histology of the Central Nervous System can be provided in the medical colleges in Calcutta and Bombay. We consider that the establishment of a Diploma in Psychological Medicine, with the necessary training facilities at both these places is of the utmost importance. We also suggest that, as soon as possible, similar diploma courses should be developed in the universities of other provincial capital also.

In the meantime it is highly desirable that a certain number of carefully selected medical men, with some experience of work in mental hospitals in India, should be sent abroad for training. We suggest that provision should be made for sending at least 20 doctors during the first five years and another 20 during the second five years of our programme.

20. As regards the training of non-medical personnel, the types of workers required to be trained are occupational therapists, psychiatric social workers, psychologists, nursing staff and male

and female ward attendants. Ranchi already possesses facilities for training occupational therapists. Both at Calcutta and Bombay facilities for the training of psychiatric social workers should be developed. The Sir Dorabji Tata Graduate School of Social Work and the Lumbini Park Mental Hospital, when developed, should be able to participate in such training. The development of facilities for the training of psychologists can, we think, be undertaken in Calcutta where the Applied Section of Psychology of the Calcutta University and the Lumbini Park Mental Hospital can help in such training. The training of nursing staff and of male and female attendants should be undertaken in all mental hospitals in India and the necessary facilities should, we recommend, be developed without delay.

*(d) The establishment of a department of mental health in the proposed All-India Medical Institute*

21. The establishment of a Department of Mental Health in the proposed All-India Institute is calculated to serve at least three purposes. These are:
  - (1) The development of facilities for the undergraduate and postgraduate training of doctors in all branches of psychological medicine and the demonstration to the provincial authorities of the standards to be aimed at, when similar training facilities are created by these authorities with their own territories;
  - (2) The promotion of research in the field of mental health; and
  - (3) Participation in the organisation of a mental health programme for the area in which the institute is located.
22. All the above three purposes are, to some extent, interrelated. No programme for training workers in mental health will be complete without the provision of a field-training centre, while the development of research in this subject also requires such a centre. The active participation of the Department of Mental Health of the proposed institute in the organisation of the mental health programme for the area in which it is located will help to secure the facilities for training and research in the field, the importance of which we have stressed.

***The Promotion of Positive Mental Health***

23. The pursuit of positive mental health requires the harmonious development of man's physical, emotional and intellectual equipment. Measures designed to create and maintain an environment conducive to healthful living and to control the specific causes responsible for all forms of physical and mental ill-health are essential for promoting such development. The comprehensive programme of health reconstruction which we have recommended in this report, will if implemented, constitutes in itself no small contribution to the development of positive mental health in the community. Apart from provision for the prevention and cure of specific forms of ill-health, physical and mental, many of our proposals, e.g. those dealing with health and physical education, the social aspects of our programmes for mothers and children, for the school going population and for industrial workers, the removal of slums and the creation of parks and other facilities for promoting community life should also help to raise the level of mental health in the community.
24. The development of an integrated personality, which will help the individual to adjust himself to the stress and strain of life, is essential if sound mental health is to be achieved and

maintained. The mental health programme, if properly organised, should be able to assist in the endeavour to secure the unhampered development of human personality. Psychologists agreed that the child requires a domestic environment which assures it a sense of security "based upon affection, consistency, fairness, regularity and serenity" if its mental development is to proceed on sound lines. At a later age the child's mental development is also influenced to a large extent by the teacher. An educational campaign for imparting to parents and teachers knowledge regarding the ways in which they can help the normal mental growth of the children for whom they are responsible is an essential part of a mental health programme. Such education will supplement the provision that the mental health service will make through child guidance clinics, to correct unsatisfactory mental or emotional states in children which, if left uncared for, lead to the development of "an aggressive anti-social attitude that is socially destructive or to a regressive attitude which is destructive to the personality".

25. The mental health programme should also include within its scope educational propaganda for the adult. Opportunities for self-expression through work and recreational facilities are of great importance for the maintenance of a man's mental health. He should therefore be encouraged to create for himself as wide a field of cultural activity as is compatible with his main occupation. The development of hobbies helps to keep alive an active interest in life. A cultivation of the love of nature enables the individual to escape from the cramping limitations of his daily round of duties and to obtain, from the changing panorama of nature, refreshment which invigorates him without leaving behind any adverse after-effects. The arts also provide a varied field for self-expression outside a person's normal range of duties.

Economic insecurity probably plays a part in preventing the attainment of full mental health in the case of many adults. The view is widely held that unemployment promotes the incidence of psycho-neurotic conditions and some evidence has been advanced in support of this view. The wider aspects of the social security problem are clearly beyond the scope of our investigation. We may, however, draw attention to the fact that the provision of adequate medical care, preventive and curative for the individual, without regard to his ability to pay for it, is becoming recognised in all progressive countries as part of the National Social Security Programme. We have advocated in this report the adoption in India of this objective of a full and free medical service to all.

### ***Diseases of the Eye and Blindness***

This subject was fully discussed and comprehensive proposals were made in 1944 by a Joint Committee of the Central Advisory Boards of Health and Education. Its report deals with the problem both in its medical and rehabilitation aspects and, as the ground has been amply covered by this Committee in these two fields, we need do no more than commend its recommendations to the earnest consideration of Governments and all organisations, public and private, which are interested in promoting the welfare of the blind and in organising preventive and curative health work for those who are afflicted with eye diseases.

### **Mental Disorders and Mental Deficiency**

#### **Estimate of Persons Suffering from Mental Ill-Health**

140. Conditions of mental ill-health may be divided into two broad groups, (1) mental disorder

and (2) mental deficiency. No estimate of the number of persons suffering from either of these two groups of mental conditions is available for India. It may therefore be of advantage to examine such evidence as is available regarding the incidence of these conditions elsewhere and attempt to draw from it interfaces applicable to this country. In England and Wales there were, at the beginning of 1937, about 129,750 patients under treatment in the mental hospitals maintained by the various local authorities, who are responsible under the law, for making such provision. This figure gives a proportion of 3.2 mental patients per 1,000 of the population. In America the rate of admission to mental hospitals has varied from 5 to 8 per 1,000 in different years and in different States. In India, there is no reason to believe that the rate of incidence of mental disorders is likely to be much less than those for England and the United States. While purely sociological causes may not be operative in India to the same extent as in the other two countries, chronic starvation or under-nutrition, tropical fevers, anaemia and frequent childbirth in women, who are unfit for motherhood, are responsible for large numbers of cases of mental breakdown in this country. Even if the proportion of mental patients requiring hospitalization in India be taken as 2 per 1,000 of the population, their number will be at least 800,000 in the country as a whole. It does not, therefore, seem unreasonable to suggest that the number of persons suffering from various forms of mental disorder must be at least a million in this country.

141. As regards mental deficiency, an estimate of 8 per 1,000 of the population was made for England and Wales in a report issued in 1929 by the Joint Committee of the Board of Education and the Board of Control on mental deficiency. Even if the rate applicable to this country were half this figure, the total number of mental deficient in India as a whole become 1.6 million, on the assumption that the total population is 400 million.

These estimates are only conjectural; nevertheless, they help to indicate the magnitude of the problem that mental ill-health constitutes in the country and the extent to which remedial and preventive health measures will have to be developed, if adequate provision for this section of the community is to be made.

### ***Provision for the Treatment of Persons Suffering from Mental Disorders and Mental Deficiency***

142. In Chapter III of this volume we have shown how the existing provision for medical relief and preventive health work in connection with the common forms of sickness is quite inadequate to meet the needs of the people. For mental patients the available facilities are of a still lower order. In this connection it may be mentioned that, at our request, Col. M. Taylor, Medical Superintendent, Ranchi European Mental Hospital, undertook a tour of the most important mental institutions in the country and prepared a report for us. It has been published as Appendix 21 in Volume III of this report. He has shown that the functioning of existing mental institutions is, in most cases, far from satisfactory. A list of these for British India, with the accommodation available in each, and the places where they are located is given in Appendix 22. The total accommodation available is about 9,889 beds and, if the states are also included, 10,189. When it is remembered that the probable number requiring institutional care may, on a conservative estimate, be at least 800,000 to 1,000,000 for the country as a whole, the inadequacy of the existing number of beds becomes unmistakably clear.

## A List of Special Hospitals and Other Institutions

S.No.	Province	Maternity Child Welfare Centres		Eye Hospitals		Mental Institutions		Tuberculosis				Leprosy Institutions		Infectious Diseases Hospitals		Venereal Diseases Hospitals	
		No.	Total maternity beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds	No.	Total beds
1	Assam	—	—	—	—	1	716	1	28	—	—	10	98	3	—	—	—
2	Bengal	37	821	1	139	2	115	2	51	3	318	27	247	6	585	1	18
3	Bihar	21	352	—	—	2	1,651	—	—	—	—	10	97	8	2,178	1	36
4	Bombay	118	—	3	3	5	2,259	8	593	5	239	15	202	13	1,625	3	424
5	Central provinces & Berar	83	323	—	—	1	600	1	151	—	—	7	91	9	2,202	2	28
6	Delhi	34	—	1	74	—	—	—	—	1	96	1	8	1	—	1	45
7	Madras	—	—	1	170	3	1,416	5	513	1	62	17	400	12	2,902	3	210
8	North-west frontier province	—	—	—	—	1	140	—	—	—	—	6	152	—	—	—	—
9	Orissa	39	97	—	—	—	—	—	—	—	13	2	483	—	—	—	—
10	Punjab	106	345	—	—	1	1,408	9	654	3	163	14	348	6	871	—	—
11	Sind	5	—	2 hospitals and 2 mobile institution	—	1	348	2	123	—	—	—	—	1	175	1	—
12	United Provinces	—	—	6	426	3	1,356	5	295	—	—	8	184	16	1,223	16	—



143. Apart from this, however, an even more important fact is that the existing institutions are working at an extremely low level of efficiency. Col. Taylor says, "The majority of the mental hospitals in India are quite out of date, and are designed for detention and safe custody without regard to curative treatment. The worst of them—the Punjab Mental Hospital, the Thane Mental Hospital and Nagpur Mental Hospital—savour of the workhouse and the prison and should be rebuilt".
144. As regards the medical staff employed in them he states that "Seven of the largest mental hospitals in India have men appointed as superintendent at salaries that a first class mechanic in Tata Work would scorn, six of them have little or no postgraduate experience or training in psychological medicine". The subordinate medical staff are also untrained in psychiatry. The number of medical men employed is quite inadequate. He rightly points out that, with one medical officer for 200 patients, only cursory attention can be given to the patients, while the additional duties they are required to perform are also carried out in a perfunctory fashion.
145. The position as regards nursing staff and ward attendants is equally unsatisfactory in most of these mental institutions. Inadequacy of number and insufficiency of training both contribute to make the standard of service of an extremely low order.

We do not propose to describe in detail individual institutions. For such details reference may be made to Col. Taylor's report.

### ***Facilities for Mental Training for Medical and other Personnel***

146. From what has been said above it will be clear that the need is urgent for providing training facilities for medical and non-medical personnel on as extensive scale as possible. The staffing of existing institutions with qualified workers and an expansion of mental health activity in institutional and other fields will become possible only with a large output of trained personnel. At the same time it will be recognised, from the brief description given above of the working of existing mental institutions that the large majority of them are ill equipped to discharge teaching functions properly. One of the purposes of the tour, which Col. Taylor undertook at our request, was to make an estimate of existing training facilities in the mental institutions in the country. In his view such facilities exist on a reasonable scale at Bangalore and in Ranchi. At other places, e.g. Calcutta and Bombay, a considerable improvement of certain existing institutions and the establishment of well staffed and satisfactorily equipped mental hospitals will be necessary to provide the conditions essential for developing them as proper training centres. These and other matters relating to the creation of training facilities in different parts of the country will be considered when we put forward our proposals for mental health services in the second volume of this report.

## **Appendix 21**

REPORT BY COL. M. TAYLOR, O.B.E., M.D., D.P.H., I.M.S., ON HIS TOUR OF MENTAL HOSPITALS AT THE REQUEST OF THE HEALTH SURVEY AND DEVELOPMENT COMMITTEE

### **Calcutta**

I commenced my tour on 30<sup>th</sup> December 1944, in order to meet Dr. G. Bose, in Calcutta, as he intended leaving the city on 1<sup>st</sup> January 1945 for some weeks.

In Calcutta, I visited and inspected the following:

- (1) Lumbini Park Mental Hospital and Clinic.
- (2) The Mental Hospital for Male Patients at Mankundu.
- (3) The Mental Hospital for Female, 78, Lower Circular Road, Calcutta.
- (4) The Observation Ward, Bhawanipore.
- (5) The Outdoor Neuro-Psychiatric Clinic, Carmichael Medical College, Calcutta.
- (6) The Outdoor Neuro-Psychiatric Clinic, Medical College Hospital, Calcutta.

### ***Lumbini Park Mental Hospital, Calcutta***

This institution is managed by the Psycho-Analytical Society. The daily average number of in-patients treated is 20 (male 14, female 6). During the period of 5 February 1940 to 31 December 1941, a total of 175 new mental cases attended the Outdoor Clinic.

The Outdoor Clinic at Lumbini Park Mental Hospital is also open to General Patients (8,191 was the total number attending from day to day during the period of 5 February 1940 to 31 December 1941).

There are two Resident Physicians, respective salaries being Rs 100/- and Rs 75/- per mensem, and a number of honorary visiting physicians who attend for a total of 14 hours per week. The work of the outdoor clinic and routine work can leave very little time at the disposal of the resident physicians for ward work, and the salaries paid to the Nursing Personnel would indicate that the nursing care cannot be of a very high standard.

The Senior Nurse receives a salary of Rs 20, and the three remaining members of the Nursing Staff receive salaries at the rate of Rs 15 per mensem, plus food and lodging. Sixteen male attendants receive salaries at Rs 25, and five female attendants Rs 10, plus food and lodging.

It is stated in the report from 5 February 1940 to 1 December 1941 that "for want of funds trained nurses cannot be employed to look after the patients".

The rates for indoor patients are as follows:

<i>Rate</i>	—	<i>Rs</i>
(i) First Class Bed	—	300 p.m.
(ii) Second Class Bed	—	200 p.m.
(iii) Third Class Bed	—	150 p.m.

and "a special charge shall be made if special nursing has to be arranged for; this shall only be done with the written sanction of the guardians; the charge for the special nurse shall be paid in advance. Special medicines will also be charged for at cost price".

The rates at the European Mental Hospital, Ranchi are as follows:

<i>Rate</i>	<i>Rs</i>
* (i) First Class (inclusive of three private attendants)	300 p.m.
* (ii) Second Class (inclusive of two private attendants)	200 p.m.
* (iii) Third Class	46 p.m.

with European diet, all drugs and no charge for extras.

\*In (i) and (ii) the guardians are called upon to meet the cost of "Dearness Allowance" to the private attendants at the scale as sanctioned by Government.

It is obvious that (apart from the one free bed) Lumbini Park Mental Hospital cannot, at present, be widely patronized by the general community.

Owing to the small numbers the *per capita* rate is extremely high—viz., Rs 2,091 per annum.

It has been pointed out that the visiting physicians, who are all highly qualified, spend a total of 14 hours per week in the hospital. This can scarcely be considered adequate for specialised treatment. One of the honorary physicians is an M.R.C.P.E., D.P.M., but he visits one day per week for two hours. Honorary Physicians are, as a rule, very jealous of their prerogative but take their responsibilities lightly.

The equipment is neither extensive nor modern, and the environment of the hospital leaves much to be desired. There is little provision for diversion, occupational therapy or rehabilitation.

The institution to all intents and purposes is a Private Home, and hampered as it is by its extensive Outdoor Clinic for general patients, and lack of funds, it cannot be considered a satisfactory institution for the treatment of mental patients. As at present conducted, I do not rate the facilities for training very highly. This institution, given adequate funds to meet the cost of expansion on modern lines, would, in time, become both a useful hospital and a good teaching school.

### ***Mankundu Mental Hospital, Calcutta***

The male section of this hospital is situated at Mankundu, about 22 miles from Calcutta City, and the female section at 78, Lower Circular Road, Calcutta.

The daily average number of patients in both sections is 56 (male 43, female 13).

The aim of this institution according to the prospectus are: -

- (1) To provide for up-to-date institutional treatment of mental cases, and to place the same within the reach of the Indian masses.
- (2) To provide facilities for training in, and research in psychiatry and psychological therapy.
- (3) To train up nurses for attending to mental cases.

The lack of funds has, so far, prevented these aims, and all that can be said for the institution, at present, is that even the standard of custodial care cannot yet be considered satisfactory.

In the male section at Mankundu, the buildings are good, but in a very bad state of repair, and the compound (there is no Mali) is an absolute jungle. I found the patients under poor control, and the whole atmosphere of the hospital was most depressing.

### ***The Mental Hospital for Females***

The female section (75, Lower Circular Road, Calcutta) is located in a rented house, not very suitable for the purpose, but the patients appeared to be happier and better cared for.

I gained the impression that the Nursing Personnel in both sections was of poor quality and totally inadequate.

Here again, there is an imposing list of Visiting Physicians. Their hours of attendance are not specified, but the state of the institution, as a whole, reflects no credit on any one. It stands as an indictment to Bengal.

The Chief Medical Officer and the Secretary to the Court of Governors of this hospital, who accompanied me on my visit, are well aware of the limitations of this Institution, as is the Court of Governors. The Court has appealed to Government for financial aid, and they have offered to hand over the institution to the control of Government. If financial aid is not forthcoming the Court envisages the early closure of this hospital. The buildings and land were a gift, but, as is usual with such gifts, carry no endowment.

The Court of Governors in 1941 appointed a sub-committee to enquire into the management of this hospital. The following are some extracts from the report of the sub-committee:

“While paying our highest compliments to the Founder Secretary for his bold and single-handed efforts, we cannot but state that the hospital has, so far, been working with thoroughly inadequate equipment”.

“It seems that the authorities of the hospital had no idea of the eminence which this institution was destined to rise to in so short time. Considering the difficulties of managing mental patients in private homes and the hardship entailed in securing accommodation in the Ranchi Hospital (Indian) where the accommodation is scarcely sufficient for Criminal Lunatics— it is no wonder that the first non-official attempt in this line was kindly received, leniently judged and eagerly availed of by the public. We hold, however, that the hospital should be properly equipped without further delay”.

I enclosed the comments of this sub-committee with regard to the Founder Secretary, whom I had the pleasure of meeting, and I would also pay a tribute to the medical men who have attempted the impossible with meagre resources at their disposal and the numerous handicaps with which they had to contend. The results attained, in spite of the very formidable obstacles, reflect credit on the entire staff. They have, in a small measure, assumed a responsibility which Government and the Corporation have, so far, shirked.

Fifty per cent of the patients in this hospital are non-paying, and the maintenance charges for paying patients are much less than at Lumbini Park.

The attending physicians receive travelling allowance only, while remuneration of the nursing staff and attendants is rather less than is normally paid to menials.

Until adequate funds are available for vast improvements in the building, adequate whole-time qualified personnel, and modern equipment, this institution is neither in a position to render modern treatment in the psychoses nor to afford any facilities for teaching in psychiatry.

### ***Mental Observation Ward, Bhawanipore, Calcutta***

This institution receives Magistrates' cases, and patients for observation sent by the police authorities.

The superintendent is the professor of Medical Jurisprudence in the University, and, *as a side-line*, he is Lecturer in Mental Diseases. The buildings are first class, in very good order (rather overdone with massive iron bars) and located in a central area of the city. There are 30 beds, and the daily average number of patients is 10.

It is here that the undergraduates receive their instruction in psychiatry (ten lecture demonstrations), and to augment the clinical material, twelve patients are transported from the Indian Mental Hospital, Ranchi. The patients so transported are classified into three groups: -

*Group I. Idiocy (1), Imbecility (1), Obsessional Neurosis (1), G.P.I. (1)*

*Group II. Mania (2), Melancholia (1), Dementia Paranoides (1)*

*Group III. Dementia Praecox (Schizophrenia) (1), Paranoia (1), Confusional Insanity (1), Drug Psychosis (1).*

The training of the Calcutta undergraduates in this most important branch of medicine is totally inadequate. The students are merely being exploited. The first essential step would be to divorce Psychiatry from Medical jurisprudence and appoint a Psychiatrist as Lecturer, and the second, and more important, the provision of suitable clinical material.

I am of the opinion that this institution could be modernized at a small cost and could more efficiently contribute to psychiatric education. I suggested to the Surgeon-General that it would make an admirable Psychiatric Unit, with out-patient department and beds. The Surgeon-General agreed.

### ***The Psychological Clinic, Carmichael Medical College, Calcutta***

This clinic is open from 8 a.m. to 10 a.m. on Tuesdays and Thursdays—Outdoor patients only.

Dr G. Bose is in charge of the Clinic and is assisted by Dr. Nagendranath De, M.B., D.T.M. (Cal.), M.R.C.P.E., D.P.M (Lond.), and Dr S. Banerjee, B.Sc., M.B. (Cal.), D.P.H. (Lon.).

During 1943, 57 new cases from Calcutta and 17 from the moffussil received treatment at this Clinic, and 17 old cases from Calcutta and 5 from the moffussil also attended. The total number of patients receiving treatment during 1943 was 96, the average daily attendance was 4 (1 new, 3 old cases), and included psychoneurotics and psychotics.

The total expenditure for the year amounted to Rs 42-2-0.

Clinical lecture and demonstrations were held regularly for senior students of the Carmichael Medical College and postgraduate students of the Department of Psychiatry, University of Calcutta.

### ***Clinic for Neurology and Psychiatry, Mental College Hospital, Calcutta***

PHYSICIAN IN CHARGE: Dr Chandra Saha, M.Sc., M.B., D.T.M.(Cal.), F.R.F.P.S. (Glas.), M.R.C.P (Lon.).

This clinic opened in July 1937, closed in December 1941, re-opened in July 1943, closed again 1943, and again re-opened in March 1944.

As will be seen, this Neuro-Psychiatric Clinic has had a chequered career, and in his report of 1942, the Physician-in-charge states “for want of beds and rooms, special methods of treatment and investigation cannot be undertaken”.

When this clinic did function, the daily average number of patients was, new cases 1.8, old cases 4, in the proportion of two Psychiatric to one Neurological case.

The Physician-in-charge rightly states that the clinic is still in its embryonic stage, and he has a scheme for further development.

The Principal of the College is against Neuro-Psychiatric Clinics, and considers there should be separate Neurological and Psychiatric Clinics. The consensus of present-day opinion is in favour of the Principal's views.

Both clinics are poorly equipped, and conducted entirely by Honorary Physicians, a subject which I shall deal with later.

While in Calcutta I took the opportunity of calling on the Surgeon-General with the Government of Bengal, the Secretary, Public Health and Local Self-Government, Government of Bengal, and the Registrar, Calcutta University. I also made contact with many other gentlemen, including the Professor of Physiology, Medical College, but space is too short to give details of all discussions. They will be embodied in my general remarks.

I left Calcutta; having formed the opinion that the mental hospitals and clinics, which I visited there cannot be considered satisfactory, and are far below the standard which one would expect to find in University city.

There is a crying need for a modern Mental Hospital for Indians in Calcutta of at least 250 beds—both in the interests of the community and the university. The bulk of the clinical material passes to the Indian Mental Hospital, Ranchi, and it is not feasible either to send a large number of patients from Ranchi to Calcutta, or to send medical students to Ranchi.

The question of expanding and modernizing the existing Mental Hospitals in Calcutta would be a matter for the Bengal Government; it is advisable that institutions where a teaching programme is carried out should come entirely under Government control and supervision.

It would be more economical, and would lead to greater efficiency, to build in Calcutta a modern Mental Hospital of 250 beds on a suitable site, with a view of possible later expansion to 1,000 beds.

A need which is equally urgent is a home for mental defectives of at least 200 beds.

If the climate of Lahore, Bombay, Agra, Nagpur, Madras is not considered a bar to the erection of mental hospitals, then the project is feasible in Calcutta, and should be seriously considered before further expansion programmes are undertaken at Ranchi.

## **Madras**

In Madras, my programme included visits to the following:

- (1) The Government Mental Hospital.
- (2) General Hospital, Madras.
- (3) The Madras University.
- (4) The Madras Medical College.
- (5) The Stanley Medical College.
- (6) Nursery Schools and Montessori Schools.
- (7) The Children's Aid Society.

### ***The Government Mental Hospital***

The hospital is built over a large area (approximately 60 acres), and there is ample ground space and playing fields. The buildings are good and are kept in a good state of repair.

The daily average number of patients during 1943 was 1,233 (male 861, female 362). There are no criminal patients.

The hospital is grossly overcrowded, and only a small percentage of the patients have cots. Some of the best wards are at present requisitioned for A.R.P. work.

In spite of this, the custodial care is of a reasonably good standard (by the term "Custodial Care" I mean the orderly and systematic methods by which physical, recreational, and hygienic activities are regularly carried on).

The Medical Superintendent holds the degree of M.B.B.S. (Madras), and has been on the staff of the hospital for 14 years; the members of the medical staff are temporary, and belong to the general service cadre and are not highly qualified.

The Deputy Superintendent who had been on the staff for 2–8/12 years informed me that he was working in the Mental Hospital merely "because he had been posted there", and he sounded as if he had a grievance.

Of the seven Medical Officers one holds the M.R.C.S., L.R.C.P. and L.M.S.S.A. (Lon.), and six are L.M.Ps. There are two women apothecaries. The medical superintendent says he is handicapped by continual changes in the medical staff. The Deputy Superintendent with 2–8/12 years service holds the longest record of service of the present staff.

The Medical Superintendent has had no postgraduate courses of instruction, and the standard of psychotherapy can well be imagined. The medical staff is barely sufficient to give proper medical and surgical care to all the patients who develop acute or chronic physical disease during the course of their psychoses. The ratio per cent discharged recovered to daily average strength is 10.79, and the ratio per cent of cases recovered to direct admissions is only 12.20. These figures indicate that detention rather than therapy is the main function of this institution.

The Medical Superintendent is responsible for the training of undergraduates from the Madras, Stanley and Missionary Medical Colleges. There are four courses (12 lectures and demonstrations) per annum; the average number of students attending each course being 35. The number of students receiving instruction is therefore 140 per annum.

I am of the opinion that this responsibility is too heavy for the present Superintendent, who has no clinical or postgraduate experience outside the Madras Mental Hospital. I understand the Madras Government proposes to press for the release of the permanent Superintendent who is at present serving as a Psychiatrist in the Army, and I consider that this is an urgent necessity.

There are no Outdoor Psychiatric Clinics at any of the Madras Hospitals, and this is well, for there are no officers with the qualification and experience to conduct such clinics.

There are at present no facilities in Madras for postgraduate training in Psychiatry. I shall return to this subject in my general remarks. Let me, however, quote Lt. Col. G.R. McRobert, I.M.S., Professor of Medicine, Madras, one of the ablest men in the medical profession in India today, in an address he delivered recently before the Council of Postgraduate Medical Education of the University of Madras:

“For diseases of mind we have not in the whole Madras Presidency, with its teeming millions, and vast amount of mental disorder and psycho-neuroses, a single Mental Expert, technically qualified to teach even up to the pass M.B. standard, is far less to instruct specialists.”

The Social Services which I was invited to visit in Madras are still in the pioneering stage. They included the Children’s Aid Society, Egmore; the Madras Vigilance Association, Mylapore; the Nursery School Projects (Vepery Nursery School); and one of the Montessori Schools. They are no doubt being conducted conscientiously by persons who are trying to do job to the best of their ability, but they lack that psychiatric background which makes for efficiency. There will be no coordination in these Social Services until Madras has an organized Mental Health Service. Efficiency is not possible until an adequate number of trained psychiatrists and psychologists is available.

I do not believe that psychiatry is the answer to all problems in life, but there is no doubt that a psychiatric approach to the understanding of human behaviour should be made to an increasing extent by all workers in the fields of physiological, social and psychological maladaptation.

## **Bangalore**

My programme here included visits to the following:

- (1) Government Mental Hospital.
- (2) Government Medical Schools.
- (3) Government General Hospitals.

And I had interviews with the Senior Surgeon (the Administrative Medical Officer, Mysore Government), the Residency Surgeon and some of the teaching staff at the General Hospitals.

### ***Mysore Government Mental Hospital***

After the depressing experience at the Mental Hospitals in Calcutta and Madras, it was a real pleasure to visit the Bangalore Mental Hospital. The hospital is comparatively new (1937), and has been planned on the villa system, the latest design for mental hospitals. The spacious lawns and gardens are well kept.

Accommodation is available for 300 patients (male 200, female 100). The pavilions for male and female patients are self-contained, and arranged in a square quadrangle, with units of 4 to 20 patients. There are single rooms (rather small) in each pavilion, which are intended for boisterous patients.

Special rooms are provided for paying patients, and some cottages are available for well-to-do patients.

All the essentials for modern treatment are present in this hospital – modern Hydrotherapeutic Units, a well-equipped Operation Theatre, a Psychological Laboratory, conducted by a full-time qualified Psychologist, a useful Occupational Therapy Department, a Club and Diversional, Therapy Units, excellent Surgical and Laboratory Equipment, and extensive Fruit and Vegetable Garden, where patients so inclined can occupy themselves.

Electro-convulsive Therapy apparatus and an Encephalography Unit will be installed as soon as they are available in the market.

The hospital is supervised by two Boards of Visitors, one, composed of State Officials, deals with the interests of Mysore State patients, the second, composed of Magistrates, Medical Officers of important hospitals, and a few non-officials, looks after the interests of civil patients (non-Mysore) and patients from the military area.

The Hospital receives paying patients from any part of India, provided there is a reasonable expectation of recovery.

Patients are to a large extent selected, and, in the circumstances, the recovery rate to direct admissions exceeds 40 per cent. This high recovery rate is the best indication of the standard of treatment.

The types of patients undergoing treatment in this hospital include the Schizophrenic-Paranoid Group, the Affective Group, the Organic Reaction Group, the Psycho-Neurotic Group, Epilepsy, Pre-senile, Senile and Arterio-Sclerotic Dementias, and Mental Deficiency.

The clinical material is ample, both for undergraduate and postgraduate teaching.

The hospital also conducts a daily Out-Patient Department, where psycho-neurotics and patients who do not require hospitalisation, and those who have been discharged but need continuation of treatment are attended.

In addition to the above class of patients, many cases are referred to this clinic for opinion where a psychological basis for physical symptoms is suspected. Problem Children, Delinquents, Dull and Backward Children of various grades and types, and children suffering from speech defects, etc., are also treated. The number of out-patients (new and old) attending the Out-Door Clinic during 1943 was 5,242, and during the same period 705 adults and 162 children were examined in the Psychological Laboratory. The Psychologist hopes for additional equipment in the near future, and plans for the extension of buildings are already in hand. The extension will include a Research Laboratory and a Neurological Laboratory.

The case records are admirably maintained, and clinical assistants and students have an excellent opportunity of a detailed study of cases placed at their disposal.

The hospital is recognised as a teaching institution for the M.B.B.S. and B.A. (Hons.) in Psychology of the Mysore University, and the L.M.P. course of the Medical School. The hospital is also recognised as a school for postgraduate work and some research work is already being under taken.

The staff as a whole gives the impression of a high standard of efficiency.

The hospital, at present, is well adapted for both undergraduate and postgraduate teaching, but caution is necessary. The Medical Superintendent is a highly trained and experienced teacher and clinician, but there is no Deputy Superintendent and under-study. The Superintendent is on a ten-year contract which is completed in March 1945. It is doubtful if he will remain in the service of the Mysore Government, and the scale of pay is so inadequate that it will never command the services of a man of comparable ability to the present Superintendent. In short, the Bangalore



Mental Hospital is a 'one man show' ran by Dr Govindaswamy. If Dr Govindaswamy leaves Bangalore, the Mental Hospital will deteriorate, and the teaching facilities will disappear.

There is an adequate staff, on a poor scale of pay. My remarks on Nursing Personnel apply equally to this institution as to all the others visited.

I would offer the following criticism on the layout of the Bangalore Mental Hospital. The residential quarters are much too near the hospital wards. The residence of Medical Superintendent is less than stone's throw from the residence of some of his subordinates. Bangalore Mental Hospital might well be accepted as model, but these defects should be avoided in the erection of new hospitals.

## Poona

At Poona, I visited the Central Mental Hospital and the Medical School Hospital, and had interviews with Lt. Col. B.Z. Shah, I.M.S. (Retd.), Medical Superintendent of the Mental Hospital, and Lt. Col. S. Prall, I.M.S., Civil Surgeon and Superintendent of Medical School Hospital.

### *Central Mental Hospital, Poona*

This institution is situated at Yeravda, about 7 miles from Poona City, and is conveniently within reach of the students of the Medical School. I understood the Poona Medical School will be upgraded to the status of a College in the near future.

The authorised accommodation is as follows:

	Male	Female	Total
Europeans	141	74	215
Indian Section No. 1	124	127	251
Indian Section No. 2	456	178	584
Acute Section	34	11	45
Infirmery	79	83	132
Total	784	443	1,227

The daily average number of patients during 1943 was 1,326 and since the authorised scale, according to floor spaces, is none too generous, this hospital can, at present, be described as overcrowded.

During 1943 there were only 21 voluntary patients.

Occupational Therapy has been restricted owing to the difficulty in procuring raw materials, and Diversion Therapy for all patients has not been possible owing to lack of funds.

The total annual expenditure (1943) was Rs 4,90,927; the amount received from paying patients was Rs 1,47,627, so that the total cost falling on government amounted to Rs 3,43,300.

The annual total *per capita* cost in 1943 was Rs 368.28, and it can therefore be assumed that in normal times the *per capita* cost was much less than one rupee per day.

*Staff:* The Superintendent, due to the present emergency, is a retired IMS officer who does not profess to be a Psychiatrist, and the remaining members of the professional staff lack experience in psychiatry.

In 1942, the ratio per cent of patients discharged recovered to direct admissions was 15.89. This is very satisfactory figure considering that the hospital has insufficient medical staff to give more than cursory attention to patients.

This institution could be converted into a first class Medical Hospital with very little expenditure. The buildings are good, well kept, and suitable. Some of the massive iron bars might well be removed.

The equipment in all departments is poor, but this can quite easily be remedied as funds become available. The outstanding deficiencies in this hospital are the lack of trained psychiatrists and trained nurses, and the Bombay Government will have to work on the theory that more and better trained personnel is the urgent need of the Central Mental Hospital at Poona.

Eight lectures, with demonstrations, are given to the students of the B.J. Medical School, Poona, by the Medical Superintendent and, with the present staff, this hospital is quite unable to extend its teaching burden to include either M.B. students or Postgraduate.

There is no Psychiatric Clinic at the B.J. Medical School Hospital, and at present there is no scheme to include one in the near future.

## **Bombay**

My programme in Bombay included interviews with the Surgeon-General, the Registrar of the University, the Dean of the Medical Faculty of the University, the Dean of Seth G.S. Medical College, the Principal of Grant Medical College, the Hon. Psychiatrists, Grant Medical College, and the Hon. Lecturer in Psychiatry, G.S. Medical College, and others.

I visited the Psychiatric Clinic, J.J. Group of Hospitals, the N.M. Mental Hospital, Thane, the Indian Institute of Psychiatry and Mental Hygiene, and the Child Guidance Clinic, Sir. D.J. Tata School of Social Work.

### ***Thane Mental Hospital***

This institution is situated about 20–23 miles from Bombay. Although not very old (1901) it cannot be described as a modern Mental Hospital. Its present function is very obviously one of segregation rather than of active therapy.

The daily average number of patients during 1944 was 500.2—a number considerably in excess of the authorised scale. The ratio per cent of patients discharged recovered in direct admissions during 1944 was 20, a figure which reflects credit on the Superintendent and his staff.

The number of voluntary patients in 1944 was 40, and the daily average number of criminal patients for the same period was 32.5.

There is, I understand, a scheme for improving the present hospital, or alternatively to erect a new Mental Hospital. The latter alternative seems the better, but with a programme for a Postgraduate course in Psychiatry and a large number of Undergraduates in Medicine, it would be worthwhile considering the erection of modern Mental Hospital on the same line as the Mental Hospital, Bangalore, of about 250–300 beds, and on a site accessible to both teachers and students. Almost a whole forenoon or afternoon is expended in travelling to and from this institution by those attending demonstrations.

The Out-Patient Psychiatric Clinic, J.J. Group of Hospitals, is under the direction of Dr Masani, the Hon. Psychiatrist, who holds a D.P.M. There are 4 beds allotted for in-patients, and the average number of patients said to attend the Outdoor Clinic is 12. The clinic functions twice weekly, and the Physician's sessions extend from 2 to 3 hours. The clinic is poorly equipped, and the House Physician (who is shared by the T.B. Clinic) is studying for his M.D. degree in Midwifery and Gynaecology.

Students for the M.D. degree attend this clinic for 7 or 8 sessions; they have 14 lecture demonstrations at the Grant Medical College, and five demonstrations at the Thane Mental Hospital. The Hon. Physician's suggestions to increase the lecture to 50 will, no doubt, be strongly opposed, in view of the already overloaded curriculum.

### ***Seth G.S. Medical College***

There is no regular outdoor Psychiatric Clinic and no beds allotted for Psychiatric cases. The Hon. Lecturer in Psychiatry visits when called upon. He is M.B.B.S. (Bombay), and did an extensive postgraduate course (18 Months) in the U.S.A. His visits average two per week, and the number of patients seen average two per week.

I have studied very carefully the syllabus for the Diploma of Psychological Medicine of the Bombay University and I have had lengthy discussions on it with the Surgeon-General, Bombay, the University authorities, and the two Physicians on whom will fall the burden of teaching in Psychology and Psychiatry.

I did not discuss the teaching of Anatomy and Physiology of the Central Nervous System. There is no Psychological Department in the University, and the two Hon. Physician-Lecturers will have no Psychological Laboratory at their disposal. The outdoor Psychiatric Clinics are poorly equipped for teaching purposes, while the Mental Hospital at Thane cannot be described as of a very high standard.

The Bombay Diploma in Psychological Medicine requires no training in Experimental and Practical Psychology, but I cannot see how Psychology can be taught in a scientific manner without a Psychological Laboratory, and a well-equipped Psychological Department.

Psychiatry cannot be learned from books and didactic lectures. It must come as a result of actual contact with patients. Theories may be discussed in the classroom, but when we attempt to fit them to conditions as they are, something is missing, and that something is skill and understanding which can only be acquired through the medium of clinical experience. I am definitely of the opinion that teachers in Psychological Medicine must have long experience of full-time clinical work in mental hospitals. This is particularly important in postgraduate instruction.

I have discussed this question in some detail. I would remind the Committee that I am discussing Principles and not individuals, and with the present facilities for teaching I cannot be convinced that the standard of the Diploma in Psychological Medicine, Bombay will be very high, and I believe most of the authorities I have interviewed take this logical view also.

I do not suggest that the scheme be dropped. On the contrary, beginning must be made some time, but the authorities must press on schemes, which will ensure better facilities for training.

The Superintendent, Thane Mental Hospital, has shown me Plans for a new Mental Hospital, and has given me a note embodying his suggestions for improvements. The document is too lengthy and in too great detail for inclusion in this report, but I have suggested that it should be forwarded to the proper authorities for careful consideration.

It would be more convenient for teachers and students if a site for a modern Mental Hospital could be found nearer the medical schools.

The Travelling Allowances granted to the Honorary Physicians permit them to visit the Thane Mental Hospital once per week, occasionally twice. It takes approximately  $2\frac{1}{2}$  to 3 hours in travelling, and therefore the time at their disposal for Psychotherapy and Clinical Study can be but limited. Teaching at Thane Hospital should obviously be the entire responsibility of the Superintendent of the Mental Hospital.

### ***Social Services in Bombay***

A creditable start has been made, and I was greatly impressed by the work of the Child Guidance Clinic of the Sir Dorabji Tata Institute of Social Sciences. The number of children dealt with is small. During 1939, the number of new cases admitted was 63, and 11 old cases remained from 1938. In spite of these small numbers, this institution will be of great help in the training of both undergraduates and postgraduates in the study of Problem Children and Child Psychology.

In the latest published report (1939) it was claimed that " the results of the work were gratifying, taking into account the extreme infancy of the clinic, and the shortage of trained staff". This has been the usual experience of most clinics. Further development of this Child Guidance Clinic will bring forth well-trained psychiatric social workers, who will be capable of treating the family members, while the psychiatrist works with the patient.

## **Nagpur**

I visited the Nagpur Mental Hospital, the Mayo Hospital and had discussions with the Inspector-General of Civil Hospitals, the Superintendent, Medical School, and the Superintendent of the Mental Hospital.

### ***The Nagpur (Central Provinces and Berar) Mental Hospital***

The Medical Superintendent (Dr J. Roy, M.B., D.P.M.) handed me a note with " certain suggestions regarding the Post-War Reorganisation Scheme about medical relief and health development". These are of interest and I shall enumerate some of them briefly. He says:

- (1) "It is not known definitely whether the Medical Relief Advisory Committee of the Health Survey and Development Committee will advise the Central Government to consider 'health problems and its development' as an All-India problem or whether the Government of India will decide to leave these problems for the consideration of Provincial Governments for necessary action. If it is the latter, then it must be admitted that there will be no uniformity in the execution of the scheme, as some of the provinces may not be in a position to give effect even to the most urgent needs on account of their financial position."

I agree entirely.

- (2) He recommends the creation of a Mental Health Service as in the United Kingdom or United States of America and advises:
  - (a) Compulsory primary education of the right type.
  - (b) Creation of a Mental Health Service consisting of psychiatrists, psychologists and trained social workers.
  - (c) Systematic psychometric investigation of all school-going children and necessary gradation as regards their capability to pursue different vocations. This implies specially trained vocational and industrial psychiatrists.
  - (d) Creation of separate and independent chairs in psychiatry and psychology in all the universities. There must be undergraduate and postgraduate courses.
  - (e) Psychology and principles of Psychological Medicine must be included in the curricula of medical education.
  - (f) Children's Clinics must be as widespread as possible.

He is also strongly advocates that the health problem (both mental and physical) be treated and dealt with as a central subject by the Central Government to ensure uniformity, as otherwise, it is just possible that some of the Provincial Governments may find it beyond their financial resources to give full effect to the scheme for which grant of a subvention might become necessary.

It is not possible to enumerate all of Dr Roy's observations. The above would be the ideal, and in due course will be practicable, but it is more than a quarter of a century since the United States of

America and United Kingdom took up mental health problems, and since the subject has, so far, been shirked in India, we cannot expect the ideal scheme to materialise for some considerable time.

The Mental Hospital has accommodation for 600 patients (beds do not yet exist for all patients, and in the isolation Block they are of cement)—male 458, female 112. There is no other mental hospital in the central provinces. The 1931 Census revealed the insane population of the central provinces to be 5,033 (male 3,161, female 1,872). There would appear to be a clear case for increasing the accommodation.

The hospital is of a very poor type, and some of the buildings date from the first half of the nineteenth century. The ratio per cent of patients discharged recovered direct admissions during 1944 was 21.15. In view of the numerous handicaps, this figure is very creditable.

The following is the list of defects, as prepared by the Medical Superintendent:

- (1) Inadequacy of the Medical Staff.
- (2) Inadequacy of the Nursing Staff.
- (3) Very poor quality of the Attendant Staff.
- (4) No Neuro-Surgeon, no Biochemist, no Pathologist. (Laboratory buildings have been completed, but the scale of pay is not likely to attract a good Bio-Chemist.)
- (5) Some of the buildings are of the archaic type.
- (6) There are no Occupational Therapists or Physical Culturists.
- (7) Inadequacy of menial establishment.
- (8) Very low scale of pay for all Staff (Medical, Nursing, Attendants).
- (9) Mental defectives have to be admitted along with the psychotic in the same hospital, as a result of the definition "Lunatic" (Section 3[4] of the Indian Lunacy Act, 1912).

I do not think the Superintendent has been ingenuous. I might add that, in my opinion, it is the poorest type of Mental Hospital, I have visited in India, which has Government support. In his observations the Medical Superintendent states: "From time to time the unsatisfactory state of affairs had been brought to notice of the Government, and a six-year planned scheme was submitted in 1943, to which effect is being given, as far as war conditions will permit." He concludes with the following: "I made it clear at that time that my recommendations were only the first stage towards making this hospital a hospital for mental diseases in fact as well as in name".

Students for the L.M.P. Diploma receive five lectures, which is included as a branch of Medical Jurisprudence, but there is an advance on Bengal—the Medical Superintendent of the Mental Hospital is the Lecturer.

There is a proposal under consideration to include a short course in psychology in the curriculum of the Medical School Students, Nagpur. This is a step in the right direction.

There are no facilities for postgraduate study in Nagpur, and there are, so far, no psychiatric units in the general hospitals.

*My General Remarks apply to Nagpur.*

It appears to me to be a mistake to go on with piece-meal expenditure on a mental hospital, which for all practical purposes is obsolete. The present Mental Hospital, with certain improvements, might well be converted into a home for senile and chronic cases, but for the treatment of the psychoses and psycho-neuroses, and a teaching programme, a new Mental Hospital of 500 beds (sited with a view to ultimate extension to 1,000 beds) should be the immediate target.

## Agra

At Agra I had lengthy discussions with Major-General Buckley, Principal of the Agra Medical College, some of the Professional Staff of the Medical College, and Dr. Lal, Superintendent of the Mental Hospital.

### *Mental Hospital*

The accommodation in this hospital is for 600 patients, and the daily average number under treatment during 1944 was 517.32.

There are no voluntary patients and no criminal patients.

This hospital stands in need of many improvements. The Superintendent is enthusiastic, and is doing his utmost to make progress. He is M.B.B.S., and had a short course of training at the European Mental Hospital, Ranchi, before he took over charge of the hospital about two years ago and he hopes that the United Provinces Government will grant him facilities to proceed to the United Kingdom to obtain the Diploma in Psychological Medicine at an early date.

I propose to make some quotations from his answers to my questionnaire. He states:

“There are no nursing arrangements of any sort. Even patients with enteric, pneumonia and other debilitating disease get no nursing. There are at the mercy of so-called attendants, popular idea being that they are just like Warders of Jails. They hesitate to touch patients when unclean, not to mention giving them bed pans or urinals, or cleaning them when necessary. They look to the sweepers to do all this for the patients. It is difficult to undertake any specialized treatment without team work, the main constituents of which should be efficient nursing and medical care. For special treatment like cardiazol shock, continuous narcosis, pyretotherapy, and hydrotherapy, careful watching and tending is necessary during and after treatment. To carry on this job it is necessary that trained nurses should be appointed in the male section and trained female nurses should be appointed in the female section...”.

“In my opinion due to the above difficulties it is necessary that nurses must be appointed for the Mental Hospital before any real attempt to give modern specialized treatment can be seriously undertaken. Nine male nurses for the male Section of this hospital, and six female nurses for the Female Section should be appointed in the first instance”.

“*Hydrotherapy* – In this hospital there is only one hydrotherapy tub in the male section and one in the female section. The result is that not more than one patient can be treated in each Section. For this treatment to be effective it is necessary that the patients should be in the bath for 6–10 hours ....I think there should be at least nine tubs before the bare needs could be met with”.

The Superintendent has constructive proposals for occupational therapy, recreational therapy, etc., and he has hopes that they will receive sympathetic consideration in the near future.

*The Superintendent goes on to state: -*

“Increase in the number of attendants is absolutely necessary in order to reduce restraint to a minimum. The other Mental Hospitals spend double the sum that is spent in this hospital per patient on supervision. Unless the number of attendants is doubled, the restraint abolished, outbursts of violence and destructive tendencies of the patients cannot be stopped, and unless the patients have a feeling of freedom, the progress of mental deterioration in the mentally sick cannot be effectively checked”.

“*Staff*— There are only two Medical Officers in the male section with a population of about 400 patients—at least two more Medical Officers are required to carry out special treatment, and

look after the patients effectively—one should be a Psychologist. One additional Medical Officer for the female section is an absolute necessity”.

“*Diet*—The diet of Class III patients is very poor as compared with other hospitals. They have hardly any changes. The same menu of *dal -roti* in the morning, and *roti-saag* in the evening goes on, day in and day out, and one can imagine the monotony of the meals and the patient’s feelings and reactions. Other Mental Hospitals spend about twice the sum per patient that is spent here on diet. Better diet, with occasional changes, will improve the physical health, and the mental health, too, will certainly improve”.

The Medical Superintendent has submitted the diet schedule of the Indian Mental Hospital, Ranchi, and has invited the attention of the authorities to the marked difference. He has also submitted scheme for improvement in the kitchens.

He has also suggested that an apparatus for electro-convulsive therapy (ECT) be installed.

I need hardly say that I endorse the condemnations enumerated by the Medical Superintendent, and I am of the opinion that they are worthy of consideration from the Medico-Legal as well as the humane point of view.

It might be mentioned that in this hospital a very large number of the patients have been suffering from ankylostomiasis. This difficult problem is being tackled by the staff, but it is still prevalent to an alarming extent. I think further comment on this institution is superfluous.

A course of 18 lectures is given to the M.B. students of the Agra Medical College, the Lucknow Medical College, and the Lady Hardinge Medical College, Delhi, and three lectures in normal Psychology are given to 2<sup>nd</sup> year students of the Agra Medical College.

Postgraduate teaching is not contemplated at this school, and in my opinion, the burden of teaching M.B. students is too heavy, and cannot be carried out efficiently by the present Superintendent until he has taken the D.P.M. course himself.

The Superintendent, however, has very progressive views, and has the makings of a first class Superintendent and Clinical teacher. He deserves every encouragement, and he should be given every facility to carry out his study programme.

## **Lahore**

At Lahore I visited the Punjab Mental Hospital, and had lengthy interviews with the Inspector-General of Civil Hospitals, and a Conference was also arranged by the Inspector-General of Civil Hospitals, which was attended by the Principal, K.E. Medical College, Lahore; the Principal, Balak Ram Medical College, Lahore; the Principal, Glancy Medical College, Amritsar; the Principal, Arya Medical School, Ludhiana; the Registrar, Punjab University, and the Secretary, Punjab State Medical Faculty.

### ***Punjab Mental Hospital***

This hospital has an authorised accommodation for 1,300 patients, and the daily average number under treatment during 1943 was 1,226.14.

The present Medical Superintendent is a retired P.C.M.S. Officer, and holds the degree of M.B.B.S. Before appointment to this onerous post (the Punjab Mental Hospital is one of the largest in India) he had no experience whatever of Mental Hospital or Psychiatry.

I propose to quote from a statement prepared by the Superintendent in answer to my Questionnaire.

- (1) The Medical Staff is most inadequate. This becomes very evident when one compares it with the Staff of the Mayo Hospital, e.g. for 85 beds for sane, responsive and co-operating patients in a section of the Mayo Hospital there are one Physician, one Clinical Assistant, and three House Surgeons, besides fully qualified nurses, etc. This staff is purely for the treatment of the cases, and have nothing to do with administrative, or laboratory work, etc. In the Mental Hospital there are 1,225 patients with only one Medical Superintendent, one Deputy Superintendent, and one Assistant Superintendent, on general duty, recently engaged, one Lady Doctor, two Sub-assistant Surgeons, and two part-time House Surgeons who work for a couple of hours only. The patients are resistive, mute, unresponsive, unclean and filthy in their habits, and some have to be tube-fed. They have to be looked after, treatment for physical ailments and mental troubles... A thousand and one other administrative duties are to be carried out by this meagre staff. They (the Medical Staff) fail or are rather forced into the habit of neglecting duties and then become callous, and finally their emotional apathy becomes level with that of a schizophrenic. It will take a doctor 20 hours to devote one minute each to a lot of 1,200 patients.

The Superintendent goes on to say:

"If any of our patients suffers from a physical ailment which we cannot properly diagnose for lack of facilities or lack of specialised knowledge, we send such cases to the Mayo Hospital. Generally there is great difficulty, I do not say reluctance, for as a rule, a bed is not available".

The Superintendent further points out that although the Asylum has been converted into a so-called hospital, the "contents of a bottle cannot be altered by changing the label". He says: "the same bars, the same rotten cells, the same counterparts of Jail Warders as Attendants remain. The trained nurse, the sympathetic Warders, the specially qualified doctor, are all conspicuous by their absence. There are no special facilities or apparatus for newly discovered forms of mental treatment". He points out that the hospital is a detention camp for criminal cases, and an asylum for demented non-criminal cases. He suggests that a Visiting Surgeon and Physician be appointed from the Mayo Hospital, but even with this arrangement, he considers that the Staff should at least be doubled.

There are no outdoor Psychiatric Clinics connected with General Hospitals in Lahore, and I agree with the Superintendent when he says that it will be several years before such Clinics can enter the realm of practical politics. He rightly states that "the training received by our Medical men in Psychiatry is very scanty, and they are likely to make a muddle of it if they are encouraged to meddle in this line".

There are three new Wards with accommodation for 300 patients in this hospital (completed in 1937), and they are of a good type. The accommodation for the remaining 1,000 patients can only be described as deplorable. There is almost a 100 per cent infestation of *Ascaris lumbricoides* in the hospital population. An entirely new hospital built on modern lines is an urgent necessity.

The Medical Superintendent admits his limitation. He has no knowledge of Mental Diseases, and his own statements reveal how such a situation reacts on a subordinate staff. He is most unhappy in the appointment, and is merely there from a sense of duty in the present emergency. I am of the opinion that the most urgent requirement in this hospital is the appointment of a qualified Medical Superintendent.

The Medical Superintendent is responsible for the training of 90 M.B.B.S., and 60 L.S.M.F. students per annum. He sums up the situation himself when he states that the "training received is very scanty".

There are at present no facilities in Lahore for Postgraduate teaching in Psychological Medicine, and none is contemplated in the near future.



My limited Survey of the conditions in the Punjab Mental Hospital convinces me that in this institution adequate understanding of Mental Disorders, and adequate Therapy are both wanting. The problem is very complex but urgent.

After my visit to the Punjab Mental Hospital I read in the daily paper that the Provincial Government had a scheme for relieving the congestion and overcrowding in Punjab Jails by opening more jails under their first Five-Year Plan. Provision is to be made for 30,000 prisoners, and in place of the old fashioned jail buildings, modern structures have been planned which will have flush latrines, etc.

These jails will have organized Occupational Therapy Schemes, and expansion of the present Jail libraries and education staff.

The Punjab Mental Hospital is worse than many of the Central Jails I have visited in India. The Government of the Punjab will no doubt exercise, in some measure, the same solicitude for unfortunate patients whose only crime is that they suffer Mental Diseases, which, in the majority of cases, can be cured or relieved.

## **Ranchi**

### ***Indian Mental Hospital, Ranchi***

*I visited this hospital on 6 February 1945.*

The daily average number of patients during 1943–44 was 1297.82 (males 1,034.41, females 263.41) of whom 424.04 (males 389.72, females 34.32) were Criminal patients.

This hospital is of a very high standard and compares favourably with the new Mental Hospital in Bangalore. It is in advance of the Bangalore Mental Hospital, as all patients are allowed beds, bed-linen and mattress, whereas a large number of the patients in the Bangalore Mental Hospital sleep on mats on the floor.

The Medical Superintendent is a very able member of the Provincial Medical Service, Bihar, and holds the degree of M.B.(Cal.) and the D.T.M.(Lond.). He was on the staff of the European Mental Hospital for some time as Medical Officer, and later as Deputy Superintendent. He is anxious to obtain and prepare to study for a Diploma in Psychological Medicine in the United Kingdom, and I consider he is the right type for employment in a Mental Hospital Service.

The first Deputy Superintendent holds the M.D. in Psychological Medicine of Patna University, but has little clinical experience. I have stressed the need for a high standard and uniformity in M.D. degree in India, and until such uniformity is attained, I think such Degree cannot be seriously considered when making appointments.

The second Deputy Superintendent is M.B. (Cal.), with no special training in Psychiatry, while the remaining five Medical Officers hold the L.M.P. Diploma.

In the female section there is a Matron and four nurses—all general trained—and the management of the patients and the Wards is superior to any other hospital I have visited on this tour.

There are no Occupational Therapists, but a well organized Work Department exists and its beneficial effects are evident. The department gives an impression of industry and contentment.

The Diversional Therapy Department is being developed, and the hospital has its own Cinema, and well-equipped entertainment rooms. These are, at present, located in one of the Wards, but a separate unit is desirable, and I understood this will be considered as soon as building programmes can return to normal.

The per capita rate per annum is Rs 570-1000—much higher than any other Mental Hospital for Indians only, but the additional expenditure is reflected in the whole atmosphere of the institution—it is a Mental Hospital.

The ratio per cent of cases discharged recovered to direct admissions in 1943-44 was 24.53, a very creditable figure, in view of the large number of Criminal patients, who can only be discharged after their individual cases have been considered by Government. It is the exception for any criminal cases to be discharged in less than five years from the date of their admission to hospital.

The students from Patna University attend the hospital for a period of three weeks, for what is described as intensive training in Mental Diseases in accordance with the Curriculum passed by the Board of Studies of the Patna University. The number of lectures per Course is 20, and 34 students attend in two batches. I consider it is not fair to call upon the present Medical Superintendent to conduct these courses of instruction. It is a very heavy burden for which, in my opinion, he is not yet equipped. I do not consider Post-Graduate students would benefit from attendance at this institution until the standard of the Professional Group has been raised.

### ***European Mental Hospital, Ranchi***

The hospital is built on modern lines and has accommodation for 300 patients. It was visited recently by the Consultant Psychiatrist of the British Army, who has had a vast experience of Mental Hospitals all over the World. He considers that the European Mental Hospital, Ranchi, compares favourably with any hospital he has visited. Other eminent Psychiatrists have made similar comments.

The Superintendent is a Specialist in Psychiatry. The Deputy Superintendent is on Military Service and is a Graded Psychiatrist, and two House Physicians have 21 years and 16 years service in the hospital, respectively. The present Deputy Superintendent is employed as a temporary measure, but is not a Psychiatrist.

There is at present a Military Wing of 60 beds and the Officer Commanding is an experienced Psychiatrist, a former Deputy Superintendent of one of the largest Mental Hospitals in England, and Psychiatrist to the Scottish Command. There is also one R.A.M.C. officer who has a limited knowledge of Psychiatry.

During the past two years the ratio per cent of patients discharged recovered to direct admissions averaged 56.33 and 4 per cent were discharged improved.

The number of Voluntary patients admitted during 1943-44 was 113 as compared with 86 the previous year. In both years there were more Voluntary patients than Committed patients.

The per capita cost per annum in 1943-44 (exclusive of interest on loans) was Rs. 2,015, but in previous year was between Rs 1,200 and Rs 1,300.

The Hospital is well-staffed.

*Nursing*—One Matron and twelve General Trained Nurses. The Matron holds triple qualifications—General Training, CMB, and the Certificate of Proficiency in Mental Nursing of the Royal Medical Psychological Association. Of the twelve Nurses seven hold the Certificate of Proficiency in Mental Nursing, and had it not been for the present emergency with constant changes among the junior Sisters, all would have been in possession of the Royal Medical Psychological Association certificates.

*Attendants*—There are 94 attendants (males 46, female 48) most of whom have gained the First Aid Certificate, and the Home Nursing Certificate (St. John's Ambulance), but, in addition, there are 148 private attendants (male 57, female 91).

This high proportion of nurses and attendants is to a large extent the reason for the success of the hospital as a treatment centre. Seclusion and restraint are not permitted, and all maniacal or excitable cases are treated by hydrotherapy or continuous narcosis.

The Occupational Therapy Department is in charge of a General Trained Sister who holds a diploma in Occupational Therapy and there are in addition two full-time Occupational Therapists. There are 25 instructors in the various arts and crafts.

*Diversion*—This department is highly developed and includes a modern Gymnasium under the control of a qualified physical culturist. There are entertainment halls, library, and other amenities conducted by qualified personnel. The Cinema at the Indian Mental Hospital is frequently placed at the disposal of this hospital.

*Outdoor Amusement*—There are tennis courts, football, hockey, and cricket grounds situated outside the hospital.

*Chapels*—There are Church of England and Roman Catholic Chapels and Chaplains of both denominations are detailed for duty in the hospital.

*Treatment*—All modern methods of treatment are employed, and there are electrical convulsant therapy units in both male and female sections, and as soon as circumstances permit, an electroencephalography unit will be installed.

There is a well-equipped operation theatre and laboratories, etc. A special Psychological Laboratory has been built, but there is, at present, no Psychologist on the staff and the Mental Staff have little time for experimental work, as they are fully occupied in the Wards.

*Teaching*—Postgraduate courses are held, and during 1943-44 even students attended the Course of Instruction. The Course includes Psychiatry (Clinical and Theoretical), Forensic Psychiatry, and Mental Hospital Administration. The instruction covers the ground in Psychiatry only, for the D.P.M. and the M.D. in Psychological Medicine.

There are no facilities for the study of advanced Anatomy, Physiology and History of the Central Nervous System, or Experimental Psychology.

The hospital is recognised as a training school for the DPM by the University of London and as a Teaching School for Nurses by the Royal Medico-Psychological Association.

Six postgraduate students could be trained per annum, and the Course would cover the requirements for the Medical Psychological Certificate, or the six months hospital residence required by the regulations for most Diplomate in Psychological Medicine. Students preparing to take the Diploma in Psychological Medicine would require to proceed to the United Kingdom to complete the requisite course.

A sum of Rs 100 per month per student is payable to the Board of Trustees of the Hospital.

## **General Remarks**

### ***The Mental Hospitals***

Mental Hospital Administration is a Speciality to which men should devote their entire lives. They can then formulate policies arising from their experience and calculated to bring advantage to the patients.

Industry has pointed the way for hospital administration. Efficient management is an indispensable factor in organisation. Industrial leaders insist that a man who has been thoroughly trained in a special line of business, and has shown characteristics that stamp him as a leader, is cheap at any price. He is the one to promote business and safeguard industrial interest, but Government rarely applies this lesson. Seven of the largest Mental Hospitals in India have men appointed as Superintendents at salaries that a first class Mechanic in Tatas Works would scorn, six of them have little or no Post-Graduate experience or training in Psychological Medicine, and yet

these men have been charged with the supervision of large hospitals, and what is more important, human lives. The Deputy Superintendents and subordinate Medical Staff are more or less of a temporary nature, utterly untrained in Psychiatry. Broadly speaking, the Institutions function, stagnant and dead, with a routine custodial care, in some instances of a very poor standard, meted out to patients.

The main interest, in the past appears to have been economic, but, in the future, the professional group must be the dominant one.

Every Mental Hospital, which I have visited, in India is disgracefully under-staffed. They have scarcely enough professional workers to give more than cursory attention to the patients, to say nothing of carrying a teaching burden. With an average ratio of 1 Medical Officer to 200 patients or more, there can be little time for the instruction of students. Government will have to work on the theory that more and better-trained professional personnel is the urgent need of Mental Hospitals. The policy of increasing bed capacity, which incidentally has led to gross overcrowding in most of the Mental Hospitals rather than personnel, has been stressed in the past, but the cure of mental patients and the prevention of Mental Diseases will not be accomplished by the use of bricks and mortar.

Two Responsibilities confront us:

- (1) Institution of Personnel.
- (2) Instruction of Students who come for practical experience in Psychiatry.

The resources of the Medical Schools and Mental Hospitals in India do not permit of Postgraduate teaching, and for the training of personnel for the Mental Hospitals, India will have to rely on foreign assistance for some years to come—ten years at least.

The course of Instruction for a Diploma in Psychological Medicine must embody an entire Mental Hygiene Scheme. Emphasis on prophylaxis and prevention must be in line with the principles of modern prevention medicine.

This is a suitable time for Government to take account of stock, overhaul resources, and re-chart the Course for the next 30 years. Public opinion will soon demand that patients in Government Mental Hospitals must be cared for by experienced and well-trained individuals.

Medical Superintendent—It is desirable to have a Superintendent who is well qualified. Every Psychiatrist has been cases in which eye specialists have tried to correct failing vision by refraction in a patient suffering from G.P.I. Surgeons have been guilty of operating on hysterics and psychiatrists have called the complaints of patients, somatic delusion until the patient finally died of cancer.

In addition to holding the Diploma in Psychological Medicine, it would be desirable for the Medical Superintendent to hold a higher degree in Medicine or Surgery.

The Deputy Superintendent should also be highly qualified men with DPM and capable of understudying the Superintendent. There should be a Deputy Superintendent in both male and female sections of every Mental Hospital.

The Senior Medical Officer in both male and female sections should hold the Diploma in Psychological Medicine, and understudy the Deputy Superintendent.

The ultimate aim should be that all Medical Officers must be obtain? Diploma in Psychological Medicine, and it is to be hoped that the Universities of Bombay and Calcutta will, in the course of a few years, be able to grant the diplomas, and perhaps later, the Madras and Punjab Universities. I think this rush by all Provincial Universities to institute Postgraduate diploma is premature. The trained personnel will not be available for years.

There are four very old Medical Schools in Scotland with much greater facilities for teaching Psychiatry than any School in India, but, so far, only Edinburgh University has instituted a Diploma in Psychiatry.

In London, there are only two Schools which conduct courses for the Diploma in Psychological Medicine, and, as far as I am aware, Leeds and Manchester are the only Universities in England which have a Diploma in Psychological Medicine course. The London University and the Royal College of Physicians and Surgeons grant a Diploma in Psychological Medicine, but merely function as examining bodies.

There is no uniformity in the teaching of Psychiatry in any of the schools in India. Carefully thought-out courses of instruction are requisite for such a programme both for M.B. and Postgraduate students. It is no use pretending that Psychological Medicine is being taught anywhere in India. Students cannot be exploited much longer, but must be given something that will repay them for their hard work and sacrifices.

My tour has brought home to me that in a teaching programme the Mental Hospital will form the one stable factor. Clinics may come and go, organizations for the correction of this and that difficulty may come in existence, flourish and fade, but the Mental Hospital goes on, hence the need for a modern Mental Hospital within easy reach of the Medical School. The Mental Hospital can become a tower of strength in the Psychiatric world if it will turn its attention to a more active Psychiatric leadership.

I have not been convinced that the utilisation of Honorary Physicians in India is a success in a teaching programme. As already pointed out, one finds that Honorary Physicians are, as a rule, very jealous of their prerogatives, but take their responsibilities lightly. There are, of course, exceptions.

I have had talks with several 'Honorary Physicians', and there is a feeling of discontent among them. Most of them are overburdened with personal problems and preoccupied with earning a livelihood. They cannot give of their best to a teaching programme, if harassed by financial worries, and no Government has the right to ask it.

To obtain real service in Mental Hospitals, Teaching Programmes, Psychiatric Clinics, Social Services, etc., it is essential to have a Mental Health Service and that Medical Officers should be specially recruited for it. Officers entering this Service must be made to realize that they are entering a very fine service for which they will have to train rigorously.

It is essential that a systematic plan be under the control of one individual, whose main business and responsibility it is. Without such centralization we shall get wasted effort and duplication. It will be necessary to visualise a plan which may take years to mature. In India, it is obvious that the Medical Superintendents of Mental Hospitals must assume greater responsibilities. The Mental Hospitals have become isolate units, having little contact with the Community they serve, and in most cases, are objects of fear and suspicion.

The Medical Superintendent of the Mental Hospital must become the Chief Medical Officer, Mental Health Service in his area or Province, and become the adviser in Mental Health matters to the Chief Administrative Medical Officer. In addition he should be *ex-officio* the Senior Physician and supervise the work of all Psychiatric Clinics. He should be the individual to coordinate and lead any Mental Hygiene movement, and to supervise the work of Social Services. As the Mental Health Services expand, he may have to take over the Mental Health Department in the office of the Chief Administrative Medical Officer.

He should, therefore, have competent Deputy Superintendents, so that he can be at liberty to inaugurate and carry out, as rapidly as circumstances will permit, a comprehensive programme dealing with all general phases of the Mental Diseases problem and education.

Every Mental Hospital in the vicinity of a Medical School must become a teaching hospital, and the professional group in such a hospital must be the dominant one. Here again, the Medical Superintendent must be the Director of Clinical Work.

The teaching hospital, from the therapeutic point of view, is superior to the one which does not have an educational outlook. The mere presence of a group of young students, interested, enthusiastic and intellectually alive, prevents hospital inertia. Teaching and being taught stimulates every member of the professional staff, and keeps the entire organisation on the *quivive*. The sum of total to and educational programme is to place the patient and his needs on a higher plan.

No one will deny the necessity for highly trained Specialists in the various fields of Psychiatry in India. At present their number is negligible, and of these the more experienced Clinicians are nearing the age of retirement.

The service must be made attractive, and graduates in medicine with a satisfactory academic career behind them must be selected. They should be given a resident appointment in a Mental Hospital in India for 6 to 12 months and then sent to the U.K. or the U.S.A. for Post-Graduate training. If twelve scholarships were granted annually for ten years there would be a nucleus of men to take over the responsible posts as Superintendents, and Deputy Superintendents, and later leadership in this Speciality. The practice of granting Study Leave to Graduates in the Medical Services might be continued, but few can avail themselves of the privilege. The Postgraduate student has to expend a large sum in Travelling Expenses, which, in many cases is borrowed. He hopes to recompense himself later in Practice, but this is not feasible in a Mental Service, and must be taken into account when graduates are sent abroad. No student should receive any fellowship in excess of maintenance, cost of books, and instruction. To pay any one to take an education indicates that the educational offering is not very valuable.

Men for Subordinate Posts may be trained in this country, and until such time as Medical College can institute a uniform and practicable syllabus for a Diploma in Psychological Medicine, I would suggest that Medical Officers be encouraged to obtain the Certificate Psychological Medicine (MPC) granted by the Royal Medical Psychological Association. There is a strong membership of the Indian Division of the Royal Medical Psychological Association, and there would be no difficulty in arranging for the examination to be held in India.

A beginning in this modest manner (it was done in the UK) would be preferable to granting Diplomat of a low standard which might later prove an embarrassment to Government. The more able men who obtain the MPC would probably later proceed to a Diploma in Psychological Medicine. As an incentive Medical Officer who obtain a DPM or MPC should be granted Special Pay. All holders of the DPM in the Mental Service in the UK received an annual allowance of £50. If Universities are to grant an MD degree in Psychological Medicine, there should be uniform high standard for the whole of India.

The general standard of Mental Hospitals, I have seen is poor. Economic factors will always affect scientific considerations. It may not be possible to do as much Psychiatric research as one desires because sufficient money is not available, but certainly the quality of professional work is subject to no such limitations. There may be too few physicians, but this is not legitimate reason why administrative medical officers should not get the best ones available, and hold them to a high level of professional performance. Financial security is not the first requisite to hospital progress — the desire and enthusiasm for progressive change must always come first.

There is an urgent necessity for better-trained Nurses. On the nursing staff of Mental Hospital depends the harmony which exists between the hospital and patient, and that may mean the difference between success and failure of treatment. If a patient is consistently irritated by tactless handling,

exasperated by petty tyrannies, and annoyed by inflexible rules enforced by poorly informed attendants and improperly trained nurses, he soon develops the idea that his welfare is not the first consideration. There is a type of Psychological abuse of mental patients which may be much more disastrous than any kind of physical abuse.

An institution with a poorly trained and inadequate nursing staff starts with a definite handicap, which will seriously interfere with its efforts. The social environment as represented by the nurse and attendant is of much greater importance than the colour of the Wards, selection of the furniture, cinemas, radios, etc. Pleasant-surroundings are a hollow mockery when a small minded unintelligent attendant constantly thwarts the patient in his attempts to enjoy them.

The Psychiatric Nurse performs a more difficult and exciting task than any General Nurse, and she should have correspondingly better educational standards. Mental Hospitals have not taken their educational responsibilities too seriously. There can be no valid excuse for the failure of a Mental Hospital to instruct its own people. Machinery exists in India for the granting of a Certificate for Proficiency in Mental Nursing by the Royal Medical Psychological Association, but, so far, only the European Mental Hospital at Ranchi has trained Nurses for this Certificate. All Mental Hospitals in India which employ Trained Nurses should take immediate steps to procure recognition as training school by the Association, and they should train and encourage their nurses to obtain the Certificate. This will mean a sacrifice in time, but administrative Medical Officers should bring home to Superintendents of Mental Hospitals that they have a responsibility in this field, and must prepare to carry out that responsibility. The Board of Trustees of the European Mental Hospital at Ranchi stipulate that all Nursing Sisters must, during an early stage of their Service, obtain the Certificate of Proficiency in Mental Nursing, and the majority of them did. Before the war there were numerous indications that good nurses were turning to Psychiatric nursing, and there was a large waiting list of good candidates for employment at the European Mental Hospital. This may be due, in some respect, to the reputation this institution has acquired, and to the generous terms of their employment. The aim should be that all wards, male and female, should have a carefully selected, well-trained Psychiatric Nurse in charge. This may take years to achieve in India, but I maintain that it is practicable.

Given a competent Psychiatric Nurse in every ward, the question of attendants remains. Where are we to get the Ward Personnel? Are we to go on with the present Personnel, who do not receive training even of the most superficial character?

It is surprising that many of the individuals placed in a ward of filthy, destructive, violent, profane, noisy patients can maintain their emotional equilibrium and remain human. It is only because of their fundamental decency, and not because they have any spark of real understanding of the basic situation. I have been connected with Mental Hospitals too long not to appreciate the difficulties inherent in this situation, but, in spite of these difficulties, I cannot feel that attempts to change the situation are impossible. Something can and must be done to increase the number and improve the quality of ward personnel. At the European Mental Hospital, Ranchi, all attendants, male and female, are required to attend courses of instruction in First Aid, and Home Nursing, and a very large number have already obtained the St John's Ambulance Certificate in both subjects, and it is amazing what this small beginning has achieved. The nursing care and treatment of the patients improved to an enormous extent. The utilisation of young and immature people—and there is much of it—for ward work, is, in my opinion, a very questionable procedure. Adolescents should not be in charge of Psychiatric patients. They are not sufficiently stabilised emotionally to be placed in such a situation.

The Indian Division of the Royal Medical Psychological Association have under consideration a scheme for the granting of a Certificate to Ward Attendants, and at Ranchi it is proposed that an

attendant would in his first year of service obtain the First Aid Certificate, in the second the Home Nursing Certificate, and in the third the Certificate in Mental Nursing. Handbooks in the Vernacular have already been published.

For the Certificate in Mental Nursing the Course would be of an elementary character, and a course of about 14 lectures would suffice. My suggestion for the lectures is as follows:

1. History of Mental Disorder.
2. Mental Disease as a Public Health Problem.
3. The Infection-Exhaustion Psychoses.
4. The Toxic Psychoses.
5. General Paresis.
6. The Symptomatic Psychoses.
7. Arteriosclerotic and Senile Psychoses.
8. Borderland States.
9. Manic-depressive Psychoses.
10. Schizophrenia.
11. What is Mental Hygiene?
12. Mental Hygiene of Childhood.
13. Mental Hygiene of Adolescence.
14. The Human Personality.

Both theoretical and practical instructions are essential. It will be seen that the above scheme of lectures, if accepted, will introduce the Attendant to Psychiatry through the Psychoses which have a direct physical causation. The simpler the course, and the more gradually it develops from the physical to the highly complex Psychological, the more successful it will be. The war has, unfortunately, delayed this scheme, but it is hoped the Indian Division of the Royal Medical Psychological Association will meet this year. Most of the Medical Superintendents of Mental Hospitals in India and Sri Lanka are members of the Association.

The custom of generalising about ratio of Ward Personnel which takes no account of admission and discharge rates, the kind of service given to the patient, or the number of essential subsidiary departments carried on, is a mistake. All of these must be considered when Ward Personnel ratio are being worked out. (see notes under European Mental Hospital, Ranchi).

Psychotics adjust themselves at different levels:

- A. Social Recovery (the ideal aim).
- B. Social Institutional Adjustment.
- C. Institutional Adjustment.
- D. Deterioration.

It was depressing to find the enormous number of patients who have 'deteriorated', and what was worse, the general attitude of pessimism and indifference which characterized the situation.

The standards of care which prevail in the hospital are responsible to a considerable extent for the level at which patients adjust. If the ideal of the institution is the discharge of patients, if the professional staff is held to a high level of accountability for such discharges, and if the



administration is called upon to defend continued residence in the institution, the last three groups will not be as large as they are. The fourth group is a definite indictment of the therapeutic standards in the Mental Hospitals in India. The vast majority of these patients have been permitted to slump into this condition of deterioration because the routine was not sufficiently insistent and compelling to keep them in reality even for brief intervals.

In all the hospitals I visited there is a need for a more systematic and better conceived plan of work therapy. None of them except the European Mental Hospital, Ranchi, employ Occupational Therapists. In advanced countries, Occupational Therapy has developed to the point where its representatives have become indispensable to many General Hospitals, Tubercular, Orthopaedic, and Mental Hospitals. In Occupational Therapy we have a powerful therapeutic weapon for the Psychiatric patient. Organised systematic work is better treatment than the careless haphazard occupation in some of the hospitals. The important thing is to create throughout the hospital an atmosphere of industry, and to make occupation an activity that is approved by the patients.

More can be done in the way of Diversional Therapy. A Mental Hospital with all modern types of therapy equipment, and installation is still a house of sorrow and discontent. Everything that can serve to alleviate any of this discontent should be utilised. Entertainment is therapeutic, it specialises the patients' mind and interest, and it is bringing him back to reality. Money spent on entertainment is a good investment, and the budget allotments under this head should be generous. Suitable programmes can readily be made available if the necessary funds are forthcoming.

All arteriosclerotic, decrepit and senile patients should be housed separately. They are fundamentally medical and nursing problems, and should be under the supervision of the Mental Services. Kindly and humane custodial care in special Homes would be more economical than treating them in Mental Hospitals. At least 50 per cent of the patients in Mental Hospitals in India could be cared for in such Homes.

In the UK, there has been a definite demand on the part of the public for psychiatric clinics, and fortunately there has been a definite swing away from the extravagant claims of early exponents of Mental Hygiene towards recognition of the limits of preventive Psychiatry. While no specific preventive measures have been discovered enough sound knowledge has been accumulated to show that a continuance of extension of outdoor clinics is a logical procedure.

The directorship of either an adult or child clinic is a full-time position. A successful Clinic will not remain so long, if it is the Secondary responsibility of anyone. The immediate establishment of Psychiatric Clinics in General Hospitals is not feasible in India at present, as there is no trained personnel. To establish them before efficient personnel is available would be extremely bad propaganda. I have already made the suggestion that the Medical Superintendents of Mental Hospitals should be ex-officio the Senior Physicians of all such Clinics. There is no reason why General Hospital should not, in due course, bear its share of mental disease prevention. It is a problem of Public Health, and as such is of interest to every agency interested in this important activity. The General Hospital sees patients in the pre-Psychotic stage, and they are in a favourable position to influence the education of psychiatrists. When trained personnel is available, it is to be hoped that psychiatric Departments in General Hospitals will be the rule rather than the exception.

These can only come when sufficient trained Psychiatrists and Social Workers are available. The collaboration of Psychiatrist and Social worker results in a therapeutic programme which is better balanced than is possible when each works alone.

The actual contact with patients in the early stages of maladjustment will be through the General Practitioner, Teacher, Juvenile Courts, Probation Officer, Police, Social Worker, YMCA,

YWCA, Boy Scouts, Girl Guides and Parents, but the Mental Hospital has a proprietary interest in the pre-psychotic and delinquent child. The Child Guidance patient becomes the mental case of tomorrow. The patients who will be received by the Mental Hospital 10, 15, 20 years hence are in the schools, and many of them showing behaviour abnormalities that stamp them as potential psychotics. It seems that the Mental Hospital has a grave responsibility in this field of prevention and must prepare to assume that duty as quickly as personnel can be secured and trained to do the work.

The stress laid upon work with children is entirely justifiable when one considers that prevention is most hopeful in childhood. It is the golden age for Mental Hygiene. The Child Guidance Clinic will be the important phase of preventive psychiatry. It will take many years to plough the ground and prepare it for the seed. Even administrative Medical Officers will probably look on this extension of clinical facilities with a jaundiced eye. The preparation must be a period of organisation and education. The average man has little understanding of this kind with children. He is apt to think that a Child Guidance Clinic is interested only in feeble-minded or psychotic individuals. These Clinics should in due course form a part of the Paediatric Department of every General Hospital.

In spite of considerable progress towards a more healthy attitude in regard to Mental Disease, the old ideas of disgrace and stigma die-hard, and the prejudice of the people must be taken into account. The relationship of Psychiatry and the Law requires attention. If the Mental Hospital is to do good work it must have the sympathy and support of the community. The walls of ignorance, superstition and suspicion will have to be torn down and a friendly relationship established. We must teach the people that we will staff our hospitals correctly, and that Mental Hospitals are directed by honest well-trained scientific men who are trying to render service to the patients. Goodwill towards Mental Hospital must be created. The process will be long, but may be built by:

- (1) Letting the community know that the Mental Hospital has a real service to be given.
- (2) Convincing people that they need what it has to offer.
- (3) Making it easily obtainable.
- (4) Making people glad that they can have what the institution has to offer.

The goal of such education effort should be more than to add to the prestige of the hospital. The ultimate purpose should be Mental Health. This is the day of Preventive Medicine. Psychiatry should be thought in terms of prevention as well as cure.

I am appending to this Report copies of the undermentioned, which I forwarded some time ago to every administrative Medical Officer in India. I find they are being seriously considered, and I would suggest that they be carefully examined by the Committee.

- \* (1) The Interim report on the Recommendations regarding the Mental Health Services by the Royal Medical Psychological Association.
- \* (2) Recommendations regarding the Future of Psychiatry by the British Medical Association.
- \* (3) The Royal Medical Psychological Association Revised Recommendations.

## **Summary**

The majority of the Mental Hospitals in India are quite out of date, and are designed for detention and safe custody without regard to curative treatment. The worst of them, the Punjab Mental Hospital, the Thane Mental Hospital, the Agra Mental Hospital, and the Nagpur Mental Hospital savour of the workhouse? and the Prison, and should be rebuilt. The remainder should be improved

and modernised with the suggestions of the Medical Superintendents. Bombay and Calcutta urgently require modern Mental Hospitals to meet both needs of the community and the Medical Colleges, and these should form part of any schemes for reconstruction or expansion. The Superintendent of the Indian Mental Hospital, Ranchi, has put forward schemes for expansion, but this hospital is quite large enough for any single Psychiatric Unit, and it is too far from Calcutta to be of service in any teaching programme.

There is gross inadequacy in the medical personnel in all the Mental Hospitals both numerically and in specialised qualification. Most of the Medical Officers employed as Superintendents and Deputy Superintendents possess neither the status nor the experience which would justify the description of Consultant or Specialist in the ordinary usage of that word. A Mental Health Service is necessary with improvement in the status, pay, and conditions of service of the Medical Staff, with increased opportunities for purely professional work.

To remedy these defects foreign assistance will be required for at least ten years. Generous terms should be offered to highly qualified Specialists to take charge of Mental Hospitals, the teaching programmes, and to organise the Social Services during the transition period. Selected graduates (as many as possible) after a period of residence in a Mental Hospital in India should be sent to the U.K. or USA for Postgraduate training in Psychological Medicine. For some time, subordinate Medical Officers might be encouraged to obtain the Medico-Psychological Certificate, granted by the Royal Medical Psychological Association.

The numerical and professional inadequacy of the Nursing staff and Attendants requires urgent attention. There is no reason why administrative Medical Officers should not tackle this problem immediately. The Indian Division of the Royal Medical Psychological Association would be prepared to assist.

Psychiatry developed as the method of treatment of those individuals whose mental illness necessitated segregation from the rest of society. This distinction, although important socially, is medically irrelevant, for there is only a difference of degree between the majority of patients in Mental Hospitals and the far more numerous sufferers from less severe mental disorders. For one case of major mental illness there are, undoubtedly, many cases of minor mental illness. Preventive Psychiatry, therefore, outside the Mental Hospital is of paramount importance. To open Psychiatric clinics in General Hospitals before there is trained personnel to conduct them would be bad propaganda. In the UK modern developments in Mental Health Services are doing much to lessen fears and prejudices among the public, but they are still a factor to be reckoned with, and in India the greatest caution will be necessary. The movement to open Psychiatric Departments in General Hospitals in the UK and USA has coincided with the development of methods of treatment, which have made it possible to treat successfully as out-patients many who would formerly have required in-patient treatment. Events have thus lent support to the movement to emphasise the links between Psychiatry and General Medicine to the advantage of both. It is vital that in any future organisation of Medicine, Psychiatry shall not remain segregated, and it should take its place in the general scheme, subject to the provision of adequate and well-trained personnel.

The few Psychiatric Clinics which have been opened in connection with General Hospitals in India are of the make-shift variety, and the facilities for diagnosis and treatment are not satisfactory. Where the Mental Hospitals are accessible it may be desirable to set up consulting centres under their own roofs. This experiment has proved successful in the Bangalore Mental Hospital and for Service Patients at the European Mental Hospital, Ranchi. Whatever steps are taken with regard to Psychiatric Clinics they will be adequate only if the arrangements allow Psychiatrists in Mental Hospitals to engage actively in out-patient work in the Psychiatric Departments of General Hospitals.

The Senior Clinician in the Mental Hospital should hold the senior post in the Psychiatric Department of the General Hospital. Junior mental hospital doctors should be appointed as assistants in General Hospitals where they would take part in the work of the psychiatric out-patient department. If all hospital medical staffs were adequately remunerated, and if domiciliary work became a recognised part of the hospital service, it would become possible for an interchange between Psychiatric staff of Mental and General Hospitals. Unless arrangements are made on these lines, there is a danger that Psychiatrists on the Staff of General Hospitals will ignore or be unaware of the opportunities offered by Mental Hospitals and the progress in therapy or research being made in them.

In the Memorandum submitted by me to the Health Survey and Development Committee in February 1944, I stressed the need for Central control. This special arrangement for the coordination and direction of Psychiatric work is necessary because of the many intricacies of the subject, technical, sociological, and legal. Provincial Administrative Medical Officers, as a rule, have had no specialised training in Psychiatry, and if the Mental Health Services in the country are to be directed by them, the integration of Psychiatry into the whole medical structure, which is so desirable, will be frustrated.

The Director-General or the Principal Medical Officer of a National Health Service, who will be advising the Minister, will himself be advised by various senior officers concerned with clinical services, preventive medicine, etc., and it is at this level that a Directorate of Mental Health fits in. I have suggested that for the Superintendent of the Mental Hospital should advise the Provincial Administration on Mental Health problem, as the Mental Health Service develops there should be at the periphery administrative officers of Mental Health, who must have direct access to the Director of Mental Health at the Centre, as well as relations with Provincial authorities. In this way the social and Preventive aspects of Psychiatry will be given full opportunities for development. Grants or subsidies should only be made to Provincial Authorities subject to adequate control and supervision from the Centre.

The cardinal points in the Indian Lunacy Act, 1912, have outlived their usefulness. Legal restraint has undoubtedly made the public reluctant to avail themselves of Mental Hospitals, and has militated against the early treatment of mental illness. Legal changes are imperative which will make provision for treatment of patients without the stigma of certification, but this is a subject outside the scope of this report. It might be suggested, however, that all private Mental Hospitals, Nursing Homes and pay-beds for mental patients should be brought under Government control and supervision.

Many patients of this category are being treated in Mental Hospitals and the arrangement is most unsatisfactory.

Legislation to deal with this very wide problem is urgent. This question is also outside the scope of this report, but any scheme will require the provision of suitable institutions and Colonies and it is suggested that in the post-war period many suitable institutions will be available; for instance the Military Camp at Ramgarh in Bihar would require little or no alteration to form a suitable Colony for 40,000 to 50,000 Mental Deficients. Doctors to be employed in such Colonies will, in addition to training in Psychiatry, require special training in Mental Deficiency.

Mental Health Services should cover at least the Psychiatric requirements in Schools, Child guidance Clinics, Psychiatric advice to approved schools, Borstal Institutions, Juvenile Jails, Remand Homes, Colonies of the Hostel type for delinquents and Psychopaths, but to formulate schemes will be the duty of the Directorate of Mental Health.

The public still regards the Mental Hospital, and all Services connected with Mental Health with unwarranted dread, and the Psychotherapist with doubt, derision, and awe. Education of the public must proceed *pari passu* with the development of the Mental Health Service.

Finally, I would stress that the conditions in some of the Mental Hospitals in India today are disgraceful, and have the makings of a major public scandal. It is suggested that a copy of this report be sent to every Administrative Medical Officer in India.

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## Appendix 22

### Mental Hospitals in India with their Bed Strength and Place of Location

Province	Location	Total beds	Total beds in province
i	ii	iii	iv
Assam	Tezpur Mental Hospital, Assam	716	716
Bengal	No mental hospital. Arrangements are made with Bihar Government for the admission of mental cases in the European and Indian Mental Hospitals at Ranchi. There are a number of private institutions for lunatics		
Bihar	European Mental Hospital, Ranchi	271	
	Indian Mental Hospital, Ranchi	1,380	1,651
Bombay	Central Mental Hospital, Yeravda	1,227	
	N.M. Mental Hospital, Thane	390	
	Mental Hospital, Ahmedabad	267	
	Mental Hospital, Ratnagiri	176	
	Mental Hospital, Dharwar	199	2,259
C.P. & Berar	Mental Hospital, Nagpur	600	600
Delhi	Nil		
Madras	Mental Hospital, Madras	888	
	Mental Hospital, Calicut	364	
	Mental Hospital, Waltair	164	1,416

(Criminal lunatics are confined in the Mental Jail at Cuddalore)

i	ii	iii	iv
N.W.F.P.	Mental Barracks 2 in the Central Prison, Peshawar, under separate staff	140	140
Orissa	Cases are sent to Bihar, Indian Mental Hospital, Ranchi where 60 beds are reserved for cases coming from Orissa		
Punjab	Punjab Mental Hospital, Lahore		1,408
U.P.	Mental Hospital, Agra	617	
	Mental Hospital, Bareilly	408	
	Mental Hospital, Benares	331	1,356
Sind	Sir C.J. Mental Hospital, Hyderabad		343
Mysore	Mysore Mental Hospital, Bangalore	300	300
Total bed accommodation			10,189

## Appendix 23

### Staff and Estimates of Cost for Three Types of Mental Institutions

Recurrent Expenses of a Thousand-bed Mental Hospital			
No. of Post	Post	Grade	Monthly expenditure in Rupees
i	ii	iii	iv
1	Psychiatrist Superintendent	1000-50-1,500	1,000
1	Psychiatrist Deputy Superintendent	750-50-1,000	750
18	Psychiatrists	350-25-650	6300
8	Occupation Therapists	200-10-300	1,600
1	Psychologists	250-15-475	250
2	Psychiatric Social Workers	250-15-475	500
1	Personal Assistant to Superintendent	300-15-525	300
1	Senior Matron	300-10-450	300
2	Junior Matrons	250-10-350	500
50	Nurses	125-5-200	6,250
500	Attendants	35-5-50	17,500
50	Menials	20-1-30	1,000
10	Clerks, accountant, storekeeper, etc.	100-5-200	1,000
1	Recorder Statistician	200-10-300	200

<b>i</b>	<b>ii</b>	<b>iii</b>	<b>iv</b>
1	Head Cook	40-1-50	40
10	Cooks	30-1-40	300
15	Darwans, peons, etc.	25-1-30	375
	Food @ Rs. 25 per head		25,000
	Medicines, Chemicals, etc.		2,500
	Washerman, Barber, Darzi, etc.		1,000
	Repair and Replacement of Beddings, Crockery, etc.		4,000
	Occupation Therapy Material		5,000
	Electricity, Telephone, Coke for Boiler, etc.		2,000
	Maintenance of Grounds, Gardens, etc.		1,000
	Miscellaneous including stamps, stationery, etc.		4,000
	<b>Total</b>		<b>82,665</b>
	Annual Recurring Expenditure		9,91,980
	Annual per capita expenditure for 1,000 patients = say		1,000

<b>Recurrent Expenses of a Thousand-Bed Mental Deficiency Home</b>			
<b>No. of Post</b>	<b>Post</b>	<b>Grade</b>	<b>Monthly expenditure in Rupees</b>
<b>i</b>	<b>ii</b>	<b>iii</b>	<b>iv</b>
1	Psychiatrist Superintendent	850-25-1,000	850
2	Psychiatrists	350-25-650	700
1	Physician – General	300-25-500	300
4	Psychiatric Social Workers	250-15-475	1,000
4	Psychologists	250-15-475	1,000
50	Trained Teachers	250-15-475	12,500
1	Personal Assistant to Superintendent	300-15-525	300
1	Senior Matron	300-10-450	300
2	Junior Matrons	250-10-350	500
25	Nurses	125-5-200	3,125
100	Ayahs or female attendants	35-5-50	3,500
50	Menials	20-1-30	1,000
5	Clerks including accountant, storekeeper, etc.	100-5-200	500

<b>i</b>	<b>ii</b>	<b>iii</b>	<b>iv</b>
1	Recorder Statistician	200-10-300	200
1	Head Cook	40-1-50	40
10	Cooks	30-1-40	300
10	Darwans, peons, etc.		250
	Food @ Rs. 20 per head		20,000
	Medicines, chemicals, etc.		1,000
	Washerman, Barber, Darzi, etc.		1,000
	Repair and Replacement of Beddings, Crockery, etc.		4,000
	Electricity, Telephone, Coke for Boiler, etc.	2,000	
	Maintenance of Grounds, Gardens, etc.		1,000
	Miscellaneous including stamps, stationery, etc.	3,000	
Total			<b>59,365</b>
Annual Recurring Expenses 12 x 59,365			7,12,380
Annual per capita expenditure for 1,000 patients = say The entire staff is to be provided with free unfurnished quarters.			700
Capital Expenditure on buildings, equipment quarters for staff, etc. , approximately =			10,00,000

<b>Recurrent Expenses of a Thousand-Bed Mental Home for Senile and Incurable Cases</b>			
<b>No. of Post</b>	<b>Post</b>	<b>Grade</b>	<b>Monthly expenditure in Rupees</b>
<b>i</b>	<b>ii</b>	<b>iii</b>	<b>iv</b>
1	Psychiatrist Superintendent	850-25-1,000	850
2	Resident Psychiatrists	350-25-650	350
2	Physician – General	300-25-500	600
1	Psychologists	250-15-475	250
1	Personal Assistant to Superintendent	300-15-525	300
1	Senior Matron	300-10-450	300
2	Junior Matrons	250-10-350	500
25	Nurses	125-5-200	3,125
75	Male Attendants	35-5-50	2,625
75	Ayahs or female attendants	35-5-50	2,625
50	Menials	20-1-30	1,000



5	Clerks including accountant, storekeeper, etc.	100-5-200	500
1	Recorder Statistician	200-10-300	200
1	Head Cook	40-1-50	40
10	Cooks	30-1-40	300
10	Darwans, peons, etc.		250
	Food @ Rs. 20 per head		20,000
	Medicines, chemicals, etc.		1,000
	Washerman, Barber, Darzi, etc.		1,000
	Repair and Replacement of Beddings, Crockery, etc.		4,000
	Electricity, Telephone, Coke for Boiler, etc.		2,000
	Maintenance of Grounds, Gardens, etc.		1,000
	Miscellaneous including stamps, stationery, etc.		3,000
	<b>Total</b>		<b>45,815</b>
	Annual Recurring Expenses :- 12 x 45,815		5,49,780
	Annual per capita expenditure for patients = say		1,000
	The entire staff is to be provided with free unfurnished quarters.		550
	Capital Expenditure on buildings equipment quarters for staff, etc. , approximately =		10,00,000

# Appendix B

## Report of Mental Health Survey: The Mudaliar Committee Report, 1961

### Appointment of Committee

The Government of India in the Ministry of Health set up a Committee on the 12 June 1959 to undertake the review of the developments that have taken place since the publication of the report of the Health Survey and Development Committee (Bhore Committee) in 1946 with a view to formulate further health programmes for the country in the third and subsequent Five-Year Plan periods. The terms of reference of this Committee were as follows:

### Terms of Reference

1. The assessment (or evaluation) in the field of medical relief and public health since the submission of the Health Survey and Development Committee's Report (the Bhore Committee);
2. Review of the first and second Five-Year Plan Health Projects; and
3. Formulation of recommendations for the future plan of health development in the country.

The following was the composition of the Committee at the time of its constitution:

- |  |          |
|--|----------|
| 1. Dr A. Lakshmanaswami Mudaliar,<br>Vice-Chancellor, Madras University                              | Chairman |
| 2. Shri Tirmual Rao, M.P.  | Member   |
| 3. Dr G.S. Melkote, M.P.   | Member   |
| 4. Shri V.K.B. Pillai, I.C.S.  | Member   |
| 5. Dr C.O. Karunakaran,<br>President, Indian Medical Association                                     | Member   |
| 6. Lt. Gen. B. Chaudhuri,<br>Director-General, Armed Forces Medical Services,<br>Ministry of Defence | Member   |
| 7. Lt. Col. Jaswant Singh,<br>Director-General of Health Services                                    | Member   |
| 8. Lt. Gen. D.N. Chakravarti,<br>Director of Health Services, West Bengal                            | Member   |

9. Dr Dukhan Ram, Vice-Chancellor, Bihar University	Member
10. Dr C.G. Pandit, Director, Indian Council of Medical Research	Member
11. Dr V.S. Mangalik, Principal, K.G. Medical College, Lucknow	Member
12. Major K.N. Rao, Director of Medical Services, Andhra Pradesh	Member
13. Dr (Miss) H.M. Lazarus, King George Hospital, Visakhapatnam, Andhra Pradesh	Member
14. Dr P.M. Mehta, Jamnagar	Member
15. Dr K.C.K.E. Raja	Member-Secretary
16. Dr T.R. Tewari	Member-Secretary

### Extracts Pertaining to Mental Health

#### Facilities for Mental Healthcare

Each district hospital should have a psychiatric clinic in the course of the next 10 years. Five to ten beds at the district level may be earmarked for psychiatric cases. Mental hospitals should be developed on a regional basis, the optimum strength being about 750. The majority of the mental hospitals are at present extremely overcrowded and understaffed. It is only in some places that there is an evidence of their transition from custodial to curative institutions. We have laid stress elsewhere on the importance of developing preventive psychiatric services, but even so the existing institutional facilities for the treatment of mental illness fall so short of the needs that within the next 10 years the number of mental hospital beds should at least be doubled.

#### (i) *Bhore Committee's Recommendations*

The Bhore Committee found that the existing provision for the medical care of mental patients was altogether inadequate and unsatisfactory. They, therefore, recommended the creation of mental health organisations as part of the establishments under the Directorate General of Health Services at the Centre and the Provincial Director of Health Services, the improvement of the existing mental hospitals and the establishment of new institutions, the provision of facilities for training in mental health for medical men and ancillary personnel in India and abroad and the establishment of a department of mental health in the proposed All-India Medical Institute.

#### (ii) *Present Position*

Reliable statistics regarding the incidence of mental morbidity in India are not available. It is believed that an enormous number of patients require psychiatric assistance and service. In India the ratio of mental patients is not less than 2:1,000 of population, that is to say, about a million persons in India require hospital accommodation. This number does not include the large number of mental defectives who need both medical and psychological treatment, and the epileptics who average about one in two hundred of the population. Including mental defectives and psychotics

and excluding psycho-neurotics, accommodation is needed for at least 2 million mental patients. If the psycho-neurotics are also included, the requirements will be of the order of 6 to 8 millions. As against this the total number of beds available now in mental hospitals in India is only 15,000. There is hardly any provision for the education of mental defectives. Provision for the treatment of psychosomatic diseases in general hospitals is inadequate.

The All India Institute of Mental Health was established in July 1954 as a result of the recommendations of the Bhore Committee, and started functioning in 1955 in association with the Mental Hospital, Bangalore. This institute provides facilities for postgraduate teaching and research. Its functions are chiefly to plan and conduct research on problems relating to mental health, to train psychiatrists, psychiatric nurses, occupational therapists and other personnel required to staff various mental hospitals and psychiatric clinics in general hospitals, to train psychologists and psychiatric social workers and to conduct surveys on the incidence of mental morbidity and the biological and ecological factors that are responsible for mental morbidity. It conducts a 2-year diploma course in Psychological Medicine (D.P.M.) and a 2-year diploma course in Mental Psychology (D.M.P.). The diploma in Psychiatric Nursing is of one year's duration.

The Mental Hospital, Ranchi, which was previously under a Board of Trustees, has now been taken over by the Central Government with a view of reorganising it on sound lines and also making it a model centre for the treatment of mental disorders. There are 420 beds at this hospital.

Under a second Five Year Plan scheme for the establishment of child guidance clinics and psychiatric departments in teaching hospitals, eight such units have come up in Andhra, Madras (2), Punjab, Uttar Pradesh, old Bombay State, Madhya Pradesh and Bihar.

### (iii) Recommendations

- (a) **General:** Having considered the comments and recommendations of the Bhore Committee and having taken stock of the present position regarding facilities for mental healthcare, we cannot help coming to the conclusion that there is a general sense of complaisance in regard to mental disease. This is, perhaps, born of the general impression that the incidence of mental illness in this country is not high. While no systematic representative surveys have been carried out, the estimates mentioned in an earlier paragraph should be sufficient to remove such an impression. There is, therefore, urgent need for the setting up of preventive mental health services, for the expansion and improvement of curative services, for the institution of training facilities, for meeting these needs and for research and survey programmes. The administrative organisation at the Centre and in the States would need to be geared up to meet these needs. In the preventive field there should be:

- Provision for mental health services at pre-primary, primary and secondary schools by the employment of not only psychiatrists and psychiatric social workers, but also by the employment of school counsellors among the teachers who have undergone intensive training and who would be able to deal with children with emotional difficulties and other problems.
- Marital and pre-marital guidance in the social field.
- Child guidance and psychiatric clinics in all teaching and other major and district hospitals.

The following curative psychiatric services for adults need to be provided to a far greater extent than at present:

- (i) In-patient and out-patient departments at lay hospitals.

- (ii) Independent psychiatric out-patient clinics or mental health clinics.
- (iii) Institutions for mental defectives.
- (b) **Training:** Training of psychiatric and mental health personnel. Orientation in mental hygiene for various professional groups in the field of family welfare and child welfare such as paediatricians, school teachers, nurses, social administrators, etc. All medical and public health personnel should be given orientation in the subject of mental health. In Appendix B-20 will be found a plan for starting schemes of training and psychiatric services on a pilot scale with the assistance of voluntary organisations and/or existing colleges and mental institutions.
- (c) **Research:** Research to increase the knowledge of the multiple causes of mental diseases and disorders, research in the factors which promote positive mental health, studies of personal and educational problems of children, the studies of the genesis of unhealthy parent/child relationships, research in association with the practitioners of indigenous systems of medicine in the treatment of mental illness with a view to benefit from the rich and ancient heritage of Ayurvedic and Unani systems of treatment, study of the possibilities of integrating psychiatric teaching within the medical curriculum, study of the role of malnutrition in the aetiology of psychiatric disorders, survey of the incidence of suicides and factors in relation to psychiatric aspects of crimes, need to be undertaken.

There is an acute shortage of personnel trained in mental health. Psychiatrists, clinical psychologists and psychiatric nurses need to be trained in large numbers. We are glad to note the increased demand on the training facilities in the All India Institute of Mental Health, Bangalore. Such facilities need to be multiplied. The Ranchi Mental Hospital should be developed into a full-fledged training institution and ultimately each region if not each state should become self-sufficient in the training of mental health personnel.

We are referring elsewhere to the questions of training psychiatric nurses and amendment of the Lunacy Act.

- 23. Each district hospital should have a psychiatric clinic and five to ten beds may be earmarked for psychiatric cases.
- 24. Mental hospitals should be developed on a regional basis, the optimum bed strength being about 750.

## Appendix C

# National Survey of Mental Health Resources (April-July 2002)

Pursuant to the orders of the Hon'ble Supreme Court in CWP No. 334 of 2001, the Government of India constituted a number of teams to inspect and report on the state of mental health services, with special focus on mental hospitals. These teams visited all state capitals and government-run mental hospitals across the country during Nov 2001-Jan 2002 and submitted their report on a standard format. The main findings of this comprehensive survey were as under:

1. As regards the status of implementation of the Mental Health Act 1987 is concerned, most of the states have implemented the same but rules thereunder have not been framed by all the states. While sufficient copies of the Act have been circulated to the concerned officers/institutions, the knowledge with regard to these statutes is rather sketchy/partial. Mental Health Cells have not been established in most of the states, though State Mental Health Authorities (SMHAs) have been constituted in a majority. However, meetings are not held regularly and their functioning needs considerable improvement. The situation in respect of licensing authorities and appointment of visitors/inspections required to be carried out by them is unsatisfactory.
2. In general, the state of the mental hospitals surveyed is not satisfactory. Generic observations in respect of these mental hospitals are as under:
  - (a) The infrastructure in most of the hospitals surveyed still leaves much to be desired though significant progress has been made in several areas following the National Human Rights Commission (NHRC) Report 1999. Many of the buildings are old, dilapidated and beyond economic repair. They had been built when the role of these hospitals was custodial rather than therapeutic. While renovation/repairs are underway at most places, there is a need to plan for modern structures which will conform to current needs, subject to the availability of resources.
  - (b) The situation with regard to staffing has improved since the NHRC report, but there are still significant gaps. Significant deficiencies or complete absence of psychiatric nurses, psychiatric social workers, clinical psychologist, occupational therapist and lab technicians were found in a majority of the mental hospitals surveyed. Posts of pathologists, radiologists, anesthetists and even the directors/medical superintendents were also vacant in many of the hospitals. Inadequacy of staff impacts adversely on the functioning of the hospitals and optimum utilisation of the available infrastructure and facilities. This aspect needs to be addressed and monitored on an ongoing basis.

- (c) Clinical services and the availability of investigative facilities are largely inadequate/ barely adequate, mainly for want of proper staff and equipments. Modern investigations like CT scans, ultrasound, etc., are mostly unavailable in these hospitals. In some of the hospitals, the services are on payment of user charges. Further upgradation with regard to investigative facilities is also required.
  - (d) Availability of drugs is generally adequate and has improved to a considerable extent in all the hospitals. However, old antipsychotic drugs are in use in most of the places. The new generation formulations of antipsychotic drugs, which have a friendlier side-effect profile and are more cost effective, need to be added to the formularies of the hospitals.
  - (e) The quality/quantity of food for the patients is better than yester years but offers scope for improvement, especially with regard to variety and the way it is served. Most hospitals do not have dining halls or proper utensils for patients to eat their food.
  - (f) Linen is inadequate or even non-existent in some hospitals. Many patients lie on floors, often without mattresses. This aspect needs urgent attention.
  - (g) Recreational facilities are an integral part of any mental hospital. The facilities for indoor as well as outdoor games are missing in most of the mental hospitals. Colour/ Black and White TVs have been installed in a majority of the hospitals. Some institutions have made efforts in this direction but overall recreational facilities need considerable augmentation and improvement.
  - (h) Vocational and rehabilitation facilities are still rudimentary and mostly obsolete, patterned for the old custodial mode of mental hospitals. Workshops and equipments therein are lacking; wherever in a small way existent, proper trained staff is deficient. Vast and radical changes are required in this regard to bring such facilities in tune with current realities.
  - (i) The lingering custodial atmosphere in mental hospitals can be traced to one common malady: the high proportion (up to 50% or even more) of long stay patients, i.e., patients who have been in hospital for two years or more, often for five years or more. The most unfortunate aspect of this problem is that these patients have been in hospital for years not because of treatment related reasons but because their families have abandoned them. Prolonged hospitalisation has further impaired their socio-vocational skills. The second common problem faced by every mental hospital is that of poor staffing particularly in relation to paramedical staff. This appears to be because of non-availability of these personnel as a consequence of inadequate training/facilities.
3. The formats employed for the survey are reproduced below:

#### ***I. Status Report: Mental Health Act 1987***

##### *General*

1. Date with effect from which the provisions of the Mental Health Act 1987 (hereinafter referred to as the Act) and the State Mental Health Rules 1990 (hereinafter referred to as the Rules) were enforced/implemented in the state?
2. Have sufficient copies of the said Act and Rules been made available to all concerned, including district officers,

- government medical officers, magistrates, officers-in-charge of police stations, etc.?
3. Has a Mental Health Cell been set up at the State Government headquarters for continuous, online monitoring of the process of implementation of the said Act/Rules and other mental health-related activities?:  
(Name/designation/telephone no. of OIC, Mental Health Cell to be appended)
  4. How many reception orders under section 22(7) of the said Act been passed during the last three calendar years (1988, 1999, 2000)?
  5. How many patients have been admitted to a psychiatric hospital or psychiatric nursing home through the process of inquisition under section 26 of the Act during the last three calendar years (1988, 1999, 2000)?
  6. How many mentally ill prisoners have been admitted to psychiatric hospitals/nursing homes under section 27 of the Act during the last three years (1988, 1999, 2000), with hospital-wise census?
  7. Have the National/State Human Rights Commission conveyed to the State Government any adverse comments/observations in respect of patients (including mentally ill prisoners) admitted to psychiatric hospitals/nursing homes during the last three years?
  8. Has any legal aid been provided to mentally ill patients at state expense under the provisions of section 91 of the Act during the last three years (1998, 1999, 2000)?
  9. Have there been any cases during the last three years where the cost of maintenance of mentally ill persons in government hospitals been recovered out of the estate of such mentally ill persons, or from persons legally bound to maintain them, under section 79 of the Act?

*Licensing Authorities*

10. Has a licensing authority been constituted under the provisions of Chapter III of the Act, read together with Chapter IV of the Rules?
11. If the response to the preceding question is in the affirmative, the name(s)/designation(s) of the aforesaid licensing authority (ies) and the date(s) from which they started functioning?
12. How many psychiatric hospitals/nursing homes have been licensed under the provisions of Chapter III of the act during the last three years (1998, 1999, 2000)? (District-wise details to be appended.)



13. How many applications for licensing of psychiatric hospitals/nursing homes been turned down during the last three years (1998, 1999, 2000)? (District-wise details to be appended.)
14. How many licenses of such psychiatric hospitals/nursing homes been revoked since the enforcement of the Act? (District-wise details to be appended.)
15. Has the state government allowed any appeals against such refusal/revocation of licensed of psychiatric hospitals/nursing homes by the licensing authority since the enforcement of the Act?

*Visitors*

16. Has the Government appointed Boards of Visitors for all psychiatric hospitals/nursing homes as prescribed in section 37(1) of the Act? (Hospital-wise lists of visitors to be appended.)
17. If the above provision has not been implemented fully/partially, what are the reasons for the same?
18. Has the State Government appointed an ex-officio visitor under the provisions of section 37(2) of the Act and the date from which the said visitor started functioning?(Name/designation of the visitor and copy of his/ her report for the year 2000 to be appended)?
19. Have monthly inspections by the boards of visitors been carried out as prescribed in section 38 of the Act and has record of such visits been maintained in accordance with the said provision? (Hospital/district-wise details to be appended.)
20. Has the Inspector General of Prisons carried out quarterly inspections of mentally ill prisoners detained in psychiatric hospitals/nursing homes in accordance with section 39(1)(i) of the Act?
21. Have six monthly reports in respect of mentally ill prisoners admitted to psychiatric hospitals/nursing homes been made regularly by the respective medical officers-in-charge as prescribed 39(3) of the Act? (Samples of any such three reports may be appended: District-wise details to be appended.)
22. What was the total number of mentally ill prisoners admitted to various psychiatric hospitals/nursing homes in the state as on 31 December 2000? (Institution-wise breakup with dates of admission, diagnosis to be appended.)

*Mental Health Authorities*

23. When was the State Mental Health Authority (hereinafter referred to as the Authority) constituted in the state in accordance with section 4 of the Act, read together with Chapter II of the Rules? (Names/designations and contact telephone numbers of the Chairman and members of the Authority to be appended.)
24. Has a permanent secretariat been established to provide administrative support to the Authority on a regular basis? (Name/designation and telephone numbers of the secretary to the Authority to be mentioned.)
25. Has the Authority met every six months as prescribed in Rule 7(1)?
26. When was the last annual meeting of the Authority held, vide Rule 7(2)?
27. Has the State Government regularly received copies of the proceedings of the Authority, as prescribed in Rule 14 and has appropriate follow-up action been taken on the same? (Copies of the proceedings of the last three meetings of the Authority along with corresponding action taken reports to be appended.)
28. Has the Authority initiated any steps for the effective implementation of the National Mental Health Programme in the state as envisaged in section 4(2)(a) of the Act?
29. What specific measures have been taken by the Authority to fulfill its supervisory role as envisaged in section 4(2)(b) of the Act? (Resume of the same may be appended.)
30. (a) What have been the key achievements of the Authority since its inception?:
  - (b) What have been the hurdles encountered in fulfilling the role assigned to the Authority under the Act?
  - (c) What are the future plans/projects of the Authority for the next two years (2001-2003)? (Detailed note may be appended.)

**II. Status Report: National Mental Health Programme (NMHP)**

31. Has the NMHP been implemented in your State ? If so, from which date.
32. Which districts are covered by the District Mental Health Programme (DMHP)? (Please append list with date from which the programme was launched and district-wise status in respect of staffing, training, provision of services, monitoring and year-wise expenditure incurred to date.)

33. Have regular reports on the performance of DMHPs been received from the respective nodal officers and have any specific problems been encountered? (Detailed note may be appended if required.)
34. Has the State Mental Health Authority exercised supervisory control over the DMHPs and has any review been carried out/report submitted to the government thereon?
35. Has the State Government funded any DMHP ab initio or on completion of central sponsorship of the same ? (Details may be appended as required.)
36. Has the State Government identified any new districts to be covered by DMHP? If so, what preliminary assessment/ pre-programme groundwork has been done?
37. Would the State Government be prepared to undertake implementation of DMHP as a centrally sponsored scheme in new districts, each affiliated to a zonal medical college for purpose of techno-managerial control? If so, detailed proposals regarding the same may be submitted.
38. Will the State Government undertake to fund the aforesaid proposed DMHPs on completion of five years of central sponsorship?
39. Has the State Government made separate provision for mental health in the State Budget and details thereof?
40. Any other suggestions/proposals the State Government would like to make in the aforesaid context.

### **III. Status Report : Mental Hospitals**

1. Name of the hospital
2. Location
3. Established in (Yr)
4. Administrative control
5. Funding

<i>Year</i>	<i>Source</i>	<i>Amount</i>	<i>Remarks</i> <i>(Adequate/inadequate)</i>
1998-1999	State Central Others (specify)		
1999-2000	State Central Others (specify)		
2000-2001	State Central Others (specify)		

6. Catchment area  
(Specify actual number of patients from each state in hospital as on 30.6.01)
7. Total area of hospital campus
8. Area under illegal encroachment, if any
9. Total covered area
10. Number of wards: Acute =  
                                   Subacute =  
                                   Chronic =  
                                   Male =  
                                   Female =  
                                   Children =  
                                   Alcohol/  
                                   drug dependence =  
                                   Criminal =  
                                   Paying =
11. (a) State of the buildings = Satisfactory/unsatisfactory/un-serviceable  
       (b) Funds for maintenance = Adequate/inadequate  
       (c) Agency for maintenance =  
       (d) Suggestions for improvement = (Append details)
12. State/number of sanitary annexes
13. State/number of cookhouses
14. State/number of dining halls
15. State/number of recreation rooms
16. Availability of occupational therapy facilities
17. Availability of TV sets (colour /B&W)  
(Available in all wards/only in recreation rooms)
18. Laboratory facilities  
(Give details of equipment, personnel, investigation facilities available, deficiencies, projected requirements, etc.)
- 19 X-Ray facilities  
(Give details as in item 18 above)
20. Ultrasonography  
(Give details of equipment/personnel/load-factor)
21. CT Scan/MRI  
(Give details as in item 20 above)
22. EEG (Give details as in item 20 above)
23. Biofeedback  
(Give details as in item 20 above)

24. ECT  
(Give details of ECT machine, whether brief pulse equipment available, modified/direct, etc.)
25. Anaesthesia  
(Give details of equipment/personnel available)
26. Clinical psychology lab.  
(Give details of instruments available/personnel/number of psychometric tests performed during the year 2000)
27. OPD block  
(Give details of accommodation/facilities, etc.)
28. Library facilities  
(Give details, including availability of internet)
29. Relations – quarters/*dharamshala* (Give details)
30. Availability of drugs = Satisfactory/unsatisfactory (Append details and list of drugs)
31. Quantity/quality of diet = Satisfactory/unsatisfactory (Append details, including weekly menu)
32. Provision of clean drinking water = Satisfactory/unsatisfactory (Give details of water coolers, etc.)
33. Hospital garden = recreational/fruit & vegetable garden.

34. Demographic data

S. No.	Parameter	1998	1999	2000
1.	Out-patients : new cases			
	Old cases			
	Total			
2.	In-patients			
	- Voluntary admissions/ referred by physicians/ brought by relations			
	- Under reception orders			
	- Convicts/under trials			
	- Total			
	(Number of female patients to be given in parenthesis)			
3.	Long-stay patients			
	- 2 Years or more			
	- 5 Years or more			
	- 10 Years or more			
	(Give % of total in parenthesis)			
4.	Average length of stay			
	- Males			
	- Females			
5.	Suicides			
	- Male/female			
6.	Other fatalities			
	- Male/female			
7.	Average expenditure per patient			
	- Diet			
	- Drugs			
	- Others			

35. OPD conducted daily (Specify days & timings, availability of drugs, amenities, staff, etc.)
36. Casualty/emergency services (Give full details, including staffing)
37. Outreach/community programmes, if any
38. Rehabilitation programmes (Give full details including those of half-way homes, day care centres)
39. Vehicles (including ambulance)
40. Staff:
 

Director	=
Medical Supdt.	=
Dy. Medical Supdt.	=
Psychiatrists	=
Physician	=
Pathologist	=
Radiologist	=
Medical Officers	=
Clinical Psychologists	=
Psychiatric Social Workers	=
Occupational Therapist	=
Psychiatric Nurses	=
Laboratory Technicians	=
Male Nurses	=
Administrative Staff	=
Safai Karmacharis	=
Others	=
Visiting Consultants	=

(Indicate disciplines)
41. Teaching activities: Undergraduate/postgraduate  
(Give details)
42. Hostel facilities
 

Postgraduates	=	Adequate/inadequate
Single Medical Officers	=	Adequate/inadequate
Single Nurses	=	Adequate/inadequate

(Give details, if required)
43. To what extent does your hospital conform to the minimum standards of care prescribed for mental hospitals by the Central Mental Health Authority during the year 2000?  
(Append detailed note, if required.)
44. What are the main problem areas identified by you?
45. What are your immediate (1 year), short-term (2 years) and long-term (5 years) requirements in terms of:
  - i. Buildings
  - ii. Equipment
  - iii. Staff
  - iv. Any other

(Detailed note to be appended, with estimated expenditure on each item)

46. Community Mental Health Activities (including the role of NMHP) = Give details
  47. Staff training = Extra mural/on job (Give details).
  48. Redressal of complaints = Give details of in-house machinery, PIL, court/NHRC orders, etc.
  49. General/concluding remarks  
(Please indicate your views regarding commercial sale of excess land in the hospital campus to raise resources for constructing a modern multistoried hospital.)
4. State-wise inferences derived from the survey are as under:

### **1. Andaman & Nicobar Islands**

The Andaman & Nicobar Islands are a unique geographical entity. The widely scattered pattern of the Islands constituting this UT and its tribal population pose unique problems in planning health delivery systems. The single psychiatric unit at G.B. Pant Hospital, Port Blair is sufficient for the basic mental health needs of the population. In order to provide community-based mental healthcare, however, it is desirable that a district mental health programme may be implemented with a view to take psychiatric outreach services to the doorstep of the people of this remote region. At least, one clinical psychologist and one psychiatric nurse should be posted to the G.B. Pant Hospital, Port Blair. Till a psychiatric social worker becomes available, a social worker with brief basic training in psychiatry can be used to augment domiciliary mental healthcare.

### **2. Andhra Pradesh**

The information received from the Government of Andhra Pradesh was, unfortunately, incomplete in several respects. The State has, however, taken the lead in rationalizing the infrastructure of the mental hospital at Visakhapatnam. In an innovative and bold step the Government, vide G.O. Ms. Nb. 336 dated 29.8.2001, has drawn up a well thought out plan to dispose off the surplus land available with the mental hospital as well as the Chest & I.D. Hospital, Visakhapatnam and utilize the sale proceeds thereof to build a modern multispeciality institute alongwith a new Hospital for Mental Care. This momentous initiative could become a model for other states which have large unmaintainable mental hospitals which can be similarly streamlined, downsized and rationalised. The State needs to expand the scope of community-based mental healthcare through District Mental Health Programmes (DMHPs) in as many districts as resources permit. Training facilities for psychiatrists as well as other mental health personnel such as clinical psychologists need to be augmented in order to meet severe shortages of trained manpower.

### **3. Arunachal Pradesh**

The State of Arunachal Pradesh should ideally have a DMHP in each district in view of its difficult geography. This may not be, however, feasible in the near future. The Government may, therefore, identify the districts where this can be started on a priority basis. The remaining districts may be provided psychiatric cover through outreach services depending on the availability of resources. The Government may also consider deputing some serving Medical Officers for brief (6 months) psychiatric training at Central Institute of Psychiatry (CIP) Ranchi or any other suitable institution as an interim measure. Local candidates may also be encouraged to go in for training as clinical psychologists, Psychiatric Social Workers (PSWs) and psychiatric nurses.

#### **4. Assam**

In spite of having a 500-bed mental hospital [now the LGB Regional Institute of Mental Health (LGBRIMH)] at Tezpur, large areas of this sensitive state are without even basic mental healthcare facilities. There are only two seats for MD (Psychiatry) at the Guwahati Medical College and the state is dependent upon psychiatrists trained in other states. There is an urgent need to augment postgraduate training facilities in the state and to implement the DMHP in as many districts as resources permit. Presently the DMHP is in operation in two of its districts, namely, Nagaon and Goalpara. The dramatic improvement in the standards of mental healthcare at the LGBRIMH, Tezpur is something, which the State can take pride in and which can become a role model for other mental hospitals to follow.

#### **5. Bihar**

The State of Bihar appears to be an area of darkness with regard to mental health services. Till the Hon'ble Supreme Court order passed in October 2001, the state had neither implemented the Mental Health Act 1987 nor constituted the SMHA/Licensing Authority (LA). At the time of the nation-wide survey of mental health facilities carried out by this Directorate during December 2001-January 2002, the situation in Bihar was the most dismal among all States/UTs. Since then there appears to have been marginal improvement in this area and SMHA/LA have been constituted. The State has a long way to go before it can reach even the basic minimum standards of mental healthcare. It is learnt that the MD (Psychiatry) awarded by the State Universities is not recognized by the Medical Council of India. In this context, it is unfortunate that the State Government has chosen to divert scarce resources towards creation of a 250-bed mental hospital at Bhojpur. This goes against expert opinion worldwide which favours community-based mental healthcare rather than prolonged incarceration in mental hospitals which eventually de-socialize and de-humanise mental patients. The Government of Bihar may be well advised to utilise whatever resources they have for implementing the DMHP in as many districts as fiscally feasible. This would be a much more cost-effective and scientifically desirable proposition.

#### **6. Chandigarh**

This UT is well served with regard to mental healthcare facilities but there is relative shortage of psychiatric social workers and psychiatric nurses. Chandigarh is home to the prestigious PGIMER and effort should be made to start training programmes leading to MSW (Psych) and DPN (Diploma in Psychiatric Nursing) where the candidates for training can be drawn from other states as well. This would not only help to meet the requirements of the UT but would also provide badly needed professionals to other States.

#### **7. Chhattisgarh**

This newly created State has inherited a poorly developed mental health structure and vast areas are without even basic facilities in this regard. It is, however, gratifying that the state government has moved quickly to create a Department of Psychiatry in the Raipur Medical College with 30 beds as well as posts of Psychiatrists in each of the 16 districts. It is desirable that DMHP should be implemented in as many districts as possible in order to provide community-based mental healthcare to people in far-flung areas.

#### **8. Daman & Diu and Dadra & Nagar Haveli**

The psychiatric services in these small UTs appear to be adequate for their limited requirements.



Qualitative improvements may be, however, required and can be identified by the UT Administration.

### **9. Delhi**

Delhi has adequate psychiatric facilities in the public as well as private sector, though these may not be evenly distributed and the large body of migrant population might be under-served in this regard. The number of clinical psychologists and psychiatric social workers needs to be augmented. Training facilities for these personnel could be developed at AIIMS and IHBAS. The number of psychiatric nurses (172) appears rather large.

### **10. Goa**

This small State reflects the distortion in the availability of mental health personnel. While there is a surfeit of psychiatrists, the number of clinical psychologists, psychiatric social workers and psychiatric nurses is far short of requirement. The State has invested huge resources in constructing a new campus for the Institute of Psychiatry and Human Behaviour (IPHB), Bambolim. Given the right kind of dynamic and imaginative leadership IPHB can become a major centre for training mental health personnel including clinical psychologists, PSWs and psychiatric nurses. The State has one DMHP.

### **11. Gujarat**

This otherwise progressive State reflects the unfortunate paradox associated with mental illness. While the Mental Health Act 1987 and the rules framed thereunder have been in operation for over a decade it was only after the intervention of the Hon'ble Supreme Court during October 2001 that the Government machinery moved to enforce licensing procedure for private psychiatric centres. As per the Chief Secretary's affidavit only one out of 46 such institutions was found to have the prescribed minimum standards while the rest had been functioning in an unregulated manner. The State needs to augment training facilities for mental health personnel, specially clinical psychologists, PSWs and psychiatric nurses. DMHP should be implemented in as many districts as fiscally feasible. In those districts where no Government psychiatrist is available at present the possibility of utilising the services of private sector psychiatrists on part-time honorary basis may be explored.

### **12. Haryana**

Located next to the national capital, Haryana offers a study in contrast with regard to mental health facilities. This paradox is aptly illustrated by PGIMS, Rohtak, which, it is understood, does not have a recognized MD (Psychiatry) course. Training avenues for clinical psychologists, PSWs and psychiatric nurses are practically non-existent. In this context, it is unfortunate that the state government continues to base its mental health plans on the 1946 Bhore Committee Report, ignoring the phenomenal advances, which have taken place over the past few decades. Availability of cheap, effective and safe psychotropic drugs has rendered hospitalization unnecessary and even undesirable in most cases. The World Health Report 2001 reflects the consensus view that the focus should now shift from mental hospitals, which are now obsolete, to community-based treatment/rehabilitation. It is, therefore, a matter of serious concern that the Haryana Government proposes to waste scarce resources in setting up a 150-bed mental hospital at Rohtak, which would become another haven for avoidable chronicity, abandonment by families and

undischargable long-stay patients. It is, therefore, strongly urged that the State Government should review this decision in consultation with the Union Ministry of Health and utilise the resources so saved to implement DMHP in all districts of the State, thereby taking mental healthcare to the doorstep of the people.

### **13. Himachal Pradesh**

This hill State with a relatively low density of population suffers from uneven distribution of mental health facilities. Considering the difficult nature of the terrain and distribution of the population in inaccessible pockets it is desirable that every District should have a district mental health programme in order to do the greatest good to the largest number. In this context, the proposed 50-bedded Himachal Institute of Mental Health and Neuro Sciences (HIMHANS) appears rather incongruous, and is perhaps yet another attempt to clone NIMHANS, Bangalore. The creation of such largely decorative showpieces absorbs huge resources, which could be otherwise utilised to provide community-based mental healthcare and rehabilitation facilities to the population at large. Even at this late stage the Himachal Government may consider reviewing this decision and instead augment the existing Departments of Psychiatry and Neurology at the Indira Gandhi Medical College and Hospital, Shimla, thereby saving on avoidable infrastructure/administrative costs involved in setting up a separate institute.

### **14. Jharkhand**

When Bihar was bifurcated all major mental health institutions in the government as well private sector went to the State of Jharkhand. These include the 500-bed Ranchi Institute of Neuro Psychiatry and Allied Sciences (RINPAS) under the State Government and the Central Institute of Psychiatry (673 beds) run by the Union Ministry of Health and Family Welfare. Apart from this Ranchi has the 140-bed Davis Institute of Neuro Psychiatry in the private sector. RINPAS with an annual budget of Rs 9.50 crore has an average bed occupancy of about 50 per cent and most of these patients are in hospital for non-psychiatric reasons, i.e., owing to abandonment of long-stay patients by their families. Do we really need two such large mental health institutes adjacently located in the same city, both having under utilized bed occupancy? This question needs to be debated. The Jharkhand Government should consider implementing DMHP in as many districts as possible, which will ensure community-based mental healthcare for a much larger population.

### **15. Jammu & Kashmir**

The people of Jammu & Kashmir have faced immense mental stress during the past 15 years of militancy and cross-border terrorism. It is, therefore, unfortunate that large parts of the State are without even basic mental healthcare facilities. The mental hospital at Srinagar has had an unfortunate history and during the mid seventies fire claimed the lives of many patients. Training facilities for mental health personnel are deficient and urgent steps are required to augment the same. Considering the special status of this disturbed State, the case for implementing DMHP in as many districts as possible needs to be supported strongly.

### **16. Karnataka**

The State occupies a unique position in the field of mental health. The premier psychiatric institution in the country, NIMHANS, is located in Bangalore. The first prototype DMHP was implemented in the Bellary district and many landmark projects have been undertaken since. It, therefore, appears rather amazing that no psychiatric facilities are available in adjacent rural

districts of Bangalore, next door to NIMHANS. This vividly reflects the broad gulf, which separates urban India from rural Bharat. There is an urgent need to correct this distortion in the distribution of mental health resources in this advanced State, which has been in the forefront of the mental health movement in India. Training facilities for clinical psychologists, PSWs and psychiatric nurses may be created at the Karnataka Institute of Mental Health, Dharwad.

### **17. Kerala**

Kerala tops in literacy rates and many other quality of life indices. It is also a role model for other States to follow in the field of mental health. It has the unique distinction of being the first state of the Union to have formulated a Mental Health Policy, vide G.O.No. (P) 92/2000-H&FWD. The private sector in Kerala is the most active in the country and it has more beds than in the Government sector. Every district in this State has psychiatric facilities in the public as well as private sector. The Kerala Mental Health Authority is undoubtedly the most active in the whole country and it has taken several pioneering initiatives, including the aforesaid mental health policy. There is, however, an urgent need to augment training facilities for clinical psychologists, PSWs and psychiatric nurses. Health administrators and mental health professionals from other states would do well to undertake a pilgrimage to Trivandrum in order to benefit from this robust success story. Kerala provides a bright ray of hope in the midst of widespread darkness in the field of mental health.

### **18. Lakshadweep**

This picturesque UT comprises several islands, which pose special problems in planning healthcare delivery systems. As of now there are no mental healthcare facilities for this remote island territory, which often remains cut off from the mainland due to bad weather/rough seas. It is, therefore, considered necessary that DMHP should be implemented in the UT, in spite of its small population. The unique population profile and socio-cultural structure of the Lakshadweep society offers interesting opportunities for psycho-social and epidemiological research.

### **19. Madhya Pradesh**

The mental health sector in the largest State of the country presents a rather desolate picture with only 12 psychiatrists and with psychiatric facilities in only six of its 45 districts. Both the mental hospitals in the State are grossly sub-standard as revealed in the NHRC Report-1999 and in the Dec 2001-Jan 2002 survey carried out by this Ministry. In spite of having well-established medical colleges at Bhopal, Indore, Gwalior, etc., there are, surprisingly, no postgraduate training facilities in psychiatry. The State needs to make a massive effort to bridge the gap in this field to ensure even basic standards of mental healthcare for the people. As things stand, even if money for implementing DMHPs was to be made available the State might not be able to find mental health professionals to staff the project. This calls for urgent remedial action.

### **20. Maharashtra**

The State provides a study in contrasts with regard to the distribution of mental health services. While there is a huge concentration of psychiatrists in places like Mumbai and Pune, almost half of the districts in the State are without even the bare minimum mental healthcare facilities. There is, therefore, an urgent need to ensure equitable distribution of resources through relatively low-cost alternatives such as modified DMHPs in as many districts as financially feasible. In-service Medical Officers can be given three months skill-based psychiatric training at the various medical

colleges in order to meet immediate manpower requirements as an interim measure. It may be mentioned here that the mental hospital at Ratnagiri on the Konkan Coast, under the dynamic leadership of a young and dedicated psychiatrist could well become a role model for all other such institutions in the country for the level of community integration and the excellence of outreach services achieved by it. Ratnagiri should become a place of pilgrimage for all mental hospital Superintendents so that they can observe at first hand this unique success story of dedication triumphing over limitation of resources in a remote town.

### **21. Manipur**

This relatively small State has performed much better than many of the larger States in the field of mental health. The State Government appears to be sensitive to the mental health needs of the people and has made significant progress in establishing psychiatric facilities such as GHPUs at both the Regional Institute of Medical Sciences (RIMS), Imphal and the J.N. Hospital, Imphal East, apart from psychiatric beds in two other district hospitals. It has also prepared a detailed proposal for establishing a 50-bedded mental hospital in the State. Considering the current thrust towards community-based mental healthcare, the State Government may reconsider this proposal and instead go in for DMHPs in as many districts as resources permit. Special attention may be given to De-Addiction Programmes and to neuro-psychiatric problems associated with AIDS.

### **22. Meghalaya**

The "Scotland of the East" presents a dismal picture with regard to mental health services. Six out of its seven districts have no community-based mental healthcare facilities and yet the State Government proposes to invest its scarce resources in creating the Meghalaya Institute of Mental Health & Neuro Sciences which is likely to become a white elephant. Creating community-based mental healthcare/rehabilitation delivery systems through DHMPs will be a much more cost-effective and pragmatic proposition. The make-shift mental hospital at what used to be the Mawlai Jail should be wound up at the earliest and the inmates relocated within the community after psychiatric treatment.

### **23. Nagaland**

The state, one of the seven sister states of the eastern part of the country, has at present five psychiatrists and 25 indoor beds in Mental Hospital, Kohima. There is complete lack of clinical psychologists and psychiatric social workers. There is only one Psychiatric nurse. Instead of increasing the bed strength of Mental Hospital at Kohima, the state authorities may be advised to spend its resources to upgrade the facilities of the existing mental hospital and initiate DMHPs in its districts and consider training its manpower in established institutes like CIP, Ranchi.

### **24. Mizoram**

This State is in the enviable position of being able to start with a clean slate in respect of mental health services. It should not, therefore, fall into the trap of trying to establish mental hospitals/exclusive psychiatric institutions. The available resources should be used to implement district mental health programme in all districts/for creating GHPU in a phased manner.

### **25. Orissa**

Tragically the land of Konark, the Sun God presents with widespread darkness in the field of mental health. Only four of its 26 districts have even basic mental healthcare facilities and

training avenues for mental health professionals are grossly inadequate. The Chief Secretary's affidavit speaks of Orissa being a poor State. That should not become an alibi for inaction. It should, instead, stimulate a search for innovative and cost-effective interventions such as a modified DMHP to make community-based mental healthcare a reality. Voluntary agencies can play a significant role in this regard. The State Government should seek advice from the Union Ministry of Health and NIMHANS, Bangalore for planning a low-cost mental healthcare delivery system.

## **26. Pondicherry**

This Union Territory is well-served in respect of mental health resources and JIPMER provides treatment as well as training facilities of a high order. The Institute should, however, take steps to establish training facilities for clinical psychologists, PSWs and psychiatric nurses in view of widespread shortages of manpower in these fields.

## **27. Punjab**

Mental Hospital, Amritsar, under the dynamic leadership of the late Dr. Vidya Sagar, had pioneered family-assisted psychiatric treatment of acutely ill mental patients nearly half a century ago. The reoriented NMHP recommends the same strategy for preventing alienation and consequent abandonment of patients admitted to mental hospitals by their families. Admission to mental hospitals should become incumbent upon the members of the patient's family staying on within the hospital premises to care for the patient during treatment for the acute phase of the illness before taking the patient back home for supervised domiciliary aftercare. With the availability of newer psychopharmacologic agents, the period of such hospitalisation should not exceed 30 days. This will automatically preclude the possibility of long stay, chronicity and abandonment by families which probably accounts for the huge arrears owed by Haryana (Rs 13.54 crore), Himachal Pradesh (Rs 2.6 crores) and Chandigarh UT (Rs 4.34 lakh) to the State of Punjab. The proposed Institute of Mental Health should pursue the practice of involving the families of mental patients in their treatment from the earliest stages in order to avoid repetition of this unfortunate state of affairs. Intensive efforts should be made to implement DMHP in the six districts, which have no mental healthcare facilities at present.

## **28. Rajasthan**

The State should concentrate on implementing DMHP in the sixteen districts, which do not have any mental health facilities at present. The existing "mental hospitals" at Jaipur and Jodhpur should be improved with regard to infrastructure and other facilities and should function conceptually as GHPU's rather than as custodial institutions. Postgraduate training leading to MD (Psych)/DPM should be made available in all medical colleges in the State and the possibility of starting M Phil (Clinical Psychology), MSW (Psych) and Diploma in Psychiatric Nursing (DPN) should be actively explored. The emphasis should be on creating community-based mental healthcare/rehabilitation services rather than institutionalized care.

## **29. Sikkim**

This small Northeastern State has done well with regard to mental health services. While two of its four districts have adequate mental healthcare facilities the other two districts need to be provided with basic services through DMHP. The State also requires clinical psychologists, psychiatric social workers and psychiatric nurses. In view of its small size it may not be feasible

to develop training facilities for these personnel within the State. The possibility of training in service candidates at NIMHANS, Bangalore and CIP, Ranchi may be explored.

### **30. Tamil Nadu**

It is rather ironical that the tragedy at Erwady attracted adverse public attention to Tamil Nadu, which is perhaps the first State in the country to have posted a Government Psychiatrist in each of its 30 districts including Ramanathapuram wherein the asylum was located. This highlights the fact that mere availability of psychiatric facilities does not ensure mental healthcare delivery at the grass-root level and a more holistic approach is needed. In this context, it is recommended that the State Government should consider implementing the DMHP using the services of psychiatrists already posted to each of the 30 District Hospitals. There is also a need to augment training facilities for clinical psychologists, PSWs, and psychiatrist nurses. Continued vigilance is required to prevent the Erwady tragedy from recurring elsewhere and intensive Information Education and Communication (IEC) initiatives are indicated.

### **31. Tripura**

The State Government appears to be alive to the mental health needs of the people. It has projected the requirement for an 89-bedded psychiatric hospital at Agartala. In view of the current trend worldwide the establishment of such a hospital is not required. The funds demand (Rs 1447.18 lakh) for this project can be better utilized to implement DMHP in each of the four Districts of the State, with provision for 10-20 beds for psychiatric/substance use disorder cases at the District Hospitals. This would be a much more cost-effective and therapeutically desirable option. The non-availability of clinical psychologists and psychiatric social workers may pose a problem in this regard. The State Government should approach NIMHANS, Bangalore and CIP, Ranchi for training facilities in these areas.

### **32. Uttaranchal**

The hill districts of Uttar Pradesh, which now constitute Uttaranchal, have total lack of any mental healthcare delivery system in the new State. The only psychiatrists available are located at Dehradun and that too in the private sector. There is an urgent need for the recruitment of psychiatrists and implementation of DMHP in as many districts as financially feasible. In the meanwhile the State Government may consider deputing one Medical Officer from each district for a brief (3 months) skill-based psychiatric training programme at NIMHANS, Bangalore; AIIMS, New Delhi; K.G. Medical College, Lucknow and CIP, Ranchi. This would help as an interim measure till qualified psychiatrists become available. The State Government should also seek training facilities for clinical psychologists, PSWs and psychiatric nurses at the aforesaid institutions on a sponsored basis.

### **33. Uttar Pradesh**

The most populous State in the country presents a rather chaotic picture. This is reflected vividly in the approximate figures ("20-25", "250-300", "1300-1600", "1700-1800") provided by the State Government in respect of psychiatric resources even in the public sector. It appears amazing that the State Government is not aware of the exact number of its employees. It is, therefore, not surprising that 60 of its 90 districts do not even have basic mental healthcare services. The three mental hospitals located in the State had been, not unexpectedly, in a terrible state till the Hon'ble Supreme Court intervened in the case of the Agra Mental Hospital, which has since improved considerably. The other

two hospitals at Varanasi and Bareilly, however, continue to be deficient with regard to the prescribed minimum standards. The State has no psychiatric nurses and only a handful of clinical psychologists and PSWs. There are no half-way homes or child guidance clinics. A massive, time-bound effort will be required if the conditions are to improve and not deteriorate further.

### **34. West Bengal**

West Bengal is fortunate in having psychiatric out-patient services in all districts. The state of mental hospitals, however, leaves much to be desired and intensive time-bound efforts will be required to improve standards of care in these hospitals and to address the problem of long-stay patients. There is also a requirement to augment the availability of clinical psychologists and psychiatric social workers. The information sheet received from the State Government indicates the number of psychiatric nurses as 5,962 in the Government sector alone. It appears that the standard criteria used in defining psychiatric nurse (Diploma in General Nursing plus Diploma in Psychiatric Nursing – DPN) has not been used while specifying the number of such personnel.

## **Status Report: Mental Hospitals**

### **LGB Regional Institute of Mental Health, Tezpur (Assam)**

<b>S.No.</b>	<b>Point for comment</b>	<b>Comments</b>
1.	Name of the hospital	<b>LGB Regional Institute of Mental Health, Tezpur, Assam.</b>
2.	Infrastructural facilities	Inadequate. Plans have been made for renovation and improvement.
3.	Staff	<ul style="list-style-type: none"> <li>• Clinical staff is inadequate.</li> <li>• Clinical Psychologist, Dietician, Recreational Therapist, Occupational Therapist are not there.</li> <li>• Psychiatrists and Medical Officers are also very few in number.</li> </ul>
4.	Clinical services (including investigation facilities)	All medical investigations are available; psychological investigations are not available; serum lithium is not being done.
5.	Availability of drugs & other treatment modalities	All drugs are available. Only direct ECT is being used; facilities for anaesthesia are not available.
6.	Quality of food/kitchen facilities	Food is satisfactory. Kitchen requires improvement. A dietician is urgently required.
7.	Availability of linen/patients' clothing	The linen and patients' clothing are satisfactory, though less in quality as per standards of minimum care.
8.	Recreational facilities	Colour TV and a large ground to play are available. No other indoor or outdoor games are available.
9.	Vocational/rehabilitation facilities	None exist.
10.	Remarks	This institute has been taken over by North East Council and is being renovated gradually.

**Mental Hospital, Berhampore (WB)**

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Mental Hospital, Berhampore, West Bengal.</b>
2.	Infrastructural facilities	Lacks most of the facilities; the building is in poor state.
3.	Staff	Staff strength of 278. However, clinical and para-clinical staff is deficient.
4.	Clinical services (including investigational facilities)	No facilities for investigations are available.
5.	Availability of drugs & other treatment modalities	Conventional drugs are available. ECT is given without modification as no anaesthetist is available.
6.	Quality of food/kitchen facilities	Satisfactory. Kitchen requires improvement.
7.	Availability of linen/patients' clothing	The linen and patients' clothing are inadequate.
8.	Recreational facilities	Lacks recreational facilities.
9.	Vocational/rehabilitation facilities	Lacks facilities in this field.
10.	Remarks	This hospital was started when the premises were vacated by an old prison when it was shifted to new buildings. It gives an impression of prison rather than a mental hospital.

**Calcutta Pavlov Hospital, Kolkata (WB)**

S.No.	Point for Comment	Comments
1.	Name of the hospital	<b>Calcutta Pavlov Hospital, Kolkata, West Bengal.</b>
2.	Infrastructural facilities	Adequate facilities. The building is satisfactory.
3.	Staff	Staff strength of 198. However, clinical and para-clinical staff are deficient.
4.	Clinical services (including investigational facilities)	No facilities for investigations are available.
5.	Availability of drugs & other treatment modalities	Conventional drugs are available. ECT is given without modification as no anaesthetist is available.
6.	Quality of food/kitchen facilities	Satisfactory. Kitchen requires improvement.
7.	Availability of linen/patients' clothing	The linen and patients' clothing are adequate.
8.	Recreational facilities	Lacks recreational facilities.
9.	Vocational/rehabilitation facilities	Lacks facilities in this field. However, one NGO is working to provide some vocational training



10.	Remarks	The female ward requires lot of improvement. The kitchen and dining hall requires repairs. Lot of improvement is required for recreational and vocational training.
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### **Lumbini Park Mental Hospital, Kolkata (WB)**

S.No.	Point for Comment	Comments
1.	Name of the hospital	<b>Lumbini Park Mental Hospital, Kolkata, West Bengal.</b>
2.	Infrastructural facilities	Inadequate facilities. The building is in a poor state.
3.	Staff	Staff strength is 131. However, the clinical staff is deficient and requires proper enhancement.
4.	Clinical services (including investigational facilities)	No facilities for investigations are available.
5.	Availability of drugs & other treatment modalities	Conventional drugs are available. ECT is given without modification as no anaesthetist is available.
6.	Quality of food/kitchen facilities	Satisfactory. Kitchen requires improvement.
7.	Availability of linen/patients' clothing	The linen and patients' clothing are inadequate.
8.	Recreational facilities	Lacks recreational facilities.
9.	Vocational/rehabilitation facilities	Lacks facilities in this field.
10.	Remarks	The building requires lot of improvement. Recreational facilities and staff position require strengthening.

### **Institute of Psychiatry, Kolkata (WB)**

S.No.	Point for Comment	Comments
1.	Name of the hospital	<b>Institute of Psychiatry, Kolkata, West Bengal.</b>
2.	Infrastructural facilities	Inadequate facilities. The building is in a poor state.
3.	Staff	Staff strength of 49. However, the clinical as well as para-clinical staff is deficient. In female wards <i>ayahs</i> are not available and, therefore, the female wards are closed.
4.	Clinical services (including investigational facilities)	No facilities for investigations are available. However, help is taken from the neighbouring hospitals.
5.	Availability of drugs & other treatment modalities	Conventional drugs available. ECT is given without modification as no anaesthetist is available.
6.	Quality of food/kitchen facilities	Satisfactory. Kitchen requires improvement.

7.	Availability of linen/patients' clothing	The linen and patients' clothing are inadequate.
8.	Recreational facilities	Lacks recreational facilities.
9.	Vocational/rehabilitation facilities	Lacks facilities in this field.
10.	Remarks	The building requires lot of improvement. Clinical, para-clinical and recreational staff position requires strengthening.

### Mental Hospital, Mankundu (WB)

S.No.	Point for Comment	Comments
1.	Name of the hospital	<b>Mental Hospital, Mankundu, West Bengal.</b>
2.	Infrastructural facilities	Requires renovation of the building, which is in a poor state.
3.	Staff	Staff strength of 70. However, lacks full-time Psychiatrists and other clinical and para-clinical staff.
4.	Clinical services (including investigational facilities)	No facilities for investigations are available.
5.	Availability of drugs & other treatment modalities	Conventional drugs are available, though not for the out-patients. ECT is given directly without modification (no anaesthesia facility is available).
6.	Quality of food/kitchen facilities	Kitchen requires improvement.
7.	Availability of linen/patients' clothing	The linen and patients' clothing are inadequate.
8.	Recreational facilities	Lacks recreational facilities. The occupational therapist is available but no infrastructure.
9.	Vocational/rehabilitation facilities	Lacks all facilities in this field.
10.	Remarks	This hospital has a very old building. Renovation of the building is a top priority area. Also, it is not manned by qualified mental health professionals.

### Central Institute of Psychiatry, Ranchi (Jharkhand)

S.No.	Point for Comment	Comments
1.	Name of the hospital	<b>Central Institute of Psychiatry, Ranchi, Jharkhand.</b>
2.	Infrastructural facilities	The buildings are old barracks type, unsatisfactory and dilapidated: all wards were constructed in 1918 except two new wards (children ward and de-addiction ward). Hostel facility for students and residents is inadequate.

3.	Staff	Out of 33 sanctioned Group 'A' posts, 20 are lying vacant and out of 12 Group 'B' posts, 10 are lying vacant. All the posts in clinical psychology and psychiatric social work are vacant and lapsed.
4.	Clinical services (including investigational facilities)	Clinic services and investigation facilities are adequate.
5.	Availability of drugs & other treatment modalities	Conventional drugs are available, both for indoor as well as outdoor patients. ECT is given directly without modification (no anaesthesia facility is available).
6.	Quality of food/kitchen facilities	The quality of food is good and kitchen facilities are satisfactory. There are separate dining halls for males and females.
7.	Availability of linen/patients' clothing	The linen and patients' clothing are satisfactory and adequate.
8.	Recreational facilities	There is color TV in all the wards. Music facility along with the music teacher is available. Besides gardening, painting facility is also available. A film is shown every week.
9.	Vocational/rehabilitation facilities	The facilities for carpentry, blacksmithy, sewing and stitching, embroidery, gardening, clay modelling, canning, weaving and carpet making, etc., are available.
10.	Remarks	This hospital has very old buildings. Renovation of the old buildings and construction of new, modern hospital buildings is required.

### **Ranchi Institute of Neuro Psychiatry and Allied Sciences, Ranchi (Jharkhand)**

S.No.	Point for Comment	Comments
1.	Name of the hospital	<b>Ranchi Institute of Neuro Psychiatry and Allied Sciences (RINPAS), Ranchi, Jharkhand.</b>
2.	Infrastructural facilities	The buildings are old and require repair/renovation. Hostel facility for students and residents is inadequate.
3.	Staff	Some of the sanctioned posts are vacant. For example, Radiologist and Pathologist.
4.	Clinical services (including investigational facilities)	Clinical services and investigation facilities are satisfactory.
5.	Availability of drugs & other treatment modalities	Conventional drugs available, both for indoor as well as outdoor patients. ECT is given directly without modification (no anaesthesia facility is available).

6.	Quality of food/kitchen facilities	Satisfactory; dining space in every ward.
7.	Availability of linen/patients' clothing	The linen and patients' clothing are satisfactory.
8.	Recreational facilities	Colour TV in each ward, water cooler and newspaper facilities are available.
9.	Vocational/rehabilitation facilities	Tailoring, weaving, carpet making, carpentry, blacksmithy, book binding, basket making, embroidery, etc., facilities are available.
10.	Remarks	The water supply is inadequate. The ratio of accommodation to the staff is less. The hospital buildings are old and require repair/renovation.

### **Institute for Mental Care, Purulia (WB)**

S.No.	Point for Comment	Comments
1.	Name of the hospital	<b>Institute for Mental Care, Purulia, West Bengal.</b>
2.	Infrastructural facilities	State of buildings is unsatisfactory, with widespread water seepage during rain; inadequate for the number of patients.
3.	Staff	Not to full satisfaction. There is only one Psychiatrist and four Medical Officers for the whole hospital.
4.	Clinical services (including investigational facilities)	The clinical services and laboratory facilities are inadequate. X-ray facilities, EEG, biofeedback and anaesthesia facilities are lacking.
5.	Availability of drugs & other treatment modalities	Availability of drugs and other treatment modalities is inadequate.
6.	Quality of food/kitchen facilities	Kitchen facilities are inadequate and there are no dining halls.
7.	Availability of linen/patients' clothing	Not sufficient.
8.	Recreational facilities	Nil.
9.	Vocational/rehabilitation facilities	Nil.
10.	Remarks	Building, equipment, staff and other facilities are insufficient.

### **Mental Health Centre, Thiruvananthapuram (Kerala)**

<b>S.No.</b>	<b>Point for comment</b>	<b>Comments</b>
1.	Name of the hospital	<b>Mental Health Centre, Thiruvananthapuram, Kerala.</b>
2.	Infrastructural facilities	Inadequate. Buildings are old, dilapidated and beyond economic repair. Major improvements are required.
3.	Staff	Total staff is much short of the sanctioned strength. Director, Physician, Pathologist and Radiologist are non-existent.
4.	Clinical services (including investigation facilities)	Adequate in respect of equipment, but technical staff is inadequate.
5.	Availability of drugs and other treatment modalities	Adequate in respect of drugs but other psycho-social interventions are practically non-existent.
6.	Quality of food/kitchen facilities	Quality of food is barely satisfactory. Kitchen facilities have been improved during the past two years but are still below the prescribed minimum standard.
7.	Availability of linen/ patients' clothing	Grossly inadequate; practically no linen/clothing is provided to patients.
8.	Recreational facilities	Colour TVs are available in most of the wards. There are no other recreational facilities.
9.	Vocational/rehabilitation facilities	Nil.
10.	Remarks	The hospital is deficient in all facilities. Some equipment has been added to the labs but basic infrastructural facilities remain grossly inadequate. The staffing in all areas is even less than the sanctioned strength. However, the OPD and records are computerised. The hospital has been able to bring down the proportion of long-stay patients significantly during the last two years.

### **Mental Health Centre, Thrissur (Kerala)**

<b>S.No.</b>	<b>Point for comment</b>	<b>Comments</b>
1.	Name of the hospital	<b>Mental Health Centre, Thrissur, Kerala.</b>
2.	Infrastructural facilities	The state of buildings is satisfactory but sanitary annexes, etc., require improvement.
3.	Staff	Total staff is much short of the sanctioned strength. Director, Physician, Pathologist and Radiologist are non-existent.

4.	Clinical services (including investigation facilities)	Grossly inadequate.
5.	Availability of drugs & other treatment modalities	Fairly satisfactory but newer drugs need to be added.
6.	Quality of food/kitchen facilities	Quality of food is barely satisfactory. Kitchen facilities have been improved during the past two years but are still below the prescribed minimum standard.
7.	Availability of linen and patients' clothing	Grossly inadequate; practically no linen/clothing is provided to patients.
8.	Recreational facilities	Colour TVs are available in most of the wards. There are no other recreational facilities.
9.	Vocational/rehabilitation facilities	Nil.
10.	Remarks	The hospital is deficient in all facilities. Some of the older buildings need to be demolished and new wards need to be constructed. Deficiency in staff impaired the functional efficiency of the hospital.

### Mental Health Centre, Kozhikode (Kerala)

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Mental Health Centre, Kozhikode, Kerala.</b>
2.	Infrastructural facilities	Inadequate. Buildings are old, dilapidated and beyond economical repair. Major improvements are required.
3.	Staff	Total staff is much short of the sanctioned strength. Director, Pathologist and Radiologist are non-existent.
4.	Clinical services (including investigation facilities)	Inadequate; investigative facilities are below minimum standard.
5.	Availability of drugs & other treatment modalities	Adequate in respect of drugs, but other psycho-social interventions are practically non-existent. Newer drugs need to be added.
6.	Quality of food/kitchen facilities	Quality of food is barely satisfactory. Kitchen facilities have been improved during the past two years but are still below the prescribed minimum standard.
7.	Availability of linen/patients' clothing	Grossly inadequate; practically no linen/clothing is provided to patients.
8.	Recreational facilities	Colour TVs are available in most of the wards. There are no other recreational facilities.

9.	Vocational/rehabilitation facilities	Workshop facilities are just satisfactory including book-binding, printing, etc. Rehabilitation services are inadequate.
10.	Remarks	The hospital requires replacement/renovation of old buildings. Deficiencies in staff affect patient care. Rehabilitation component requires augmentation.

### **Institute of Mental Health, Chennai (TN)**

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Institute of Mental Health, Chennai, Tamil Nadu</b>
2.	Infrastructural facilities	Inadequate. It is understood that a plan for demolition of obsolete structures in phases and building a modern structure is under formulation.
3.	Staff	Just adequate. The post of permanent Director is held by an officiating incumbent. While the number of psychiatrists is adequate, the strength of other mental health professionals is below the sanctioned level.
4.	Clinical services (including investigation facilities)	Just adequate. Further augmentation of laboratory and X-ray facility is required.
5.	Availability of drugs & other treatment modalities	Adequate in respect of drugs but other psycho-social interventions are the bare minimum. Newer drugs need to be added.
6.	Quality of food/kitchen facilities	Quality of food is satisfactory and the kitchen has modern equipments.
7.	Availability of linen/patients' clothing	Inadequate; steps are underway to improve the quality of linen as well as patients' clothing.
8.	Recreational facilities	Colour TVs are available in most of the wards. There are no other recreational facilities.
9.	Vocational/rehabilitation facilities	Inadequate but efforts are being made to improve this area through an officially sponsored NGO.
10.	Remarks	This hospital has undergone significant changes over the past two years, though the vestiges of the old custodial legacy remain. The proportion of long-stay patients is still high. Plans have been submitted to the Government for construction of a modern hospital and half-way home.

### Regional Mental Hospital, Nagpur (Maharashtra)

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Regional Mental Hospital, Nagpur, Maharashtra.</b>
2.	Infrastructural facilities	The state of buildings and sanitary annexes is generally satisfactory but the boundary wall is broken/non-existent in many places, leading to unauthorised access of nearby slum-dwellers and unhygienic conditions. Many state agencies have encroached upon the hospital campus and a PIL has been filed in the local High Court against this unfortunate state of affairs.
3.	Staff	The Medical Superintendent and Deputy Medical Superintendent are non-psychiatrists. There is no Director; a position of Pathologist and many other junior technical positions are vacant. Over 100 posts are vacant.
4.	Clinical services (including investigation facilities)	Adequate in respect of equipment, but technical staff is inadequate.
5.	Availability of drugs & other treatment modalities	Adequate in respect of drugs but other psycho-social interventions are not up to the mark.
6.	Quality of food/kitchen facilities	Quality of food is satisfactory. Kitchen facilities are adequate.
7.	Availability of linen/patients' clothing	Adequate, but of sub-standard quality.
8.	Recreational facilities	Colour TVs are available in most of the wards. There are no other recreational facilities.
9.	Vocational/rehabilitation facilities	Kitchen and gardening are conducted as occupational therapy. No other facilities.
10.	Remarks	The hospital has a large number of vacant posts and this affects patient care. No research or library facilities are available. Community outreach services are non-existent.

### National Institute of Mental Health and Neuro Sciences, Bangalore (Karnataka)

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, Karnataka.</b>
2.	Infrastructural facilities	Good. Except for two pavilion type buildings, all others are open wards.



3.	Staff	Adequate and of very high calibre, with a high degree of motivation.
4.	Clinical services (including investigation facilities)	Good. All modern investigation facilities are available.
5.	Availability of drugs & other treatment modalities	All modern drugs and psycho-social therapeutic modalities are available.
6.	Quality of food/kitchen facilities	Quality of food as well as kitchen facilities are satisfactory.
7.	Availability of linen/patients' clothing	Satisfactory.
8.	Recreational facilities	Colour TVs are available in all wards.
9.	Vocational/rehabilitation facilities	Good. There are active departments of rehabilitation and occupational therapy.
10	Remarks	This institution has attained national/international fame due to its professional and research activities. It has become a model for other institutions in the country.

### **Mental Hospital, Varanasi (UP)**

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Mental Hospital, Varanasi, UP.</b>
2.	Infrastructural facilities	Total area is about 26.91 acres. Buildings are approx. 200 years old. Several buildings have been condemned. The hospital has ample open space. Patients are kept in closed wards. Although cells exist, they are no longer used. Condition of wards is very poor, lighting is inadequate, no fans, patients sleep on floor beds.
3.	Staff	Inadequate: Only 2 Psychiatrists; Medical Superintendent is a non-psychiatrist; No Psychologist, Psychiatric Social Worker or Psychiatric Nurse.
4.	Clinical services (including investigation facilities)	The essential psychiatric medical and paramedical staff as well as group C & D staff is inadequate. No facility for X-ray, lab, ambulance, psychology lab & anaesthesia.
5.	Availability of drugs & other treatment modalities	Medicines are adequate. Only direct ECT is given as there is no anaesthetist.
6.	Quality of food/kitchen facilities	Only one cook, kitchen is old and dilapidated; quality of food could be improved in terms of calorific value and variety.

7.	Availability of linen/patients' clothing	Clothing & blankets are inadequate; many patients are sleeping without mattresses.
8.	Recreational facilities	Two Black & White TVs only; no recreational room for patients.
9.	Vocational/rehabilitation facilities	Very poor: only some patients are involved in horticulture.
10.	Remarks	This hospital needs major improvements in buildings and maintenance, basic facilities for patients such as clothing, proper sleeping and living conditions. The food also needs improvement in quality and variety. Specific facilities like medical and paramedical care, investigation facilities, communication facilities between working units are needed. In rehabilitation and recreation, a lot is needed to bring the services closer to adequate. Needs CRISIS RESPONSE.

### **Dr. Vidya Sagar Institute of Mental Health, Amritsar (Punjab)**

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Dr. Vidya Sagar Institute of Mental Health, Amritsar, Punjab</b>
2.	Infrastructural facilities	The campus area measures 108 acres. A new building is being constructed and will become functional by October 2002. The old building is being demolished.
3.	Staff	The number of Psychiatrists is six for four hundred in-patients. A lot of vacant posts of Psychologists and Social Workers exist.
4.	Clinical services (including investigation facilities)	Clinical services are adequate. Basic investigations are being done in the hospital. However, special investigations are not available (like clinical psychology testing).
5.	Availability of drugs & other treatment modalities	Adequate.
6.	Quality of food/kitchen facilities	Good; a modern kitchen is being constructed as part of the new building.
7.	Availability of linen/patients' clothing	Satisfactory at present.
8.	Recreational facilities	Colour and Black & White TVs are available in most of the wards.
9.	Vocational/rehabilitation facilities	There are adequate facilities (music, painting, tailoring, embroidery, pottery) and the staff concerned appear quite committed.

10. Remarks
- The main limitation of this hospital is shortage of qualified Psychiatrists, Clinical Psychologists, Psychiatric Social Worker, Trained Nurses and Paramedical Staff. However, if these shortcomings could be overcome and with the construction of the new building, the centre has the potential of becoming a model psychiatric hospital.

### **Institute of Mental Health, Agra (UP)**

<b>S.No.</b>	<b>Point for comment</b>	<b>Comments</b>
1.	Name of the hospital	<b>Institute of Mental Health, Agra.</b>
2.	Infrastructural facilities	Total area 172 acres; there is ample open space for patients to move about. Total 28 wards, 1 family ward, 1 half-way home and 1 emergency ward. Buildings are being renovated. Sanitary facilities are not up to the mark; new kitchen and dining hall are built adequately.
3.	Staff	32 sanctioned posts for doctors and other class A staff; 19 posts are filled. In group C & D, 264 are filled out of 297. There is 1 Director, 1 Medical Superintendent, 7 Senior Medical Officers, 2 Senior Psychiatrists (in total 4 Specialists). There is lack of junior level specialists.
4.	Clinical services (including investigation facilities)	Emergency/routine OPD services are available, clinical psychology services are available but are in the inceptual stage. Psychiatric social work services are poor. No drugs are given to OPD patients, X-ray, lab investigation facilities are available, but emergency investigations are not available.
5.	Availability of drugs & other treatment modalities	Drugs as well as ECT facilities are available only for in patients.
6.	Quality of food/kitchen facilities	Kitchen facility is satisfactory. Patients are working in kitchen, but no facility for transport of food from kitchen to dining area is available.
7.	Availability of linen/patients' clothing	Clothing and linen are provided, but quality is poor.
8.	Recreational facilities	TV facility in most wards and dining area is available; one full size auditorium recently built; and one recreation room each for male and female patients.
9.	Vocational/rehabilitation facilities	Agricultural activities are being done as rehabilitation activities for patients. No other rehabilitation activity is available.

10. Remarks	Institute lacks funds. Specialists in psychiatry and psychology, social workers and junior level specialists including motivated postgraduate students and staff are needed. Institute has tried to improve upon building, general facilities for patients, food and amenities, but is lagging behind in coordination with State Government for recruiting staff. There is need for proper autonomy in functioning, as per Supreme Court guidelines most importantly in administrative and financial areas. This is probably the major reason for slowing of the process of improvement.
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### Hospital for Mental Health, Ahmedabad (Gujarat)

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Hospital for Mental Health, Ahmedabad, Gujarat.</b>
2.	Infrastructural facilities	Total area of the hospital is about 32,000 sq m, with open land of about 15,000 sq m. Current condition of the building is not satisfactory. New buildings are under construction and one wing will be ready soon.
3.	Staff	Out of 222 sanctioned posts; 163 are filled. The number of Psychiatrists and other Mental Health Professionals is not adequate. Group C & D staff is adequate. Training of staff members is necessary.
4.	Clinical services (including investigation facilities)	Adequate but clinical services and laboratory facilities (including investigation facilities) can be improved. The large proportion of patients on "leave of absence" needs to be reviewed.
5.	Availability of drugs & other treatment modalities	Adequate in variety and amount.
6.	Quality of food/kitchen facility	Adequate.
7.	Availability of linen/patients' clothing	Adequate, but can be improved. All the patients are provided with adequate clothing and bedding but quality can be improved.
8.	Recreational facilities	Adequate, 3 Black & White TVs in recreational room; other facilities are adequate in terms of staff and utilisation.
9.	Vocational/rehabilitation facilities	Rehabilitation and vocational services are provided in various areas but can be improved.

10.	Remarks	The hospital is one of the oldest mental hospitals in the country and has been well-managed and looked after. The new buildings will provide the infrastructure required. No instance of physical abuse reported. The hospital has good potential not only in services, but also as a training resource centre.
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### Hospital for Mental Health, Vadodara (Gujarat)

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Hospitals for Mental Health, Vadodara, Gujarat.</b>
2.	Infrastructural facilities	State of the building is unsatisfactory. The maintaining agency is PWD; funds for maintenance are inadequate.
3.	Staff	Out of total 141 vacancies, 111 are filled. There are 3 Psychiatrists and 1 Medical Officer. Other mental health professionals are inadequate in number. Group C & D personnel is inadequate due to unfilled vacancies. Training of all groups of staff is required.
4.	Clinical services (including investigation facilities)	Clinical services are adequate, while laboratory facilities can be improved. The large proportion of patients on "leave of absence" needs to be reviewed.
5.	Availability of drugs & other treatment modalities	Adequate.
6.	Quality of food/kitchen facilities	Adequate in quality and variety.
7.	Availability of linen/patients' clothing	Clothing for patients, bedding, etc., are adequate but can be improved.
8.	Recreational facilities	Adequate.
9.	Vocational/rehabilitation facilities	Adequate.
10.	Remarks	The hospital is one of the oldest mental hospitals. It is reasonably well-managed at clinical as well as administrative level. The engineering maintenance leaves a lot to be desired. No instance of physical abuse or chaining has been reported. The inadequate group C & D and paramedical staff adversely affects the patient care services.

### Mental Hospital, Indore (MP)

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Mental Hospital, Indore, MP.</b>
2.	Infrastructural facilities	Total area 19,500 sq m; covered about 2,250 sq m. State of the hospital building is poor and funds for maintenance are also inadequate. The overall state of the hospital is unsatisfactory.
3.	Staff	The staff is inadequate in numbers, although some of them show adequate commitment to patient care services. The staff requires to be sensitised/trained. Currently no one is appointed in the disciplines of Clinical Psychology, Psychiatric Social Work and Occupational Therapy.
4.	Clinical services (including investigation facilities)	Inadequate. No X-ray and lab facilities.
5.	Availability of drugs & other treatment modalities	Adequate.
6.	Quality of food/kitchen facilities	Unsatisfactory and inadequate. Building for kitchen is old and poorly maintained. The quantity and quality of food is inadequate and unsatisfactory.
7.	Availability of linen/patients' clothing	Patient clothes, basic toileteries and items for personal hygiene, woollens, bedding, etc., are inadequate.
8.	Recreational facilities	Only two Black & White TVs are available in recreation room.
9.	Vocational/rehabilitation facilities	Some effort is being made but inadequate in terms of infrastructure facility and staff.
10.	Remarks	The hospital is in a highly deplorable state in almost all aspects of patient care as well as the working conditions for the staff members. The overall scenario and atmosphere are highly regrettable. Evidence of chaining of patients, clinical abuse and active neglect seen. Needs CRISIS RESPONSE .

### Mental Hospital, Bareilly (UP)

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Mental Hospital, Bareilly, UP.</b>
2.	Infrastructural facilities	The hospital was established in 1862; some buildings have been renovated and their condition is

3.	Staff	satisfactory. Other old buildings should be gradually demolished and new wards will be constructed. Most of the wards are closed wards. There are cells, but these are not currently in use.
4.	Clinical services (including investigation facilities)	The Director, Medical Superintendent and Deputy Medical Superintendent are non-psychiatrists. The hospital is managed by 3 Psychiatrists; other staff strength is 114. There are no Psychiatric Nurses, Pathologist and Radiologist.
5.	Availability of drugs & other treatment modalities	OPD and indoor facilities are satisfactory. Emergency facilities are available and satisfactory. X-ray and lab facilities are there but cannot be used as there are no technicians.
6.	Quality of food/kitchen facilities	Drugs and ECT facility available for both in- and out-patients.
7.	Availability of linen/patients' clothing	Kitchen is being renovated; quality of food satisfactory, clean water is available; and diet is satisfactory.
8.	Recreational facilities	Warm clothes are available and all the patients are dressed properly, linen is clean and adequate.
9.	Vocational/rehabilitation facilities	10 TVs and 2 music systems in recreation rooms are available. Recreational facilities are adequate.
10.	Remarks	Agricultural land available for farming by the patients; occupational therapy—stitching and wood work—is done; trainers are available in these fields to provide proper training.
		Food, clothing, and medicines are adequate and satisfactory. Within the available resources the patients are managed properly. The building needs renovation (to be converted to wards). Emergency lab facility needs to be started. Staff including psychiatric nurses needs to be recruited urgently. Anaesthetist should also be appointed.

### **Himachal Institute of Mental Health and Neuro Sciences, Shimla (HP)**

S.No.	Point for comment	Comments
1.	Name of the hospital	<b>Himachal Institute of Mental Health and Neuro Sciences (HIMHANS), Shimla, Himachal Pradesh</b>
2.	Infrastructural facilities	Total area 997.24 sq m. A new building for 3 male and 3 female wards, 2-bed acute ward and one subacute ward is planned/under construction, but the budgetary sanction for it was inadequate.

3.	Staff	—
4.	Clinical services (including investigation facilities)	— —
5.	Availability of drugs & other treatment modalities	— —
6.	Quality of food/kitchen facilities	—
7.	Availability of linen/patients' clothing	—
8.	Recreational facilities	—
9.	Vocational/rehabilitation facilities	—
10.	Remarks	Not yet functional

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## Appendix D

# Andhra Pradesh Model for Disinvestment/ Restructuring of Fixed Assets

### Government of Andhra Pradesh

#### Abstract

Health, Medical and Family Welfare Department, Visakhapatnam – Modernisation of Mental Care Hospital and Chest & I.D. Hospital, Visakhapatnam – by bringing together at one place – Improvement of Medical Institutions including King George Hospital, Visakhapatnam – Expert Committee constituted for implementation of the Project – Recommendations of Expert Committee -Accepted - Orders -Issued.

#### Health, Medical and Family Welfare (M1) Department

G.O.Ms.No.336

Dated: 29-8-2001

Read the following:-

1. G.O.Ms.No.223. HM&FW (M2)Deptt. Dated: 6-7-2000.
2. Judgement of the Hon'ble A.P. High Court. Hyd. in W.P. No.18873/2000. Dated: 27-4-2001. filed by Dr. Ramamurthy represented on behalf of I.M.A.; Visakhapatnam.
3. G.O.Rt.No.588. HM&FW(M1)Deptt. Dated: 31-5-2001.
4. Expert Committee report on the Mental Care Hospital and Chest & I.D. Hospital, Visakhapatnam.

#### Order

In the G.O.1st read above. Government has constituted an Empowered Committee for implementation of the Project relating to modernisation of Mental Care Hospital and Chest & I.D. Hospital, Visakhapatnam. These 'orders were challenged before, the Honourable Andhra Pradesh High Court, Hyderabad and the Court had delivered its verdict through the reference 2nd read above. In pursuance of the directions given by the Honourable Court, the Government had constituted an Expert Committee with the members as mentioned therein, through the reference 3rd read above. The Expert Committee had visited the institutions and held extensive discussions with various interest groups at Visakhapatnam. The Committee had submitted the report and made the following recommendations through the reference 4th read above:

1. The Chest and I.D. Hospitals may be shifted from Seethammadhara and relocated at Mental Care Hospital site at Peda Waltair. An extent of 17.14 acres of land belonging to these Institutions may be put to public auctions and amount so accrued may be used for the improvement of healthcare system in Visakhapatnam city itself.
2. The Mental Care Hospital may be continued in the same place over an extent of 15.00 acres of land utilising the remaining 33.56 acres of land for setting up Chest and I.D. Hospitals and other Medical Care Institutions.
3. The Mental Care Hospital and Chest & I.D. Hospitals can be located in the same present Mental Care Hospital site with 80 ft. road in between them and providing 20 ft. wide greenery all around the Chest & I.D. Hospitals.
4. This will satisfy the recommendations of the National Human Rights Commission.
5. ENT Block of King George Hospital is required to be demolished. A new hospital may be constructed in the Mental Care Hospital site. The regional lab which is situated at I.D. Hospital site may also be relocated in this site. In the remaining land it may be considered to establish regional super-speciality hospital for Andhra areas on the model of Sri Venkateswara Institute of Medical Sciences, Tirupathi and Nizams Institute of Medical Sciences, Hyderabad.

Government have examined the recommendations of the above Expert Committee in detail. The Government have decided to accept the recommendations of the Expert Committee and decided to issue the following orders:

- I. A committee with following members is constituted to attend to the job of auctioning of land in Chest and I.D. Hospitals, Visakhapatnam:

(a) The Principal Secretary to Govt. H.M. & F.W. Department	Chairman
(b) The Director of Medical Education, Andhra Pradesh, Hyderabad	Member
(c) The Commissioner of A.P. Vaidya Vidhana Parishad, Hyderabad	Member
(d) The District Collector, Visakhapatnam	Member
(e) The Vice-Chairman, V.U.D.A., Visakhapatnam	Member
- II. The sale of Chest and I.D. Hospitals, Visakhapatnam land has to be done by the above committee in two phases viz. (i) open land be sold straight way. (ii) After construction of new Chest and I.D. Hospitals existing old Hospitals, i.e., chest and I.D. Hospitals be demolished and land sold.
- III. The sale proceeds shall be remitted to Andhra Pradesh Health and Medical Housing and Infrastructure Development Corporation, Hyderabad who will undertake construction of hospitals, equipment required and undertake other developmental works.
- IV. Modern Mental Care Hospital be constructed over an extent of 15.00 acres with the sale proceeds of chest and I.D. Hospitals land and continued in the same place. The remaining 33.56 acres of land will be utilised for construction of Chest & I.D. Hospitals and other Medical Care Institutions in the present Mental Care Hospital site.
- V. Construction of super-speciality hospital in the premises of mental care hospital will be made with the savings of out of sale proceeds of land in Chest & I.D. Hospitals and with the financial support from Simhachalam Devasthanam Endowments Department and

balance, if any, amount required for construction be re-appropriated from the overall savings of the department. The required equipment for the hospital will be supplied under DUTCH project which is separately finalised. The name of the super-speciality Hospital shall be called "Sri Narasimha Swamy Institute of Medical Sciences, Simhachalam (SNIMS)" by Endowment Department participating in funding of the Project.

A copy of this order is available on the Internet and can be accessed at the address <http://apts.gov.in/apqos>.

*(By order and in the Name of the Governor of Andhra Pradesh)*

C. Arjuna Rao,  
Special Chief Secretary To Government.

To ,  
The Principal Secretary to Govt., H.M. & F.W. Department.  
The Principal Secretary, Revenue (Endt.) Department.  
The Director of Medical Education, A.P., Hyderabad.  
The Commissioner of A.P. Vadhya Vidhana Parishad, Hyderabad.  
The District Collector, Visakhapatnam.  
The Vice-Chairman, V.U.D.A., Visakhapatnam.  
The M.D., A.P.H.M.H.I.D.C., Hyderabad.  
The Superintendent, K.G. Hospital, Visakhapatnam.  
The Superintendents, Chest & I.D. Hospitals, Visakhapatnam.  
The Superintendent, Govt. Mental Care Hospital, Visakhapatnam. The Commissioner of Endowments Department.

Copy to: P.S. to J.S. to Hon'ble C.M.  
P.S. to Hon'ble Minister (H.M. & F.W.).  
P.S. to Hon'ble Minister (Revenue).  
P.S. to Spl.C.S. (H.M. & F.W.).  
The E.O., Sri Narasimhaswamy Devasthanam,  
Simhachalam, Visakhapatnam.

S.F./S.Cs.

//FORWARDED: BY ORDER//

SECTION OFFICER.

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# Appendix E

## Mental Health Act 1987 and Mental Health Rules 1990

### Chapter 1 Preliminary

#### 1. *Short Title, Extent and Commencement*

- (1) This act may be called the Mental Health Act 1987.
- (2) It extends to the whole of India.
- (3) It shall come into force on such date as the Central Government may, by notification, appoint and different dates may be appointed for different States and for different provisions of this Act, and any reference in any provision to the commencement of this Act in a State shall be construed as a reference to coming into force of that provision in that State.

#### 2. *Definitions*

In this Act, unless the context otherwise requires: -

- (a) "Cost of maintenance", in relation to a mentally ill person admitted in a psychiatric hospital or psychiatric nursing home, shall mean the cost of such items as the State Government may, by general or special order, specify in this behalf;
- (b) "District Court" means, in any area for which there is a city civil court and in any other area the principal civil court of original jurisdiction, and includes any other civil court which the State Government may, by notification, specify as the court competent to deal with all or any of the matters specified in this Act;
- (c) "Inspecting officer" means a person authorised by the State Government or by the licensing authority to inspect any psychiatric hospital or psychiatric nursing home;
- (d) "Licence" means a licence granted under section 8;
- (e) "Licensee" means the holder of a licence;
- (f) "Licensed psychiatric hospital" or "licensed psychiatric nursing home" means a psychiatric hospital or psychiatric nursing home, as the case may be, licensed, or deemed to be licensed, under this Act;
- (g) "Licensing authority" means such officer or authority as may be specified by the State Government to be the licensing authority for the purposes of this Act;

- (h) "Magistrate" means: -
  - (i) in relation to a metropolitan area within the meaning of clause (k) of section 2 of the Code of Criminal Procedure, 1973, a Metropolitan Magistrate; and
  - (ii) in relation to any other area, the Chief Judicial Magistrate, Sub-Divisional Judicial Magistrate or such other Judicial Magistrate of the first class as the State Government may, by notification, empower to perform the functions of a Magistrate under this Act;
- (i) "Medical officer" means a gazetted medical officer in the service of Government and included a medical practitioner declared, by a general or special order of the State Government, to be a medical officer for the purposes of this Act;
- (j) "Medical officer in charge", in relation to any psychiatric hospital or psychiatric nursing home, means the medical officer who, for the time being, is in charge of that hospital or nursing home;
- (k) "Medical practitioner" means a person who possesses a recognised medical qualification as defined:-
  - (i) in clause (h) of section (2) of the Indian Medical Council Act, 1956, and whose name has been entered in a State Medical Register, as defined in clause (k) of that section;
  - (ii) in clause (h) of sub-section 2 of the Indian Medicine Central Council Act, 1970, and whose name has been entered in a State Register of Indian medicine, as defined in clause (j) of sub-section (1) of that section; and
  - (iii) in clause (g) of sub-section (1) of section 2 of the Homeopathy Central Council Act, 1973, and whose name has been entered in a State Register Homeopathy, as defined in clause (i) of sub-section (1) of that section.
- (l) "Mentally ill person" means a person who is in need of treatment by reason of any, mental disorder other than mental retardation;
- (m) "Mentally ill prisoner" means a mentally ill person for whose detention in, or removable to, a psychiatric nursing home, jail or other place of safe custody, an order referred to in section 27 has been made;
- (n) "Minor" means a person who has not completed the age of eighteen years;
- (o) "Notification" means a notification published in the Official Gazette;
- (p) "Prescribed" means prescribed by rules made under this Act;
- (q) "Psychiatric hospital" or "psychiatric nursing home" means a hospital or, as the case may be, a nursing home established or maintained by the Government or any other person for the treatment and care of mentally ill persons and includes a convalescent home established or maintained by the Government or any other person for such mentally ill persons, but does not include any general hospital or general nursing home established or maintained by the Government and which provides also for psychiatric services;
- (r) "Psychiatrist" means a medical practitioner possessing a postgraduate degree or diploma in psychiatry, recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical

- officer who, having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purpose of this Act;
- (s) "Reception order" means an order made under the provisions of this Act for the admission and detention of a mentally ill person in a psychiatric hospital or psychiatric nursing home;
  - (t) "Relative" includes any person related to the mentally ill person by blood, marriage or adoption;
  - (u) "State Government", in relation to a Union Territory, means the Administrator thereof.

## Chapter II

### Mental Health Authorities

#### 3. *Central Authority for Mental Health Services*

- (1) The Central Government shall establish an Authority for mental health with such designation as it may deem fit.
- (2) The Authority established under sub-section (1) shall be subject to the superintendent, direction and control of the Central Government.
- (3) The Authority established under sub-section (1) shall:
  - (a) be in charge of regulation, development, direction and coordination with respect to Mental Health Services under the Central Government and all other matters which, under this Act, are the concern of the Central Government or any officer or authority subordinate to the Central Government;
  - (b) supervise the psychiatric hospitals and psychiatric nursing homes and other Mental Health Service Agencies (including places in which mentally ill persons may be kept or detained) under the control of the Central Government;
  - (c) advise the Central Government on all matters relating to mental health; and
  - (d) discharge such other functions with respect to matters relating to mental health as the Central Government may require.

Explanation – For the purposes of this section 4, "Mental Health Services" include, in addition to psychiatric hospitals and psychiatric nursing homes, observation wards, day-care centres, in-patient treatment in general hospitals, ambulatory treatment facilities and other facilities, convalescent homes and half-way homes for mentally ill persons.

#### 4. *State Authority for Mental Health Services*

- (1) The State Government shall establish an Authority for mental health with such designation as it may deem fit.
- (2) The Authority established under section 1 shall:

- (a) be in charge of regulation, development and coordination with respect to Mental Health Services under the State Government and all other matters which, under this Act, are the concern of the State Government or any officer or authority subordinate to the State Government;
- (b) supervise the psychiatric hospitals and psychiatric nursing homes and other Mental Health Service Agencies (including places in which mentally ill persons may be kept or detained ) under the control of the State Government;
- (c) advise the State Government on all matters relating to mental health; and
- (d) discharge such other functions with respect to matters relating to mental health as the State Government may require.

### Chapter III

## Psychiatric Hospitals and Psychiatric Nursing Homes

### 5. *Establishment or Maintenance of Psychiatric Hospitals and Psychiatric Nursing Homes*

- (1) The Central Government may, in any part of India, or the State Government may, within the limits of its jurisdiction, establish or maintain psychiatric hospitals or psychiatric nursing homes for the admission, treatment and care of mentally ill persons at such places as it thinks fit; and separate psychiatric hospitals and psychiatric nursing homes may be established or maintained for:
  - (a) those who are under the age of sixteen years;
  - (b) those who are addicted to alcohol or other drugs which lead to behavioural changes in a person; and
  - (c) those belonging to such other class or category of persons may be prescribed.
- (2) Where a psychiatric hospital or psychiatric nursing home is established or maintained by the Central Government, any reference in this Act to the State Government shall, in relation to such hospital or nursing home, be construed as a reference to the Central Government.

### 6. *Establishment or Maintenance of Psychiatric Hospitals or Psychiatric Nursing Homes only with Licence*

- (1) On and after the commencement of this Act, no person shall establish or maintain a psychiatric hospital or psychiatric nursing home unless he holds a valid licence granted to him under this act:

Provided that psychiatric hospital or psychiatric nursing home (whether called asylum or by any other name) licensed by the Central Government or any State Government and maintained as such immediately before the commencement of this Act may continue to be maintained, and shall be deemed to be a licensed psychiatric hospital or licensed psychiatric nursing home, as the case may be, under this Act:

- (a) for a period of three months from such commencement; or
  - (b) if an application made in accordance with section 7 for a licence is pending on the expiry of the period specified in clause (a), till the disposal of such application.
- (2) Nothing contained in sub-section (1) shall apply to a psychiatric hospital or psychiatric nursing home established or maintained by the Central Government or a State Government.

### **7. Application for Licence**

- (1) Every person, who holds, at the commencement of this Act, a valid licence authorizing that person to establish or maintain any psychiatric hospital or psychiatric nursing home, shall, if the said person intends to establish or continue the maintenance of such hospital or nursing home after the expiry of the period referred to in clause (a) of the proviso to sub-section (1) of section 6, make, at least one month before the expiry of such period, an application to the licensing authority for the grant of a fresh licence for the establishment or maintenance of such hospital or nursing home, as the case may be.
- (2) A person, who intends to establish or maintain, after the commencement of this Act, a psychiatric hospital or psychiatric nursing home, shall, unless the said person already holds a valid licence, make an application to the licensing authority for the grant of a licence.
- (3) Every application under sub-section (1) or sub-section (2) shall be in such form and be accompanied by such fee as may be prescribed.

### **8. Grant or Refusal of Licence**

On receipt of an application under section 7, the licensing authority shall make such enquiries as it may deem fit and where it is satisfied that:

- (a) the establishment or maintenance of the psychiatric hospital or psychiatric nursing home or the continuance of the maintenance of any such hospital or nursing home established before the commencement of this Act is necessary;
- (b) the applicant is in a position to provide the minimum facilities prescribed for the admission, treatment and care of mentally ill persons; and
- (c) the psychiatric hospital or psychiatric nursing home will be under the charge of a medical officer who is a psychiatrist.

It shall grant a licence to the applicant in the prescribed form, and where it is not so satisfied, the licensing authority shall by order refuse to grant the licence applied for:

Provided that, before making any order refusing to grant a licence, the licensing authority shall give to the applicant a reasonable opportunity of being heard and every order of refusal to grant a licence shall set out therein the reasons for such refusal and such reasons shall be communicated to the applicant in such manner as may be prescribed.

### **9. Duration and Renewal of Licence**

- (1) A licence shall not be transferable or inheritable.
- (2) Where a licensee is unable to function as such for any reason or where a licensee dies, the licensee or, as the case may be, the legal representative of such licensee shall



forthwith report the matter in the prescribed manner to the licensing authority and notwithstanding anything contained in sub-section (1), the psychiatric hospital or psychiatric nursing home concerned may continue to be maintained and shall be deemed to be a licensed psychiatric hospital or licensed psychiatric nursing home, as the case may be,

- (a) for a period of three months from the date of such report or in the case of the death of the licensee from the date of his death; or
  - (b) if an application made in accordance with sub-section (3) for a licence is pending on the expiry of the period specified in clause (a), till the disposal of such application.
- (3) The legal representative of the licensee referred to in sub-section (2), shall, if he intends to continue the maintenance of the psychiatric hospital or psychiatric nursing home after the expiry of the period referred to in sub-section (2), make, at least one month before the expiry of such period, an application to the licensing authority for the grant of a fresh license for the maintenance of such hospital or nursing home, as the case may be, and the provisions of section 8 shall apply in relation to such application as they apply in relation to an application made under section 7.
- (4) Every licence shall, unless revoked earlier under section 11, be valid for period of five years from the date on which it is granted.
- (5) A licence may be renewed, from time to time, on an application made in that behalf to the licensing authority, in such form and accompanied by such fee, as may be prescribed, and every such application shall be made not less than one year before the date on which the period of validity of the licence is due to expire:

Provided that the renewal of a licence shall not be refused unless the licensing authority is satisfied that:

- (i) the licensee is not in a position to provide in a psychiatric hospital or psychiatric nursing home, the minimum facilities prescribed for the admission, treatment and care of mentally ill persons; or
- (ii) the licensee is not in a position to provide a medical officer who is a psychiatrist to take charge of the psychiatric hospital or psychiatric nursing home; or
- (iii) the licensee has contravened any of the provisions of this Act or any rule made thereunder.

### ***10. Psychiatric Hospital or Psychiatric Nursing Home to be Maintained in Accordance with the Prescribed Conditions***

Every psychiatric hospital or psychiatric nursing home shall be maintained in such manner and subject to such conditions as may be prescribed.

### ***11. Revocation of Licence***

- (1) The licensing authority may, without prejudice to any other penalty that may be imposed on the licence, by order in writing, revoke the licence if it is satisfied that:
  - (a) the psychiatric hospital or psychiatric nursing home is not being maintained by the licensee in accordance with the provisions of this Act or the rules made thereunder; or

- (b) the maintenance of the psychiatric hospital or psychiatric nursing home is being carried on in a manner detrimental to the moral, mental or physical well-being of the in-patients thereof;

Provided that no such order shall be made except after giving the licensee a reasonable opportunity of being heard, and every such order shall set out therein the grounds for the revocation of the licence and such grounds shall be communicated to the licensee in such manner as may be prescribed.

- (2) Every order made under sub-section (1) shall contain a direction that the in-patients of the psychiatric hospital or psychiatric nursing home shall be transferred to such other psychiatric hospital or psychiatric nursing home as may be specified in that order and it shall also contain such provisions (including provisions by way of directions) as to the care and custody of such in-patients pending such transfer.
- (3) Every order made under sub-section (1) shall take effect:
  - (a) where no appeal has been preferred against such order under section 12, immediately on the expiry of the period prescribed for such appeal; and
  - (b) where such appeal has been preferred and the same has been dismissed, from the date of the order of such dismissal.

## ***12. Appeal***

- (1) Any person, aggrieved by an order of the licensing authority refusing to grant or renew a licence, or revoking a licence, may, in such manner and within such period as may be prescribed, prefer an appeal to the State Government:

Provided that the State Government may entertain an appeal preferred after the expiry of the prescribed period if it is satisfied that the appellant was prevented by sufficient cause from preferring the appeal in time.

- (2) Every appeal under sub-section (1) shall be made in such form and be accompanied by such fee as may be prescribed.

## ***13. Inspection of Psychiatric Hospitals and Psychiatric Nursing Homes and Visiting of Patients***

- (1) An Inspecting Officer may, at any time, enter and inspect any psychiatric hospital or psychiatric nursing home and ask for the production of any records, which are required to be kept in accordance with the rules made in this behalf, for inspection:

Provided that any personal records of a patient inspected shall be kept confidential except for the purposes of sub-section (3).

- (2) The Inspecting Officer may interview in private any patient receiving treatment and care therein:
  - (a) for the purpose of enquiring into any complaint made by or on behalf of such patient as to the treatment and care; or
  - (b) in any case, where the inspecting officer has reason to believe that any in-patient is not receiving proper treatment and care.

- (3) Where the Inspecting Officer is satisfied that any in-patient in a psychiatric hospital or psychiatric nursing home is not receiving proper treatment and care, he may report the matter to the licensing authority and thereupon the licensing authority may issue direction as it may deem fit to the medical officer in charge or the licensee of the psychiatric hospital, or, as the case may be, the psychiatric nursing home and every such medical officer in charge or licence shall be bound with such directions.

#### ***14. Treatment of Out-patients***

Provision shall be made in every psychiatric hospital or psychiatric nursing home for such facilities as may be prescribed for the treatment of every mentally ill person, whose condition does not warrant his admission as an in-patient or who, for the time being, is not undergoing treatment as an in-patient.

## **Chapter IV**

### **Admission and Detention in Psychiatric Hospital or Psychiatric Nursing Home**

#### **Part I : Admission on Voluntary Basis**

##### ***15. Request by Major for Admission as Voluntary Patient***

Any person (not being minor), who considers himself to be mentally ill person and desires to be admitted to any psychiatric hospital or psychiatric nursing home for treatment, may request the medical officer in charge for being admitted as a voluntary patient.

##### ***16. Request of Guardian for Admission to a Ward***

Where the guardian of a minor considers such minor to be a mentally ill person and desires to admit such minor in any psychiatric hospital or psychiatric nursing home for treatment, he may request the medical officer in charge for admitting such minor as a voluntary patient.

##### ***17. Admission of, and Regulation with respect to, Voluntary Patient***

- (1) On receipt of a request under section 15 or section 16, the medical officer in charge shall make such enquiry as he may deem fit within a period not exceeding twenty-four hours and if satisfied that the applicant or, as the case may be, the minor requires treatment as an in-patient in the psychiatric hospital or psychiatric nursing home, he may admit therein such applicant or, as the case may be, minor as a voluntary patient.
- (2) Every voluntary patient admitted to a psychiatric hospital or psychiatric nursing home shall be bound to abide by such regulations as may be made by the medical officer in charge or the licensee of the psychiatric hospital or psychiatric nursing home.

### **18. Discharge of Voluntary Patients**

- (1) The medical officer in charge of a psychiatric nursing home shall, on a request made in that behalf:
  - (a) by any voluntary patient; and
  - (b) by the guardian of the patient, if he is a minor voluntary patient, discharge, subject to the provisions of sub-section (3) and within twenty-four hours of the receipt of such request, the patient from the psychiatric hospital or psychiatric nursing home.
- (2) Where a minor voluntary patient who is admitted as an in-patient in any psychiatric hospital or psychiatric nursing home attains majority, the medical officer in charge of such hospital or nursing home shall, as soon as may be, intimate the patient that he has attained majority and that unless a request for his continuance as an in-patient is made by him within a period of one month of such intimation, he shall be discharged, and if, before the expiry of the said period, no request is made to the medical officer in charge for his continuance as an in-patient, he shall, subject to the provisions of sub-section (3), be discharged on the expiry of the said period.
- (3) Notwithstanding anything contained in sub-section (1) or sub-section (2), where the medical officer in charge of a psychiatric hospital or psychiatric nursing home is satisfied that the discharge of a voluntary patient, he shall, within seventy-two hours of the receipt of a request under sub-section (1), or, if no request under sub-section (2) has been made by the voluntary patient before the expiry of the period mentioned in that sub-section, within seventy-two hours of such expiry constitute a Board consisting of two medical officers and seek its opinion as to whether such voluntary patient needs further treatment and if the Board is of the opinion that such voluntary patient needs further treatment in the psychiatric hospital or psychiatric nursing home, the medical officer shall not discharge the voluntary patient, but continue his treatment for a period not exceeding ninety days at a time.

## **Part II: Admission under Special Circumstances**

### **19. Admission of Mentally Ill Persons under Certain Special Circumstances**

- (1) Any mentally ill person who does not, or is unable to, express his willingness for admission as a voluntary patient, may be admitted and kept as an in-patient in a psychiatric nursing home on an application made in that behalf by a relative or a friend of the mentally ill person if the medical officer in charge is satisfied that in the interests of the mentally ill person it is necessary to do so:

Provided that no person so admitted as an in-patient shall be kept in the psychiatric hospital or psychiatric nursing home as an in-patient for a period exceeding ninety days except in accordance with the other provisions of this Act.

- (2) Every application under sub-section (1) shall be in the prescribed form and be accompanied by two medical certificates from two practitioners of whom one shall be a medical practitioner in the service of Government, to the effect that the condition of such mentally ill person is such that he should be kept under observation and treatment as an in-patient in a psychiatric hospital or psychiatric nursing home:

Provided that the medical officer in charge of the psychiatric hospital or psychiatric nursing home concerned may, if satisfied that it is proper to do so, cause a mentally ill person to be examined by two medical practitioners working in the hospital or in the nursing home instead of requiring such certificates.

- (3) Any mentally ill person admitted under sub-section (1) or his relative or friend may apply to the Magistrate for his discharge and the Magistrate may after giving notice to the person at whose instance he was admitted to the psychiatric hospital or psychiatric nursing home and after making such enquiry as he may deem fit either allow or dismiss the application.
- (4) The provisions of the foregoing sub-section shall be without prejudice to the powers exercisable by a Magistrate before whom the case of a mentally ill person is brought, whether under this section or under any other provision of this Act, to pass a reception order, if he is satisfied that it is necessary to do so in accordance with the relevant provisions of this Act.

### **Part III: Reception Orders**

#### ***A. Reception Orders on Applications***

##### ***20. Application for Reception Order***

- (1) An application for a reception order may be made by psychiatric nursing home, or
  - (a) the medical officer in charge of a psychiatric hospital or psychiatric nursing home; or
  - (b) by the husband, wife or any other relative of the mentally ill person.
- (2) Where a medical officer in charge of psychiatric hospital or psychiatric nursing home in which a mentally ill person is undergoing treatment under a temporary treatment order is satisfied that:
  - (a) the mentally ill person is suffering from mental disorder of such a nature and degree that his treatment in the psychiatric hospital or, as the case may be, psychiatric nursing home required to be continued for more than six months; or
  - (b) it is necessary in the interests of the health and personal safety of the mentally ill person or for the protection of others that such person shall be detained in a psychiatric hospital or psychiatric nursing home.

He may make an application to the Magistrate within the local limits of whose jurisdiction the psychiatric hospital or, as the case may be, psychiatric nursing home is situated, for the detention of such mentally ill person under a reception order in such psychiatric hospital or psychiatric nursing home, as the case may be.

- (3) Subject to the provisions of sub-section (5), the husband or wife of a person who is alleged to be mentally ill, or where there is no husband or wife, or where the husband or wife is prevented by reason of any illness or absence from India or otherwise from making the application to the Magistrate within the local limits of whose jurisdiction the said person ordinarily resides, for the detention of the alleged mentally ill person under a reception order in a psychiatric hospital or psychiatric nursing home.

- (4) Where the husband or wife of the alleged mentally ill person is not the applicant, the application shall contain the reasons for the application not being made by the husband or wife and shall indicate the relationship of the applicant with the alleged mentally ill person and the circumstances under which the application is being made.
- (5) No person:
  - (i) who is a minor; or
  - (ii) who within fourteen days before the date of the application has not seen the alleged mentally ill person, shall make an application under this section.
- (6) Every application under sub-section (3) shall be made in the prescribed form and shall be signed and verified in the prescribed manner and shall state whether any previous application had been made for enquiry into the mental condition of the alleged mentally ill person and shall be accompanied by two medical certificates from two medical practitioners of whom one shall be a medical practitioner in the service of Government.

### ***21. Form and Contents of Medical Certificates***

Every medical certificate referred to in sub-section (6) of section shall contain a statement:

- (a) that each of the medical practitioners referred to in that sub-section has independently examined the alleged mentally ill person and has formed his opinion on the basis of his observations and from the particulars communicated to him, and
- (b) that in the opinion of each practitioner the alleged mentally ill person is suffering from mental disorder of such a nature and degree as to warrant the detention of such person in a psychiatric hospital or psychiatric nursing home and that such detention is necessary in the interests of the health and personal safety of that person or for the protection of others.

### ***22. Procedures upon Application for Reception Order***

- (1) On reception of an application under sub-section (2) of section 20, the Magistrate may make a reception order, if he is satisfied that:
  - (i) the mentally ill person is suffering from mental disorder of such a nature and degree that it is necessary to detain him in a psychiatric hospital or psychiatric nursing home for treatment; or
  - (ii) it is necessary in the interests of the health and personal safety of the mentally ill person and for the protection of others that he should be so detained, and a temporary treatment order would not be adequate in the circumstances of the case it is necessary to make a reception order.
- (2) On reception of an application under sub-section (3) of section 20, the Magistrate shall consider the statements made in the application and the evidence of mental illness as disclosed by the medical certificates.
- (3) If the Magistrate considers that there are sufficient grounds for proceeding further, he shall personally examine the alleged mentally ill person unless for reasons to be recorded in writing that it is not necessary or expedient to do so.

- (4) If the Magistrate is satisfied that a reception order may properly be made forthwith, he may make such order, and if the Magistrate is not so satisfied, he shall fix a date for further consideration of the application and may make such enquiries concerning the alleged mentally ill person as he thinks fit.
- (5) The notice of the date fixed under sub-section (4) shall be given to the applicant and to any other person to whom, in the opinion of the Magistrate, such notice shall be given.
- (6) If the Magistrate fixes a date under sub-section (4) for further consideration of the application, he may make such order as he thinks, for the proper care and custody of the alleged mentally ill person pending disposal of the application.
- (7) On the date fixed under sub-section further date as may be fixed by the Magistrate, he shall proceed to consider the application in camera, in the presence of:
  - (i) the applicant;
  - (ii) the alleged mentally ill person (unless the Magistrate in his direction otherwise directs);
  - (iii) the person who may be appointed by the alleged mentally ill person to represent him; and
  - (iv) such other person as the Magistrate thinks fit, and if the Magistrate is satisfied that the alleged mentally ill person, in relation to whom the application is made, is so mentally ill that in the interests of the health and personal safety of that person or for the protection of others it is necessary to detain him in a psychiatric hospital or psychiatric nursing home for treatment, he may pass a reception order for that purpose and if he is not so satisfied, he shall dismiss the application and may by order provide for the payment of the costs of the enquiry by the applicant personally or from out of the estate of the mentally ill person, as the Magistrate may deem appropriate.
- (8) If any application is dismissed under sub-section (7), the Magistrate shall record the reasons for such dismissal and a copy of the order shall be furnished to the applicant.

## ***B. Reception Orders on Production of Mentally Ill Persons Before Magistrate***

### ***23. Powers and Duties of Police Officers in respect of Certain Mentally Ill Persons***

- (1) Every officer in charge of a police station:
  - (a) may take or cause to be taken into protection any person found wandering at large within the limits of his station whom he has reason to believe to be so mentally ill as to be incapable of taking care of himself; and
  - (b) shall take or cause to be taken into protection any person within limits of his station whom he has reason to believe to be dangerous by reason of mental illness.
- (2) No person taken into protection under sub-section (1) shall be detained by the police without being informed, as soon as may be, on the grounds for taking him into such protection, or where, in the opinion of the officer taking the person into protection, or

where, in the opinion of the officer taking the person into protection, such person is not capable of understanding those grounds, without his relatives or friends, if any, being informed of such grounds.

- (3) Every person who is taken into protection and detained under this section shall be produced before the nearest Magistrate within a period of twenty-four hours of taking him into such protection excluding the time necessary for the journey from the place where he was taken into such protection to the Court of the Magistrate and shall not be detained beyond the said period without the authority of the Magistrate.

#### ***24. Procedure on Production of Mentally Ill Person***

- (1) If a person is produced before a Magistrate under sub-section (3) of section 23, and if, in his opinion, there are sufficient grounds for proceeding further, the Magistrate shall:
  - (a) examine the person to assess his capacity to understand;
  - (b) cause him to be examined by a medical officer; and
  - (c) make such enquiries in relation to such person as he may deem necessary.
- (2) After the completion of the proceedings under sub-section (1), the Magistrate may pass a reception order authorising the detention of the said person as an in-patient in a psychiatric hospital or psychiatric nursing home:
  - (a) if the medical officer certifies such person to be a mentally ill person; and
  - (b) if the Magistrate is satisfied that the said person is a mentally ill person; and that in the interests of the health and personal safety of that person or for the protection of others it is necessary to pass such order.

Provided that if any relative or friend of the mentally ill person desires that the mentally ill person be sent to any particular licensed psychiatric hospital or licensed psychiatric nursing home for treatment and undertakes in writing to the satisfaction of the Magistrate to pay the cost of maintenance of the mentally ill person in such hospital or nursing home, the Magistrate shall, if the medical officer in charge of such hospital or nursing home consents, make a reception order for the admission of the mentally ill person into that hospital or nursing home and detention therein:

Provided further that if any relative or friend of the mentally ill person enters into a bond, with or without sureties for such amount as the Magistrate may determine, undertaking that such mentally ill person will properly taken care of and shall be prevented from doing any injury to himself or to others, the Magistrate may, instead of making a reception order, hand him over to the care of such relative or friend.

#### ***25. Order in case of Mentally Ill Person Cruelly Treated or not under Proper Care and Control***

- (1) Every officer in charge of a police station who has reason to believe that any person within the limits of his station is mentally ill and is not under proper care and control, or is ill-treated or neglected by any relative and other person having charge of such mentally ill person, shall forthwith report the act to the Magistrate within the local limits of whose jurisdiction the mentally ill person resides.



- (2) Any private person who has reason to believe that any person is mentally ill and is not under proper care and control, or is ill-treated or neglected by any relative or other persons having charge of such mentally ill person, may report the fact to the Magistrate within the local limits of whose jurisdiction the mentally ill person resides.
- (3) If it appears to the Magistrate on the report of a police officer or on the report or information derived from any other person, or otherwise that any mentally ill person within the local limits of his jurisdiction is not under proper care and control, or is ill-treated or neglected by any relative or other person having the charge of such mentally ill person, shall summon such relative or other person who is, or who ought to be, in charge of such mentally ill person.
- (4) If such relative or any other person is legally bound to maintain the mentally ill person, the Magistrate may, by order, require the relative or the other person to take proper care of such mentally ill person and where such relative or other person neglects to comply with the said order, he shall be punishable with fine which may extend to two thousand rupees.
- (5) If there is no person legally bound to maintain the mentally ill person, or if the person legally bound to maintain the ill person refuses or neglects to maintain such person, or if, for any other reason, the Magistrate thinks fit to do so, he may cause the mentally ill person to be produced before him and, without prejudice to any action that may be taken under sub-section (4), proceed in the manner provided in section 24 as if such person had been produced before him under sub-section (3) of section 23.

### ***C. Further Provisions Regarding Admission and Detention of Certain Mentally Ill Persons***

#### ***26. Admission as In-patient after Inquisition***

If any District Court holding an inquisition under Chapter VI regarding any person who is found to be mentally ill is of opinion that it is necessary to do so in the interests of such person, it may, by order, direct that such person shall be admitted and kept as an in-patient in a psychiatric hospital or psychiatric nursing home and every such order may be varied from time to time or evoked by the District Court.

#### ***27. Admission and Detention of Mentally Ill Prisoner***

An order under section 30 of the Prisoners Act, 1900, or under section 144 of the Air Force Act, 1950, or under section 145 of the Army Act, 1950, or under section 143 or section 144 of the Navy Act, 1957, or under section 330 or section 335 of the Code of Criminal Procedure, 1973, directing the reception of a mentally ill prisoner into any psychiatric hospital or psychiatric nursing home shall be sufficient authority for admission of such person in such hospital or as, the case may be, such nursing home or any other lawfully transferred for detention therein.

#### ***28. Detention of Alleged Mentally Ill Person Pending Report by Medical Officer***

- (1) When any person alleged to be a mentally ill person appears or is brought before

a Magistrate under section 25, the Magistrate may, by order in writing, authorise the detention of the alleged mentally ill person under proper medical custody in an observation ward of a general hospital or general nursing home or psychiatric hospital or psychiatric nursing home or in any other suitable place for such period not exceeding ten days as the Magistrate may consider necessary for enabling any medical officer to determine whether a medical certificate in respect of that alleged mentally ill person may properly be given under clause (a) of sub-section (2) of section 24.

- (2) The Magistrate may from time to time, for the purpose mentioned in sub-section (1), by order in writing, authorise such further detention of the alleged mentally ill person for periods not exceeding ten days at a time as he deem necessary: provided that no person shall be authorised to be detained under the sub-section for a continuous period exceeding thirty days in the aggregate.

### ***29. Detention of Mentally Ill Person Pending his Removal to Psychiatric Hospital or Psychiatric Nursing Home***

Whenever any reception order is made by a Magistrate under section 22, section 24 or section 25, he may, for reason to be recorded in writing, direct that the mentally ill person in respect of whom the order is made may be detained for such period not exceeding thirty days in such place as he may deem appropriate, pending the removal of such person to a psychiatric nursing home.

## ***D. Miscellaneous Provisions in Relation to Orders under this Chapter***

### ***30. Time and Manner of Medical Examination of the Mentally Ill***

Where any order under this chapter is required to be made on the basis of a medical certificate, such order shall not be made unless the person who has signed the medical certificates, or where such order is required to be made on the basis of two medical certificates, the signatory of the respective certificates has certified that he has personally examined the alleged mentally ill person:

- (i) in the case of an order made on an application, not earlier than ten clear days immediately before the date on which such application is made; and
- (ii) in any other case, not earlier than ten clear days immediately before the date of such order.

Provided that where a reception order is required to be made on the basis of two medical certificates such order shall not be made unless the certificate examined the alleged mentally ill person independently of the signatory of the other certificate.

### ***31. Authority for Reception Order***

A reception order made under this chapter shall be sufficient authority:

- (i) for the applicant or any person authorised by him; or
- (ii) in the case of a reception order made otherwise that on an application, for the person authorised to do so by the authority making the order, to take the mentally ill person to the place mentioned in such order or for his admission and treatment as an in-patient in the psychiatric nursing home specified in the order or, as the case may be, for his admission and detention therein, or in any psychiatric hospitals or psychiatric nursing home to which he may be removed in accordance with the provisions of this Act, and the medical officer in charge shall be bound to comply with such order:

Provided that in any case where the medical officer in charge finds accommodation in the psychiatric hospital or psychiatric nursing home inadequate, he shall, after taking admission, intimate that fact to the Magistrate or the District Court which passed the order and thereupon the Magistrate or the District Court, as the case may be, shall pass such order as he or it may deem fit. Provided further that every reception order shall cease to have effect:

- (a) on the expiry of thirty days from the date on which it was made, unless within that period the mentally ill person has been admitted to the place mentioned therein; and
- (b) on the discharge, in accordance with the provisions of this Act, of the mentally ill person.

### ***32. Copy of Reception Order to be Sent to Medical Officer in Charge***

Every Magistrate or District Court making a reception order shall forthwith send a certified copy thereof together with copies of the requisite medical certificates and the statement of particulars to the medical officer in charge of the psychiatric hospital or psychiatric nursing home to which the mentally ill person is to be admitted.

### ***33. Restriction as to Psychiatric Hospitals and Psychiatric Nursing Homes into which Reception Order may Direct Admission***

No Magistrate or District Court shall pass a reception order for the admission of an in-patient to, or for the detention of any mentally ill person in, any psychiatric hospital or psychiatric nursing home outside the State in which Magistrate or the District Court exercises jurisdiction:

Provided that an order for admission or detention in a psychiatric hospital or psychiatric nursing home situated in any other State may be passed if State Government has, by general or special order and after obtaining the consent of the Government of such other State authorised the Magistrate or the District Court in that behalf.

### ***34. Amendment of Order or Document***

If, after the admission of any mentally ill person to any psychiatric hospital or psychiatric nursing home under a reception order, it appears that the order under which he was admitted or detained or any of the documents on the basis of which such order was made is defective or incorrect, the same may, at any time thereafter, be amended with the permission of the Magistrate or the District Court by the person or persons have effect and shall be deemed always to have had effect as if it had been originally made, as so amended, or as the case be, the documents upon which it was made had been originally furnished as so amended.

### ***35. Power to Appoint Substitute for Person upon whose Application the Reception Order has been made***

- (1) Subject to the provision of this section the Magistrate may, by order in writing (hereinafter referred to as the order of substitution), transfer the duties and responsibilities under this Act, of the person on whose application a reception order was made, to any other person who is willing to undertake the same and such other person shall thereupon be deemed for the purpose of this Act to be the person on whose application the reception order was made and all references in this Act to the latter person shall construed accordingly:

Provided that no such order of substitution shall absolve the person upon whose application the reception order was made or, if he is dead, his legal representative, from any liability incurred before the date of the order of substitution.

- (2) Before making any order of substitution, the Magistrate shall send a notice to the person on whose application the reception order was made, if he is alive, and to any relative of the mentally ill person who, in the opinion of the Magistrate, shall have notice.
- (3) The notice under sub-section (2) shall specify the name of the person in whose favour it is proposed to make the order of substitution and the date (which shall be not less than twenty days from the date of issue of the notice) on which objections, if any, to the making of such order shall be considered.
- (4) On the date specified under sub-section (3), or on any subsequent date to which the proceedings may be adjourned, the Magistrate shall consider any objection made by any person to whom notice was sent, or by any other relative of the mentally ill person, and shall receive all such evidence as may be produced by or on behalf of any such person or relative and after making such enquiry as the Magistrate may deem fit, make or refrain from making the order of substitution:

Provided that, if the person on whose application the reception order was made is dead and any other person is willing and is, in the opinion of the Magistrate, fit to undertake the duties and responsibilities under this Act of the former person, the Magistrate shall, subject to the provisions contained in the proviso to sub-section (1), make an order to that effect.

- (5) In making any substitution order under this section, the Magistrate shall give preference to the person who is the nearest relative of the mentally ill person, unless, to be recorded in writing, the Magistrate considers that giving such preference will not be in the interests of the mentally ill person.
- (6) The Magistrate may make such order for the payment of the costs of an enquiry under this section by any person or from out of the estate of the mentally ill person as he thinks fit.
- (7) Any notice under sub-section (2) may be sent by post to the last known address of the person for whom it is intended.

### ***36. Officers Competent to Exercise Powers and Discharge Functions of Magistrate under Certain Sections***

In any area where a Commissioner of Police has been appointed, all the powers and functions of the Magistrates under sections 23, 24, 25 and 28 may be exercised or discharged by the Commissioner of Police and all the functions of an officer in charge of a police station under this Act may be discharged by any police officer not below the rank of an inspector.

## Chapter V

# Inspection, Discharge, Leave of Absence and Removal of Mentally Ill Persons

### Part I : Inspection

#### *37. Appointment of Visitors*

- (1) The State Government or the Central Government, as the case may be, shall appoint for every psychiatric hospital and every psychiatric nursing home not less than five visitors, of whom at least one shall be a medical officer, preferably a psychiatrist and two social workers.
- (2) The Head of the Medical Services of the State or his nominee preferably a psychiatrist shall be an ex officio visitor of all the psychiatric hospitals and psychiatric nursing homes in the State.
- (3) The qualification of persons to be appointed visitors under sub-section (1) and the terms and conditions of their appointment shall be such as may be prescribed.

#### *38. Monthly Inspection by Visitors*

Not less than three visitors shall, at least once in every month, make a joint inspection of every part of the psychiatric hospital or nursing home in respect of which they have been appointed and examine every minor admitted as a voluntary patient under section 17 and, as far as circumstances will permit, other mentally ill person admitted therein and the order for the admission of, and the medical certificates relating to, every mentally ill person admitted subsequent to the joint inspection immediately deem appropriate in regard to the management and condition of such hospital or nursing home and of the in-patients thereof:

Provided that the visitors shall not inspect any personal record of an in-patient which in the opinion of the medical officer in charge is confidential in nature :

Provided further that if any of the visitors does not participate in the joint inspection of the psychiatric hospital or psychiatric nursing home in respect of which he was appointed a visitor for three consecutive months, he shall cease to hold office as such visitor.

#### *39. Inspection of Mentally Ill Prisoners*

- (1) Notwithstanding anything contained in section 38, where any person is detained under the provisions of section 144 of the Air Force Act, 1950, or section 145 of the Army Act, 1950, or section 144 of the Navy Act, 1957, or section 335 of the Code of Criminal Procedure, 1973:
  - (i) the Inspector-General of Prisons, where such person is detained in a jail; and
  - (ii) all or any three of the visitors including at least one social worker appointed under sub-section (1) of section 37, where such person is detained in a psychiatric hospital or psychiatric nursing home;

shall, once in every three months, visit the place where he is detained, in order to assess the state of mind of such person and make a report thereon to the authority under whose order such person is so detained.

- (2) The State Government may empower any of its officers to discharge all or any of the functions of the Inspector-General of prisons under sub-section (1).
- (3) The medical officer in charge of a psychiatric hospital or psychiatric nursing home wherein any person referred to in sub-section (1) is detained, shall once in every six months make a special report regarding the mental physical condition of such person to the authority under whose order such person is detained.
- (4) Every person who is detained in jail under the various Acts referred to in sub-section (1) shall be visited at least once in every three months by a psychiatrist, or where a psychiatrist is not available, by a medical officer empowered by the Government in this behalf and such psychiatrist or, as the case may be, such officer shall make a special report regarding the mental and physical condition of such person to the authority under whose order such person is detained.

## **Part II: Discharge**

### ***40. Order of Discharge by Medical Officer in Charge***

- (1) Notwithstanding anything contained in Chapter IV, the medical officer in charge of a psychiatric hospital or psychiatric nursing home may, on the recommendation of two practitioners one of whom shall preferably be a psychiatrist, by order in writing, direct the discharge of any person, other than a voluntary patient detained or undergoing treatment therein as an in-patient, and such person shall thereupon be discharged from the psychiatric hospital or psychiatric nursing home:

Provided that in order under this sub-section shall be made in respect of a mentally ill prisoner otherwise than as provided in section 30 of the Prisoners Act, 1900 or in order any other relevant law.

- (2) Where any order of discharge is made in respect of a person who has been detained or is undergoing treatment as in-patient in pursuance of an order of any authority, a copy of such order shall be immediately forwarded to that authority by the medical officer-in-charge.

### ***41. Discharge of Mentally Ill Persons on Application***

Any person detained in a psychiatric hospital or psychiatric nursing home under an order made in pursuance of an application made under Act shall be discharged on an application made in that behalf to the medical officer in charge by the person on whose application the order was made:

Provided that no person shall be discharged under this section if the medical officer in charge certifies in writing that the person is dangerous and unfit to be discharge.

**42. Order of Discharge on the Undertaking of Relatives or Friends, etc., for due Care of Mentally Ill Person**

- (1) Where any relative or friend of a mentally ill person detained in a psychiatric hospital or psychiatric nursing home under section 22, section 24 or section 25 desires that such person shall be delivered over to his care and custody, he may make an application to the medical officer in charge who shall forward together with his remarks thereon to the authority under whose orders the mentally ill person is detained.
- (2) Where an application is received under sub-section (1), the authority shall, on such relative or friend furnishing a bond, with or without sureties, for such amount as such authority may specify in this behalf, undertaking to take proper care of such mentally ill person, and ensuring that the mentally ill person shall be prevented from causing injury to himself or to others, make an order of discharge and thereupon the mentally ill person shall be discharged.

**43. Discharge of Person on his Request**

- (1) Any person (not being a mentally ill prisoner) detained in pursuance of an order made under this Act who feels that he has recovered from his mental illness may make an application to the Magistrate, where necessary under the provisions of this Act, for his discharge from the psychiatric hospital or psychiatric nursing home.
- (2) An application made under sub-section (1) shall be supported by a certificate either from the medical officer in charge of the psychiatric hospital or psychiatric nursing home where the applicant is undergoing treatment or from a psychiatrist.
- (3) The Magistrate may after making such enquiry as he may deem fit, pass an order discharging the person or dismissing the application.

**44. Discharge of Person Subsequently Found on Inquisition to be of Sound Mind**

If any person detained in a psychiatric hospital or nursing home in pursuance of a reception order made under this Act is subsequently found, on an inquisition held in accordance with the provisions of Chapter VI, to be of sound mind or capable of taking care of himself and managing his affairs, the medical officer in charge shall forthwith, on the production of a copy of such finding duly certified by the District Court, discharge such person from such hospital or nursing home.

**Part III: Leave of Absence**

**45. Leave of Absence**

- (1) An application for leave of absence on behalf of any mentally ill person (not being a mentally ill prisoner) undergoing treatment as an in-patient in any psychiatric hospital or psychiatric nursing home may be made to the medical officer in charge:
  - (a) in the case of a person who was admitted on the application of the husband or wife, by the husband or wife of such mentally ill person, or where by reason of

mental or physical illness, absence from India or otherwise, the husband or wife is not in a position to make such application, by any other relative of the mentally ill person duly authorised by the husband or wife; or

- (b) in the case of any other person, by the person on whose application the mentally ill person was admitted:

Provided that no application under this sub-section shall be made by a person who has not attained the age of moturity.

- (2) Every application under sub-section (1) shall be accompanied by a bond, with or without sureties for such amount as the medical officer in charge may specify, undertaking:
  - (i) to take proper care of the mentally ill person;
  - (ii) to prevent the mentally ill person from causing injury to himself or to others; and
  - (iii) to bring back the mentally ill person to the psychiatric hospital or, as the case may be, psychiatric nursing home, on the expiry of the period of leave.
- (3) On receipt of an application under sub-section (1), the medical officer in charge may grant leave of absence to the mentally ill person for such period as the medical officer in charge may deem necessary and subject to such conditions as may, in the interests of the health and personal safety of the mentally ill person or for the protection of others, be specified in the order:

Provided that the total number of days for which leave of absence may be granted to a patient under this sub-section shall not exceed sixty days.

- (4) Where the mentally ill person is not brought back to the psychiatric hospital or psychiatric nursing home on the expiry of the leave granted to him under this section, the medical officer in charge shall forthwith report that fact to the Magistrate within the local limits of whose jurisdiction such hospital or nursing home is situated and the Magistrate may, after making such enquiry as he may deem fit, make an order directing him to be brought back to the psychiatric hospital or psychiatric nursing home, as the case may be.
- (5) Nothing contained in this section shall apply to a voluntary patient referred to in section 15 or section 16 and the provisions of section 18 shall apply to him.

#### ***46. Grant of Leave of Absence by Magistrate***

- (1) Where the medical officer in charge refuses to grant leave of absence to a mentally ill person under section 45, the application may apply to the Magistrate within the local limits of whose jurisdiction the psychiatric hospital or psychiatric nursing home, wherein the mentally ill person is detained, is situated, for the grant of leave of absence to the mentally ill person and the Magistrate may, if he is satisfied that it is necessary to do so, and on the applicant entering into a bond in accordance with the provisions of sub-section (2), by order, grant leave of absence to the mentally ill person for such period and subject to such conditions as may be specified in the order.
- (2) Every bond referred to in sub-section (1) shall be with or without sureties and for such amount as the Magistrate may decide shall contain the undertaking referred to in sub-section (2) of section 45.



- (3) The Magistrate shall forward a copy of his order to the medical officer in charge and on receipt of such order the medical officer in charge shall entrust the mentally ill person to the person on whose application the leave of absence was granted under this section.

#### **Part IV: Removal**

##### ***47. Removal of Mentally Ill Person from one Psychiatric Hospital or Psychiatric Nursing Home to any other Psychiatric Hospital or Psychiatric Nursing Home***

- (1) Any mentally ill person other than a voluntary patient referred to in section 15 or section 16 may, subject to any general or special order of the State Government, be removed from any psychiatric hospital or psychiatric nursing home to any other psychiatric hospital or psychiatric nursing home within the State, or to any other psychiatric hospital or nursing home in any other State with the consent of the Government of that other State:

Provided that no mentally ill person admitted to a psychiatric hospital or psychiatric nursing home under an order made in pursuance of an application made under this Act shall be so removed unless intimation thereof has been given to the applicant.

- (2) The State Government may make such general or special order as it thinks fit directing the removal of any mentally ill prisoner from the place where he is for the time being detained, to any psychiatric hospital, psychiatric nursing home, jail or any other place of safe custody in the State or to any psychiatric hospital, psychiatric nursing home, jail or other place of safe custody in any other State with the consent of the Government of that other State.

##### ***48. Admission, Detention and Retaking in Certain Cases***

Every person brought into a psychiatric hospital or psychiatric nursing home under any order made under this Act may be detained or, as the case may be, admitted as an in-patient therein until he is removed or is discharged under any law and in case of his escape from such hospital or nursing home he may by virtue of such order be taken by any police officer or by medical officer in charge or any officer or servant of such hospital or nursing home or by any other person authorised in that behalf by the medical officer in charge, and conveyed to, and received and detained or, as the case may be, kept as an in-patient in such hospital or nursing home:

Provided that in the case of a mentally ill person (not being a mentally ill prisoner) the power to retake as aforesaid under this section shall not be exercisable after the expiry of a period of one month from the date of his escape.

##### ***49. Appeal from Orders of Magistrate***

Any person aggrieved by any order of a Magistrate, passed under any of the foregoing provisions may, within sixty days from the date of the order, appeal against that order to the District Court within the local limits of whose jurisdiction the Magistrate exercised the powers, and the decision of the District Court on such appeal shall be final.

## Chapter VI

### **Judicial Inquisition Regarding Alleged Mentally Ill Person Possessing Property, Custody of his Person and Management of his Property**

#### ***50. Application for Judicial Inquisition***

- (1) Where an alleged mentally ill person is in possession of property, an application for holding an inquisition into the mental condition of such person may be made either;
  - (a) by any of his relatives; or
  - (b) by a public curator appointed under the Indian Succession Act, 1925; or
  - (c) by the Advocate-General of the State in which the alleged mentally ill person resides; or
  - (d) where the property of the alleged mentally ill person comprises land or interest in land, or where the property or part thereof is of such a nature as can lawfully be entrusted for management to a Court of Wards established under any law for the time being in force in the State, by the Collector of the District in which such land is situated, to the District Court within the local limits of whose jurisdiction the alleged ill person resides.
- (2) On receipt of an application under sub-section (1) the District Court shall, by personal service or by such other mode of service as it may deem fit, serve a notice on the alleged mentally ill person to attend at such place and at such time as may be specified in the notice or shall, in like manner, serve a notice on the person having the custody of the alleged ill person to produce such person at the said place and at the said time, for being examined by the District Court or by any other person from whom the District Court may call for a report concerning the mentally ill person:

Provided that, if the alleged mentally ill person is a woman, who according to the custom prevailing in the area where she resides or according to the religion to which she belongs, ought not to be compelled to appear in public, the District Court may cause her to be examined by issuing a Commission as provided in the Code of Civil Procedure 1908.

- (3) A copy of the notice under sub-section (2) shall also be served upon the applicant and upon any relative of the alleged mentally ill person or other person who in the opinion of the District Court shall have notice of judicial inquisition to be held by it.
- (4) For the purpose of holding the inquisition applied for, the District Court may appoint two or more persons to act as assessors.

#### ***51. Issues on which Finding Should be given by the District Court after Inquisition***

On completion of the inquisition, the District Court shall record its findings on:

- (i) whether the alleged mentally ill person is in fact mentally ill or not; and

- (ii) where such person is mentally ill, whether he is incapable of taking care of himself and of managing his property, or incapable of managing his property only.

**52. *Provision for Appointing Guardian of Mentally Ill Person and for Manager of Property***

- (1) Where the District Court records a finding that the alleged mentally ill person is in fact mentally ill and is incapable of taking care of himself and of managing his property, it shall make an order for the appointment of a guardian under section 53 to take care of his person and of a manager under section 54 for the management of his property.
- (2) Where the District Court records a finding that the alleged mentally ill person is in fact mentally ill and is incapable of managing his property but capable of taking care of himself, it shall make an order under section 54 regarding the management of his property.
- (3) Where the District Court records a finding that the alleged mentally ill person is not mentally ill, it shall dismiss the application.
- (4) Where the District Court deems fit, it may appoint under sub-section (1) the same person to be guardian and manager.

**53. *Appointment of Guardian of Mentally Ill Person***

- (1) Where the mentally ill person is incapable of taking care of himself, the District Court or, where a direction has been issued under sub-section (2) of section 54, the Collector of the District may appoint any suitable person to be his guardian.
- (2) In the discharge of his functions under sub-section (1), the Collector shall be subject to the supervision and control of the State Government or of any authority appointed by it in that behalf.

**54. *Appointment of Manager for Management of Property of Mentally Ill Person***

- (1) Where the property of the mentally ill person who is incapable of managing it is such as can be taken charge of by a Court of Wards under any law for the time being in force, the District Court shall authorise the Court of Wards to take charge of such property, and thereupon notwithstanding anything contained in such law, the Court of Wards shall assume the management of such property in accordance with that law.
- (2) Where the property of the mentally ill person consists in whole or in part of land or of any interest in land which cannot be taken charge of by the Court of Wards, the District Court may, after obtaining the consent of the Collector of the District in which the land is situated, direct the Collector to take charge of the person and such part of the property of interest therein of the mentally ill person as cannot be taken charge of by the Court of Wards.
- (3) Where the management of the property of the mentally ill person cannot be entrusted to the Court of Wards or to the Collector under sub-section (1) or sub-section (2), as the case may be, the District Court shall appoint any suitable person to be the manager of such property.

### ***55. Appointment of Manager by Collector***

Where the property of a mentally ill person has been entrusted to the Collector by the District Court under sub-section (2) of section 54, he may, subject to the control of the State Government or of any authority appointed by it in that behalf, appoint any suitable person for the management of the property of the mentally ill person.

### ***56. Manager of Property to Execute Bond***

Every person who is appointed as the Manager of the property of a mentally ill person by the District Court or by the Collector shall, if so required by the appointing authority, enter into a bond for such sum, in such form and with such sureties as that authority may specify, to account for all receipts from the property of the mentally ill person.

### ***57. Appointment and Remuneration of Guardians and Manager***

- (1) No person, who is the legal heir of a mentally ill person shall be appointed under section 53, 54, or 55 to be the guardian of such mentally ill person or, as the case may be, the manager of his property unless the District Court or, as the case may be, the Collector for reasons to be recorded in writing, considers that such appointment is for the benefit of the mentally ill person.
- (2) The guardian of a mentally ill person or the manager of his property or both appointed under this Act shall be paid from out of the property of the mentally ill person, such allowance as the appointing authority may determine.

### ***58. Duties of Guardian and Manager***

- (1) Every person appointed as a guardian of a mentally ill person or manager of his property, or of both, under this Act shall have the care of the mentally ill person or his property, or of both, and be responsible for the maintenance of the mentally ill person and of such members of his family as are dependent on him.
- (2) Where the person appointed as a guardian of a mentally ill person or manager of his property, the manager of his property shall pay to the guardian of the mentally ill person such allowance as may be fixed by the authority appointing the guardian for the maintenance of the mentally ill person and of such members of his family as are dependent on him.

### ***59. Power of Manager***

- (1) Every manager appointed under this Act shall, subject to the provisions of this Act, exercise the same powers in regard to the management of the property of the mentally ill person in respect of which he is appointed as manager, as the mentally ill person would have exercised as owner of the property had he not been mentally ill, and shall release all claims due to the estate of the mentally ill person and all debts and discharge all liabilities legally due from that estate:

Provided that the manager shall not mortgage, create any charge on, or, transfer by sale, gift, exchange or otherwise, any immovable property of the mentally ill person or lease out any such property for a period exceeding five years, unless he obtains the permission of the District Court in that behalf.

- (2) The District Court may, on an application made by the manager, grant him permission to mortgage, create a charge on, or, transfer by sale, gift, exchange or otherwise, any immovable property of the mentally ill person or to lease out any such property for a period exceeding five years, subject to such conditions or restrictions as the Court may think fit to impose.
- (3) The District Court shall cause notice of every application for permission to be served on any relative or friend of the mentally ill person and after considering objections, if any, received from the relative or friend and after making such enquiries as it may deem necessary, grant or refuse permission having regard to the interests of the mentally ill person.

### ***60. Manager to Furnish Inventory and Annual Accounts***

- (1) Every manager appointed under this Act shall, within a period of six months from the date of his appointment, deliver to the authority, which appointed him, an inventory of the immovable property belonging to the mentally ill person and all assets and other moveable property received on behalf of the mentally ill person, together with a statement of all claims due to and all debts and liabilities due by such mentally ill person.
- (2) Every such manager shall also furnish to the said appointing authority within a period of three months of the close of every financial year, an account of the property and assets in his charge, the sums received and disbursed on account of the mentally ill person and the balance remaining with him.

### ***61. Manager's Power to Execute Conveyances under Orders of District Court***

Every manager appointed under this Act may in the name and on behalf of the mentally ill person:

- (a) execute all such conveyances and instruments of transfers by way of sale, mortgage or otherwise of property of the mentally ill person as may be permitted by the District Court; and
- (b) subject to the orders of the District Court exercise all powers vested in that behalf in the mentally ill person, in his individual capacity or in his capacity as a trustee or as a guardian.

### ***62. Manager to Perform Contracts Directed by District Court***

Where the mentally ill person had, before his mental illness, contracted to sell or otherwise dispose of his property or any portion thereof, and if such contract is, in the opinion of the District Court, of such a nature as ought to be performed, the District Court may direct the manager appointed under this Act to perform such contract and to do such other acts in fulfilment of the contract as the court considers necessary and thereupon the manager shall be bound to act accordingly.

### ***63. Disposal of Business Premises***

Where a mentally ill person had been engaged in business before he became mentally ill, the District Court may, if it appears to be for the benefit of the mentally ill person to dispose of his business premises, direct the manager appointed under this Act in relation to the property of such person, to sell and dispose of such premises and to apply the sale proceeds thereof in such

manner as the District Court may direct and thereupon the manager shall be bound to act accordingly.

#### ***64. Manager may Dispose of Leases***

Where a mentally ill person is entitled to a lease or underlease, and it appears to the manager appointed under this Act in relation to the property of such person that it would be for the benefit of the mentally ill person to dispose of such lease or underlease, such manager may, after obtaining the orders of the District Court, surrender, assign or otherwise dispose of such lease or underlease to such person for such consideration and upon such terms and conditions as the Court may direct.

#### ***65. Power to Make Order Concerning any Matter Connected with Mentally Ill Person***

The District Court may, on an application made to it by any person concerning any matter whatsoever connected with the mentally ill person or his property, make such order, subject to the provisions of this Chapter, in relation to that matter as in the circumstances it thinks fit.

#### ***66. Proceeding if Accuracy of Inventory or Accounts is Impugned***

If any relative of the mentally ill person or the Collector impugns, by a petition to the District Court, the accuracy of the inventory or statement referred to in sub-section (1), or as the case may be, any annual account referred to in sub-section (2) of section 60, the Court may summon the manager and summarily enquire into the matter and make such order thereon as it thinks fit:

Provided that the District Court may, in its discretion, refer such petition to any Court subordinate to it, or to the Collector in any case where the manager was appointed by the Collector and the petition is not presented by the Collector.

#### ***67. Payment into Public and Investment of Proceeds of Estate***

All sums received by a manager on account of any estate in excess of what may be required for the current expenses of the mentally ill person or for the management of his property shall be paid into public treasury on account of the estate and shall be invested from time to time in any of the securities specified in section 20 of the Indian Trusts Act, 1882, unless the authority which appointed him, for reasons to be recorded in writing, directs that, in the interests of the mentally ill person such sums be otherwise invested or applied.

#### ***68. Relative may Sue for Account***

Any relative of a mentally ill person may, with the leave of the District Court, sue for an account from any manager appointed under this Act, or from any such person after his removal from office or trust, or from his legal representative in the case of his death, in respect of any property then or formerly under his management or of any sums of money or other property received by him on account of such property.

#### ***69. Removal of Managers and Guardians***

- (1) The manager of the property of a mentally ill person may, for sufficient cause and for reasons to be recorded in writing, be removed by the authority which appointed him and such authority may appoint a new manager in his place.

- (2) Any manager removed under sub-section (1) shall be bound to deliver the charge of all property of the mentally ill person to the new manager, and to account for all money received or disbursed by him.
- (3) The District Court may, for sufficient cause, remove any guardian of a mentally ill person and appoint in his place a new guardian.

***70. Dissolution and Disposal of Property of Partnership on a Member becoming Mentally Ill***

- (1) Where a person, being a member of a partnership firm, is found to be mentally ill, the District Court may, on the application of any other partner for the dissolution of partnership or on the application of any other person who appears to the Court to be entitled to seek such dissolution, dissolve the partnership.
- (2) Upon the dissolution under sub-section (1), or otherwise, in due course of law, of a partnership firm to which that sub-section applies, the manager appointed under this Act may, in the name and on behalf of the mentally ill person, join with the other partner in disposing of the partnership upon such terms, and shall do all such acts for carrying into effect the dissolution of the partnership, as the District Court may direct.

***71. Power to Apply Property for Maintenance of Mentally Ill Person without Appointing Manager in Certain Cases***

- (1) Notwithstanding anything contained in the foregoing provision, the District Court may, instead of appointing a manager of the estate, order that in case of cash, the cash in the case of any other property, the produce thereof, shall be realised and paid or delivered to such person may be appointed by the District Court in this behalf, to be applied for maintenance of the mentally ill person and of such members of his family as are dependent on him.
- (2) A receipt given by the person appointed under sub-section (1) shall be valid discharge to any person who pays money or delivers any property of the mentally ill person to the person so appointed.

***72. Power to Order Transfer of Stock, Securities or Shares belonging to Mentally Ill Person in Certain Cases***

Where any stock or government securities or any share in a company (transferable within India or the dividends of which are payable therein) is or standing in the name of, or vested in a mentally ill person beneficially entitled thereto, or in the manager appointed under this Act or in a trustee for him, and the manager dies intestate, or himself becomes mentally ill, or is out of the jurisdiction of the District Court or it is uncertain whether the Manager is living or dead, or he neglects or refuses to transfer the stock, securities or shares, or to receive and pay over thereof the dividends to a new manager appointed in his place, within fourteen days after being required by the Court to do so, then the District Court may direct the company or Government concerned to make such transfer, or to transfer the same, and to receive and pay over the dividends in such manner as it may direct.

**73. Power to Order Transfer of Stock, Securities or Shares of Mentally Ill Person Residing out of India**

Where any stock or government securities or shares in a company is or are standing in the name of, or vested in any person residing out of India, the District Court upon being satisfied that such person has been declared to be mentally ill and that his personal estate has been vested in a person appointed for the management thereof, according to the law of the place where he is residing, may direct the company or Government concerned to make such transfer of the stock, securities or shares or if any part thereof, to or into the name of the person so appointed or otherwise, and also to receive and pay over the dividends and proceeds, as the District Court thinks fit.

**74. Power to Apply Property for Mentally Ill Person's Maintenance in Case of Temporary Mental Illness**

If it appears to the District Court that the mental illness of a mentally ill person is in its nature temporary, and that it is expedient to make provision for a temporary period, for his maintenance or for the maintenance of such members of his family as are dependent on him, the District Court may, in like manner as under section 71, direct his property or a sufficient part thereof to be applied for the purpose specified therein.

**75. Action Taken in Respect of Mentally Ill Person to be Set Aside if District Court Finds that his Mental Illness has Ceased**

- (1) Where the District Court has reason to believe that any person who was found to be mentally ill after inquisition under this Chapter has ceased to be mentally ill, it may direct any Court subordinate to enquire whether such person has ceased to be mentally ill.
- (2) An enquiry under sub-section (1) shall, so far as may be, be conducted in the same manner as an inquisition conducted under this Chapter.
- (3) If after an enquiry under this section, it is found that the mental illness of a person has ceased, the District Court shall order all actions taken in respect of the mentally ill person under this Act to be set aside on such terms and conditions as that Court thinks fit to impose.

**76. Appeals**

An appeal shall lie to the High Court from every order made by a District Court under this Chapter.

**77. Power of District Court to Make Regulations**

The District Court may, from time to time, make regulations for the purpose of carrying out the provisions of this Chapter.



## Chapter VII

### **Liability to Meet Cost of Maintenance of Mentally Ill Persons Detained in Psychiatric Hospital or Psychiatric Nursing Home**

#### ***78. Cost of Maintenance to be Borne by Government in Certain Cases***

The cost of maintenance of a mentally ill person detained as an in-patient in any psychiatric hospital or psychiatric nursing home shall, unless, otherwise provided by any law for the time being in force, be borne by the Government of the State wherein the authority which passed the order in relation to the mentally ill person is subordinate, if:

- (a) that authority which made the order has not taken an undertaking from any person to bear the cost of maintenance of such mentally ill person; and
- (b) no provision for bearing the cost of maintenance of such a District Court under this Chapter.

#### ***79. Application to District Court for Payment of Cost of Maintenance out of Estate of Mentally Ill Person or from a Person Legally Bound to Maintain Him***

- (1) Where any mentally ill person detained in a psychiatric hospital or psychiatric nursing home has an estate or where any person legally bound to maintain such person has the means to maintain such person, the Government liable to pay cost of maintenance of such person under section 78 or any local authority liable to bear the cost of maintenance of such mentally ill person under any law for the time being in force, may make an application to the District Court within whose jurisdiction the estate of the mentally ill person is situate or the person legally bound to maintain the mentally ill person is situate or the person legally bound to maintain the mentally ill person and having the means; therefore resides, for an order authorising it to apply the estate of the mentally ill person to the cost of maintenance or, as the case may be, directing the person legally bound to maintain the mentally ill person and having the means therefore to bear the cost of maintenance of such mentally ill person.
- (2) An order made by the District Court under sub-section (1) shall be enforced in the same manner, shall have the same force and effect and be subject to appeal, as a decree made by such Court in a suit in respect of the property or person mentioned therein.

#### ***80. Persons Legally Bound to Maintain Mentally Ill Person not Absolved from such Liability***

Nothing contained in the foregoing provisions shall be deemed to absolve a person, legally bound to maintain a mentally ill person, from maintaining such mentally ill person.

## Chapter VIII

### Protection of Human Rights of Mentally Ill Persons

81. (1) No mentally ill person shall be subjected during treatment to any indignity (Whether physical or mentally) or cruelty.
- (2) No mentally ill person under treatment shall be used for purposes of research, unless:
- (i) such research is of direct benefit to him for purposes of diagnosis or treatment; or
  - (ii) such person, being a voluntary patient, has given his consent in writing or where such person (whether or not a voluntary patient ) is incompetent, by reason of minority or otherwise, to give valid consent, the guardian or other person competent to give consent on his behalf has given his consent in writing for such research.
- (3) Subject to any rules made in this behalf under section 94 for the purpose of preventing vexatious or defamatory communications or communications prejudicial to the treatment of mentally ill persons, no letters or other communications sent by or to mentally ill persons under treatment shall be intercepted, detained or destroyed.

## Chapter IX

### Penalties and Procedure

#### ***82. Penalty for Establishment or Maintenance of Psychiatric Hospital or Psychiatric Nursing Home in Contravention of Chapter III***

- (1) Any person who establishes or maintains a psychiatric hospital or psychiatric nursing home in contravention of the provisions of Chapter III shall, on conviction, be punishable with imprisonment for a term which may extend to three months, or with fine which may extend to two hundred rupees, or with both, and in case of second or subsequent offence, with imprisonment for a term which may extend to six months, or with fine which may extend to one thousand rupees, or with both.
- (2) Whoever, after under sub-section (1), continues to maintain a psychiatric hospital or nursing home in contravention of the provisions of Chapter III shall, on conviction, be punishable with fine which may extend to one hundred rupees for every day after the first day during which the contravention is continued.

#### ***83. Penalty for Improper Reception of Mentally Ill Person***

Any person who receives or detains or keeps mentally ill person in a psychiatric hospital or psychiatric nursing home otherwise than in accordance with the provisions of this Act, shall, on conviction, be punishable with imprisonment for a term which may extend to two years, or with fine which may extend to one thousand rupees, or with both.

#### **84. Penalty for Contravention of Sections 60 and 69**

Any manager appointed under this Act to manage the property of a mentally ill person, who contravenes the provisions of section 60 or sub-section (2) of section 69, shall, on conviction, be punishable with fine which may extend to two thousand rupees and may be detained in a civil prison till he complies with the said provisions.

#### **85. General Provision for Punishment of Other Offences**

Any person who contravenes any of the provisions of this Act or of any rule or regulation made thereunder, for the contravention of which no penalty is expressly provided, in this Act, shall on conviction be punishable with imprisonment for a term which may extend to six months, or with fine which may extend to five hundred rupees, or with both.

#### **86. Offences by Companies**

- (1) Where an offence under this Act has been committed by a company, every person who, at the time the offence was committed, was in charge of, and was responsible to the company for the conduct of the business of the company, as well as the company, shall be deemed to be guilty of the offence and shall be liable to be proceeded against and punished accordingly:

Provided that nothing contained in this sub-section shall render any such person liable to any punishment, if he proves that the offence was committed without his knowledge or that he had exercised all due diligence to prevent the commission of such offence.

- (2) Notwithstanding anything contained in sub-section (1), where an offence under this Act has been committed by a company and it is proved that the offence has been committed with the consent or connivance of, or is attributable to any neglect on the part of, any director, manager, secretary or other officer shall also be deemed to be guilty of that offence and shall be liable to be proceeded against and punished accordingly .

Explanation – For the purposes of this section:

- (a) “company” means a body corporate and includes a firm or other association of individuals; and
- (b) “director”, in relation to a firm, means a partner in the firm.

#### **87. Sanction for Prosecution**

Notwithstanding anything contained in the Code of Criminal Procedure, 1973, no court shall take cognizance of any offence punishable under section 82, except with the previous sanction of the licensing authority.

## **Chapter X**

### **Miscellaneous**

#### **88. Provision as to Bonds**

The provisions of Chapter XXXIII of the Code of Criminal Procedure, 1973, shall, as far as may be, apply to bonds taken under this Act.

#### **89. Report by Medical Officer**

The medical officer in charge of a psychiatric hospital or psychiatric nursing home shall, as soon as may be, after any mentally ill person detained therein has been discharged, make a report in respect of his mental and physical condition to the authority under whose order such person had been so detained.

#### **90. Pension, etc., of Mentally Ill Person Payable by Government**

- (1) Where any sum is payable in respect of pay, pension, gratuity or any allowance to any person by any government and the person to whom the sum is payable is certified by a Magistrate under this Act to be a mentally ill person, the officer under whose authority such sum would be payable may pay to the person having regard to the cost of maintenance of such person and may pay to such members of the family of the mentally ill person as are dependent on him for maintenance, the surplus, if any, or such part thereof, as he thinks fit, having regard to the cost of maintenance of such members.
- (2) Where there is any further surplus amount available out of the funds specified in sub-section (1) after making payments as provided in that sub-section, the Government shall hold the same to be dealt with as follows, namely:
  - (a) where the mentally ill person is certified to have ceased to be mentally ill by the District Court within the local limits of whose jurisdiction such person resides or is kept or detained, the whole of the surplus amount shall be paid back to that person;
  - (b) where the mentally ill person dies before payment, the whole of the surplus amount shall be paid over to those of his heirs who are legally entitled to receive the same; and
  - (c) where the mentally ill person dies during his mental illness without leaving any person legally entitled to succeed to his estate, the whole of the surplus amount shall, with the prior permission of the District Court, be utilised for such charitable purpose as may be approved by the District Court.
- (3) The Central Government or the State Government, as the case may be, shall be discharged of all liability in respect of any amounts paid in accordance with this section.

#### **91. Legal Aid to Mentally ill Person at State Expense in Certain Cases**

- (1) Where a mentally ill person is not represented by a legal practitioner in any proceeding under this Act before a District Court or a Magistrate and it appears to the District Court or Magistrate that such person has not sufficient means to engage a legal practitioner, the District Court or Magistrate shall assign a legal practitioner to represent him at the expense of the State.

- (2) Where a mentally ill person having sufficient means to engage a legal practitioner is not represented by a legal practitioner in any proceeding under this Act before a District Court or a Magistrate and it appears to the District Court or Magistrate, having regard to all the circumstances of the case, that such person ought to be represented by a legal practitioner, the District Court or Magistrate may assign a legal practitioner to represent him and direct the State to bear the expenses with respect thereto and recover the same from out of the property of such person.
- (3) The High Court may, with the previous approval of the State Government, make rules providing for:
  - (a) the mode of selecting of legal practitioners for the purpose of sub-sections (1) and (2);
  - (b) the facilities to be allowed to such legal practitioners; and
  - (c) the fees payable to such legal practitioners by the Government and generally for carrying out the purpose of sub-sections (1) and (2).

Explanation— In this section “legal practitioner” shall have the meaning assigned to it in clause (i) of section 2 of the Advocates Act, 1961.

### **92. Protection of Action taken in Good Faith**

- (1) No suit, prosecution or other legal proceeding shall lie against any person for anything which is in good faith done or intended to be done on pursuance of this Act or any rules, regulations or orders made thereunder.
- (2) No suit or other legal proceeding shall lie against Government for any damage caused or likely to be caused for anything which is in good faith done or intended to be done in pursuance of this Act or any rules, regulations or orders made thereunder.

### **93. Construction of Reference to Certain Laws, etc.**

- (1) Any reference in this Act to a law which is not in force in any area shall, in relation to that area, be construed as a reference to the corresponding law, if any, in force in that area.
- (2) Any reference in this Act to any officer or authority shall, in relation to any area in which there is no officer or authority with the same designation, be construed, as a reference to such officer or authority as may be specified by the Central Government by notification.

### **94. Power of the Central Government and the State Government to make Rules**

- (1) The Central Government may, by notification, make rules providing for the qualifications of persons who may be appointed as Mental Health Authority under section 3 and the terms and conditions subject to which they may be appointed under that section and all other matters relating to such authority.
- (2) Subject to the provisions of sub-section (1), the State Government, with the previous approval of the Central Government may, by notification, make rules for carrying out the provisions of this Act:

Provided that the first rules shall be made by the Central Government by notification.

- (3) In particular, and without prejudice to the generality of the foregoing power, rules made under sub-section (2) may provide for all or any of the following matters, namely:

- (a) the qualifications of persons who may be appointed as Mental Health Authority and the terms and conditions subject to which they may be appointed under section 4 and all other matters relating to such authority;
- (b) the class or category of persons for which separate psychiatric hospitals and psychiatric nursing homes may be established and maintained under clause (d) of sub-section (1) of section 5;
- (c) the form in which:
  - (i) an application may be made for grant or renewal of a licence and the fee payable in respect thereof under section 7 or, as the case may be, section 9;
  - (ii) a licence may be granted for the establishment or maintenance of a psychiatric hospital or a psychiatric nursing home under section 8;
  - (iii) an application may be made for a reception order under section 20;
- (d) the manner in which an order refusing to grant, or revoking, a licence shall be communicated under section 8 or, as the case may be, section 11;
- (e) the manner in which a report may be made to the licensing authority under sub-section (2) of section 9;
- (f) the minimum facilities referred to in the proviso to sub-section (5) of section 9, including:
  - (i) psychiatrist-patient ratio;
  - (ii) other medical or paramedical staff;
  - (iii) space requirement;
  - (iv) treatment facilities; and
  - (v) equipment;
- (g) the manner in which and the conditions subject to which a psychiatric hospital or psychiatric nursing home shall be maintained under section 10;
- (h) the form and the manner in which and the period within which an appeal against any order refusing to grant or renew a licence or revoking a licence shall be preferred and the fee payable in respect thereof under section 12;
- (i) the manner in which records shall be maintained under sub-section (1) of section 13;
- (j) the facilities to be provided under section 14 for the treatment of a mentally ill person as an out-patient;
- (k) the manner in which application for a reception order shall be signed and verified under sub-section (6) of section 20;
- (l) the qualifications of persons who may be appointed as visitors and the terms and conditions on which they may be appointed, under section 37 and their function;
- (m) prevention of vexatious or defamatory communications and other matters referred to in sub-section (3) of section 81;
- (n) any other matter which is required to be, or may be, prescribed.

**95. Rules made by the Central Government or the State Government to be Laid before the Legislature**

- (1) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament, while it is in session, for a total period of thirty days which may be comprised in one session or in two or more successive sessions, and if, before the expiry of the session immediately following the session or the successive session aforesaid, both Houses agree in making any modifications in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be no effect, as the case may be; so however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.
- (2) Every rule made by the State Government under this Act shall be laid, as soon as may be after it is made, before the State Legislature.

**96. Effect of Act on other Laws**

The provisions of this Act shall have effect notwithstanding anything inconsistent therewith contained in any other law for the time-being in force and to the extent of such inconsistency that other law shall be deemed to have no effect.

**97. Power to remove Difficulty**

If any difficulty arises in giving effect to the provisions of this Act in any State, the State Government may, by order do anything not inconsistent with such provisions which appears to it to be necessary or expedient for the purpose of removing the difficulty.

**98. Repeal and Saving**

- (1) The Indian Act 1912, and the Lunacy Act, 1977, are hereby repealed.
- (2) Notwithstanding such repeal, anything done or any action taken under either of the said Acts shall, insofar as such thing or action is not inconsistent with the provisions of this Act, be deemed to have been done or taken under the corresponding provisions of this Act and shall continue in force until superseded by anything done or any action taken under this Act.

## **The Central Mental Health Authority Rules, 1990**

**G.S.R.1004 (E), dated 29<sup>th</sup> December 1990** – In exercise of the powers conferred by sub-section (1) of Sec. 94 of the Mental Health Act, 1987 (14 of 1987), read with Sec. 22 of the General Clauses Act, 1897 (10 of 1897), the Central Government hereby makes the following rules, namely

## Chapter I

### Preliminary

#### 1. *Short Title and Commencement*

- (1) These rules may be called the Central Mental Health Authority Rules, 1990.
- (2) They shall come into force on the date of commencement of the Act.

#### 2. *Definitions*

In these rules unless the context otherwise requires:

- (a) "Act" means the Mental Health Act, 1987 (14 of 1987);
- (b) "Authority" means the Central Mental Health Authority established under Sec. 3 of the Act;
- (c) "Chairman" means the Chairman nominated under rule 5;
- (d) "Member" means a member of the Authority established under rule 3;
- (e) "Membership" means the membership of the Authority established under rule 3;
- (f) "Non-official member" means a member appointed under sub-rule (2) of rule 3;
- (g) "Official member" means a member appointed under sub-rule (1) of rule 3;
- (h) "Secretary" means a member appointed under sub-rule (1) of rule 13; and
- (i) Words and expressions used herein and not defined but defined in the Act shall respectively have the meaning assigned to them in the Act.

## Chapter II

### Central Mental Health Authority

#### 3. *Constitution of the Authority*

The Authority shall consist of the following members, namely

##### (1) **Official Members**

- (a) Secretary or Additional Secretary, Ministry of Health and Family Welfare, Government of India.
- (b) Joint Secretary, Ministry of Health and Family Welfare dealing with Mental Health.
- (c) Additional Director-General of Health Services dealing with Mental Health.
- (d) Director, Central Institute of Psychiatry, Ranchi.
- (e) Director, National Institute of Mental Health and Neuro Sciences, Bangalore.
- (f) Medical Superintendent, Hospital for Mental Diseases, Shahdara, Delhi.



**(2) Non-Official Members**

Three members including one Social Worker, one Clinical Psychologist and one Medical Psychiatrist who, in the opinion of the Central Government, have special interest in the field of Mental Health.

**4. Disqualification**

A person shall be disqualified for being appointed as a member or shall be removed from membership by the Central Government if he:

- (a) has been convicted and sentenced to imprisonment for an offence which in the opinion of the Central Government involves moral turpitude; or
- (b) is an undischarged insolvent; or
- (c) is of unsound mind and stands so declared by a competent court; or
- (d) has been removed or dismissed from the Government or a body corporate owned or controlled by the Government.

**5. Chairman**

- (1) The Central Government may nominate any official member to act as the Chairman of the Authority.
- (2) The Chairman shall cease to hold office when he ceases to be a member of the Authority.

**6. Term of Office of Members**

- (1) Every official member shall hold office as such member so long as he holds the office by virtue of which he was so appointed.
- (2) Every non-official member shall hold office for a period of three years from the date of his appointment and shall be eligible for re-appointment.
- (3) A non-official member may at any time resign from membership of the Authority by forwarding his letter of resignation to the Chairman and such resignation shall take effect only from date on which it is accepted.
- (4) Where a vacancy occurs by resignation of a non-official under sub-rule (3) or otherwise, the Central Government shall fill the vacancy by appointing from amongst category of persons referred to in sub-clause (2) of rule 3 and the person so appointed, shall hold office for the remainder of the term of office of the member in whose place he was so appointed.
- (5) Where the term of office of any non-official is about to expire, the Central Government may appoint a successor at any time within three months before the expiry of the term of such member but the successor shall not assume office until the term of the member expires.

## **Chapter III**

### **Proceedings of the Authority**

#### **7. Meetings of the Authority**

- (1) The Authority shall ordinarily meet once in every six months at such time and place as may be fixed by the Chairman

Provided that the Chairman:

- (i) may call a special meeting at any time to deal with any urgent matter requiring the attention of the Authority.
  - (ii) shall call a special meeting if he receives a requisition in writing signed by not less than four members and stating the purpose for which they desire the meeting to be called.
- (2) The first meeting of the Authority to be held in any calendar year shall be the annual meeting for that year.

#### **8. Subjects for Special Meeting**

Where a meeting referred to in the proviso to sub-rule 7 has been convened only the subjects for the consideration of which the meeting was convened shall be discussed.

#### **9. Subjects for the Annual Meeting**

At the Annual Meeting of the Authority, the following subjects shall be considered and disposed of, namely:

- (a) review of the progress of implementation of the various provisions of Mental Health Act during the preceding one year;
- (b) other business on the agenda; and
- (c) any other business brought forward with the consent of the Chairman or where he is absent, with the consent of officer presiding at the meeting.

#### **10. Procedure for Holding Meetings**

- (1) Every notice calling for a meeting of the authority shall:
  - (a) specify the place, date and hour of the meeting; and
  - (b) be served upon every member of the Authority not less than twenty-one clear days in the case of annual meeting and fifteen clear days in the case of other meetings before the day appointed for the meeting.
- (2) The Secretary shall prepare and circulate to the members along with the notice of the meeting an agenda for such meeting showing the business to be transacted.
- (3) A member who wishes to move a resolution on any matter included in the agenda shall give notice thereof to the Secretary not less than seven days before the date fixed for the meeting.
- (4) A member who wishes to move any motion not included in the agenda shall give notice to the Secretary not less than fourteen days before the date fixed for the meeting.

### ***11. Proceedings of the Authority***

- (1) The Chairman or in his absence any member authorised by him shall preside at the meetings of the Authority.
- (2) The quorum for the meeting of the Authority shall be four members.
- (3) If within half an hour from the time appointed for holding a meeting of the Authority quorum is not present, the meeting shall be adjourned to the same day in the following week at the same time and the presiding officer of such meeting shall inform the members present and send notice to other members.
- (4) If at the adjourned meeting also, quorum is not present within half an hour from the time appointed for holding the meeting, the members present shall constitute the quorum.
- (5) In the adjourned meeting if the Chairman is not present and no member has been authorised to preside at such meeting, the members present shall elect a member to preside at the meeting.
- (6) Each member including the Chairman shall have one vote. In the case of an equality of votes, the Chairman or any member presiding over such meeting shall, in addition, have a casting vote.
- (7) All decisions of the meeting of the Authority shall be taken by a majority of the members present and by voting.

### ***12. Approval by Circulation***

Any business which may be necessary for the Authority to transact except as such may be placed before the annual meeting, may be carried out by circulation among all members and any resolution so circulated and approved by a majority of members, shall be valid and binding, as if such resolution had been passed at the meeting of the Authority.

### ***13. Secretary to the Authority***

- (i) The Chairman shall cause to be appointed a Secretary to the Authority from amongst persons possessing postgraduate degree in psychiatry and having three year's experience in the field of psychiatry.
- (ii) The Secretary shall be a full-time or part-time servant of the Authority and shall function as the Administrative Officer of the Authority.
- (iii) The Secretary shall be responsible for the control and management of office accounts and correspondence.
- (iv) The Secretary shall attend and take notes of the proceedings of the meetings of the Authority.
- (v) The Secretary shall cause to be appointed such members of the ministerial and non-ministerial staff which are essential for the functioning of the Authority.
- (vi) The Secretary shall exercise such other powers and discharge such other functions as may be authorised in writing by the Chairman for the efficient functioning of the Authority.

### ***14. Forwarding of Copies of the Proceedings of the Authority to the Central Government***

The Secretary shall forward copies of the proceedings of the Authority to the Central Government periodically.

## Appendix-VII

# The State Mental Health Rules, 1990

*G.S.R. 1005 (E), dated 29<sup>th</sup> December, 1990*— In exercise of the powers conferred by the proviso to sub-section (2) of Sec. 94 of the Mental Health Act, 1987 (14 of 1987), read with Sec. 22 of the General Clauses Act, 1987 (10 of 1897), the Central Government hereby makes the following rules, namely

## Chapter I

### Preliminary

#### 1. *Short Title and Commencement*

- (1) These rules may be called the State Mental Health Rules, 1990.
- (2) They shall come into force in a State on the date of commencement of the Act in the State.

#### 2. *Definitions*

In these rules unless the context otherwise requires:

- (a) "Act" means the Mental Health Act, 1987 (14 of 1987);
- (b) "Applicant" means the person who makes an application to the licensing authority for grant of a licence;
- (c) "Authority" means the State Mental Health Authority constituted under Sec. 4 of the Act;
- (d) "Chairman" means the Chairman nominated under rule 5;
- (e) "Form" means form annexed to these rules;
- (f) "Licence" means licence granted under Sec. 8 of the Act;
- (g) "Member" means a member of the Authority appointed under rule 3;
- (h) "Membership" means membership of the Authority established under Sec. 4 of the Act;
- (i) "Non-official member" means a member appointed under sub-rule (2) of rule 3;
- (j) "Official member" means a member appointed under sub-rule (1) of rule 3;
- (k) "Secretary " means Secretary to the Authority appointed under rule 13; and
- (l) Words and expressions used herein and not defined but defined in the Act shall respectively have the meanings assigned to them in the Act.

## Chapter II

### State Mental Health Authority

#### 3. *Constitution of the Authority*

The Authority shall consist of the following members, namely

##### (1) **Official Members**

1. Secretary, Department of Health;
2. Joint Secretary, Department of Health dealing with Mental Health;
3. Director of Health Services;
4. Medical Superintendent, Government Mental Hospital or Head of the Department of Psychiatry, Government Medical College and Hospital.

##### (2) **Non-official Members**

Three members including one Social Worker, one Clinical Psychologist and one Medical Psychiatrist, who in the opinion of the State Government have special interest in the field of Mental Health.

#### 4. *Disqualification*

A person shall be disqualified for being appointed as a member or shall be removed from membership by the State Government, if he:

- (a) has been convicted and sentenced to imprisonment for an offence which in the opinion of the State Government involves moral turpitude; or
- (b) is an undischarged insolvent; or
- (c) is of unsound mind and stands so declared by a competent court; or
- (d) has been removed or dismissed from the service of the Government or a body corporate owned or controlled by the Government.

#### 5. *Chairman*

- (1) The State Government may nominate any official member to act as the Chairman of the Authority.
- (2) The Chairman shall cease to hold office when he ceases to be a member of the Authority.

#### 6. *Term of Office of members*

- (1) Every official member shall hold office as such member so long as he holds the office by virtue of which he was so appointed.
- (2) Every non-official member shall hold office for a period of three years from the date of his appointment and shall be eligible for re-appointment.
- (3) A non-official member may at any time resign from membership of the Authority by forwarding his letter of resignation to the Chairman and such resignation shall take effect only from the date on which it is accepted.

- (4) Where a vacancy occurs by resignation of a non-official member under sub-section (3) or otherwise, the State Government shall fill the vacancy by appointing from amongst category of persons referred to in sub-rule 2 of 3 and the person so appointed, shall hold office for the remainder of the term of office of the member in whose place he was so appointed.
- (5) Where the term of office of any non-official member is about to expire, the State Government may appoint a successor at any time within three months before the expiry of the term of such member but the successor shall not assume duty until the term of the member expires.

## **Chapter III**

### **Proceedings of the Authority**

#### **7. Meetings of the Authority**

- (1) The Authority shall meet once in every six months at such time and place as may be fixed by the Chairman  
Provided that the Chairman:
  - (i) may call a special meeting at any time to deal with any urgent matter requiring the attention of the Authority; and
  - (ii) shall call a special meeting if he receives a requisition in writing signed by not less than four members and stating the purposes for which they desire the meeting to be called.
- (2) The first meeting of the Authority to be held in any calendar year shall be the annual meeting for that year.

#### **8. Subjects for Special Meeting**

Where a meeting referred to in the proviso to sub-rule (1) of the rule 7 has been convened, only the subjects for the considerations of which the meeting was convened shall be discussed.

#### **9. Subjects for the Annual Meeting**

At the Annual Meeting of the Authority, the following shall be considered and disposed of, namely:

- (a) review of the progress of implementation of the various provisions of the Mental Health Act during the preceding one year; and
- (b) other business brought forward with the consent of the Chairman or where he is absent with the consent of the officer presiding at the meeting.

#### **10. Procedure for Holding Meetings**

- (1) Every notice for meeting of the Authority shall:
  - (a) specify the place, date and hour of the meeting; and

- (b) be served upon every member of the Authority not less than twenty-one clear days in the case of annual meeting and fifteen clear days in the case of other meetings before the day appointed for the meeting.
- (2) The Secretary shall prepare and circulate to the members along with the notice of the meeting, an agenda for such meeting showing the business to be transacted.
- (3) A member who wishes to move a resolution on any matter included in the agenda shall give notice thereof to the Secretary not less than seven days before the date fixed for the meeting.
- (4) A member who wishes to move any motion not included in the agenda shall give notice thereof to the Secretary not less than fourteen days before the date fixed for the meeting.

### ***11. Proceedings of the Authority***

- (1) The Chairman or in his absence any member authorised by him shall preside at the meetings of the Authority.
- (2) The quorum for the meeting of the Authority shall be four members.
- (3) If within half an hour from the time appointed for holding a meeting of the Authority, quorum is not present, the meeting shall be adjourned to the same day in the following week at the same time and place and the presiding officer of such meeting shall inform the members present, and send notice to other members.
- (4) If at the adjourned meeting also, quorum is not present within half an hour from the time appointed for holding the meeting, the members present shall constitute the quorum.
- (5) In the adjourned meeting if the Chairman is not present and no member has been authorised to preside at such meeting, the members present shall elect a member to preside at the meeting.
- (6) Each member including the Chairman shall have one vote. In the case of an equality of votes, the Chairman or any member presiding over such meeting, shall in addition, have a casting vote.
- (7) All decisions of the meeting of the Authority shall be taken by a majority of the members present and by voting.

### ***12. Approval by Circulation***

Any business which may be necessary for the Authority to transact except such as may be placed before the annual meeting, may be carried out by circulation among all members and any resolution so circulated and approved by a majority of members shall be valid and binding as if such resolution had been passed at the meeting of the Authority.

### ***13 Secretary to the Authority***

- (1) The Chairman shall cause to be appointed a Secretary to the Authority from amongst persons possessing a postgraduate degree in Psychiatry and having three years' experience in the field of psychiatry.
- (2) The Secretary shall be a full-time servant of the Authority and shall function as the Administrative Officer of the Authority.

- (3) The Secretary shall be responsible for the control and management of office accounts and correspondence.
- (4) The Secretary shall attend and take notes of the proceedings of the meeting of the Authority.
- (5) The Secretary shall cause to be appointed such members of the ministerial and non-ministerial staff which are essential for efficient functioning of the Authority.
- (6) The Secretary shall exercise such other powers and discharge such other functions as may be authorised in writing by the Chairman for the efficient functioning of the Authority.

#### ***14. Forwarding of Copies of the Proceedings of the Authority to the State Government***

The Secretary shall forward copies of the proceedings of the Authority to the State Government periodically.

## **Chapter IV**

### **Licence**

#### ***15. Application for Licence***

Every application for a licence under sub-section (1) or sub-section (2) of Sec. 7 of the Act shall be:

- (a) made to the licensing authority in Form I or Form II as the case may be; and
- (b) accompanied by a fee of rupees two hundred in the form of a bank draft drawn in favour of the licensing authority.

#### ***16. Grant of Licence***

If the licensing authority is satisfied that the applicant fulfils the conditions laid down in Cls. (a), (b) and (c) of Sec. 8 of the Act, it shall grant the licence in Form III.

#### ***17. Refusal of Licence and Manner of Communicating the Order***

- (1) If the licensing authority is satisfied that the applicant does not fulfil the conditions laid down in Sec. 8 of the Act, it may, after giving the applicant a reasonable opportunity of being heard against the proposed refusal of licence, by order setting out the reasons therein, refuse to grant the licence.
- (2) Every order refusing to grant a licence under Sec. 8 shall be communicated to the applicant by sending a copy of the order by registered post to the address given in the application.
- (3) A copy of the order shall also conspicuously displayed on the notice-board of the licensing authority.



### **18. Application for Renewal**

Every application for renewal of a licence under sub-section (5) of Sec. 9 of the Act shall be:

- (a) made to the licensing authority in Form IV; and
- (b) accompanied by a fee of rupees one hundred in the form of a bank draft drawn in favour of the licensing authority.

### **19. Refusal of Licence**

- (1) If the licensing authority is satisfied that the conditions mentioned in the proviso to sub-section (5) of Sec. 9 of the Act are not attracted, it shall renew the licence.
- (2) If the licensing authority is of the opinion that the licence should not be renewed in view of the fact the conditions mentioned in the proviso to sub-section (4) of Sec. 9 are attracted, it may, after giving the applicant a reasonable opportunity of being heard against the proposed refusal of renewal of the licence by order setting out the reasons therein, refuse to renew the licence.
- (3) Every order refusing to renew the licence under the proviso to sub-section (5) of Sec. 9 shall be communicated to the applicant by sending a copy of the order by registered post to the address in the application for renewal.

### **20 Manner and Conditions of Maintaining Psychiatric Hospitals or Psychiatric Nursing Homes**

Every Psychiatric Hospital or Nursing Home shall be maintained subject to the condition that:

- (a) such hospital or nursing home is located in an area approved by the local authority;
- (b) such hospital or nursing home is located in a building constructed with the approval of the authority;
- (c) the building, where such hospital or nursing home is situated, has sufficient ventilation and is free from any pollution which may be detrimental to the patients admitted in such hospital or nursing home;
- (d) such hospital or nursing home has enough beds to accommodate the patients.
- (e) the nurses and other staff employed in such hospital or nursing home are duly qualified and competent to handle the work assigned to them; and
- (f) the supervising officer-in-charge of such hospital or nursing home is a person duly qualified having a postgraduate qualification in psychiatry recognised by the Medical Council of India.

### **21. Time for Appeal**

- (1) Any person aggrieved by the order of the licensing authority refusing to grant or renew a licence or revoking a licence, may prefer an appeal to the State Government within sixty days of the communication of such order:

Provided that the State Government may entertain an appeal preferred after the expiry of the period specified in sub-rule (1) if it is satisfied that the applicant was prevented by sufficient cause from preferring the appeal in time.

- (2) The appeal shall be in "Form V" and shall be sent to the State Government by registered post or by appearing in person before and delivering the same to the Secretary to the State Government, Department of Health or any other officer nominated by him in this behalf.
- (3) Every appeal shall be accompanied with a fee of five hundred rupees.

## Chapter V

### Psychiatric Hospital and Nursing Home

#### **22. Minimum Facilities for Treatment of Out-Patients**

The minimum facilities required for every psychiatric hospital or psychiatric nursing home for treatment of patients mentioned in Sec. 14 of the Act shall be as follows:

##### **1. Staff for 10-bedded hospital or nursing home**

- (a) One full time qualified psychiatrist.
- (b) One mental health professional assistant (clinical psychologist or psychiatric social worker).
- (c) Staff nurses in the nurse : patient ratio 1:3.
- (d) attendants in the attender : patient ratio 1:5

##### **2. Physical Features**

Adequate floor space depending on the number of beds shall be provided.

##### **3. Support /Facilities**

The minimum support/facilities shall be as under:

- (a) provision for emergency care for out-patients and for handling medical emergencies for out-patients and in-patients;
- (b) a well-equipped Electro-Convulsive Therapy facility;
- (c) psychodiagnostic facilities;
- (d) provision for recreational, rehabilitation activities; and
- (e) facilities for regular out-patient care.

#### **23 Revocation of Licence**

- (1) Where the licensing authority is satisfied that the licence of any psychiatric hospital or nursing home is required to be revoked in pursuance of Cl. (a) or (b) of sub-section (1) of Sec. 11 of the Act, it may, after giving the licensee a reasonable opportunity of being heard against the proposed revocation, by order setting out the grounds therein, revoke the licence.
- (2) Every order revoking the licence under sub-rule (1) shall be communicated to the licensee by sending a copy of the order by registered post to the address given in the application.

- (3) A copy of the order shall also be conspicuously displayed on the notice-board of the office of the licensing authority and in the psychiatric hospital or nursing home.

#### **24. Maintenance of Records**

Every psychiatric nursing home shall maintain the records of the treatment of patients in Form VI.

### **Chapter VI**

#### **25. Admission and Detention in Psychiatric Hospital or Psychiatric Nursing Home**

- (1) Application by Medical Officer in charge:
  - (a) the application for reception order may be made by the Medical Officer in charge of a Psychiatric Nursing Home in "Form VII"; or
  - (b) by the husband, wife or any other relative of the mentally ill person in "Form VIII".
- (2) Application from husband or wife:
  - (a) every application by the husband, wife relative or friend of a person who is alleged to be mentally ill shall be accompanied by necessary medical certificates;
  - (b) such application shall be signed either by the husband or wife or relative or friend as the case may be, and verified by two independent witnesses; and
  - (c) the name, address occupation and other details of all the applicants and the attesting witness shall be clearly given in such application.

#### **26. The Qualifications and Functions of the Visitors**

- (1) The qualifications of persons to be appointed as visitors under Sec. 37 of the Act shall be as follows:
  - (a) a degree in Medicine with postgraduate degree in psychiatry awarded by any University in India recognised by the Medical Council of India and having at least ten years' standing in the profession, who has held/is holding the post of Medical Superintendent, Professor in psychiatric hospital or psychiatric wing of a hospital; or
  - (b) experience as a social worker/clinical psychologist/psychiatric nurse connected with any mental hospital for a period of not less than ten years.
- (2) The visitors appointed by the government under Sec. 37 of the Act shall be responsible for:
  - (a) review of admission and discharge of patients;
  - (b) inspection of the wards, outdoor patient department and kitchen;
  - (c) facilities to be provided;

- (d) suggestion for improvement; and
- (e) functioning as liaison officer between the government and hospital.

### ***27. Leave of Absence***

Every application by relative or any other person on behalf of the patient for leave of absence under Sec. 45 of Act shall be made in "Form IX".

### ***28. Interception of the Letters and other Communications Addressed to the Mentally Ill Persons***

No letter or other communication addressed to a mentally ill person intended for delivery either through the postal department or otherwise shall be intercepted, detained or destroyed except under following circumstances, namely:

- (i) any letter or other communication intended for delivery to a mentally ill person shall be opened only if the person having the supervisory control over the hospital or nursing home is of the opinion that such letter or communication contains any information or material which if communicated to such patient will be detrimental to his health; or
- (ii) that the interception, detention or destruction of any letter or communication intended to be delivered to the mentally ill person is necessary in the interests of the public or the State.

FORM - I  
(see rule 15)

**Application for Maintaining a Psychiatric Hospital/Nursing Home**

To

The.....Officer,

Government.....

.....

Dear Sir/Madam

I/We intend to establish /maintain a Psychiatric Hospital/ Psychiatric Nursing Home in respect of which I am/we are holding a valid licence for the establishment/maintenance of such Hospital/ Nursing Home. The details of the Hospital/Nursing Home are given below:

1. Name of the applicant
2. Details of licence with reference to the name of the Authority issuing the licence and date
3. Age
4. Professional experience in psychiatry
5. Permanent address of the applicant
6. Location of the proposed Hospital/ Nursing Home
7. Address of the proposed Hospital/Nursing Home
8. Proposed accommodation:
  - (a) Number of rooms
  - (b) Number of beds.

***Facilities provided***

- (a) Out-patient
- (b) Emergency services
- (c) In-patient facilities
- (d) Occupational and recreational facilities
- (e) ECT facilities
- (f) X-ray facilities
- (g) Psychological testing facilities
- (h) Investigation and laboratory facilities
- (i) Treatment facilities.

**Staff Pattern**

- (a) Number of Doctors
- (b) Number of Nurses
- (c) Number of Attendants
- (d) Others.

I am sending herewith a bank draft for Rs..... drawn in favour of..... as licence fee.

I hereby undertake to abide by the rules and regulations of the Mental Health Authority.

I request you to consider my application and grant the licence for establishment/maintenance of Psychiatric Hospital/Nursing Home.

Yours faithfully,

Signature.....

Name.....

Date.....

---

**FORM II**  
(see rule 15)

**Application for Establishment of Psychiatric Hospital/ Nursing Home  
under sub-section (2) of Sec. 7**

To

The.....Officer,

Government.....

.....

Dear Sir/Madam,

I/We intend to establish a Psychiatric Nursing Home/ Psychiatric Hospital at..... (mention the place). I am herewith giving you the details.

1. Name of the applicant
2. Qualification of Medical Officer to be in charge of Nursing Home/Hospital (Certificates to be attached)

3. Age
4. Professional experience in psychiatry
5. Permanent address of the applicant
6. Location of the proposed Hospital/Nursing Home
7. Address of the proposed Hospital/Nursing Home
8. Proposed accommodation:
  - (a) Number of rooms
  - (b) Number of beds.

***Facilities Provided***

- (a) Out-patient
- (b) Emergency services
- (c) In-patient facilities
- (d) Occupational and recreational facilities
- (e) ECT facilities
- (f) X-ray facilities
- (g) Psychological testing facilities
- (h) Investigation and laboratory facilities
- (i) Treatment facilities.

***Staff Pattern***

- (a) Number of Doctors
- (b) Number of Nurses
- (c) Number of Attendants
- (d) Others.

I am herewith sending a bank draft for Rs.....drawn in favour of..... as licence fee.

I hereby undertake to abide by the rules and regulations of the Mental Health Authority. I request you to consider my application and grant licence.

Yours faithfully,

Signature.....

Date .....

---

FORM III  
(see rule 15)

**Application for Establishment of Psychiatric Hospital/Nursing Home**

I, ..... being the licensing authority under the Mental Health Act 1987, after considering the application received under Sec. 7 and satisfying the requirements provided for in Sec. 8 and the other provisions of the Mental Health Act, 1987 (Central Act 14 of 1987) and the rules made thereunder, hereby grant the licence for establishment/ maintenance of a psychiatric hospital or nursing home in favour of..... (the applicant).

The licence shall be valid for the period commencing from..... and ending with..... . The licence shall be subject to the conditions laid down in the Mental Health Act, 1987 (14 of 1987) and the rules made thereunder.

Licensing Authority

Place:

Date:

FORM IV  
(see rule 18)

**Application for Renewal of Licence**

Seal

From

Dr .....

.....

To

District Health Officer,

.....

.....

Sir,

Subject: Renewal for licence No..... dated..... I request you to kindly renew my licence No ..... dated ..... for the next 5 years. I am providing the facilities as prescribed by the Act and the rules framed thereunder. I have herewith attached a demand draft for Rs 100 only.

Yours faithfully,

Signature.....

Date.....

Place:

Date:



FORM V  
(see rule 21)

**Application for Appeal**

To

The Appellate Authority

Government of.....

.....

Sir,

I, Dr..... of..... had applied for a licence for establishing a Psychiatric Nursing Home/Hospital at.....(Copy of the earlier application to be attached). My application was rejected by the licensing authority as per his/her letter No .....dated ..... with the following:

- 1.
- 2.
- 3.

(Copy enclosed)

The above reason(s) appear to be not valid. I request you to reconsider my application. My justifications are:

- 1.
- 2.
- 3.

I am willing to appear before you for a personal hearing, if necessary, I am herewith enclosing a draft for Rs 500.

Yours faithfully,

Signature.....

Date .....

Place:

Date:

---

FORM VI  
(see rule 24)

**Proforma of Case Record**

Name of the Hospital /Nursing Home..... Patient's Name.....Age.....  
Sex..... Date of admission.....Date of discharge.....Mode  
of admission .....

- Voluntary Reception order :
  - Complaints (Reports from relative or other sources) :
  - Mental State Examination :
  - Physical Examination :
  - Laboratory investigations :
  - Provisional diagnosis :
  - Initial treatment :
  - Treatment and progress notes :
  - Date Clinical State :
  - Side-effect :
  - Treatment :
  - Final diagnosis :
  - Condition at discharge :
  - Follow-up recommendations :
-

FORM VII  
(see rule 25)

**Application for Reception Order**

(By Medical Officer in charge of a Psychiatric Hospital)

From

Dr.....  
.....  
.....

To

The Magistrate  
.....  
.....

Sir

Subject: reception order for ..... Son/ daughter of ..... I, Dr .....  
maintain Psychiatric Hospital/Nursing Home at ..... under licence No.....  
dated.....

I request you to issue reception order in respect of Sh./Smt ..... son/  
daughter of..... who is being treated at my hospital as voluntary patient and is  
not willing to continue. He/she has the following symptoms and/or signs.

- 1.
- 2.
- 3.
- 4.
- 5.

He/She requires to be in the hospital for treatment/personal safety/others protection.

Yours faithfully,

Signature.....

Date.....

\*Magistrate" means,

- (1) in relation to a metropolitan area within the meaning of Cl.(K) of Sec. 2 of the Code of Criminal Procedure, 1973, a Metropolitan Magistrate;
- (2) in relation to any other area , the Chief Judicial Magistrate, Sub-Divisional Judicial Magistrate or such other Judicial Magistrate of the first class as the State Government may, by notification, empower to perform the functions of a magistrate under this Act.

FORM VIII  
(see rule 25)

**Application for Reception Order**

(By relative or others)

To

.....  
.....  
.....

Sir,

Subject: Admission of ..... son/daughter of .....into psychiatric hospital/nursing home as in-patient.

I, ..... son/daughter of ..... residing at ..... request you kindly arrange for admission in respect of Sh./ Smt.....aged .....years.....son/daughter of .....as in-patient to ..... (name of the hospital) or any other hospital/nursing home. He/she has the following suggestive of mental illness.

- 1.
- 2.
- 3.
- 4.
- 5.

I, who is.....(relationship) of Sh./ Smt..... have an income .....Rs..... and agree to pay the charges of treatment, if any, according to the rules and also assure that I shall abide by the rules and regulations of the Institution. I state that, I have/ have not made any such regard to the mental condition of ..... As required, I herewith enclose the two medical certificates needed for the purpose.

Yours faithfully,

Witnesses:

Signature.....

Name in Capital .....

1. Name :  
Address :  
Occupation :
2. Name :  
Address :  
Occupation :

\_\_\_\_\_

FORM IX  
(see rule 27)

**Application for Leave of Absence**

(By relative or others)

To

Dr .....  
.....  
.....

Sir,

Subject: request for leave of absence of Sh./Smt.....aged.....Years admitted on.....  
to your Institute.

I request that Sh./Smt..... son/daughter of ..... be delivered to my care and  
custody on leave of absence.

I hereby bind myself that on the said Sh./ Smt.....being made over to my care and custody,  
I will have him/here properly taken care of and prevent from doing injury to himself/herself or to  
others.

Yours faithfully,

Signature.....

Name.....

---

**Appendix F**

**Order of the Supreme Court in Writ Petition  
(Cr1) No 432 of 1995 –  
Anamika Chawla vs Metropolitan Magistrate**

Date of disposal: 1 May 1997

*(1997) 5 Supreme Court Cases 346*  
(Before Suhas C. Sen and K.S. Paripoornam. JJ)

Anamika Chawla

...Petitioner

Versus

Metropolitan Magistrate and others

... Respondents

Writ Petition (Cr1) No 432 of 1995, decided on May 1, 1997

Constitution of India - Art 31 - Wrongful confinement - Allegation of ill-treatment of wife by her husband and his father - Magistrate ordering her to be admitted to Psychiatry Centre for observation and treatment - Such order passed with undue haste and even without seeing the patient - Warden of the hostel where the wife resided stating that she found her behaviour normal - Court personally questioning her but finding no mental aberration - Order of Magistrate Quashed.

Advocates who appeared in this case:

Ms Indira Jaising, Senior Advocate (Sanjay Parikh, Sakesh Kumar and Ms Anita, Advocates, with her) for the petitioner:

Ms Anamika Chawla and her father R.K. Soral, Arguments Concluded.

R.K. Jain, Senior Advocate (Sushil Kumar Jain, Prakash Srivastava, S. Atreya and R. Vasudeva, Advocates, with him) for the Respondents.

**Order**

1. This case arises out of alleged ill-treatment of Mrs Anamika Chawla by her husband and his father. The case is going on since 29-7-1995. Smt Anamika Chawla came up against the order passed by the Metropolitan Magistrate on 29-7-1995 ordering her to be admitted to Delhi Psychiatry Centre, 35, Defence Enclave, Vikas Marg, New Delhi for observation and treatment.

This order was passed with undue haste even without seeing the alleged patient. Medical certificates were produced from Dr Sunil Mital and Dr S.C. Malik. The case of the petitioner, Mrs Chawla is that neither of the two doctors had ever met her or examined her. The allegation appears to be true.

2. When the application was moved by Mrs Anamika Chawla, she was staying in Guild of Service Hostel in New Delhi. The warden of the hostel appeared in person and stated that she found Mrs Chawla's behaviour normal. She was on friendly terms with the other inmates of the hostel. It was also recorded in the order of this Court held on 3-8-1993 that this court had personally questioned the petitioner and had not noticed any mental aberration but since the medical certificates had been produced before the Magistrate, we wanted to examine the case in greater detail.
3. The case has now gone on for a number of days. We heard the doctors and examined the reports, heard all the parties. Mrs Chawla has appeared before us personally on a number of days. We have spoken to her on all these days. We have not noticed the slightest abnormality in her behaviour.
4. We tried to bring about a reconciliation between the husband and wife but unfortunately no reconciliation could be brought about. The parties were directed to undergo counselling which has gone on for some time. We have seen records sent by the counsellor. We are of the view that no useful purpose will be served by prolonging this case any further.
5. We hold that there was no basis for passing the impugned order dated 29-7-1995 by the Metropolitan Magistrate. The order is quashed. The writ petition filed in this Court by Anamika Chawla is disposed off finally as above. There will be no order as to costs.

## Appendix G

# Proceedings of a National Workshop on Mental Health Concerns Relating to Women and Children New Delhi, September 2002

### *National Workshop*

#### **Mental health concerns relating to women and children: problem definition, sensitising the police-judicial system and preparation of strategies**

*“Much of the world is facing rapid economic reforms and social change, including economic transitions that are linked to alarming rates of unemployment, family breakdown, personal insecurity and inequality of income. Poverty remains a reality for much of the world, and mostly affects women. Women face great pressures through a range of gender-based disadvantages, and huge numbers experience physical and sexual violence, resulting in high rates of depression and anxiety disorders. Young people, particularly street children and those exposed to violence, are undergoing social upheaval, which is accompanied by climbing suicide rates. In many parts of the world, mental health systems are poorly funded and organized”.*

Report of the Ministerial Round Tables: Mental Health,  
54<sup>th</sup> World Health Assembly – May 2001. WHO, Geneva

#### **Preamble**

Mental health issues related to women and children have remained relatively even more neglected than mental health in general. There is a large body of evidence to suggest that women experience and respond to stress in distinctive ways compared to men. Their response patterns are qualitatively as well as quantitatively different from those of men in both psychological and biological domains. The nature of women’s lives and realities render them more vulnerable to stress and other related mental problems than men. Children are at even greater risk in this regard. The situation is made worse by the inadequacy and uneven availability of mental health services in our country. In general, economically well-off males in cities have access to the best available health services while the poor women and children in slums and rural areas receive the least satisfactory healthcare. Unfortunately, as in many other areas of socio-economic activity, it is the men who make the decisions for women. It is they who decide when a woman is ill, what kind of care she requires and who should treat her. Empowerment of women in this regard remains largely on paper. The



ground realities are appalling and the situation with regard to women and children involved in any type of police-judiciary proceedings is even more tragic. Insensitive investigation and trial involving women or child victims of sexual or other abuse, rape, marital or dowry-related violence, spouse-neglect or abandonment/divorce inflict further mental trauma on the victims. The National Commission for Women has repeatedly drawn attention to this human problem. At its last meeting held in July 2001, the Central Council of Health had reiterated its concern for care and support to victims of sexual or other abuse, rape, marital or dowry-related violence, spouse neglect or abandonment/divorce. The present workshop is a small step in this direction.

The new millennium has been marked by several major initiatives in the field of mental health. The Government of India has accorded high priority to the development of community-based mental healthcare services during the 10<sup>th</sup> Five Year Plan with an allocation of Rs 190 crore, up from Rs 28 crore in the 9<sup>th</sup> Five Year Plan. Following the Erwady tragedy in August 2001 the Hon'ble Supreme Court had directed several remedial measures to be taken in this area. The Central Mental Health Authority (CMHA) in the Ministry of Health & Family Welfare had identified as a priority area sensitisation of the judicial system to Mental Health Act 1987 and related laws. A survey of women and children in the prisons of Andhra Pradesh revealed that almost all were "suffering from a disturbed mind in one way or another and that "women face even greater problems when they are released from jail", "the taint of their offences, their alienation from their families and the stigma of the jail sentences stays with them almost forever." The situation with regard to women committed to mental hospitals under magisterial orders is even worse. They are more likely to be abandoned by their husbands/families and a majority of fit to be discharged long-stay patients in mental hospitals are women who have been languishing in these institutions for years without any communication from their families or contact with the outside world. This is ironic, for women are not only more frequent sufferers from mental illness, they are also the primary carers for persons with mental illness. The issues referred to above come under the purview of different agencies and organs of the constitution, women's groups, the police/ judicial system and mental health professionals. There is need for coordination and synergy within these sectors.

### **The Present Initiative**

The workshop, organised by the Ministry of Health & Family Welfare in association with the All India Institute of Medical Sciences with support from WHO India on 7-9 September 2002 at New Delhi, provided a multidisciplinary platform for all stakeholders in this area of national concern. Leading mental health professionals, members of the legal profession, police officers, social workers and those associated with voluntary agencies came together to address the complex issues involved and evolve pragmatic corrective strategies over three days of intense discussions. The recommendations of the workshop are outlined in the following paragraphs.

### **Recommendations**

1. The group feels that this workshop has provided a very useful forum for constructive interaction between members of the judicial system, law enforcement officers, mental health professionals and other stakeholders. By removing inhibitions, misconceptions and even mistrust, it has met an hitherto unmet need. Such structured dialogue at various levels should continue in the future as well.

2. Women and children suffer relatively higher prevalence of mental disorders but are at a disadvantage in respect of health service utilisation. This vulnerability and disadvantage continue to handicap women and children when they come in contact with law enforcement agencies as victims or as accused. Unequals need to be treated preferentially in order to neutralise the negative effects of such inequality and bring them at par with the more privileged. Investigative as well as judicial agencies must therefore take into account the vulnerability of women and children when they interface with the law and necessary changes, attitudinal and otherwise, should be brought about in both domains. Towards this end major curricular changes need to be introduced in judicial as well as police training programmes at entry and at regular intervals thereafter in the form of in-service refresher courses. The Ministry of Law in consultation with the Hon'ble Supreme Court of India and the Ministry of Home Affairs may constitute empowered committees to formulate such training modules with the help of mental health professionals.
3. The group noted that such profound attitudinal changes cannot be conceptualised and implemented in vacuum and must be viewed in a wider situational perspective. Abysmal living and working conditions cannot lead to good policing, just as dilapidated court-rooms and over-worked judges are incompatible with sensitive jurisprudence. It, therefore, recommends that effective remedial measures should be undertaken to address the aforesaid issues and thereby reduce stress levels among police personnel and judicial officers.
4. Laws concerning women and children and those relating to the mentally ill should be kept under constant review in order to make them rights-sensitive in accordance with the UN Charter and our constitutional provisions, as also to bring them in tune with societal change/needs. In this context the group recommends that:
  - a. The Criminal Procedural Code (CrPC) should be amended to make it mandatory for a lady special public prosecutor to be assigned in cases of rape, incest and sexual abuse.
  - b. Presiding judges should be empowered to restrict entry of relations, lawyers and others to the minimum necessary at their discretion in order to reduce the victims' trauma in reliving the experience of rape or sexual abuse in full public view. Necessary amendments in the relevant provisions may be incorporated to expand the definition of "in-camera" proceedings.
  - c. Modern devices/technology such as one-way mirrors and closed circuit TV should be employed to protect the prosecutrix from the mocking/intimidating gaze of the accused in cases of rape.
  - d. A more informal court-room atmosphere should be ensured in order to make victims of child rape or sexual abuse feel more at ease.

*(Note: Pending necessary amendments in the Criminal Procedural Code (CrPC) and other statutes, the aforesaid measures may be implemented through appropriate changes in High Court Rules and Orders)*
5. The group noted that the specialised judicial skills required for handling cases of rape, incest and sexual abuse require specially trained judicial officers. It therefore recommends that special courts on the lines of the envisaged family courts should be set up in a phased manner to deal with such cases.

Systemic delays and long-winded procedures which are a hallmark of the criminal justice system work against the interests of women who rarely have the time or the economic resources to sustain them through extended proceedings, and evidentiary requirements make them doubly victimised. The group, therefore, recommends that cases of rape, incest and sexual abuse may be assigned to "fast-track" courts to ensure expeditious disposal.

The group noted with concern that the age-determined definition of a child differed depending on the administrative-legal context. In the case of rape, the age of consent is defined as 16 years under Section 375 of the Indian Penal Code (IPC), whereas under Section 361 IPC it is 18 years. Such discordance within the same statute, or between different laws, creates legal as well as administrative problems. It is, therefore, recommended that the Law Commission may be requested to look into this aspect and formulate appropriate amendments in these laws.

Individual responses to stressful or traumatic events vary, depending on the victim's psycho-social and economic circumstances. The relatively novel concept of "victim impact statement" has evolved in response to this determinant of victim-distress. The group felt that this aspect assumes even greater importance in a heterogeneous society like ours. It is, therefore, recommended that police officers may be trained in the special skills required for recording and evaluating the victim impact statement which should form a part of the investigation report submitted to the court. This would provide a useful input to the judicial process.

It is essential to foster a feeling of security among those who approach the police for succour. The role of the police needs to change from the archaic colonial status-quoists to that of agents of a social order based on respect for the rights of the individual. In addition to attitudinal changes it is essential that every police station/cell dealing with crimes against women and children should have an in-house psycho-social unit, consisting initially of a trained counsellor and a psychiatric social worker/medical social worker, integrated into its establishment under the administrative control of the officer-in-charge of the police station/cell concerned. This would bring about a definitive change in the quality of psycho-social support available to the victims of rape, incest and sexual abuse during the investigative process.

6. Victims of rape, incest or sexual abuse often need to be removed from the antecedent socio-familial context to a more secure/supportive environment of a shelter home at least temporarily, till the contributory situational factors can be modified by appropriate socio-psychological intervention. The same applies in the case of victims of domestic discord or violence, and those sent up to a magistrate for committal proceedings under the Mental Health Act 1987. The group noted that at present the state of remand homes and other places of shelter for women and children involved in the police-judicial process is highly unsatisfactory both with regard to physical facilities and, even more importantly, lack of motivation/specialised skills in the staff deployed at such facilities. It is recommended that these lacunae should be addressed on a priority basis. The existing district level supervisory committees comprising the Collector, District Judge and the Superintendent of Police should take the initiative in this regard and play their prescribed role effectively.
7. The group noted that social support systems for victims of rape, incest and sexual abuse are either non-existent or grossly deficient. To address this issue it is recommended that networking between the various professional agencies involved (law enforcement, health, legal aid and social/voluntary sector) should be evolved in a systematic manner and integrated in a victim-centered approach. Existing representative organisations such as Resident Welfare Associations, Mohalla Committees and Village Panchayats could become useful components of such social support networks. This networking may be coordinated by sub-divisional officers or police officers of equivalent rank.
8. Magisterial committal proceedings under the Mental Health Act 1987 also require specialised skills/inputs. The group recommends that a standing panel of mental health experts may be constituted for every district to provide technical assistance to the judicial officers.

9. The group felt that the courts often find it difficult to come to the correct conclusion because of vague, equivocal and prolix psychiatric opinions. Among other things this is rooted in deficiencies in postgraduate psychiatric training which does not equip the trainee with the necessary communication/medicolegal skills. It is, therefore, recommended that postgraduate training programmes should be augmented in this regard and psychiatric opinions/evidence given in the course of legal proceedings should be in simple and unambiguous language, shorn of superfluous technical jargon.

### **Proceedings of a National Workshop on Assessment of the Role of Tobacco as a Gateway Substance and Evaluation of Available Evidence Relating to Tobacco, Alcohol and other Forms of Substance Abuse; New Delhi, 4-6 September 2002**

*"Of the many adverse and secret influences on tobacco control, the impact of tobacco companies on the policy processes of government and WHO must rank as their biggest success and public health's biggest loss. Decades of work have meant that tobacco control remains severely underfunded by the governments, and implementation of effective policies by international agencies remains the topic of dispute rather than commonsense."*

*"However the changes are coming and increasing public outrage about the extent of "duping" that has occurred now joins the solid health and economic arguments as the driving force for better health and truth in public policy."*

*"The current and projected epidemiological and economic impact of tobacco demands a new approach that harnesses the political and scientific capabilities of the governments. The Framework Convention on Tobacco Control (FCTC) will do that. It represents the first time that WHO is using Article 19 of its Constitution – the right to develop legally binding treaties and conventions to address a public health threat."*

Dr D. Yach  
Executive Director NCD & Mental Health  
World Health Organization, Geneva

### **Preamble**

Tobacco is the most prevalent drug of abuse and one that is associated with maximum mortality. WHO estimates that about one-third of the global adult population are smokers. Each year, tobacco causes about 3.5 million deaths in the world. By 2020, it is predicted that tobacco will become the leading cause of death and disability in the world, causing more deaths than HIV, tuberculosis, maternal mortality, motor vehicle accidents, suicide and homicide combined together. Tobacco use is even more common among persons suffering from psychiatric morbidity and among drug dependent persons than in the general population. Although tobacco use in western nations has decreased over the years, it is increasing in the developing countries. In 1997, it was reported that about 194 million men and 45 million women above 15 years of age use tobacco in India and it causes about 800,000 deaths annually. The NSSO data also indicate that tobacco use is increasing in India.

There is increasing recognition that tobacco use is a form of substance dependence. It is also believed that efforts to prevent illicit drug use and alcohol use may benefit from efforts to prevent and reduce tobacco use. Treatment of alcoholism and other forms of drug dependence too may benefit from treatment of concurrent nicotine dependence. Nicotine dependence also provides a useful model for the study of other forms of drug dependence.

The gateway hypothesis is underpinned by the stage theory of substance use. This theory

states that drug follows a developmental sequence where those using the 'gateway' drug will move on to using more harmful illicit drugs such as heroin. Tobacco, alcohol and cannabis have been put forward as gateway drugs by various researchers. Both cross-sectional and longitudinal studies have been conducted to test the gateway hypothesis. Although not necessarily a causal determinant of illicit drug use, tobacco use is highly associated with such drug use. Majority of people who have ever used illicit drugs have previously used alcohol and tobacco. People who have never smoked tobacco rarely abuse illicit drugs or alcohol.

The pharmacological and behavioural factors that determine nicotine addiction are similar to those that determine addiction to other drugs such as heroin. When use of tobacco progresses to regular use, it gets associated with various problems related to addiction, tolerance and physical dependence, as in case of other drugs of abuse. Nicotine is considered as addictive as other drugs such as heroin and cocaine. The high abuse liability of nicotine is evident from the fact that out of the persons who have used tobacco even once in their lifetime, a large percentage starts using it on a regular basis. Fewer than 10% smokers are able to smoke occasionally on a non-daily basis and about 90% tobacco users are dependent. Most smokers want to give up tobacco, but they usually fail when they try and on a given quit attempt, only 5–10% stop tobacco use permanently.

The dependence producing effects of nicotine appear to be modulated by dopamine as in the case of most drugs of abuse. Nicotine intake increases dopamine availability and dopamine blockers attenuate its self-administration. Initiation and cessation of tobacco use are as heritable as alcohol abuse or dependence. Some of the genetic variance related to tobacco is shared with alcohol. The psycho-social factors that are associated with tobacco use are very similar to those that are associated with the abuse of other drugs. A high need to conform, low academic achievement, rebelliousness, depressive symptoms, poor self-esteem, peer influence and family stressors are some of the factors associated with abuse of tobacco and other drugs.

A National Conference on Tobacco or Health was held on 27–28<sup>th</sup> July 1991 in New Delhi. This Conference identified tobacco as a major public health hazard and noted that the consumption of tobacco is not compatible with the goal of "Health for All". The present workshop goes a step further and examines the relationship between tobacco and other drugs of abuse. The conference held in 1991 suggested the need for an integrated educational, legislative and agro-economic strategy with an operational time-frame and political, administrative, financial and research support. The Conference made the following recommendations:

- a. Establishment of a National Tobacco Control Commission to plan, co-ordinate and monitor tobacco control activities;
- b. Prohibition of smoking in certain public places as per Cabinet Secretariat OM 27/1/3/90 (7.9.90), ban on consumption of tobacco products in other public places and on sale of tobacco to minors, ban on advertising and other forms of sales promotion.
- c. Statutory warning on all tobacco products, printing of tar and nicotine levels and compulsory licensing of tobacco products.
- d. Aforestation drive by tobacco producers, regulation of tobacco production, varied economic and agro-industrial restructuring measures aimed at reduction of the area under tobacco cultivation, with rehabilitation of the affected farmers, removal of subsidies, safeguards against involvement of foreign players, increased taxation etc.
- e. Health education through various strategies, involvement of NGOs in anti-smoking campaigns, a national research action plan and a White Paper on government policy on tobacco. The 22<sup>nd</sup> Report of the Parliamentary Committee on Sub-ordinate Legislation

(December '95) made wide ranging suggestions for tobacco-control, which read close to the recommendations of the National Workshop held in 1991.

## **Recent Developments**

The progress in this area has been rather tardy and India is today the second largest producer of tobacco in the world, having displaced the US from the second place. Tobacco use is increasing, more so among the young as indicated by the Global Youth Tobacco Survey (GYTS). While some of these recommendations of the 1991 Workshop have been partly implemented, much more remains to be done. Various steps that have been taken for tobacco control so far are:

- (a) Setting-up of the National Tobacco Control Cell in the Ministry of Health in Feb 2001. This cell is responsible for coordinating all activities related to Tobacco Control and assisting the Ministry of Health and Family Welfare (MOH & FW) in the same.
- (b) Mass media counter advertising campaign against tobacco. Grass-roots level anti-tobacco awareness dissemination programmes through Nehru Yuva Kendra Sangathan (SEAT Flame) and Directorate of Field Publicity.
- (c) NGO capacity-building for tobacco control interventions in Schools and in specific communities.
- (d) Economic & Policy Research in areas like taxation, subsidies. Environmental consequences, etc.
- (e) Introduction of the Tobacco Control Bill, 2001 in the Parliament by the MoH & FW.
- (f) Strong support and representation for FCTC, including being the regional Coordinator for SEARO region.
- (g) Taking Tobacco Control to the state level by organizing sensitisation workshops for MLAs. Similar workshops are planned for law enforcement officers as well.

## **The Present Initiative**

This national workshop organised by the MOH & FW, Government of India, in association with the All India Institute of Medical Sciences, New Delhi with support from WHO discussed various issues related to nicotine dependence and its relationship to other drugs of dependence, especially assessing its role as a gateway drug. Specific issues like tobacco use among women and adolescents as well as abuse of smokeless tobacco were also discussed. Various prevention and tobacco control strategies were evaluated. In view of sufficient evidence to support the association between tobacco and other drugs of abuse, the need to link tobacco control measures to other substance use control programmes was highlighted and it was felt that these should be integrated.

## **Recommendations**

The present workshop endorsed the recommendations made by the National Workshop in 1991. While the ultimate aim is total elimination of tobacco use, interim strategies are required for the transitional period. The recommendations are as under:

1. A multi-sectoral body should be constituted for tobacco control by 31 May 2003. This will help in preparing a plan in accord with the Framework Convention on Tobacco Control (FCTC). This should include the Secretaries of the Ministries of Health, Agriculture, Finance, and Education, with the MOH & FW as the nodal ministry.

2. A core-working group on tobacco control should be set-up to provide technical inputs to the aforesaid multi-sectoral body, and to carry forward the agenda of tobacco control. The core working group, consisting of senior researchers from the area of substance abuse and related fields, should further interact with other sectors such as agriculture and agro-economics to evolve an integrated tobacco control strategy. The task of forming this core working group may be assigned to the MOH & FW.
3. Supply-side measures should be targeted in conjunction with demand-side measures for tobacco control. The empowered body of secretaries that will be constituted can formulate the specific measures and their time-frame in conjunction with the core-working group of experts.
4. Effective control measures for non-manufactured types of tobacco products should be implemented concurrent with the above, and should be supplemented by intensive IEC initiatives at the grass-root rural level.
5. Training of undergraduates and existing medical practitioners on substance abuse including tobacco-related issues be strengthened by introducing the necessary changes in the medical curriculum and through CMEs, conferences and seminars organised by professional organisations as well as medical colleges. The Medical Council of India and the National Drug Dependence Treatment at AIIMS may be requested to initiate follow-up action in this regard.
6. Therapeutic interventions to target current smokers should be initiated through the existing healthcare delivery system. Medical colleges should take the lead in this regard and tobacco-cessation clinics should be started in each teaching hospital as the first step. These can be then replicated in other hospitals. The De-addiction centres under the MOH & FW should also provide tobacco cessation treatment. A directive in this regard can be sent to the state governments so that all medical college hospitals and de-addiction centres under the drug dependence programme can provide tobacco cessation treatment, using the existing infrastructure.
7. The people should be educated about the harmful effects of tobacco, including its potential for leading to other forms of substance abuse. A prevention programme with special focus on the school population, for example life-skills training, should be conducted and may be integrated with the existing school health programmes. These measures can be implemented by the MOH & FW, the Ministry of Human Resource Development and the Ministry of Information and Broadcasting.
8. Adequate measures to enforce the Supreme Court Directive (November 2001) banning tobacco smoking in public places and public transports in all states and union territories should be taken on a war footing. Adequate funds should be made available for this. All organisations which are receiving funds from the Government should follow tobacco control policies and measures and should ensure smoke-free environment in their premises/meetings/functions. The MOH & FW can coordinate this.
9. A part of the exercise and other duties collected from sale of tobacco products should be directed towards the tobacco control programme. This matter can be taken up by the MOH & FW with the Ministry of Finance.
10. There should be a special focus on prevention and treatment of tobacco use in the rural population and of smokeless tobacco products. This aspect can be taken up by the MOH & FW with other related actions such as Rural Development and Human Resource Development.
11. Harm minimisation strategy for tobacco was briefly discussed. However, the group felt that there was a need to review the research in this area and the issue needs to be deliberated at a subsequent meeting before arriving at any consensus.

**Appendix H**

**Orders of the Supreme Court in Civil Writ  
Petition No 334/2001 & 562/2001 –  
Erwady-Saarthak Public Interest  
Litigation (PIL)**

ITEM No.20

Court No. 1

SECTION PIL  
A/N/MATTER

SUPREME COURT OF INDIA  
Record of the Proceedings

Writ Petition (Civil) No 334/2001  
RE: DEATH OF 25 MENTAL ASYLUM PATIENTS  
VERSUS

Petitioner(s)

UNION OF INDIA & ORS.

Respondent (s)

Date: 17/08/2001 this Petition was called on for hearing today.

CORAM:

HON'BLE THE CHIEF JUSTICE  
HON'BLE MR. JUSTICE R C LAHOTI  
HON'BLE MR. JUSTICE P VENKATARAMA REDDY

For Petitioner(s) by post

For Respondent (s) Mr. Krishan Mahajan, Adv.  
No. 1                      Ms. Sushma Suri, Adv.

RR 2 & 3    Mr. K. Ramamurthi, Sr. Adv.  
                  Ms. Revathy Raghavan, Adv.  
                  Ms. Shwetha Garg, Adv.



UPON hearing counsel the Court made the following  
ORDER

A factual report has been filed on behalf of the State of Tamil Nadu concerning the death of 25 mentally challenged inmates in an Asylum fire in Tamil Nadu. The report is filed on the affidavit of the Chief Secretary, Shri P. Shankar. The report is taken on record.

Learned counsel submits that this affidavit is also on behalf of respondent No.3 - Secretary, Department of Home, Chennai. On behalf of the Union of India, Mr. Krishan Mahajan, learned counsel appears and submit that he shall file a response on behalf of the Union of India. Let the needful be done within two weeks.

Dr. Abhishek Singhvi, learned senior counsel is present in Court. We have requested him to assist the Court as Amicus in this case. Dr. Singhvi along with Shri Pranab Kumar Mullick, advocate-on-record has agreed to do so. Copy of the report of respondents 2 and 3 shall be furnished by learned counsel for the State of Tamil Nadu to him. Mr. Mahajan shall also give an advanced copy of the response of the Union of India to Dr. Singhvi.

The matter shall be listed for further orders after three weeks.

Sd/-  
(Neena Verma)  
Court Master

Sd/-  
(Prem Prakash)  
Court Master  
17/8/2001

ITEM No.32

Court No. 1

SECTION PIL  
A/N/MATTER

SUPREME COURT OF INDIA  
Record of the Proceedings

Writ Petition (Civil) No 334/2001

RE: DEATH OF 25 MENTAL ASYLUM PATIENTS

Petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s)

(With office report)

(For further directions)

Date: 15/08/2001 this Petition was called on for hearing today.

CORAM:

HON'BLE THE CHIEF JUSTICE

HON'BLE MR. JUSTICE R. C. LAHOTI

HON'BLE MR. JUSTICE P. VENKATARAMA REDDY

For Petitioner (s) Dr. A. M. Singhvi, Sr. Adv.(A.C.)  
Mr. Pranab Kumar Mullick, adv.

For Respondent(s) Mr. Harish Salve, SG  
Mr. Krishan Mahajan, Adv.  
Ms. Sunita Sharma, Adv.  
Mrs. Sushma Suri, Adv.

Mr. K. Ramamurthy, Sr. Adv.  
Mrs. Revathy Raghavan, Adv.  
Ms. Shweta Garg, Adv.

UPON hearing Counsel the Court made the following  
ORDER

The Union of India as well as the State of Tamil Nadu have filed their affidavits in response to the notice issued by this Court on 7<sup>th</sup> August 2001.

From a perusal of the two affidavits, we find that it was only after serious concern was expressed by this Court regarding the treatment of mentally challenged patients housed in the mental asylum at Erwadi in Ramanthapuram District, where more than 25 such inmates were reported to have been charred to death, the State as well as the Union of India started taking some initiative in the matter.

From the affidavit filed on behalf of the State of Tamil Nadu, we find that after the gruesome tragedy, the district administration "as an interim measure" sent intimation to the family members of the patients who had survived to take them back to their homes in their native places and also to allow inmates to be retained in the 'homes' only on condition that a companion from the family

will stay with the inmates and not to permit any female inmate in the home. As a result of this action, out of 571 inmates, 254 inmates are reported to have been sent back to their native places with their relatives, while 20 inmates are reported to have been admitted to government hospitals. Whether these patients were sent back after proper psychiatric examination and on the basis of medical report that they did not require any further treatment, is not forthcoming from the affidavit.

The affidavit further discloses that on 10<sup>th</sup> August, 2001, the Chief Minister of Tamil Nadu conducted a meeting to discuss measures to be taken for regulating the functioning of the homes for mentally ill and it was decided in that meeting that 16 homes for mentally ill located around Erwadi "will be closed down immediately and the inmates will be taken into the care of the State Government". It is further stated that those who are "actually mentally ill" be admitted to the Mental institutions run by the State Government but those "who are not really mentally ill, they will be returned to their families". At the meeting, it was also disclosed that "apart from Erwadi, in other parts of the State of Tamil Nadu similar homes exist where similar practices are being followed". 18 such homes were identified in the state and in order to tackle the problem, following measures were directed to be taken:-

- (a) In future, such Homes I should obtain licence under the Mental Health Act, 1987 before being started. All existing homes will be given a month to obtain the license.
- (b) There will be a Monitoring Committee in each District headed by the District Collector. This Committee will include the Joint Director (Health), a trained Psychiatrist and other Medical personnel. Periodical inspection will be carried out by the Committee to ensure that these Centres are maintained as per the guidelines. All Mental Asylums located in thatched sheds in other parts of the State will be closed immediately. Wherever mentally ill patients are found to be in chains, they will be unchained immediately. Those with violent tendencies will be admitted in government mental institutions for further care.
- (c) In respect of inmates who are found to be not mentally ill but abandoned by their families, Old Age Pension under the category of destitute persons will be sanctioned to them by the District Collectors. Further, those who do not have homes to return to will be admitted in the Old Age Homes or Destitute Homes run by the State Government and reputed Non Government Organisations.
- (d) The District Mental Health programme for Ramanathapuram and Madurai districts with an outlay of Rs. 2 crores will be implemented immediately.
- (e) Out of 25 District Headquarter Hospitals, only 11 hospitals have Psychiatrists posted as of now. Hence it was decided by the Chief Minister that Psychiatrists will be posted in the remaining 14 districts also immediately.
- (f) All the recommendations of the National Human Rights Commission and the State Human Rights Commission will be implemented scrupulously.
- (g) A Commission of enquiry headed by a retired District judge would be constituted to go into the incidents of death due to fire in Erwadi.

Measure (c) (supra) records that in respect of inmates who are found "to be not mentally ill but abandoned by their families", Old Age Pension under the category of destitute persons will be sanctioned to them by the District Collectors. Whether all those 254 patients who had been sent back to their native places along with relatives have been granted Old Age Pension or not, is not forthcoming from the record.

The State of Tamil Nadu is directed to state on affidavit as to what follow-up action, if any, has been taken insofar as these measures are concerned. The affidavit shall specifically disclose

whether the monitoring committee has commenced its work and the result of its “periodical inspections”.

From the affidavit filed on behalf of Union of India by the Director, Union Home Ministry, we find that Central Government has also set up an authority under Section-3 of the Mental Health Act, 1993. The composition of the committee has been disclosed in para-8 of the affidavit. The Union Government is stated to have written to the Chief Secretaries of all State Governments to have all the asylums in their respective states inspected by a competent authority and to submit a report regarding the conditions in the asylums including the facilities available and treatment of the patients in such asylums. The Chief Secretaries have further been directed to identify the illegal asylums and take action against them as per law.

The learned Solicitor General submits that as a first step towards dealing with the case of mentally challenged, it may be desirable that the authority set up under Section 3 by the Central Government be directed to conduct a survey on an all-India basis with a view to identify registered and un-registered asylums as also about the state of facilities available in such asylums for treating the mentally challenged. We agree and issue a direction accordingly. The committee is directed to submit a report in this behalf within three months. Besides this, it appears appropriate to us to get the following information:

State	Whether Authority u/s4 of Mental Health Act constituted (if yes, composition thereof and recommendations made by it)	Whether Mental Hospital or Nursing Homes established u/s 5 of Mental Health Act (if yes, districtwise details as per Annx.1)	Whether rules framed under Mental Health Act	Whether District Mental Health Programme initiated (District wise details)	Whether visitors appointed u/s 37 of Mental Health Act	Whether visitors conducts 12 monthly inspections during 2000-2001	Whether NHRC recommendations accepted /Action taken Report
1	2	3	4	5	6	7	8

The information, as sought for above, from Columns (1) to (3) shall be furnished by the State Government /Union Governments on an affidavit of a competent authority. We expect that needful shall be done within three months.

Post the matter for further directions after three months.

sd/-  
(Neena Verma)  
Court Master

sd/-  
(Prem Prakash)  
Court Master

ITEM No.29

Court No 8

SECTION PIL  
A/N/MATTER

SUPREME COURT OF INDIA  
Record of Proceedings

Writ Petition (Civil) No 334/2001

RE: DEATH OF 25 MENTAL ASYLUM PATIENTS

Petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s)

(With Appln(s) for extension of time and with Office Report)

Date: 21.01.2002 This Petition was called on for hearing today.

CORAM:

HON'BLE MR. JUSTICE M.B. SHAH

HON'BLE MR JUSTICE B. N. AGRAWAL

For Petitioner(s)	Dr. A. M. Singhvi, Sr. Adv. (A.C.) Mr. Pranab Kumar Mullick, Adv. (A.C)
For Respondents (s) for State of TN	Mr. K. Ramamurthy, Sr. Adv. Mrs. Revathy Raghavan, Adv.
For UOI Home Ministry:	Mr. K. N. Rawal, ASG Ms. Sunita Sharma, Adv. Ms. Sushma Suri, Adv. Mr. D. S. Mahra, Adv.
For Rajasthan State:	Mr. Panji Thomas, Adv. for Mr. Javed Mahmood Rao, Adv.
For Karnataka State:	Mr. Satya Mitra, Adv. for Mr. Sanjay R. Hegde, Adv.
For Pondicherry State:	Mr. V. G. Pragasam, Adv. (N/P)
For Nagaland State:	Mr. Sanjat K. Shandilya Adv for Mrs. V. R. _____ Adv.
For Sikkim State:	Mr. A. Marisnputham Adv. Mrs. Aruna Mathur, Adv.
For Chhattisgarh State:	Mr. Prakash Shrivastava Adv.
For Arunachal Pradesh:	Mr. Anil Shrivastav, Adv.
For A.P. State:	Mr. T. V. Ratnam, Adv. Mr. K. Subba Rao, Adv. Mr. Krishnan Mahajan, Adv.
For Manipur State	Mr. K. H. Nobin Singh, Adv (N/B)

For Uttaranchal State	Mr. Mahesh Chandra Adv, for Mr. Ajay K. Agrawal, Adv.
For U.P. State	Mr. Arohi Bhalla, Adv. for Mr. Ajay K. Bhalla, Adv.
For Tripura State	Mr. Gopal Singh, Adv. Mr. R. Singh Adv.
For Assam State:	Ms. Asha G. Nair, Adv. for Corporate Law Group

Upon hearing counsel the Court made the following  
ORDER

It appears that there is total negligence on the part of the State Governments in not implementing the Mental Health Act, 1987, The Persons with Disabilities, (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and The National Trust for Welfare of Persons with Autism, Cerebral Palsy Mental Retardation and Multiple Disabilities Act, 1999. Despite the services of notice almost all States have not filled necessary counter affidavit and complied with the directions issued by this Court on 15.10.2001.

In this view of this matter, time to comply with the directions issued by this Court is extended up to 29.1.2002. On that date concerned Principal Health Secretary of each State shall personally remain present before this Court.

Health Secretary, Government of India is also directed to file its response.

sd/-  
(Vijay Kumar Sharma)  
Court Master

sd/-  
(K. K. Chadha)  
Court Master

Copy of the order be given today itself

IN THE SUPREME COURT OF INDIA  
CIVIL ORIGINAL JURISDICTION

Writ Petition (Civil) No. 334 of 2001

In : Death of 25 chained inmates in  
Asylum Fire in Tamil Nadu

Petitioner

Versus

Union of India and Others

Respondents

ORDER

On the basis of submission note of the Registrar (Judicial) to a news item published in all leading national dailies about a gruesome tragedy in which more than 25 mentally challenged patients housed in a mental asylum at Erwadi in Ramanathapuram district were charred to death, the patients could not escape the blaze as they had been chained to poles or beds, this Court took suo moto action.

After considering the factual report, Dr. Abhishek Manu Singhvi, learned senior counsel was appointed as Amicus Curiae to assist the Court and notice was also issued to the Union of India.

Thereafter, by order dated 15.10.2001 this Court called for the report of the State of Tamil Nadu on the subject and also sought information on the topics which are mentioned, from the State Governments and Union Governments on an affidavit of competent authority.

Thereafter, when the matter was placed before this Court on 21.1.2002, most of the States sought extension of time for compliance with the order passed by this Court. The matter was adjourned for 29.1.2002. On that day also, some of the State Governments again sought extension of time for compliance with the directions issued by this Court. Further, learned Amicus Curiae submitted that the Mental Health Act, 1987 (for short "the 1987 Act") is not at all implemented by the concerned authorities and there is failure on the part of Central/State Governments to implement the 1987 Act.

Mr Soli J Sorabjee, learned Attorney General appearing on behalf of the Union Government submitted that the 1987 Act is for the benefit of mentally ill persons and is to be implemented right earnestly. He submitted that the Centre would make appropriate action for implementation of the 1987 Act as early as possible.

In our view it appears that there is slackness on the part of the concerned authorities to implement the laws enacted by the Parliament. This is one such instance.

One of the objects of the 1987 Act is to provide a law relating to the treatment and care of the mentally ill persons. Notification for implementing the Act was published in the Gazette of India on 11.1.1993

For the time being we would refer to the definition clause 2(1) which provides 'mentally ill person' to mean a person who is in need of treatment by reason of any mental disorder other than mental retardation. Further, clause 2(q) inter alia provides 'psychiatric hospital' and 'psychiatric nursing home' to mean a nursing home established by any other person for the treatment and care of mentally ill persons and includes a convalescent home established or maintained by any other person for such mentally ill persons. The section reads thus: -

**"2 (q) 'Psychiatric hospital' or 'psychiatric nursing home' "** means a hospital or, as the case may be, a nursing home established or maintained by the Government or any other person for the treatment and care of mentally ill persons and includes a convalescent home established or

maintained by the Government or any other person for such mentally ill persons, but does not include any general hospital or general nursing home established or maintained by the Government and which provides also for psychiatric services.

Further, **Section 3** provides that—

- (1) The Central Government shall establish an Authority for mental health with such designation as it may deem fit.
- (2) The Authority established under sub-section (1) shall be subject to the superintendence, direction and control of the Central Government.
- (3) The Authority established under sub-section (1) shall—
  - (a) Be in charge of regulation, development, direction and co-ordination with respect to Mental Health Services under the Central Government and all other matters which under this Act, are the concern of the Central Government or any officer or authority subordinate to the Central Government.
  - (b) Supervise the psychiatric hospitals and psychiatric nursing homes and other Mental Health Service Agencies ( including places in which mentally ill persons may be kept or detained) under the control of the Central Government.
  - (c) Advise the Central Government on all matters relating to mental health and
  - (d) Discharges such other functions with respect to matters relating to mental health as the Central Government may require.

Similar provision is made under section 4 for the establishment of such authority by the State Government. Thereafter, Section 5 provides that Central Government may, in any part of India , or the State Government may, in any part of India, or the State Government may, within the limits of its Jurisdiction, establish or maintain psychiatric hospitals or psychiatric nursing homes for the admission, treatment and care of mentally ill persons at such places as it thinks fit. Other important section is Section 6 which provides that on and after psychiatric hospital or psychiatric nursing home unless he holds a valid license granted to him under this Act. No person shall establish or maintain a psychiatric nursing home unless he holds a valid license granted to him under this Act Section 8 further provided—when license to continue or establish psychiatric hospital or psychiatric nursing home should be refused. Prayer is for implementation of these provisions. It appears that the aforesaid provisions are not implemented. Therefore, learned Amicus Curiae sought for issuance of following directions.

- (i) Every State and Union Territory must undertake a district-wise survey of all registered and unregistered bodies, by whatever name called purporting to offer psychiatric mental health care. All such bodies should be granted or refused license depending upon whether minimum prescribed standards are fulfilled or not. In case license is rejected, it shall be the responsibility of the SHO of the concerned police station to ensure that the body stops functioning and patients are shifted to Government Mental Hospitals. The process of survey and licensing must be completed within 2 Months and the Chief Secretary of each State must file a comprehensive compliance report within 3 Months from date of this order. The compliance report must further state that no mentally challenged person is chained in any part of the State.
- (ii) The Chief Secretary or Additional Chief Secretary designated by him shall be the nodal agency to co-ordinate all activities involved in implementation of the Mental Health Act,



1987, The Persons with Disabilities (Equal Opportunities Protection of Rights and Full participation ) Act, 1995 and the National Trust for Welfare of Persons with Autism, Cerebral Palsy. Mental Retardation and Multiple Disabilities Act, 1999. He shall ensure that there are no jurisdictional problems or impediments to the effective implementation of the three Acts between different ministries or departments. At the Central level, the Cabinet Secretary, Government of India or any Secretary designated by him shall be the nodal agency for the same purpose.

- (iii) The Cabinet Secretary, Union of India shall file an affidavit in this Court within one month from date of this order indicating: -
- (a) The contribution that has been made and that proposed to be made under Section 21 of the 1999 Act which would constitute corpus of the National Trust.
  - (b) Policy of the Central Government towards setting up at least one Central Government-run mental hospital in each state and Union Territory and definite time schedule for achieving the said objective.
  - (c) National Policy, if any, framed u/s 8(2)(b) of the 1995 Act.
- (iv) In respect of State Union Territories that do not have even one full-fledged State Government run mental hospital the Chief Secretary of the State Union Territory must file an Affidavit within one month from date of this order indicating steps being taken to establish such full-fledged State Government run mental hospital in the State/Union Territory and a definite time schedule for establishment of the same.
- (v) Both the Central and State Governments shall undertake a comprehensive awareness campaign with a special rural focus to educate people as to provisions of law relating to mental health, rights of mentally challenged persons, the fact that chaining of mentally challenged persons is illegal and that mental patients should be sent to doctors and not to religious places such as Temples or Dargahs.
- (vi) Every State shall file an affidavit stating clearly:
- (a) Whether the State Mental Health Authority under Section 3 of the 1987 Act exists in the State and if so, when it was set up.
  - (b) If it does not so exist, the reasons therefore and when such an Authority is expected to be established and operationalised.
  - (c) The dates of meetings of those Authorities, which already exist, from the date of inception till date and a short summary of the decisions taken.
  - (d) A statement that the State shall ensure that meetings of the Authority take place in future at least once in every four months or at more frequent intervals depending on exigency and that all the statutory functions and duties of such Authority are duly discharged.
  - (e) The number of prosecutions, penalties or other punitive/coercive measures taken, if any by each State under the 1987 Act."

At this stage, we have again heard learned counsel for the parties and learned Attorney General submitted that as a first step the aforesaid directions as suggested by the Amicus Curiae be issued and information as sought for be called for.

We direct accordingly. The State Government as well as Central Government shall file affidavits

complying the directions mentioned in the aforesaid paragraph nos. (i) to (vi) . It is further directed that the necessary affidavits as per order dated 15.10.2001 be also submitted, if not already tendered.

Stand over for 9.4.2002.

.....J  
(M. B. SHAH)

.....J  
(B. N. AGRAWAL)

.....j  
(ARIJIT PASAYAT)

New Delhi  
February 5, 2002

IN THE SUPREME COURT OF INDIA  
ORIGINAL JURISDICTION  
Writ Petition (Civil) No.334 of 2001

“IN RE: DEATH OF 25 CHAINED INMATES  
IN ASYLUM FIRE IN TAMIL NADU

WITH

WRIT PETITION (CIVIL) NO. 562 OF 2001

SAARTHAK REGISTERED SOCIETY & ANR.

Petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s)

ORDER

We have heard learned Additional Solicitor General Mr. Altaf Ahmed and counsel for the parties.

In continuation of our order dated 5<sup>th</sup> February, 2002 and considering various provisions of the Mental Health Act, 1987, particularly Section 5 which inter alia provides that Central Government may in any part of India or State Government may within the limits of its jurisdiction establish or maintain psychiatric hospital or psychiatric nursing homes for the admission, treatment and care of mentally ill persons at such places as it thinks fit, it is directed as under:

1. Every State and Union Territory (UT) shall undertake a comprehensive Need Assessment survey and file the Report thereof on the following aspects:
  - (a) Estimated availability of Mental Health Resource personnel in the State, including psychologists, psychiatric social workers and psychiatric nurses in both the public and private (licensed) sector;
  - (b) Type of Mental Health Delivery System available in the State, including the available bed strength, out-patient services and rehabilitation services in the public and private (licensed) sector;
  - (c) An estimate of the Mental Health Services (including personnel and facilities) that would be required having regard to the population of the State and the incidence of mental illness.
2. The Chief Secretary of each State and Administrator /Commissioner of every UT shall file and Affidavit stating clearly:
  - (i) Whether any minimum standards have been prescribed for licensing of Mental Health institutions in the State/UT and in case such minimum standards have been prescribed, full details thereof;
  - (ii) Whether each of the existing registered Mental Health institutions in the state/UT, whether private or run by the State, meet such minimum prescribed standards as on date of passing this order and if not, what steps have taken to ensure compliance of licensing conditions and/or withdrawal of the licence;

- (iii) How many unregistered bodies, by whatsoever name called, purporting to offer psychiatric/ mental health care exist in the State on date of this order and whether any of them comply with minimum standards and are entitled to grant of licence and if not, whether steps have been taken to close down the same;
- (iv) Whether any mentally challenged person has been found to be chained in any part of the State/UT;
- (v) Conclusions on the basis of the Need Assessment Survey undertaken in terms of direction (1) above.

It is made clear that each affidavit must specifically and comprehensively deal with each of the queries set out above.

3. The Report of Need Assessment Survey and Affidavit as set out in directions(1) and (2) above shall be submitted to the Health Secretary, Union of India so as to reach him latest by 1<sup>st</sup> July, 2002. The Health Secretary, Union of India shall thereafter compile and collate the information as above and present the same in the form of a self-explanatory Note/Chart to this Court along with his conclusions. The Affidavits filed by the States/UTs shall be annexed to the Note/Chart. The Health Secretary, Union of India shall file the said Note/Chart in this court by 15<sup>th</sup> July, 2002.

It is further directed that the Chief Secretaries of all States and Commissioners of all UTs who fail to file such Affidavit with the Health Secretary, Union of India by 1<sup>st</sup> July, 2002 shall have to personally remain present on the next date of hearing and explain the default.

4. Further Union of India is directed:
  - (a) To frame a policy and initiate steps for establishment of at least one Central Government run Mental Hospital in each State (As provided under Section 5 of the Act);
  - (b) To examine the feasibility of formulating uniform rules regarding standard of services for both public and private sector Mental Health Institutes;
  - (c) To constitute a committee to give recommendations on the issue of care of mentally challenged persons who have no immediate relatives or who have been abandoned by relatives;
  - (d) To frame norms for non-Government Organisations working in the field of Mental Health and to ensure that the services rendered by them are supervised by qualified/ trained persons.
5. All State Governments are also directed to frame Policy and initiate steps for establishment of at least one State Government run Mental Health Hospital in each state. It is clarified that a Mental Health Hospital as stated above means a full-fledged Hospital catering only to mentally challenged persons and does not include separate psychiatric ward in a Medical College or Government Hospital.
6. Legal Aid: Under Section 434 of the Mental Health Act (MHA), a patient is enquired to apply to the Magistrate in order to be discharged. The procedure prescribed under the Section, on occasions causes difficulties to the patients in as much as many patients may not be in a position to make the requisite applications before a Magistrate, nor would they be aware of their rights and the procedure to seek discharge.

Hence, it is directed that two members of the Legal Aid Board of each State be appointed to make monthly visit to such institutions, so as to assist the patients and their relatives in applying for discharge from the institutions if they have fully recovered, and do not require institutional assistance any longer or to find out whether as a matter of fact they require any such treatment as indoor patients.

## 7. Rights

### 1. Informing Patients of their Rights.

Patients and their guardians shall be explained their rights by a team of 2 members of the Legal Aid and Judicial Officer, under the Mental Health Act, in a language known to them, at the time of the admission to any institute. They should also be informed whom to approach in case their rights are being infringed.

### 2. Inspection By The Board of Visitors.

Section 37 provides for inspection of psychiatric hospital and psychiatric nursing home. In view of the said Section a Board of Visitors must be formed by the State Mental Health Authority in every State within a time bound period, and a compliance report be filed to the Court. The Board of Visitors shall be required to visit every State or Private Institution for the time being at least once every month. The membership of the Board of Visitors is contained in Section 37 of the Mental Health Act, 1987, which includes:

- (a) Not less than 5 members.
- (b) At least one psychiatrist.
- (c) Two Social Workers preferably with knowledge of the issues in the hospital and may be from the NGO Sector.
- (d) Head of Medical Services or their nominees (preferably a psychiatrist) as ex-officio member of Board of Visitors in the State;

The Board of Visitors should also include:

1. The Additional District Judge, and /or Chief Judicial Magistrate, and / or the President of the Bar Association of the Area;
2. State Disability Commissioner or his /her nominee.

A monthly record of visits of the Board of Visitors and the quarterly report should be filed with the State Mental Health Authority.

Further, it has been suggested by the learned counsel for the parties that appropriate norms be prescribed for maintenance of Mental Hospitals and Institutions for which various suggestions are made by the learned counsel for the parties but are not discussed at present as it is for the concerned authorities for first frame of such norms.

### 8. A Scheme may be envisaged for rehabilitation process for those who are not having any backing, or lack of support in the community. The Scheme may be on the basis of quarter-way homes ( Supported Shared Home-Like Accommodation) for all patients ready to be discharged, but are not being discharged due to family not taking them back, or lack of support in the community, should be placed in a home-like accommodation created

on the hospital campus itself. This accommodation could be an existing ward converted to have a home-like environment, with patients being taught house keeping skills, cooking, shopping and also encouraged to take up responsibilities in the hospital for which they should be paid for and then gradually encouraged to go the community for work.

Learned Amicus Curiae Dr. Singhvi submitted that if any suggestions are made by any interested parties, the same may be submitted through Mr. Pranab Kumar Mullick, Advocate (Amicus Curiae) and we order accordingly.

.....J  
(M.B. SHAH)

.....J  
(BISHESHWARPRASAD SINGH)

.....J  
(H.K. SEMA)

New Delhi,  
April 12, 2002

ITEM NO. 28  
MATTER

Court No.5

SECTION PIL  
A/N

SUPREME COURT OF INDIA  
RECORD OF PROCEEDINGS

Writ petition (Civil) No. 334/2001  
RE: DEATH OF 25 MENTAL ASYLUM PATIENTS

petitioner(s)

VERSUS

UNION OF INDIA & ORS.

Respondent(s)

(With Appln(s).for intervention and exemption from personal appearance and directions and impleading party and office report)

with W.P. (c) 562/2001 (with office report)

Date : 29/11/2002 These petitions were called on for hearing today.

CORAM:

HON'BLE MR. JUSTICE M.B.SHAH  
HON'BLE MR. JUSTICE D.M.DHARMADHIKARI  
HON'BLE MR. JUSTICE S.B.SINHA

For petitioner (s)	Dr. A. M. Singhvi, Sr. Adv. (A.C.) Mr. Pranab Kumar Mullick, Adv. (A.C.) Ms. Indu Malhotra, Adv.
For Respondent (s) For State of T.N.	Mr. K. Ramamurthy, Sr. Adv.,
For UOI:	Mr. Altaf Ahmed, ASG Ms. Sunita Sharma, Adv., Mr. Krishan Mahajan, Adv., Mr. D.S. Mahra, Adv.
For NCT of Delhi: Andaman & Nicobar Dadra & Nagar Haveli, Lakshadweep, Daman & Diu	Mr. Krishan Mahajan, Adv., Ms. Sunita Sharma, Adv., Mr. D.S. Mahra, Adv.
For Rajasthan State:	Mr. Ranjit Thomas, Adv Ms. Bharati Upadhyay, Adv., Mr. D.K. Thakur, Adv. Mr. Javed Mahmood Rao, Adv.
For Karnataka State:	Mr. Satya Mitra, Adv. for Mr. Sanhay R. Hugde, Adv.
For Pondicherry State:	Mr.V.G. Pragasam, Adv.

For Nagaland State:	Mr. Sanhay K.Shandilya, Adv. Mrs V.D. Khanna, Adv.
For Sikkim State:	Mr. A. Mariarputham, Adv., Mrs. Aruna Mathur, Adv. Mr. Anurag D. Mathur, Adv.
For Chhattisgarh State:	Mr. Prakash Shrivastava, Adv.
For Arunachal Pradesh:	Mr. Anil Shrivastav, Adv.
For A.P. State:	Mr. T.V. Ratnam, Adv., Mr. K. Subba Rao, Adv.
For Manipur State:	Mr. K.H. Nobin Singh, Adv.
For U.P. State:	Mr. Ajay K. Agarwal, Adv., Ms. Alka Agarwal, Adv., Mr. K.L. Janjani, Adv., Mr. C. Siddharth, Adv.
For Tripura State:	Mr. Gopal Singh, Adv., Mr. R. Singh, Adv.
For Assam State:	Ms. Asha G. Nair, Adv. For Corporate Law Group.
In IA 6	Mr. C.S. Vaidyanathan, Sr. Adv., Mrs. V. Mohanna, Adv.
For Maharashtra State:	Mr. S.V. Deshpande, Adv., Mr. S.S. Shinde, Adv.
For impleading Party:	Mr. S. Udaya Kumar Sagar, Adv., Mr. Prasanth P. Adv. for M/S. Lawyers Knit
For Jharkhand State:	Mr. Ashok Mathur, Adv, Mr. Rajesh Pathak, Adv.
For Punjab State:	Ms. Naresh Bakshi, Adv.
For Gujarat & Mizoram:	Ms. Hemantika Wahi, Adv., Ms. Anu Dubey, Addv.
For Haryana State:	Mr. Satinder S. Gulati, Adv., Mr. Kamaldeep Gulati, Adv. Mr. J.P. Dhanda, Adv. (N/P) Mr. J.R. Das, Adv., Mr. G. Biswal, Adv., Mr. S. Misrha, Adv.



For W.B. State: Mr. Tara Chandra Sharma, Adv.,  
Ms. Neelam Sharma, Adv.

For Bihar State: Kumar Rajesh Singh, Adv.,  
Mr. B.B. Singh, Adv.

For Chandigarh: Ms. Kamini Jaiswal, Adv.,  
Mrs. Shomila Bakshi, Adv.  
Ms. Tehmina Ram, Adv.

For Kerala: Mr. K.R. Sasiprabhu, Adv.,  
Ms. K. Sangeeta, Adv.,  
Mr. Sushil Tekriwal, Adv.

For Meghalaya: Mr. Ranjan Mukherjee, Adv.  
Mr. D.N. Ray, Adv.,  
Ms. Sunita Mukherjee, Adv.

For the parties: M/s. B.S. Banthia, R.S. Jena, A. Subhashini, Rachna Srivastava, Naresh K. Sharma, Anis Suhrawardy, M/s. Temple Law Firm, Rajeev Sharma, S.N. Terdol, Gopal Prasad, Adv.

UPON hearing counsel the Court made the following  
ORDER

Learned ASG appearing on behalf of the Union of India admits that affidavit dated 16.7.2002 filed by Mr. S.K. Naik, Secretary, Department of Health, Ministry of Health and Family Welfare, Government of India is totally inadequate and does not deal with the issue which was required to be dealt with after proper understanding of the law and the orders passed by this Court. He, therefore, seeks six weeks time for filing necessary affidavit with the necessary action plan for implementing The Mental Health Act, 1987 and the orders passed by this Court from time to time .

Dr. A.M. Singhvi, learned senior counsel (A.C.) has pointed out that in the submissions filed by him, this aspect is made clear and the concerned authority be directed to take them into consideration before filing additional affidavit.

We order accordingly.

Two weeks time as prayed for by the learned A.C. is granted for filing further written submissions.

Stand over for eight weeks.

*I.A.No.6.* This application is rejected. It would be open to the petitioner to file substantive petition challenging the constitutional validity of Section 2 (Q) of The Mental Health Act, 1987.

Sd/-  
(Vijay Kumar Sharma)  
Court Master

Sd/-  
(Janki Bhatia)  
Court Master

**Appendix I**

**Orders of the Supreme Court in Writ  
Petition (Crl) No 237/1989 –  
Sheela Barse vs Union of India and Others**  
*(1993) 4 Supreme Court Cases 204*

(Before M.N. Venkatachaliah, C.J and S. Mohan, J)

Sheela Barse Petitioner;

Versus

Union Of India And Another Respondents,

Writ Petition (Crl) No 237 of 1989, decided on August 17, 1993  
Under Article 32 of the Constitution of India

1. Constitution of India-Arts. 21 and 32-Jailing of non-criminal mentally ill persons in West Bengal -Held, illegal and unconstitutional and must be stopped-Report submitted by Commission appointed by the Court by its order dated June 16, 1992 considered-Judicial Magistrate, instead of Executive Magistrate, to get such persons examined by a Mental Health Professional/Psychiatrist and on his advice send them to nearest place of treatment and care-State Govt. to take immediate action and issue instructions for implementation, to order enquiry into death of such persons in jails and to take remedial action-State Govt. also to take immediate steps for Upgradation of mental hospitals, setting up of psychiatric services in all teaching and district hospitals and integrating mental health care with the primary health care system-Calcutta High Court requested to appoint a committee which will submit its report and detailed recommendations-Recommendations of the Commission appointed on Court's order dated June 16, 1992 should be implemented by other States also-Directions issued-Mental Health Act, 1987-Mental Health Authority Rules, 1990-Lunacy Act, 1912, S. 13

Advocates who appeared in this case:

S. Muralidhar, Advocate, for the Petitioner;

Santosh Hegde and V.C. Mahajan, Senior Advocates (D.K. Sinha, J.R. Das, Mukul Mudgal, R.S. Suri, T.C. Sharma, Ms Anil Katiyar and Ms A. Subhashini, Advocates with them) for the Respondents.

The Judgment of the Court was delivered by

MOHAN, J.- This writ petition has been preferred by Ms Sheela Barse, a social activist. She has forwarded a copy of the write-up under the title "Jailing the mentally ill": This write-up was published by her.

2. The said write-up narrates the following:

Many children and adults are committed to jail in Calcutta as lunatics. In fact they are not mentally ill at all. Some are normal, some temporarily under stress or undergoing a phase of mental disturbance, and a few are mentally retarded. Once they are jailed, they are all categorised as "Non-criminal Lunatics". This jailing deprives them of their liberty on the pretext that he is interned for treatment. When these persons are produced before the Judicial or the Executive Magistrate of West Bengal an instant assessment is made of their mental health and they are committed to jail without fixing the case, date of hearing or the duration of detention. Thereafter they are never produced before the Magistrate. During their confinement these persons lose all the contacts with the outside world, more often than not the Magistrates purporting to act under Section 13 of the Lunacy Act (which Act has been repealed) arrogating to themselves a power which they do not have.

3. There are no health facilities inside the jail. Their conditions are miserable. The apathy on the part of the various departments of the State Government is a matter of regret. Having failed to get the necessary redressal from the authorities this petition has come up to be moved. Having regard to the nature of allegations the matter being of a great public importance, requiring judicial notice, this Court ordered to issue notice to the State of West Bengal and Union of India.

4. The State of West Bengal has filed a counter. It is averred that the jails in West Bengal receive prisoners only on the authority of a Q writ/warrant/custody, etc., issued by a competent court under seal and signature of a Magistrate or Judge for detention in such jails. In case of Non-criminal Lunatics, also these jails act upon and honour the orders of the court.

"The Medical Officers of the jails look after these inmates sent by the courts and also observe their mental condition and submit report to the court, as desired. There are visiting psychiatrists in Central Jails but in case of other smaller jails the Medical Officer of the jail performs this function. Jails are meant for lodging criminals charged under the Indian Penal Code, Criminal Penal (sic) Code and other law of the land. Jails are not equipped with men and material to lodge Non-criminal Lunatics permanently. However, with the financial constraints and available men and materials, every possible effort is made to look after the Non-criminal Lunatics so long they are inside the jail.

Alipore Special Jail is still functioning as a jail under the Prisons Directorate and this jail is lodging only curable and cured Non-criminal Lunatics who are looked after and treated by well-known visiting psychiatrists, medical officers, part-time psychologists and female nursing staff. There are many cases where cured, Non-criminal Lunatics have been released to the care of their relatives.

Most of the Non-criminal Lunatics, mentally ill persons are lodged in Presidency Jail, Dum Dum Central Jail, Alipore Special Jail, Alipore Central Jail, Berhampore Central Jail and Midnapore Central Jail. Only a few such persons are detained in other districts, special and Sub-jails.

Non-criminal Lunatics are supplied with wearing apparel including bedding while in jails. Male inmates are provided with Jangia, Pajamas and Kurtas and female inmates are provided with

Sarees, Blouse and other clothes. They are also provided with Blankets, Bed sheets and Napkins for their daily use.

In Presidency Jail, Calcutta, a Television Set has also been provided inside the Non-criminal Lunatic ward for their recreation. Interview and letter writing facilities are also extended to them very liberally.

These non-criminal Lunatics are also provided with food in the same scale as that of the ordinary undertrial prisoners. In addition, they are also provided with extra diet and medical diet consisting of loaf, meat, egg, butter, milk, fruit, curd, etc., on the advice of the Medical Officer."

5. The Union of India has filed a counter-affidavit for the limited purpose of placing on record, the date on which the Mental Health Act of 1987 and the rules made thereunder have come into force.

"In this behalf, it is submitted the Mental Health Act, 1987 was notified on May 22, 1987. Further, the Central and State Mental Health Authority Rules, 1990 were notified on December 29, 1990.

It is further submitted that the Central Government has also established and constituted an Authority called Central Mental Health Authority under the aforesaid rules. It is further submitted that the Central Government has requested the State Governments and the Administration of Union Territories vide letter dated November 10, 1981 to take necessary steps for constituting and establishing the State Mental Health Authority in accordance with the aforesaid rules and appointment of visitors as required under the Act.

It is further submitted that after the State Government and Administration of Union Territories confirm having established the State Mental Health Authorities, appointed not less than 5 visitors for each Psychiatric Hospital/Nursing Home and appointed a licensing authority, as required under the Act, the Central Government shall notify the date on which the said Act will come into force in a particular State/Union Territory:"

6. This Court appointed a Commission by order dated June 16, 1992. In accordance with that order; the Commission had gone into the matter at some great length. The substantive part of the report is presented in four parts:

- (1) Introductory (Sections 1 to 6)
- (2) Report of the field work (Sections 7 to 8)
- (3) Conclusions emerging from the investigations (Section 9)
- (4) Recommendations (Sections 10 to 12)

7. As to the concept of Non-criminal Lunatics, it is stated in the report as under:

"The mentally ill housed in jails are referred to as 'Non-criminal Lunatics'. This term is meant to include persons who are sent to jail for medical observation to determine the state of mind of the individual (Section 16, Indian Lunacy Act, 1912 hereinafter ILA) and persons who are to be kept a place of safe custody pending removal to a mental hospital (Section 23, ILA). The procedure of medical observation is either required for wandering and dangerous mentally ill (Section 13, ILA) or for mentally ill persons who are cruelly treated and not under proper care and custody (Section 15, ILA). Apart from these statutory categories any mentally ill person who is admitted in jail and is not a criminal lunatic is in prison terminology referred to as 'Non-criminal lunatic'."

8. After analysing the position in the various jails regarding the facilities available for treatment, it is stated as follows:

### **“Treatment Deprivatory Consequences of Commitment to Jail**

- (1) Delay in specialist help reaching the patient: Mentally ill are kept in varying numbers in the various central district and sub-jails in West Bengal. No psychiatrist is on the permanent staff of any jail. Jails only have consultancy arrangements either with a psychiatrist visiting the jail (as is the procedure in the central jails and Krishnanagar) or the patient is sent to the District Hospital (Purulia) or Medical College (Bankura).

Even in the jails where the psychiatrist visits the jail such visits are not daily but at a frequency of 4 times a week (Presidency) or once in a fortnight (Dum Dum) or even once in a month (Midnapore). At this frequency a time-lag of 10–15 days can easily occur before a patient is evaluated. Thus in Dum Dum Central Jail we met a patient who had been in the jail for more than 15 days but who had neither been evaluated nor had received any treatment because the psychiatrist had been on leave during that period.

If the patient has to be sent to the hospital for evaluation, delay may occur because of lack of vehicle or escort. Thus in Purulia District Jail we met Suparna Banerjee who was brought to Purulia District Jail on September 13, 1992. Though she was actively disturbed and suffering from mania she was not examined for three days. On September 16, 1992 she was taken to the Sadar Hospital where she was examined and prescribed medicines. Even on the next day, i.e. September 17, 1992 the patient could not get drugs because the doctor on duty was on leave. There was no other mechanism for the distribution of drugs in the jail since the post of pharmacist was vacant. The result was the patient was kept in a locked cell for an illness which with adequate care is totally treatable within a few days.

- (2) Lack of specialised human resource: Even the delayed treatment mechanism only operates in districts where specialist facilities exist. The specialised psychiatrist help is not available in the districts of West Dinajpur, Maldah, Birbhum, Bardhaman. In Cooch Behar and Jalpaiguri though postings for psychiatrists exist there is no psychiatrist in position. Thus, the mentally ill persons detained in jails in these districts receive no treatment whatsoever.
- (3) Lack of supervision of care: Currently there are no methods for the supervision of the care provided to the mentally ill. As a result patients are diagnosed after a single examination. They do not receive any review nor is any reevaluation of the developing mental problems undertaken. For example, in Purulia Jail Mr. Padmalochan Das was admitted on August 11, 1992, and was diagnosed to be subnormal. Since this condition is untreatable he was not on any treatment. During the visit of the Commission he was found to be severely depressed, with suicidal ideas and had a definite history of both past and current mental illness. Since there is no system of re-evaluation this patient was not receiving any treatment for the oncoming mental illness problems.
- (4) Absence of mental health team: Treatment for mental illness is not provided only by psychiatrists. Such treatment has to be provided by a mental health team of clinical psychologists, psychiatric nurses and social workers. In the jails of West Bengal other than a visiting psychiatrist there are no other trained personnel for the treatment of mentally ill persons.

The only place where there are nurses is the Alipore Special Jail, Calcutta which has been renamed the Institute of Mental Health. At all other jails life convicts give the medicines to

the patients when they have no training or expertise for undertaking the job. Even at the Institute where nurses are on the staff, nursing care is not available at night since Jail rules do not permit women to be on the premises after lockup.

- (5) Lack of variety or treatment facilities necessary for mental health care: The treatment facilities available in the jail are extremely limited. Only one or two drugs like chlorpromazine and nitrazepam are available. Electro-convulsive therapy cannot be provided in jail.

The Commission declares the Excessive deprivation of liberty:

When a mentally ill person is sent to jail he is sent to an institution which is essentially geared towards security of society from the dangerous person it houses and safety of the inmates from each other. The mentally ill being inducted into this set-up are only managed as dangerous individuals and not as sick persons. This results in deprivation of liberty in several ways which is more excessive than is required either for the protection of the mentally ill person or for the safety of society."

9. Various remedial methods are suggested. The Improvement Schemes for Mental Hospitals are outlined as follows:

"It is suggested that managing bodies should be set up for all the mental hospitals in West Bengal. The composition of the bodies could be according to the Ranchi model, i.e. a consenting sitting Judge from the Calcutta High Court or a District Judge nominated by the Chief Justice of Calcutta High Court should be chairperson.

Senior officers from the departments of health, welfare, prisons, police along with a professor of psychiatry from a teaching hospital could be members. And, the Medical Superintendent of each hospital could function as the member secretary of the Committee.

These committees will be under a duty to formulate schemes for improving both the living and therapeutic conditions in the mental hospitals.

Without being exhaustive initially the improvement schemes will need to ensure that the living environment of the hospitals (*sic*).

The aim of the improvement schemes however should not just be to remove the deficiencies of the old hospitals but to create and to transform these old custodial institutions to active treatment centres supportive of care in the community."

10. The establishment of State level rehabilitation centres and the association of voluntary agencies is emphasised by the Commissioners (Dr R. Srinivasa Murthy and Ms Amita Dhanda).

11. From the above, it is clear that the problem presented before us is a vexed one of treating these unfortunate persons whose cases will have to be viewed in a humanitarian spirit. In England the position as obtaining is stated in *Imprisonment in England and Wales* by Christopher Harding, Bill Hines, Richard Ireland and Philip Rawlings as under:

"The Mental Deficiency Act of 1913 diverted the so-called mental defectives (retarded persons) from the penal system: it was provided that if such persons were convicted, they could be placed in an appropriate institution, such as Rampton and Moss Side hospitals, or under guardianship. This approach provided the model for the wider system eventually adopted under the Mental Health Act of 1959. Section 60 of that Act enabled courts to order that

convicted offenders be treated in a hospital, if there was evidence of mental disorder, as defined in the Act. Therefore, even though convicted, and perhaps in some cases the kind of persons who ought for reasons of public safety to be held in secure conditions, mentally disordered offenders could then be diverted straightaway from the prison system. The problem of the 'dangerous patient' was provided for in Section 65, which enabled a court to couple a hospital order with a restriction order, the latter making release from hospital dependent on the Home Officer's consent. Since 1959, the courts have become acclimatised to this different form of disposal, gradually coming to think in terms of treatment rather than punishment for such offenders. But the procedures laid down in the mental health legislation of 1959 and 1983 still leave certain categories of disordered person to be dealt with by the prison system. The disorder must be of a kind listed in the legislation (broadly, mental illness, retardation or psychopathic disorder) and must be susceptible to treatment. Moreover, some patients need to be held in secure conditions and there have been a limited number of secure hospital places (at Broadmoor, established in 1863, and Rampton and Moss Side, opened respectively in 1910 and 1919, although both catering mostly for the mentally retarded before 1959). As a result, some seriously disordered offenders may find themselves in prison, for reasons of security, if only temporarily. In addition, in recent years many hospitals have been unwilling to accept psychopathic offenders since it is open to doubt whether there is any effective treatment for many who suffer from this condition. For those psychopaths who are aggressive and violent, the prison system has been used to a large extent to provide a convenient form of secure institution. It has therefore been necessary for the prison authorities to develop suitable accommodation and a certain level of psychiatric and therapeutic care, if not treatment.

In some respects the prison authorities have in the past been happy to take on such a role. In the earlier years of this century the reformist tradition in the penal system quite naturally took on board some of the methods of treatment being worked out in the fields of psychology, psychiatry and psychotherapy. In 1932, the Departmental Committee on Persistent Offenders commented that: 'there is reason to believe that certain delinquents may be amenable to psychological treatment ... A medical psychologist should be attached to one or more penal establishments to carry out psychological treatment in selected cases'.

In due course, psychiatric treatment became an integral part of the prison sentence for some categories of prisoners and in the post-war period staff with expertise in this kind of treatment were brought into the prison service and centres for psychiatric treatment were set up in some prisons, notably Wakefield and Wormwood Scrubs. For more seriously disturbed prisoners, a special prison was opened in 1962 at Grendon in Buckinghamshire, mainly to cater for the more moderate kind of psychopath, and comprising a therapeutic regime within conditions of maximum security. There is also a wing at Parkhurst Prison for the most seriously disturbed prisoners, where the object is to minimise violent and aggressive behaviour rather than apply a positive regime of treatment.

The prison system has therefore come to take on some treatment functions, despite the intention of the legislation of 1959 to divert the mentally disordered to more appropriate institutions. This has come about more through the failure to develop suitable alternative institutions than through the conviction that a prison is the best place for some categories of disordered offenders."

12. On an anxious consideration of the matter, we issue the following directions:
- (1) It is declared that admission of non-criminal mentally ill persons to jails is illegal and unconstitutional.
  - (2) It is directed that admissions of mentally ill persons to jails in West Bengal on any ground whatsoever be stopped forthwith and the State of West Bengal is directed to issue instructions to this effect immediately.
  - (3) It is directed that the function of getting mentally ill persons examined and sent to places of safe custody hitherto performed by Executive Magistrate shall hereafter be performed only by Judicial Magistrates.
  - (4) The Judicial Magistrate will upon a mentally ill person being produced, have him or her examined by a Mental Health Professional/Psychiatrist and if advised by such MHP Psychiatrist send the mentally ill person to the nearest place of treatment and care.
  - (5) The Judicial Magistrate will send reports every quarter to the High Court setting out the number of cases of persons sought to be screened and sent to places of safe custody and action taken by the Judicial Magistrate thereon.
  - (6) The Government of West Bengal is hereby directed to:
    - (i) take immediate action and issue instructions in the implementation of the directions given herein above.
    - (ii) order enquiry into the death of 19 persons in the Dum Dum Central Jail in December 1991 and take action to rectify the factors that resulted in such a calamity. A copy of report of the enquiry and the details of the steps taken thereon to be placed before the court given a period of two months from today.
    - (iii) take simultaneous immediate steps for:
      - (a) immediate upgradation of mental hospitals.
      - (b) setting up of psychiatric services in all teaching and district hospitals. This will include filling up the posts of psychiatrists in these places.
      - (c) Integrating mental health care with the primary health care system.
    - (iv) Regulate the procedure from admission to discharge from the mental hospitals in West Bengal of mentally ill persons by a fresh set of instructions in accordance with the recommendations made in the report of the Commissioners. (Guidelines 10.2.9 to 10.1.13 at paras 119-123)
    - (v) The Health Secretary of the State of West Bengal will send a quarterly report to this Court on the steps taken to implement each of the directions given in this Order. This will be in the form of an affidavit.

Any difficulty encountered in the implementation of the order will be forthwith brought to the notice of this Court.
  - (7) The High Court of Judicature at Calcutta is requested to appoint a committee comprising a mental health professional/ psychiatrist, a Social Worker and a Law Person to evaluate the state of the existing mentally ill in jails. The Committee will in a report make detailed recommendations to:
    - (a) discharge such of those persons found fit and ensure their return to their homes and/ or their rehabilitation.



(b) move out such of those persons requiring continued treatment and care from out of the jails, to the nearest places of treatment and care.

The report will be submitted within two months of its appointment by the Committee to the High Court with a copy to this Court. The High Court is requested to monitor, in such manner as it deems fit, the implementation of the recommendations of the Committee. This Court will be kept informed of the steps taken in this regard.

13. Though the report of the Commission relates to only the State of West Bengal in order that these recommendations are properly implemented in other States as well, it is hereby directed:
  - (1) Notice shall be sent to the Chief Secretary of every State together with:
    - (a) a copy of the order dated June 16, 1992 passed by this Court,
    - (b) a copy of the report submitted by the Commissioners (Volume I).
  - (2) The Chief Secretary is hereby directed to indicate to the Standing Counsel of the State in the Supreme Court:
    - (a) the facts and figures in respect of every item mentioned in the order dated June 16, 1992 of this Court;
    - (b) the response of State Government to the recommendations and plan of action suggested in the report of the Commissioners;
    - (c) the willingness of the State Government in taking action in line with the recommendations made by the Commissioners in their report.
  - (3) The Chief Secretary shall respond to this notice within a period of 3 months and this time-limit will be adhered to strictly. In addition to the service of notice to the Chief Secretary, notice will also be served upon the Standing Counsel of the State to ensure strict compliance with this order.
14. The writ petition is disposed off accordingly.

## Annexure

[Before M.N. Venkatachaliah, J. (Vacation Judge)]

*(Record of Proceedings)*

### Order

1. This is a public interest litigation concerning the condition of the children and adults committed to jail as lunatics in Calcutta.
2. On March 13, 1990 this Court made an order calling upon the State of West Bengal to furnish the following particulars:
  1. The total number of institutions and/or jails in which the persons suffering or alleged to be suffering from any mental illness are being kept or detained in the State of West Bengal together with all the relevant particulars relating to these places.

2. The total number of such mentally ill inmates at those places together with particulars of their classification, if any, and the period of their stay.
  3. Details of the procedure and practice adopted for admission of the inmates and for their discharge or release wherefrom.
  4. The care and facilities provided in each such place for keeping the inmates and for their treatment.
  5. The procedure and practice adopted for their medical examination at the time of admission and periodic check-up thereafter and the records maintained for this purpose to monitor the progress made by each inmate.
  6. The pattern of staff at such places with their qualifications including suitability for the nature of work.
  7. The procedure for the follow-up action, if any, of those discharged or released from such places.
  8. Social workers or organisations, or any other outside agency, if any, associated with this exercise.
  9. The steps, if any, taken in this behalf to implement the guidelines indicated in *Veena Sethi vs. State of Bihar* for looking after the mentally sick persons during the period they are kept in such institutions and after their release therefrom.
3. The affidavit was required to be filed on behalf of State of West Bengal by a senior officer of the department concerned within 6 weeks from March 11, 1990.
  4. On May 25, 1990 an affidavit in purported compliance with the direction was filed. That affidavit is conspicuous by its lack of relevant and full particulars required to be furnished. On the previous occasion i.e. on May 13, 1992 Shri Tapash Ray, learned senior counsel appearing for the State of West Bengal sought time to file a proper further affidavit. It was also mentioned to Mr Ray that the matter be called in the second week of June 1992. However, in the last two hearings the State of West Bengal has remained unrepresented.
  5. The questions raised in this public interest litigation are serious and of importance. Now that the State of West Bengal has not been able to assist the Court fully and effectively in the matter, it is necessary to ascertain the particulars through a Commission appointed by the Court.
  6. On the suggestion of the Supreme Court Legal Committee, I appoint:
    1. Dr Srinivasa Murthy,  
Prof. and Head, Department of Psychiatry,  
National Institute of Mental Health and Neuro Sciences,  
Post Bag No. 2900, Bangalore-560 029
    2. Ms Amita Dhanda, Asstt. Research Professor,  
Indian Law Institute, Bhagwandas Road, New Delhi-110001  
as Commissioners to do and carry out the following:
      1. The Commission will visit a representative sample of jails and Central hospitals in the State of West Bengal and submit a detailed report to the Supreme Court on the following matters:
        - (i) The total number of institutions and/or jails in which the persons suffering or alleged to be suffering from any mental illness are being kept or detained in the State of West Bengal together with all the relevant particulars relating to these places.

- (ii) The total number of such mentally ill inmates at those places together with particulars of their classification, if any, and the period of their stay.
  - (iii) Details of the procedure and practice adopted for admission of the inmates and for their discharge or release therefrom.
    - (a) Who is the committing authority?
    - (b) How is this authority activated?
    - (c) What procedure is followed by it before granting or refusing an application?
  - (iv) The care and facilities provided in each such place for keeping the inmates and for their treatment.
  - (v) A districtwise break-up of mental health facilities, i.e. primary health centres providing psychiatric care; district hospitals having psychiatric care facilities; general and teaching hospitals having psychiatric departments; public and private mental hospitals.
  - (vi) The procedure and practice adopted for their medical examination at the time of admission and periodic check-up thereafter and the records maintained for this purpose to monitor the progress made by each inmate.
  - (vii) The pattern of staff at such places with their qualifications including suitability for the nature of the work.
  - (viii) The procedure for the follow-up action, if any, of those discharged *or* released from such places.
  - (ix) Aftercare and rehabilitation facilities available in the State of West Bengal.
  - (x) Social workers or organisations or any other outside agency, if any, associated with this exercise.
  - (xi) The steps, if any, taken in this behalf to implement the guidelines indicated in *Veena Sethi vs. State of Bihar* for looking after the mentally sick persons during the period they are kept in such institutions and after their release therefrom.
  - (xii) Complete information on the reported death of 19 lunatics, prisoners in Dum-Dum jail, vide report dated December 25, 1991 appearing in the *Times of India*. New Delhi Edition, p. 16.
2. The Commission will also formulate draft guidelines that may be used for the purpose of monitoring the commitment of non-criminal lunatics in West Bengal including:
    - (i) What should be the procedure of commitment;
    - (ii) The minimum care and treatment facilities that should be available at the places of commitment.
  3. The Commission will indicate the most appropriate monitoring mechanism.
  7. The State of West Bengal and its authorities shall accord to the Commission all facilities for executing the commission. A copy of this order shall be sent to the Chief Secretary of West Bengal with a direction to facilitate compliance with the terms of this order.
  8. The State of West Bengal is directed to deposit a sum of Rs 20,000 initially in the Registry of this. Court to defray the expenses of the Commission. This shall be done within 3 weeks.
  9. Call this matter on July 15, 1992.

# Appendix J

## Mental Health Legislation in India: Historical Review

*D. S. Goel*

The history of laws relating to the mentally ill in India may be summarized asunder:

**1. English laws applied to India during East India Company Rule:**

- (a) Act for Regulating Mad Houses, 1774
- (b) Country Asylum Act, 1808
- (c) Lunatic Act, 1845
- (d) Pauper Lunatics Act, 1845
- (e) Lunacy Regulation Act, 1853
- (f) Lunacy Care and Treatment Amendment Act, 1853
- (g) Lunatic Asylums Amendment Act, 1853.

**2. British India Laws**

- (a) Indian Lunacy Act (No. 36), 1858
- (b) Indian Lunacy Act, 1912  
(Note: Lunatic asylums were renamed mental hospitals in 1920).

**3. Indian Law**

- (a) Mental Health Act, 1987  
(implemented w.e.f. 1<sup>st</sup> April 1993)
- (b) Central and State Mental Health Rules, 1990.

At this point it might be relevant to look at the background of the present Mental Health Act, 1987 (MHA-1987). The significant milestones in this rather slow and tortuous journey make interesting, albeit painful, reading.

**1. Bhore Committee Report, 1946:**

- 19 Mental Hospitals (=10,181 beds) surveyed; mostly obsolete – modernisation recommended.
- Indian Lunacy Act, 1912 describe as outdated; replacement recommended.
- Creation of Directorates of Mental Health at Central/State level recommended.

2. Indian Psychiatric Society (IPS) Committee for drafting the “Indian Mental Health Act” constituted in 1949 under the chairmanship of Maj R.B. Davis; draft Act prepared, but the process was apparently aborted.
3. Dr. D. Satyanand’s draft Mental Health Act (1959) prepared on the directions of the Central Government but no consensus could be reached at the Mental Hospital Superintendents’ Conference, 1960; draft Act dropped.
4. Psychiatric Legislative Committee of the IPS constituted in 1969 to energise the move towards a new Mental Health Act; progress, however, remained slow.
5. Mental Health Act introduced in Lok Sabha, 1979: lapsed when the house was dissolved in 1980.
6. Reintroduced in 1981: referred to Joint Committee on 27 July 1982, discussed in 22 meetings. 7<sup>th</sup> Lok Sabha dissolved on 31 Dec 1984. Bill lapsed.
7. Referred to new Joint Committee on 29<sup>th</sup> April 1985: 18 meetings, amended Bill adopted on 24<sup>th</sup> April 1986; passed by the Rajya Sabha on 26<sup>th</sup> Nov 1986 and by the Lok Sabha, with amendments, on 22<sup>nd</sup> April 1987.
8. President’s assent accorded on 22<sup>nd</sup> May 1987: Act no. 14 of 1987, implemented w.e.f. 1<sup>st</sup> April 1993.

It is important to bear the aforesaid time frame in mind while discussing the many “demerits” of MHA-1987 and the even more numerous demands for its abrogation/amendment. The present Act reached the Lok Sabha after decades of sustained efforts by several stalwarts of Indian Psychiatry. It took another eight years for it to be enacted into law, and further six years before being notified for implementation by the Government of India. The situation on the ground is even gloomier. The state of Bihar moved to implement the Act only after the Supreme Court cracked the whip in April 2002. The nationwide survey conducted during Nov 2001–Jan 2002 revealed that copies of the Act and the Central/State Mental Health Rules -1990 framed thereunder were not available where it mattered the most; at the district level. At many places the repealed Indian Lunacy Act, 1912 was still being followed.

The demands for amendments to MHA-1987 should be viewed in the above context. It might be wiser to await fuller implementation of the present statute and benefit from the experience gained before contemplating drastic changes in the Act. It will be also desirable to elicit the views of all stake-holders and initiate a dialogue with the various consumer interest groups before undertaking this exercise.