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S. Rajkumar
Schizophrenia Research Foundation - Madras, India

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S. RAJKUMAR

Schizophrenia Research Foundation
Madras, India

India has a population of over 800 million of which about 20 million are suffering from a mental illness. In terms of numbers of patients alone, mental health planners are presented with quite a challenge. How the challenge is being met is the topic of this article. Governmental efforts need to be augmented by voluntary agencies and private practitioners for optimal mental health care. Despite deficiencies, India is a pace setter for many developing countries. It has the political will to initiate needed changes. Aftercare services for the mentally ill should be a top future priority.

India is the second most populated country in the world with a population of over 800 million people. The predominant religion is Hinduism, although Islam, Christianity, Sikhism, Buddhism and Jainism are also widely practised. The country is primarily dependent on an agrarian economy and 70% of the people live in villages. Over the last few decades, however, this agrarian society has been moving toward urbanization and industrialization.

The vast subcontinent of India is divided into 32 States and Union territories. Among these are 7 large States with a population of over 50 million each, including Tamilnadu in the South with 58 million, and Uttar Pradesh in the North with 133 million. In 1981, as part of an administrative decentralisation process, the States were divided into 361 districts, each having a population of 1 to 2 million. These districts are further divided into smaller units called block samithis and village panchayats (see map in the Appendix).

History of Mental Health Services

Indian culture, one of the most ancient in the world, exerted considerable influence over the Far East for centuries. Medicine occupied an important place among the physical sciences in

ancient India. The traditional system of medicine, Ayurveda, dates back to the 6th century B.C. Ayurveda (Ayur-life, Veda-knowledge) means the science of the knowledge and prolongation of life. According to Charaka, life is divided into 4 kinds — Sukha (happy), Dukha (unhappy), Hita (good) and Ahita (bad) and the objective of Ayurveda is to teach what is conducive to a healthy and long life (Venkoba, 1978). Ayurveda is subdivided into 8 specialties one of which is Bhuta Vidya which deals with psychiatry. Ayurveda recognised the importance of mental diseases when it classified the human maladies into 3 categories — exogenous, endogenous, and psychic. The doctrine of Tridosha (3 humors described as Vata, Pitta, and Kapha) plays a pivotal role in the consideration of etiology, pathology, diagnosis, and Ayurvedic therapeutics.

The Siddha system of medicine was indigenous to the old culture of the Tamils, who live in South India, and is still practiced by people of Tamil origin. The Unani and Graeco — Arab medicine was developed during the Arab civilization and is practised widely in the Indo-Pak subcontinent. It is interesting to note that traditional systems of medicine form a vital force in the delivery of health care in India. This comprises 70% of overall health care. The other 30% is provided by qualified physicians and general practitioners (Taylor, 1976).

Religious and superstitious beliefs exercised a strong influence in the daily lives of the people. Those who acted strangely by the standards of the day were thought to be afflicted with devils and demons. The remedies for such afflictions were in the form of ceremonies, rituals punishments, and sacrifices. Certain shrines, for instance, attained fame for the treatment of various mental disorders and continue to be popular today.

The advent of British rule in India, brought with it the early mental hospitals which primarily reflected the needs and demands of the European patients in India during that period. They were built with a view to protecting the community rather than caring for the insane (Sharma, 1984). However, marked changes were brought about by the Indian Lunacy Act of 1912 by which lunatic asylums were brought under central supervision. Even more significant was the recognition of specialists in psychiatry, who were appointed full-time officers. After India

attained Independence in 1947 the emphasis of the Government was more on the creation of psychiatric departments in general hospitals (GH) rather than mental hospitals. G.H. psychiatric care meant shorter hospitalization and a better involvement of the family members. The shift in emphasis from that of the mental hospital base to the general hospital setting, brought about a definite change in the care of the mentally ill.

The effect of stigma, as well as the large number of untreated mentally ill in the community, brought to the fore the importance of community intervention in the comprehensive care of the mentally ill. Keeping in mind the urgency of formulating a policy on mental health to improve the current mental health delivery system, the Government has drawn up the national mental health program (NMHP, 1982). This program aims at integrating mental health with primary care at a reasonable cost and also promotes healthy psychosocial development. The role of the voluntary sector, in this regard, assumes special significance.

Sociocultural Correlates of Mental Health

A knowledge of the health care system that operates in India demands a certain understanding of the cultural practices and beliefs intrinsic to the Indian psyche. Indian culture tends to foster dependence right from birth akin to oriental cultures (Neki, 1976). The aged and the infirm are not abandoned but looked after by their families. However, the social change caused by exposure to Western norms and practices is bringing in an era of industrialization and modernization, which is having its impact on the Indian structure.

The concept of setting up homes for the care of sick people has not yet gathered momentum and the family continues to bear the brunt of caregiving. However, migration and the large number of women entering the work force because of economic necessity are likely to reduce the number of family caregivers. The conflict faced by the family is obvious, and does not augur well for the family's continued mental health.

Epidemiological studies estimate that 20 per 1000 of the population are affected by a severe mental illness (NMHP, 1982). Severe mental illness thus constitutes a major problem with around 16 million people suffering from these illnesses. Mental

retardation is estimated at 0.5–1.0% of all children. Alcohol and drug dependence rates, though still low as compared to the West, reveal a disturbing rising trend, particularly in the urban setting.

Psychiatric problems of the elderly especially in the large urban areas are assuming importance due to the weakening of the traditional family structure and social support systems. It is estimated that by 2000 A.D. persons aged 65 and over in India will total 53 million, which is 5.6% of the population (UN, 1986). The risk of dementia has also been found to be high in this population. It is interesting to note that life expectancy at birth has gone up from 38.7 years in 1955 to 55.4 years in 1985. Improved delivery of health care has undoubtedly contributed to a better quality of life. It is therefore ironic to note that India, while reaping the benefits of modernization, is also struggling to cope with its adverse effects.

Current Mental Health Delivery System

Mental health care is largely provided by the government. It is grossly inadequate considering that there are 20 million people needing care and facilities have only 25,000 beds. Such a lack of public facilities has encouraged the growth of a large number of private nursing homes. As the government sector has severe financial constraints on account of other health priorities, the voluntary sector has initiated a few mental health care programs.

Psychiatric care is not covered by insurance or social security. However, most government centres provide care free of cost not only for inpatients and outpatients, but also for specialised services. Notable among these are programs for mental retardation, drug addiction, suicide prevention and psychogeriatric care. The three major providers of mental health care are institutions, aftercare services, and general hospital and community services.

Institutional Care

Forty one mental hospitals with 20,000 beds offer institutional care for the severely mentally ill. Most states have at least

one such institution. Initially planned for long term custodial care, these centres provide special clinics and outpatient care. The ratio of mental hospital beds is .025 per 1000 population in India, which contrasts significantly with the United Kingdom which has between 2.9–3.0 beds per 1000. The availability of most beds gets blocked by long-stay patients and much of the mental health budget is spent on maintaining the infrastructure. Health planners therefore discourage further mushrooming of such centres.

Aftercare Options

Few organised services exist for the rehabilitation of the mentally ill in India. The centrally supported institutes, such as National Institute of Mental Health & Neurosciences (NIMHANS), Bangalore and Central Institute of Psychiatry (CIP), Ranchi, have well organised industrial, occupational and recreational services. Apart from government agencies, a few voluntary organisations provide aftercare facilities for the mentally ill. The Schizophrenia Research Foundation (SCARF) established in Madras is a pioneering effort in this direction. Other institutions of a similar kind are Sanjeevini in Delhi and Abhaya in Trivandrum. These primarily deal with severe mental illness in contrast to those involved with addiction, alcohol and suicide prevention, and mental retardation.

The unfortunate fact is that most of these largely urban based agencies are poorly funded and are not able to fully address themselves to the issues involved in the rehabilitation of the mentally ill. Halfway homes, sheltered workshops, daycare centres, and child psychiatry units exist, though conglomerated in urban areas. As a result, rural areas suffer considerable neglect as they have large numbers of people in need of mental health care.

All welfare schemes of the disabled are coordinated by the Central and State Ministries of Social Welfare and Health. The physically disabled and the mentally retarded have been given high priority by the government and policies have been framed for long-term support to provide vocational rehabilitation and employment. Mental illness, however, has not been classified as a handicap. As a result, the mentally ill are not eligible for

welfare benefits. The absence of adequate care and benefits for the mentally ill is fast becoming a cause for much concern.

General Hospital Psychiatric Units

The establishment of General Hospital Psychiatric units has led to a qualitative change in overall psychiatric care. Around 5,000 beds are available. These are largely in teaching hospitals attached to the 67 medical colleges. Efforts have been made to start such units in the remaining medical colleges. Both major and minor psychiatric morbidity is dealt with in these settings and their establishment has led to a larger clientele seeking help.

Outpatient and Emergency Services

Much of the minor psychiatric morbidity is contained by the Medical and Casualty Clinics of the hospitals in towns and districts. Cases unmanageable by several practitioners, indigenous therapists, faith healers, teachers, and key informants are referred to such treatment units. Patients with psychoses, dementia, mental retardation, drug and alcohol problems, neuropsychiatric disorders, and psychosomatic illnesses are provided care. The emergency services treat acutely excited patients. Often clients in a subacute delirious state or postfebrile confusion are referred to these centres. Attempted suicide forms a large category of referrals needing resuscitation and crisis intervention

Staffing Patterns

Within state differences. The staff in an institution or a general hospital psychiatric unit is comprised of psychiatrists, clinical psychologists, social workers, nurses, and trained attendants. The number varies according to the size, capacity and roles of the treatment setting. For example, the Tezpur Mental Hospital in Assam, has only 1 psychiatrist and no other mental health professionals to look after 1000 inpatients. In contrast, the Mental Hospital in Madras, Tamilnadu State has 28 psychiatrists, 24 social workers and 4 clinical psychologists and 200 ward attendants to cater to 1800 inpatients and outpatient and special clinics.

Centre-state differences. A similar disparity exists between centrally sponsored institutions such as National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, Central Institute of Psychiatry (CIP), Ranchi, and state hospitals. While the central organizations are well funded and staffed, the others are inadequately supported. Latest estimates on all mental health services place the number of psychiatrists in India around 2,000, clinical psychologists around 600, and social workers around 1,000.

City-district differences. The Districts which have a population of 2 or more million have the administrative capability and the infrastructural support to cater to clients from a large number of towns and villages. However a few districts have psychiatric units functioning with one psychiatrist and no other members of the mental health team. Efforts have been made to strengthen the District or Block level hospital psychiatric units from which outreach programs can be extended into the community. No psychiatric staff are available beyond the district setting.

District-primary health center differences. The Primary Health Center (PHCs), with its subhealth centres are the most peripheral health posts catering to a few villages. Recently a few PHCs have been upgraded to form the Community Health Centres (CHC) to look after 100,000 people. Each PHC looks after 30,000 people and has a staff of 2 doctors, 1 pharmacist and 1 auxiliary nurse supervisor. The Subhealth Centre (SHC) looks after 5,000 people in a group of villages called collectively the 'Panchayat'. The SHC has a Multipurpose Health Worker (MPW) who is a person with school education and an 18 month midwifery in service training.

No mental health care is available beyond the districts, and it is in the villages that most Indians live.

Treatment Modalities

Facilities for Electro-Convulsive therapy (ECT) and pharmacotherapy exist on a pattern similar to western countries. The dosage requirement of neuroleptics is, however, much lower. ECT is known to provide quick results with judicious use.

Among the psychosocial therapies, family therapy has been found to be most relevant and useful in India. Behaviour

therapy is beneficial particularly in neuroses and psychosomatic disorders. Psychoanalytic therapy has not taken root in India, due to concepts alien to the culture, the high cost factor, and reluctance on the part of clients and families to seek this mode of treatment. Yoga as an adjunct to these therapies has enhanced mental health and contributed to a reduction of psychosocial stress thereby improving the general adaptations of the individual.

Yoga Therapy

The word Yoga derived from the sanskrit word Yuj is used to connote the "Yoking of all the powers of the body, mind and soul to God" and facilitates a person practising it to function at the peak of his potential and harmony in his everyday transactions. Patanjali, one of the foremost exponents of Yoga, defined it as Chitta Vritti Nirodha. Chitta is the mind constantly bridled with thoughts, emotions and ideas, all of which cause a turmoil or whirlpool (Vritti) within it. Nirodha signifies control or restraint. The essential purpose of Yoga is therefore to control the mind, maintaining it in a state of tranquility and peace. To many Indians, Yoga is a way of life and not merely a form of treatment.

Consisting as it does of 8 steps, it encompasses physical, mental and social behaviour. Yama and Niyama are comprised of abstentions of the mind; Asanas, the adoption of right posture; Pranayama the right breathing, the Dhyana, meditation. Yoga and meditation as a form of psychotherapy have been stressed by several workers. Its utility in anxiety states, depression, and other forms of neurotic and psychosomatic disorders has been established. It has also been used for treatment of insomnia, to increase productivity in industry, and learning abilities in children.

Psychotherapy and group therapy are mostly supportive and didactic in nature. This is effective and pragmatic considering that in a day, 2 or 3 psychiatrists/social workers have to manage an out-patient clinic. For instance, a general hospital psychiatric setting, such as the one in Madras, manages 100 continuing and 15–29 new clients every day. They are managed by a staff of 2 or 3 psychiatrists/social workers.

Community Services

Services for the community have been initiated by both the government and voluntary sector, particularly after the national mental health program (NMHP) was drawn up in 1981. The main objective of NMHP is to provide basic mental health care at the grassroots level, apart from ensuring availability and accessibility of services to the most vulnerable and underpriviledged sections. The specific approaches involve diffusing mental health skills to the peripheral health service system, territorial distribution of resources, and integration of mental health care with general health services. Pilot studies linking mental health with community development have been initiated by NIMHANS in Bangalore through district mental health training programs in Bellary in Karnataka state. Similar tasks have been taken up in Goa, West Bengal and Rajasthan.

Voluntary agencies such as SCARF, Madras, have implemented community based rehabilitation as part of NMHP in the district of Chinglepet in Tamilnadu. The guidelines offered to the ministry suggest that service programs be located in the community. Vocational-rehabilitation, public education programs, and training of health workers to identify disability and provide care have been found to be beneficial.

Current Issues and Future Trends

Funding and Relationship to the Health Care System

The oft repeated statements of the government justifying poor funding for mental health is changing after a Charter for Health Development has been agreed upon with the World Health Organization. Mental health is expected to form a part of the overall health development program. There is the likelihood of a reordering of priorities in the 8th Five Year Plan (1990–1995). However India will not be in a position to spend 5% of the Gross National Product (GNP) on Health, as suggested by the Health for all by 2000 agenda. The percentage of GNP currently available for health is around 2%. Only a small proportion of this amount is available for mental health — and that is taken by large institutions and mental hospitals.

The 7th Five Year Plan of India (1985–1990) has allotted 10 million rupees for NMHP and the amount would be raised three times during the 8th Five Year Plan. It is expected that there would be a shift from curative to preventive, urban to rural and privileged to less privileged groups. Although NMHP is a major movement, the basic flaws are variations between urban and rural facilities, distorted priorities, and neglect of the governmental sector.

Privatization

Privatization of psychiatric care in organised settings has not taken root in India, as has been the case in the U.S. The majority of the patients consult private psychiatrists for a fee and are at times admitted to nursing homes which are not strictly psychiatric units. With a change in the Mental Health Act of India more nursing homes are likely to function.

A few institutions in cities offer custodial care to the mentally handicapped. But this is done without governmental support. The laws pertaining to mental illness continue to be restrictive. Most industries and organised sectors prefer not to have psychiatric units, but recently some public and private sector undertakings are beginning to provide psychiatric care.

These enterprises have actually taken up provision of mental health care for their employees and families. Large organizations like Tata steel, Indian Airlines, Port Trusts and others, provide for reimbursement of medical expenses of their employees. To some privatization means poor service provided at high cost. The Government however, does not link with private, profit-making agencies. Exploitation, corruption, and competition for profits are some of the factors that restrict the growth of private nursing homes.

While the cost of psychiatric care has increased, no provision exists in the insurance industry to provide benefits. Persons with a psychiatric breakdown cannot claim insurance if labelled psychiatric, and often take refuge in a medical diagnosis covered by insurance policies.

Privatization has also brought about growth in health care through support from international agencies such as United States Aid for International Development (USAID), Canadian

International Development Agency (CIDA), Swedish International Development Agency (SIDA), Norwegian Aid for Development (NORAD), Danish International Development Agency (DANIDA) and others. These are some of the leading health promotion agencies that offer financial support for priorities set up by the government of India. Unfortunately, none of the agencies has taken up programs in mental health, because they are of low priority. Recently some support has emerged for mentally handicapped children.

Issues of Service Delivery

Deinstitutionalisation. Unlike the West, deinstitutionalisation has not been a major problem in India. It is noninstitutionalisation which is of grave concern. As indicated earlier, several million people need hospitalisation but facilities are not available. Hence these patients are kept in the backyards of homes, or cared for by the local people. Family support is fairly adequate or at least it seems so for want of other options. But such a situation will not last long, as the caregivers are under extreme duress and family structure too is changing from a joint to a nuclear type. Despite the fairly integrated family set up, a large number of chronic mentally ill remain without homes, treatment or community supports.

Efforts are being made to offer shelter through outreach programs and community homes (both traditional and permanent). Cooperative enterprises between a social service agency (e.g., SCARF) and a church or temple affiliated organisation are also being planned in some parts of the country. A range of settings needs to be established to provide hostels, halfway homes, fostercare and partial hospitalization.

Homelessness. A homeless individual, according to the Alcoholism, Drug Abuse and Mental Health Administration (ADAMHA), is one who lacks shelter, resources and community ties (ADAMHA 1983). The increasing problem of homelessness among the CMI in the U.S. is due to deficits in service delivery, rapid discharge of mental hospital patients, and lack of alternative strategies in providing shelter (Bachrach, 1987). The homeless, mentally ill also constitute a major problem in India. It is not clear as to what proportion of the homeless in India are

mentally ill. Millions of normal but socially handicapped people sleep in the open air and in the streets for want of shelter. A vast proportion live in subhuman conditions in huts, tenements and slums. Therefore, the mentally ill among them have not drawn the attention of planners of mental health workers.

A detailed study is required to differentiate the mentally ill and the socially disadvantaged within the category of homelessness. While in the West, the cause of homelessness is mainly due to deinstitutionalisation, the problem in India is one of noninstitutionalisation. The ministries of Housing and urban Development, Health and Social Welfare need to assess the extent of problem and make provisions for their shelter.

Future Trends

Integrating Mental Health in Primary Care

The most effective way mental health care can reach the vast numbers living in the villages is by providing mental health training in the PHC setting. This has been started by several governmental and nongovernmental agencies and it is expected that high priority will be given by the health planners through the NMHP. The district hospital should be a nodal point for the referral of more acute mentally ill. In some states such as Kerala, Tamilnadu, and Maharashtra, a full fledged psychiatric service is available in most districts and this is an encouraging trend. Social workers, public health nurses and trained multipurpose health workers are able to actively supplement psychiatric services in the community by helping in detection of mental illnesses and distribution of basic drugs.

Mental Health in Medical Curriculum

The current medical curriculum has meager provisions for the teaching and training of psychiatry to undergraduate students. This is indeed a glaring lapse in that much of the mental health care is provided by general practitioners and primary care physicians rather than by the psychiatrists. Recommendations to incorporate behavioural aspects of the illness in the

curriculum have been submitted to the Indian Medical Council and it is hoped that psychiatry will soon be recognised as a definite branch of study for undergraduates.

Social Security and Insurance Schemes

Social security and insurance schemes which are the norm in the West have not really caught on in India. Although there are insurance schemes which cover various medical disorders, a psychiatric illness is not one of them. A psychiatric diagnosis is enough to bar an individual from any benefit, be it monetary or employment. While the physically disabled and handicapped receive a measure of welfare benefits, only recently have there been a few job reservations for those with mental retardation. This is a major change brought about by the Welfare Ministry and there is a possibility that disability caused by chronic mental illnesses will soon be recognised as a handicap. It is hoped that certain concessions will be given to the families of the mentally ill in availing treatment at low cost. This trend promises much hope to the families who are burdened by the strain of providing care to those afflicted with disorders such as schizophrenia and dementia.

Aftercare Services

Although medical intervention and provision of acute care is well planned out, the need for rehabilitation and aftercare of the mentally ill, is, as yet, inadequate. Aftercare services in the form of sheltered workshops, cooperative enterprises and halfway homes would go a long way in enhancing the quality of mental health care in India. Several psychosocial rehabilitation models appropriate to both the urban and rural communities need to be planned, which would further augment mental health care in the community.

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Figure 1
Distribution of state mental hosptials, central institutions, and voluntary organizations in India.

Legend
- State Mental Hospitals
- ▲ Central Institutions
- ★ Voluntary Organizations