MENTAL HEALTH SERVICES IN INDIA

A CASE STUDY OF JAHANGIRPURI

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CERTIFICATE

This dissertation entitled **"Mental Health Services in India: A Case Study of Jahangirpuri"**, is submitted in partial fulfilment of six credits for the degree of Master of Philosophy of this University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work.

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Dedicated to

those children who remain gallant in their suffering in the aftermath of Gujrat Earthquake

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CHAPTER – I

INTRODUCTION

INTRODUCTION

UNDERSTANDING THE PROBLEM

Mental health is undeniably one of our most precious possessions, to be nurtured, promoted and preserved as best we can. It is the state of mind in which the individual can experience sustained joy of life while working productively, interacting with others meaningfully and facing up to adversity without loosing capacity to function physically, psychologically and socially. It is undoubtedly a vital resource for a nation's development and its absence represents a great burden to the economic, political and social functioning of the nation.

The WHO defines mental health as a positive sense of well being encompassing the physical, mental, social, basic economic and spiritual aspects of life, not just the absence of disease. Mental health is a barometer of the social life of a population and the rising level of morbidity and mortality are a sign of social as well as individual malaise. The scope of mental health is not only confined to the treatment of some seriously ill persons admitted to mental health centres but related to the whole range of health activities.

In the past and present also, in the field of health our mind has been preoccupied with communicable diseases, because they were the biggest cause of death in the population. We have been looking at health in terms of physical health, while neglecting mental health. Over the years mental illnesses have increased manifold. Although there has not been any epidemiological study, psychiatrist estimate that about two percent of Indian suffer from mental illnesses, a staggering twenty million out of a population of one billion.

In the past, besides various steps taken by the Government, Non Governmental Organisations and other agencies to improve mental health services, mental health did not find its appropriate place in the national and state health planning. Since independence, time and again the Government of India recognised the need to be proactive in its approach to promote the good mental health of its citizens and responsible in its efforts to provide good quality care to those suffering from mental disorders. But unfortunately, these efforts are reflective in various recommendations and meetings only, perhaps due to various reasons and the common misconception that prevalence of mental illness is low in India particularly as compared to West.

The Government and policy makers have been remiss in that they have not provided adequate means of treatment to their people. And people have continued to discriminate against those who suffer from these disorders. Human rights violations in mental hospitals, insufficient provision of community mental health services, unfair insurance schemes and discriminatory hiring practices are only some of the examples. We have to accept that by accident or by design, we all are responsible for this situation today.

It is unfortunate that after fifty years of independence, besides having a National Mental Health Programme, we don't have any country wide epidemiological data of mental illnesses and whatever available are only estimates and those estimates are based on the prevalence and incidence of other countries. Although we don't have any epidemiological data, research studies from different parts of the country have shown that mental illness is as common

in India as it is elsewhere and it is equally common in rural and urban areas. Mental disorders cause an enormous burden on affected individuals, their families and society, although this suffering may not be visible to others. Information about the prevalence and pattern of mental disorders in rural urban populations, school children and population exposed to special stresses like, disaster and migrations have shown that mental disorders are of public health importance.

In this background, I want to examine the Mental Health services in India from public health perspective considering preventive and promotive aspects of mental health recognising the socio cultural factors in mental health services.

RATIONALE OF THE STUDY

The driving force behind the study was my interest in mental health & illnesses and my basic training in clinical and applied social psychology. During my course work, I realised that most of the professionals or research workers are looking health, in terms of physical health overlooking mental health and different people have different reasons for that. Even there was no consensus whether it is a public health problem or not. Although we have a National Mental Health Programme since 1982, there is no mention of it on further health plan and policy documents and the programme was mainly on paper. All these developments were reasons enough for me to find out how our policy makers and professional are looking at mental health. Rationale behind the study was to examine Mental Health Services in India from a public health perspective

considering preventive and promotive aspects of mental health and recognising socio-cultural factors in mental health services.

OBJECTIVE OF THE STUDY

Objectives of the study are:

1. To understand mental health services in India from a public health perspective.
2. To analyse Programme and policies in India and their relevance to Mental health Services.
3. To review the development of mental health services in India and to analyse the implementation of DMHP under NMHP.

METHODOLOGY

The study largely relied upon the various secondary sources (viz., government reports, policy papers related to mental health published by Ministry of Health and Family Welfare, Directorate General of Health Services, Planning Commission, books and articles published in various Journals) for literature review and conceptual clarity on the area of mental health. For the in depth qualitative insights the study was done using observation technique (Psychiatric OPD at BJRMH) and nine in-depth case studies with patients visiting the clinic in Jahangirpuri area during September –December 2000. In observation, emphasis was on service delivery, doctor-patient relationship, infrastructure availability and problems in service delivery in the background of DMHP guidelines and objectives of DMHP and NMHP. Informal interview were also

done with 25 patients and 25 family members (Care-Givers) about the services available at Psychiatric Unit (DMHP, Jahangirpuri) and their understanding and perception of mental health and illness. Apart from these, secondary data from various sources and in some cases informal unstructured interview was also carried out. The details of the study and the methodology are given in chapter V. Case studies and the interview schedule is given in the appendix.

LIMITATIONS OF THE STUDY

The study was done with a purpose to understand the mental health services, mental health programs and it's policy implications on mental health services. The major limitation of this study is its study area because it comprises a small area and on the basis of that we can understand the mental health services and problems in programme implementation but we can not make any broad generalizations. The study area cannot be a proper representative of either the state or the country as whole. And hence the conclusions can at best represent a glance in the gamut of problems facing implementation of DMHP under NMHP and any further policy conclusions would need a more detailed study than what has been attempted here.

CHAPTERISATION

This dissertation is arranged in four main chapters headed and followed by introduction and concluding observations. The second chapter looks into the various conceptual issues and concerns related to the study. In this chapter an

attempt is made to understand and examine the various issues related to mental health viz., concept and scope of mental health, various dimensions and component of mental health, nature of mental health and illness, perception and cultural issues involved in understanding of mental health, theories, definitions and other issues. The third chapter gives a historical perspective of the development of mental health as a discipline and the development of the mental health services in India since colonial period. The fourth chapter outlines the evolution of the mental health programmes and policies in India since independence and discusses the various policy issues and recommendations.

The fifths chapter deals with the main findings and the analysis of the primary investigation of the mental health services delivery with reference to DMHP in the Jahangirpuri, Delhi. And finally chapter six deals with the conclusions and observations drawn on the basis of the study.

CHAPTER – II

MENTAL HEALTH:

ISSUES AND CONCERNS

MENTAL HEALTH: ISSUES AND CONCERNS

UNDERSTANDING MENTAL HEALTH

Going by the definition of World Health Organization on health, couple of words draw our attention. Words like ' physical', 'mental' and 'social' force us to ponder more and more, more than the boundaries of biomedical model, which addresses only physical ailments, that too not comprehensively. What is our understanding and explanation of words like 'mental' and 'social'? How far they are mutually exclusive and inclusive? And is there a strong interplay between these two?

The same set of questions can be asked in another way, that is – Can somebody be healthy, physically but not mentally and socially or Is it possible to be healthy socially, while being unhealthy physically and mentally or Can there be anybody who is mentally healthy but not socially and physically?

These questions naturally expand our views and the concept of health looks broader. There are number of dimensions, which contribute to positive health like, spiritual, emotional, vocational, philosophical, cultural, socio-economic, environmental, educational and nutritional along with physical, mental and social dimension. Thus health is multidimensional. Although these dimensions function and interact with one another, each has its own nature.

The scope and importance of mental health ranges from care of the ill to the promotion of mental health. According to one of the earliest Indian psychiatrists

Govindaswamy (1984)[1], " The field of mental health in India has three objectives. First of these has to do with mentally ill persons. For them the objective is the restoration of health. A second has to do with those people who are mentally healthy but who may become ill if they are not protected from conditions that are conducive to mental illness which however are not the same for every individual. The objective for those people is prevention. The third objective has to do with the promotion of mental health with normal persons, quite apart from any question of disease or infirmity. This is positive mental health. It consists of protection and development of all levels of human society of secure, affectionate and satisfying human relationships and in the reduction of hostile tensions in the community"(p.2).

Perhaps the easiest dimension of health to understand is 'physical', which is nothing but biomedical definition of health. Mental health is not mere absence of mental illness. Good mental health is ability to respond to many varied experiences of life with flexibility and a sense of purpose. More recently mental health has been defined as " A state of balance between the individual and the surrounding world, a state of harmony between oneself and others, a coexistence between the realities of the self and that of other people and that of the environment?" (The question is how many of us fall within this definition).

On the other hand social well being implies harmony and integration within the individual between each individual and other members of society and

[1] *Development of Mental Health Care in India*, 1947-1995, VHAI, 2000.

between individuals and the world in which they live (Park, 1995)[2]. It has been defined as the "quantity and quality of the individual's interpersonal ties and the extent of involvement with the community" (Donald, 1978).

The social dimension of health includes the levels of social skills one possesses, social functioning and the ability to see oneself as a member of a larger society. In general, social health takes into account that every individual is part of a family and a wider community and focuses on social and economic conditions and well being of the whole person in the context of his social network. Social health is rooted in "positive material environment" (focusing on financial and residential matters), and "positive human environment" which is concerned with the social network of the individual (Fillenbaum, G.G., 1984)[3].

At the outset, these definitions and explanations of social and mental components of health look similar. But they have subtle differences, which have to be understood so that any issues on these dimensions could be analysed with clarity.

Broadly, mental health or mental dimension refers to the inner harmony of an individual while social health component of health refers to the external harmony of an individual, the way one adjusts with his/her residential and financial matters. Mental health component of health looks at how one solves his/her internal conflicts, the level of self-esteem, needs, problems and goals and ability to strike a balance between rationality and emotionality.

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[2] Park (1995): *Parks textbook of Preventive and Social Medicine*, Banarsidas Bhanot publishers, New Delhi.

[3] Fillenbaum, G.G., 1984. The Well being of the elderly, WHO offset publication 1984.

A few decades ago, the mind and body were considered independent entities. Recently however, researchers have discovered that psychological factors can induce all kinds of illnesses, not simply mental ones. They include conditions such as essential hypertension, peptic ulcer, and bronchial asthma (WHO 1964 Technical Report Series, 275)[4].

The above discussion has been given here in the context of understanding various dimensions and components of health. The purpose is to highlight the need to adopt a broader approach to health as against the present biomedical approach. So far our views, analysis and our concentration has centered on the physical component and other components have been seen subsidiary.

In the field of health our mind has been preoccupied with communicable diseases because they are the biggest causes of death in the population. These diseases have partly been conquered. We have been looking at health in terms of physical health, while neglecting mental health. The life expectancy of an average Indian at birth, which was around 30 years in 1947, is now over 60 years. Mortality due to plague, cholera, malaria, TB, typhoid fever and pneumonia has declined over the years. Though there is a sharp decline, still our achievement is questioned, D. Banerjee in an interview to " Health for the Millions"(July-August, 1997) raises two questions: what is the correlation between access to health services and improvement in the health status. And secondly, with an acute problem of human ecology caused due to expansion of the population from 350 million in 1951 to the estimate of 950 million at present, with acute problems of access to housing, sanitation, protected water, food,

[4] WHO, 1964 Technical Report Series, 275.

employment, etc., to what extent can we use the very encouraging vital rates to claim improvement of the health status of the people? But all these 'achievements' we claim is in terms of physical health overlooking mental health.

In any society how the people perceive any phenomena or event has a major impact on its understanding. The study of mental health should also take into account the social construct surrounding it. If we see the history of mental health and illnesses in India, we will find that from the very beginning mental illness has been viewed as an inherited idiosyncrasy or a family 'curse', or a life long affliction with near supernatural origins and consequently, in this view treatment falls beyond the realm of science and rationality. I think it is one of the major factors influencing our attitude, perception and our understanding of mental health and illnesses. Even today, when we have already entered the new millennium, we are not able to challenge and break people's false belief and myth related to it and it is a major hurdle in our achievement in the field of mental health. I think, in such a context, the path from 'mental illness' to 'mental health has been long, arduous and conflict ridden.

The changes in terminology associated with the mentally ill and their treatment are significant. A few centuries ago, the mental patients were locked up in "mad houses". Later they were given shelter in "mental asylums" away from the harassment of a society that could neither understand nor tolerate their behaviour. Some decades latter, mental hospitals appeared on the scene as treatment centres for the treatment of patients. Today we have "mental health

institutes" to provide a variety of services for the care, treatment, and rehabilitation of mentally ill, and programmes for the prevention of mental illnesses and promotion of mental health. One may be tempted to conclude that new modes of reference have been followed by brisk action and that everything is all right in the field of mental health today.

But the reality is different. Though much has been done, it is not enough compared to what needs to be done. It is indeed reflective of the sorry state of the field of mental health in India that even today mental illness has generally been viewed from the biomedical rather than the social-psychological model. It is of crucial importance in the field of mental health to understand the transition from mental illness to mental health and all that this transition symbolizes.

It is also important to understand the concept and politics of medical profession and their vested interests, where illness implies technical judgment by medically qualified persons. Thus, power is vested in this profession for deciding when a group of symptoms or behaviour is aberrant enough to be labelled as 'illness' (Flew, 1983: 115-116)[5]. This politicisation of medical practice has mystified the field of health care and promotion and there is a need to examine and question it. 'Health' is neither a technical matter nor the exclusive arena of expertise of some. A wider vista of individuals, groups and institutions need to be able to contribute towards the well being of individuals, families and communities.

[5] Flew, Anthony, 1983 "Mental Health, Mental Disease, Mental illness: The Medical Model", *Mental Illness, Change and Trends*, Philip Bean (rd), Chichester, N.Y., John Wiley and Sons.

Disease or illness when explained by a social scientist is not generally recognised. The explanations are sometimes criticised on the question of his authority and right. The implied meaning of the criticism is that only biomedical research can provide the cause of disease, assuming that the causes are only chemical, electrical and physical. The biomedical solution is bringing the body back into functional status through clinical medicine. But the understanding of social sciences of disease is different from that of the biomedical model. The slightest scraping of the surface of this notion of biomedical model, reveals the underlying fabric of health with its interwoven biological, physical, social, economic, and political threads (Qadeer, 1993).

The germ theory, mother of biomedical model proposes that a specific biological process produces each disease. All individuals are conceived as having similar body machines and, in accordance with the disease are to be treated in the same way (Kelvyn and Moon, 1987)[6].

To understand the fact that disease is not only the result of any synchronic cause, it would be better if we analyse the assumptions of biomedical model. Modern medicine, treating the body as a sort of machine, regards illness as malfunctions of the body's mechanism, which can be ultimately identified and treated (Brayan S, 1987)[7]. Machines generally operate as a linear causal sequence so that A causes B that causes C and so on; if a breakdown occurs, it is usually traceable to one component part. Similarly the body machine is seen to

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[6] Kelvyn Jones and Graham Moon (1987): *Health, Disease and Society – An Introduction to Medical Geogrophy*, Routledge and Kegan Paul, UK.

[7] Bryan S. Turner (1987): *Medical Power and Social Knowledge*, Sage Publications, London.

be made up of interacting but separable parts; the physician as body mechanic, must find the diseased part and the single cause of the disease, and that is why we need specialists in particular organs or processes (Kelvyn & Moon, 1987).

These assumptions ultimately played an unmitigated role in influencing the attitude of the policy makers and consequently shaped the policy decisions in the arena of health. Health is predominantly viewed as the 'absence of disease' and as 'functional fitness'. Health services are geared mainly towards treating sick and diseased people. A high value is put on the provision of specialist medical services, in mainly institutional settings. Doctors and other qualified experts diagnose illness and disease and sanction and supervise the withdrawal of patients from productive labour. The main function of health services is remedial or curative – to get people back to productive labour. Disease and sickness are explained within a biological framework that emphasises the physical nature of disease, that is biologically reductionism. A high value is put on using scientific methods of research (hypothetical- deductive method) and on scientific knowledge. Qualitative evidence (given by lay people or produced through academic research) generally has a lower status as knowledge than quantitative knowledge (Jones Linda, 1994).

If we are able to appreciate the above passage, definitely we can analyse the popular and most commonly accepted definitions of health given by W.H.O. – "Health is a state of complete physical, mental, and social well-being and not just absence of disease and illness". This definition tends to focus on ideal rather actual, since it assumes the notion of absolute, i.e., the 'complete well-being' of

an individual rather than examine the relationship of the individual with his social environment. It also ignores the fact that health or well-being has a range and cannot be an absolute quantity or quality. Health in reality then, is a social concept evolved and determined by the perceptions of a group or community and therefore differs from community to community (Qadeer, 1993).

Thus, by notifying the demerits and limitations of biomedical model of health, there is a need to understand and emphasise the need to understand disease and illness in terms of social, economic, political and ecological reality.

It is evident that global trends in mental health have a clear and direct bearing upon the mental health in India. Paradoxically, the definitions of normality and abnormality, and social deviance differ across cultures. In this context, it's necessary to see and understand the definition of mental health; well-being, and interventions directed towards it are essentially culture-specific, raising especially problems in terms of universal understanding and consensus.

The Indian approach to health encompasses mental harmony, which is often equated with spiritual harmony. This view can be used as one of the approaches for the promotion of mental health in India. I think it is relatively freer from the Western obsession with institutionalisation and illness, and thereby, more in tune with current global thinking on de-institutionalisation and positive mental health promotion. This view is also more psychosocial than bio-medical, which is by itself a heartening matter as it is more holistic.

Another very important issue related to mental health is legal aspects of field realities. Policy in mental health advocates de-institutionalisation and other

innovative concepts, but the legislative order does not seem to reiterate this position. A debate on these issues was sparked off prior to the passing of the Mental Health act among mental health professionals and other allied professions. However, the debate seems to have died down. The issue needs a fresh consideration specially for understanding why the Mental Health Act has not been implemented in most states, what are the gaps that need attention and what the implementation of the act mean for the field of mental health. The practical aspects of its application will, thus, need special focus.

An important area that is very disturbing is related to community mental health. As we have seen in the West, in India too, there have been changes in the state of mental health care from custodial care to therapeutic interventions and community care. By now it is well accepted that the community's role in the prevention of mental illness, the promotion of mental health and the treatment and rehabilitation of the mentally ill is significant. In a society such as that of India, where bonding within communities is still evident, and where institutionalised services for different areas of assistance fall short of the demand, involvement of the community in mental health work would be valuable asset in addition to the possibility of reducing stigmatisation. It is in this context that the National Mental Health programme (NMHP) of 1982 envisages availability and accessibility of mental health services at the grass root level and encourages self-help initiatives within the community.

Another important area is related to the social support and social structure in the context of mental health care. We have seen that in the last few years, societal

support to vulnerable groups like those undergoing different crisis in a variety of ways and social support as an approach has been causing considerable excitement. In the Indian society, the importance of such network is paramount, partly since there is paucity of organised and professional supportive services and partly since the socio-cultural ethos is appropriate for such ventures. The family as support has of course been extremely important in India in view of rapidly changing family situation, especially in urban areas.

In view of the linkages between social and psychological problems and mental health, it is imperative to view the connection between environment and mental health. One would go as far as to argue that macro-level developments also impinge upon the mental health of a society. Groups marginalized in the process of development suffer grievously in terms of the loss of earlier sources of gratification and self-fulfilment. It would be revealing, for example, to examine the mental health of those affected by developmental projects.

Another very serious critical issue is related to the mental health care is the mental Health service in rural areas. It is widely believed in rural areas that the symptoms of mental illnesses are caused by the visitations and wrath of spirits, demons and ghosts. Consequently it is believed that religious, magical and other traditional methods by god men and traditional healers can alleviate the symptoms. The bases of these beliefs have to be examined in the context of the oppressive social structure in which there is widespread illiteracy and ignorance.

In view of the existing situation, the efforts of scientists and researchers need to be directed towards making efforts not only to operationally define mental health but also to develop tools to examine mental health.

Considering the needs of the community, mental health professionals (A.V. shah, 1982)[8] believe that the existing number of trained professionals and the available mental health facilities in the country are far from adequate. Hence, mental health planners are advocating innovative means for expanding and extending an appropriate delivery system of mental health care. Thus it becomes imperative to examine the views, beliefs, attitudes, and sensitivity or awareness of the community about mental health problems, lest the mental health facilities provided by the planners remain unused and. Some of the researches dealing with the community's views, attitude and awareness regarding mental health problems and the facilities available also need to be considered.

CONCEPT OF HEALTH AND MENTAL ILLNESS

The concept of mental health encompasses several aspects. Its scope is not confined to the treatment of more seriously mentally ill persons admitted to mental hospitals: it relates to the whole range of activities which are not limited to health sector alone. The varied theoretical frameworks guide mental health concepts leading to the broad ranging and overlapping varieties of settings, modalities and treatment strategies that can be observed at particular time or

[8]Shah A.V. (1982): Integration of mental health, *Indian Journal of Psychiatry*, 24 (1).

place. In this way, mental health is closely interlinked with the physical and social problems and has intimate relationship with all the health programmes meant to improve the quality of life of people

The phenomenon of mental disturbance usually hits the layman and often the involved (caregivers/family members) person too, by its apparent unintelligent ability and by its irrationality. A lower level of mental and physical functioning is frequently considered to be its symptoms. The other characteristic that is perceived by the people is that of suffering which accompanies mental disturbances. Both irrationality and suffering are highly subjective concepts/ perceptions, and thus they do not lend themselves easily to generalisation or quantification.

In this section, I would like to emphasise on our understanding of the concept of health and mental illness from a psycho-sociological perspective. Social dimension of health and illness covers three main areas: namely, the conceptualisation of health and illness; the study of their measurement and social distribution; and the explanation of patterns of health and illness. Clarification of the concepts of health and illness is the starting point of any psycho-sociological discussion, with emphasis given to the cultural variability of the boundaries of health and illness, to the multi-faceted nature of the concepts, and to their evaluative nature.

There can be no doubt, whatever the difficulties of measurement, that there are major differences in patterns of health and illness between societies, over time, and within a particular society. Historically, there have been long term

reductions in mortality in industrial societies, and on average life expectancies are considerably higher in developed than developing societies. Ill health and mortality are also related to age and sex. The young and the old are more vulnerable to sickness and death, and in most societies women live longer than men, though by some indices women experience more ill health. There are also major differences by social class and ethnicity within societies.

Mental Illness: Mental illness as a disputed concept is founded on the everyday contrast between mind and body which, when applied to illness, generates an opposition between two contrasting types of illness- mental and physical. Mental illnesses are illnesses characterised by the presence of mental pathology: that is, disturbances of mental functioning, analogous to disturbances of bodily functioning. Like physical illness the concept is, therefore, fundamentally evaluative and linked to issues of social control and regulation. The disturbances of thought and feeling that characterise mental illness, such as delusions, hallucinations, excessive elation or depression, are often associated with behaviour that is considered bizarre, awkward, disruptive, or disturbing. It is this disturbed and disruptive behaviour that, more than anything else, leads to mental illness being treated as a very distinctive form of illness, requiring special services and attention.

DEFINITION OF MENTAL ILLNESS AND HEALTH

Mental illness can be defined as an interpersonal deviation from socially accepted standards of behaviour, or as breakdown in the performance of social

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roles. Conversely, mental health can be viewed as interpersonal behaviour, which seems to fulfil social norms and role requirements. Under prevailing social conditions of normlessness, anomie, and family disruption, criteria for mental illness tend to be vague and ill defined; indeed, "pathological" interpersonal behaviour may have transient adaptive functions. Solely medical or psycho-physiological conceptions of mental illness are no longer tenable; interpersonal space always frames the picture. Mental health or illness is not inherent in the individual but in his interaction with a social matrix.

Till date very few published Indian literature are available on the definition and criteria of mental health. Even the epidemiological studies concerning psychiatric morbidity in India only provide operational definitions for identifying index cases but make no effort to define what mental health really is. Accordingly, these studies have reported the prevalence rate of mental illness in their samples but have not mentioned the mental health status of the remaining subjects. Thus in India also no appreciable efforts have been made to define mental health apart from a few passing references like: "The concept of ideal and social functioning is the social equivalent of 'Positive mental health'" (Carstairs & R. L. Kapur, 1976, p.81)[9] and "... In the larger context, mental health is the other name of quality of life..." (Wig, 1979, p.16). Mental health professionals however agree that positive mental health is not the mere absence of mental illness but something different (Nagaraja, 1983).

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[9] Carstairs, G.M. and Kapur, R.L. (1976): The Great Universe of Kota: Stress, Change and Mental Disorders in an Indian Village, London: The Hogarth Press.

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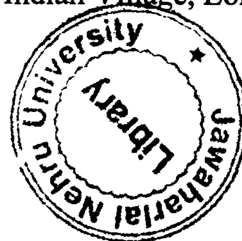

All definitions of the term mental illness are arbitrary. However, common consensus about the meaning of the key concepts used by professionals is scanny. The need for clarity with regard to the definition of a case, diagnostic criteria, and various diagnostic categories has been emphasised by many misconceptions about mental illness. It is among the most poorly understood and underestimated problems, particularly in our country where mental illness is often confused with physical illness (K.C. Dubey, 1978). Mental health and mental disorder, though both are priority conditions, are often confused even today.

The proposed Mental Health Bill of 1981, which has not been passed as an act, has defined a "mentally ill person" as ' a person who is in need of treatment by reason of any mental disorder, other than mental retardation". Two points are worth noting here. First, it has omitted the definition of "mental disorder" as such. Second, in a significant departure from the earlier legal definition (as per the Indian Lunacy Act of 1912 which is still in force) it has made a clear distinction between mental illness and mental retardation. There is a strong felt need in professional circles in India that such a Bill may be passed to replace the existing one. A number of professional bodies and professionals have made representations in writing and in person, before the parliamentary committee formed for this purpose.

"Mental illness" can be operationally defined as a clinically significant and identifiable behavioural or psychological syndrome or pattern. Such a definition should have the following characteristics for wider acceptability: (a) having

clinical usefulness for making treatment and management decisions; (b) has wide acceptability among clinicians and researchers; and (c) has usefulness for educating people.

For community mental health workers, general physicians, parents, teachers and other interested, intelligent relatives and laypersons, a simpler definition, in more concrete terms and with suitable examples has to be evolved.

RESEARCH DEFINITION OF MENTAL HEALTH AND MENTAL ILLNESS

A serious obstacle to research in the area of mental illness lies in the lack of a clear definition of the phenomenon to be studied. The term "mental ill health" has been used by different researchers to refer to such diverse manifestations as schizophrenia, suicide, unhappiness, juvenile delinquency, and passive acceptance of an intolerable environment. Whether some or all of these various reactions should be included in a single category of "mental illness" is not clear from a survey of the current literature. Theories describing the nature and antecedents of one sort of disturbance rarely relate it to another, and there is paucity of research evidence indicating the extent to which such manifestations are empirically inter-correlated.

In the face of such ambiguity it appears useful, to attempt an organized review of the various definitions of mental illness which are explicit or implicit in recent research, with a view toward highlighting their commonalities and discrepancies on both a theoretical and an empirical level.

The research criteria for mental illness to be reviewed here are subsumed under the following categories:

1. Exposure to psychiatric treatment;
2. Social maladjustment;
3. Psychiatric diagnosis;
4. Subjective unhappiness;
5. Objective psychological symptoms; and
6. Failure of positive adaptation

The most frequently used operational definition of mental illness, at least in terms of number of studies employing it, is simply the fact of a person's being under psychiatric treatment. And this definition is usually restricted to hospital treatment, rather than outpatient service. Nearly all the ecological studies correlating mental illness with demographic characteristics use this as criterion. They obtain their information from hospital records or, in unusual instances, from psychiatrist in the area who furnishes information about persons treated on an outpatient basis.

The various categories of definitions of mental illness discussed here have been distinguished primarily on the basis of their differing operational definitions: The dependent variable employed in empirical research on the phenomena are clearly different. Moreover, the conceptualisations of mental illness explicit or implicit in the empirical criteria are often quite divergent-viz., the radically different viewpoints underlying the 'maladjustment', "subjective unhappiness", and " lack of positive striving" definitions.

Certain conceptual and methodological difficulties in each of these types of definition are important like; "Exposure to treatment" is deficient in that only treatment aspect of the problem is dealt with. "Social maladjustment" is open to question because of the varying requirements of different social systems and the diversity of criteria for adjustment employed by community members. "Psychiatric diagnosis" provides an expensive, and often unreliable, method of assessing the state of mental health. "Subjective unhappiness' can be criticized as a criterion since it may be a function of intolerable environmental conditions as well as the psychological state of the person, and is subject to distortion by defence mechanism.

THE NATURE OF MENTAL HEALTH AND ILLNESS

A search of the social science literature concerning the nature and meaning of mental health and illness reveals several basic themes.

- There is no consensus regarding a definition of mental health and mental illness.
- There is general agreement that the two terms- mental health and mental illness- refer to behaviour which is interpersonal in nature and, with respect to mental illness, is judged to be dysfunctional according to the norms of an observer. This judgment is often made without any somatic or physiological evidence.
- Many social scientists oppose the application of a "medical model" to the area of disturbances in interpersonal behaviour.

- Many others question the medical model on pragmatic grounds. They assert that treatment under this model has not been effective.
- Use of the medical model has led to a preoccupation with pathology and a relative absence of work in the area of positive health.

The current status of research and theory in the field has resulted in separate listing of the attributes of mental illness and health. Most of the literature has concerned itself with pathological conditions, although some of the more recent studies have focused more on mental health.

SOCIAL DIMENSIONS OF MENTAL HEALTH

Mental illness is social, not only in definition, but also in origin. "Proximal variables, such as child rearing practices, family interaction, parental loss, peer groups, race, socio economic status, migration social crisis, war and employment, are all believed in some degree to cause mental illness. The likelihood of social factors playing a role in the aetiology of mental illness and health, gains support from recurring evidence that different population groups differ in frequency and type of mental illness. Social scientist have been intrigued by the challenge of discovering the ways in which different population groups produce varying rates of healthy and unhealthy individuals.

The facts[10] compelling society and social scientists toward concern over mental health as a social issue may be summarized as follows:

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[10] Wechsler, H., Solomon, L., Kramer, B.M. (1970): *Social Psychology and Mental Health*, Holt, Rinehart and Winston, Inc, pp. 3-5.

1. The sheer size of the problem-the number of persons presently afflicted with some form of mental disorder may be as high as one in three. Many of these will be severely impaired over a long term,
2. The cost of mental illness is very high in human terms (personal anguish, family disruption) and social and economic terms. Lost productivity and waste of human resources, along with direct expenditure of capital and operational funds, contribute to the total cost.
3. Present means are inadequate to cope fully with the problem. The supply of facilities and personnel is insufficient. Moreover, methods of treatment proven effective are pitifully rare.
4. Mental illness is unevenly distributed through the sectors of society and is inversely related to availability of treatment. This fact has important implications for the social and political structure of Indian society,
5. The incidence and nature of mental symptoms are likely to be affected by such social forces as automation, population growth, and the culture of poverty, racial conflict, and international tensions. An understanding of the manner in which such distal social forces affect family and personal life may help shape planned change.
6. The magnitude of mental disorder and the relative shortage of coping resources may be symptoms of pathology in our social system and, as such are fit subjects for social psychological study

EPIDEMIOLOGICAL ASPECTS OF MENTAL HEALTH

'Epidemiology may be defined as the study of the distribution of a disease in space and time within a population, and of the factors that influence this distribution' (Lin and Stanley, 1962)[11]. Results of epidemiological studies are presented in terms of prevalence or incidence rates. Prevalence is defined as the number of cases of the disease present in a population at a given time, while incidence is the number of new cases occurring within a specified time period. Rates of these are normally expressed as per1000 population.

Mental disorders can occur throughout the life span, but the type and nature of illness vary with age. One of the major problems that we face in planning mental health services is that we do not have a reliable estimate of what is going on in the country due to lack of epidemiological data. According to most of the surveys conducted in various part of the country, about 10-20 per thousand of population are affected by serious mental disorders at any point of time.

From about 1960, epidemiological studies of psychiatric morbidity in different samples of the Indian population have been conducted. Although these studies have told us about mental illness in specific population samples, the implication for the country in general which is undergoing fast urbanization and industrialization have not been analysed.

The Bhore Committee (India, 1946) extrapolated from rates in the United Kingdom and the United States of America and concluded that mental patients requiring hospitalisation in India be taken as 2 per 1000.

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[11] Lin, Tsung-Yi and Stanley, C.C. (1962): *The Scope of Epidemiology in Psychiatry*, Geneva: World Health Organisation.

Recently, Fifteen epidemiological studies on psychiatric morbidity in India have been analysed (Ganguli, H.C., 2000)[12] and prevalence rates for all mental disorder for all-India and six regions have been worked out. The national prevalence rates for 'all mental disorders' arrived are: 70.5 (rural), 73 (urban) and 73 (rural + urban) per 1000 population. Prevalence of schizophrenia is 2.5/1000 and this seems to be the only disorder whose prevalence is consistent across cultures and over time.

The major groups of problems associated with mental health are psychosis, neurosis and mental retardation. The prevalence rate for each of these disorders differs across studies according to (i) the characteristics of the population groups (e.g., rural/urban), (ii) the methods used to screen the population, and (iii) diagnostic procedures utilized in the particular survey. The prevalence rate for psychosis is largely uniform- around one percent of the general population. The neurosis prevalence rate is about 50 to 100 per thousand of the general population. It has also been found that there is a relative preponderance of females in the neurotic illness group. The prevalence rate for mental retardation is around 1 to 2 percent, depending upon the degree of mental retardation.

The drug abuse surveys carried out in the general population and special groups like school and college students report relatively high prevalence rates for 'all forms of drug abuse'. However the rate for 'drug dependence' is less (about 1 per cent). An emerging problem of recent times is the high user level of alcohol

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[12] Ganguli, H.C. (2000): Mental Disorders in India: An Analysis of Epidemiological Studies, *The Indian Journal of Social Work*, pp.394-419, Vol. 61, Issue 3, July 2000, TISS

in both rural and urban areas. Three recent studies from Bangalore, Pondicherry and Madras report alcohol dependence to be 6 per cent among the adult population. There is clear evidence that alcohol-related syndromes can become a major public health problem in India, especially in south India. The prevalence of psychiatric problems in children has been the subject of a limited number study. Verghese et al. (1973)[13] and Verghese and Beig (1974)[14] report a prevalence rate of 82 per 1,000, which includes enuresis (52/1,000), mental deficiency (20/1,00), behaviour disorder (8/1,000), and sleep walking (2/1,000). Similar results were found in a recent study covering a rural population of 32,000 from Bangalore district (Srinivasa Murthy 1991). Other studies of special population groups like the elderly have reported a very high prevalence rate (around 200/1,000) of emotional disorders in those above the age of 50; a majority of these are depressive disorders.

Beyond the striking figures related to those suffering from defined mental disorders, there exist a number of groups of people who because of extremely difficult conditions or circumstances are at special risk of being affected by the burden of mental health problems. These include children and adolescents experiencing disrupted nurturing, abandoned elderly, abused women, those traumatized by war and violence, refugees and displaced persons, many indigenous people and obviously persons in extreme poverty. To respond to such

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[13] Verghese, A., Beig, A., Senseman, L.A., Sunder Rao, S.S. and Benjamin, V. (1973): A Social and Psychiatric Study of a Representative Group of Families in Vellore Town, *Indian Journal of Medical Research*, 61 (4), pp. 608-620.

[14] Verghese, A. and Beig, A. (1974): Neuroses in Vellore Town: An Epidemiological Study, *Indian Journal of Psychiatry*, 16 (1), pp. 1-7.

a dramatic challenge the World Health Organization is substantially expanding its investment in mental health and the Department of Mental Health and Substance Dependence represents one of its major arms for this purpose. Besides these, there are many more issues and many disorders in the field of mental health epidemiology of greater concern.

In the end, one thing that comes out clearly is the fact that there is no consensus as far as the various issues related to mental health are concerned. Most often even though there is concern, it is either misplaced or misdirected. Definitely such divergence of opinions among scholars and policymakers does not help in identifying the specificities of the problem nor does it help in evolving a definitive policy framework. Much of this divergence of the opinion has its root in the very way the whole concept of mental health has developed in this country or even outside the country. The historical context, which led to the development of the concept of mental health as such, is also responsible for this. The next chapter attempts to look at the historical development of the mental health institutions of the country and the various conceptions and underlying issues behind it.

CHAPTER – III

MENTAL HEALTH IN TIME AND SPACE

MENTAL HEALTH IN TIME AND SPACE

In this chapter an attempt is made to understand and examine the development of mental health services in colonial period and historical development of mental health in India. The development during colonial period has significant importance in context of development of mental health services after independence and in that context it is important to understand the structure and development of mental hospitals in India and problems in existing mental health services and needs. The development during this period had major impact on the future of mental health in India in context to the programmes and it's policy implications in India.

BRIEF HISTORY OF MENTAL HEALTH

Until the arrival of the European power in the 18th and 19th centuries, there were no separate services for the mentally ill. The traditional Indian medical system, such as ayurveda or unani, recognized various types of mental illness. Traditional medical practitioners provided the necessary treatment as part of their practice long before the discovery of modern tranquillisers (Wig 1990)[15]. In ayurveda, for instance, sarpagandha, a preparation containing reserpine, was used for mental disorders. Indian philosophy attaches great importance to concept of mental health, which are contained in such Indian philosophical text as the

[15] Wig, N.N. (1990): "Indian Concepts of Mental Health and their Impact on the Care of the Mentally Ill", *International Journal of Mental Health*, 18 (3): 71-80.

Yogasutra (Taimni1979). The well-known methods of yoga and meditation emphasize the value of the inner life and the need for mental reflection. They stress the temporary withdrawal of mind and senses from outer things towards a contemplation of one's inner reality (Wig 1990). Thus, what is striking about traditional mental health care is that there is no separation of the mind and body in understanding illness and its treatment.

Since Independence, India has been progressively developing the infrastructure for basic health services. The overall goal as originally stated in the Bhore Committee Report and reiterated in policy documents periodically. Indira Gandhi in May 1981, while addressing the World Health Assembly, recalled this by saying that the goal should be: 'to go to homes instead of gravitating towards centralized hospitals in large numbers. Services must begin where people are and where problems arise'. The growth of general health services shifted from the vertical programmes of the 1950s to an integrated health service in the 1970's. The current norm is one sub-centre for every 5,000 population with one male and female health worker, and one primary health centre for every 30,000 population. The role of the health worker and health centres is to provide comprehensive preventive, promotive and curative services. It is against this background of the development of health policy in the country that the formulation of the National Mental Health Programme for India and the development of mental health have to be viewed (Government of India, 1982).

HISTORICAL DEVELOPMENT OF MENTAL HEALTH

Development of mental health services in Colonial period

It was during Lord Cornwallis's tenure (1786-1793) that there is a first reference to a mental hospital in Calcutta in 1787 (Sharma and Verma 1984)[16] – this hospital was established by the English surgeon Dr. George M. Kenderline, which however, ended propitiously some time later (Mondal, P 1996)[17]. In 1795, another mental hospital was established at Monghyr (Bihar), this was primarily meant for mentally disturbed soldiers. In 1794, the mental hospital at Kilapauk (Madras) was built. It was only in 1817, that Sergeant Bredmore tried to improve the conditions of the mental patients in Calcutta – this hospital had fifty to sixty European patients living in clean and pleasant surroundings. The therapies included opium, hot baths, bloodletting and blistering. Music as a form of treatment was carried out at the mental hospital established in Dacca in 1885. In Southern India, the gradual expansion of the British influence led to the establishment and expansion of these hospitals. In Western India, The first mental hospital was established at Colaba (Bombay) in 1806.

After the 1857 rebellion, the British Crown succeeded the East India Company as rulers of India. In 1858 the Lunacy act was enacted, detailing the procedures for the establishment of the mental hospitals and for admitting patients. This Act was further modified in 1888 resulting in greater details and

[16] Sharma, S. and Varma, L.P. (1984): Ministry of Mental Hospitals in Indian Subcontinent, *Indian Journal of psychiatry*, 25 94), 295-300.
[17] Mondal, Parthasarthy (1996): The Mental Hospitals and Colonialism in India, The Indian Journal of social Work, Vol. 57, Issue 4, Oct 1996, pp591-604.

guidelines for admission and treatment of 'criminal lunatics'. After 1858, there was a more determined expansion of colonized India and more mental hospitals were established in eastern India in the next twenty years. By 1874, in this region there were six mental hospitals at Calcutta, Patna, Berhampur, Dallunda, Cuttak and Dacca. In the Madras presidency, new ones were established at Waltair (1871), Tiruchirapalli (1871), and again in Madras (1871). In the Bombay presidency, six more such institutions were established at Colaba, Poona, Dharwar, Ahmedabad, Ratnagiri and Hyderabad. The one at Colaba was mainly meant for the Europeans with 285 beds. In 1876, a new mental hospital was opened at Tezpur after the separation of Assam and Bengal; the central provinces also witnessed similar expansion – Jabalpur (1866), Elichpur (1866), Banaras (1854), Agra (1858) and Bareily (1862).

It was, may be, owing to adverse publicity and growing problems in these institutions that the early twentieth century witnessed some healthy improvements in what were now actually called mental hospitals (previously they termed as lunatic asylums). By 1906, it was contemplated to have a central supervision of these hospitals. After the decision of Lord Morley, the charge of the mental hospitals shifted from the Inspector-General of Prisons to the Civil Surgeons of the Indian Medical Service. The second historical change was in the appointment of psychiatrists as full-time medical officers of these hospitals. In 1912, the establishment of the Central European Mental Hospital at Ranchi in 1918 closely followed the enactment of the Indian lunacy act. Much later, in the decade before independence, stress was again laid on the improvement of the

conditions. In 1946, the Bhore Committee Report revealed the existence of seventeen mental hospitals with 10,189 patients all living in terrible conditions.

It will be useful here to briefly trace the treatment facilities in these institutions, which so rapidly proliferated. The Calcutta (1856) and Dullunda (1857) Reports emphasised the importance of good diet, smoking, and interaction with "sensible" people, recreational activities, amusement, and visits to the local marts and fairs (with keepers, of course). Accommodation was minimal and one of the main improvements was the provision of wooden platforms to be used as beds in the Dacca hospital in 1872. In the latter half of the nineteenth century, considerable attention was given to the use/ non-use of restraints in the mental hospitals. The Calcutta (1856) and Dullunda (1857) reports state that although mechanical restraints remained, chains and manacles were reserved for cases of extreme violence, and that it was preferable to subdue European patients with impersonal mechanical devices than to humiliate them by being controlled physically by native attendants (Weise, 1983)[18]. The majority of the patients were from the lower orders and the use of labour as a therapeutic modality was much publicised, not merely because of the disciplinarian discourse of the European institutions but also to justify the use of mental labour at cheap rates, and by saying that the European patient scorned labour. Other aspects of treatment varied throughout India. Some drugs such a digitalis and hydrata of chloral were occasionally used in the Delhi and Ahmedabad hospitals (Weise

[18] Weiss, M. (1983): The Treatment of Insane Patients in India in the Lunatic Asylums of the Nineteenth Century, *Indian Journal of psychiatry*, 25 (4), 312-316.

1983). Electrical shocks were first tried at Dullunda but soon after, in 1873, it was stopped owing to some technical hitches. An innovation in therapy was the Gheel system of boarding out patients in Dacca between 1860 and 1870. For those whom it was felt safe, arrangements were made to live in the home of 'responsible' persons, where periodically the medical officers of the mental hospital checked them. This method was financial success but the fear remained, amongst the hosts, that they would be held responsible should the patient escape. The treatment facilities and conditions were, therefore, very much unsatisfactory and inhumane, as it is, surprisingly (?), also the case today with many mental hospitals in India (Government of India, 1984).

Actually the developments of mental hospitals in India both in terms of treatment and concepts broadly followed the pattern in Britain and Europe. The eighteenth century in Britain and Europe can be Psychiatrically termed the era of confinement (Kaplan and Sadock, 1985)[19]. With the rise of liberalism in the economy and Puritanism in religion, labour became equated with morality and idleness with sin. The mentally disturbed, thus, together with other non-productive people, were made the outcasts of society. This Puritanism and economic motive led to the development and strengthening of the mental hospitals as an institution for social control. But the late eighteenth and nineteenth centuries saw reforms in the treatment of the patients. Tuke, Pinel and Chiarugi tried to find ways of 'alleviating' the suffering of the patients and

[19] Kaplan, H.I. and Sadock, B.J. (1985): *Comprehensive Textbook of Psychiatry*, Baltimore: Williams and Witkins Publications.

'kindness', 'understanding', and 'freedom' from mechanical restraints were emphasised.

Before Independence, there were no clear strategies for the care of the mentally ill. The approach was largely to build 'asylums' which were custodial rather than therapeutic centres. According to the report of the health survey and development committee, 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. There is gross inadequacy in the medical personnel in all the Mental Hospitals both numerically and in specialised qualifications. Most of the Medical Officer 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.

The situation with regard to mental health services at the time of Independence is clearly illustrated in the recommendations of the Bhore Committee as," Even if the proportion of mental patients is taken as two per thousand population in India, hospital accommodation should be available for at least 8,00,000 patient's as against the existing provision for a little over 10,000 beds for the country as a whole. In India, the existing number of mental hospitals bed is in the ratio of one bed to about 40,00 population, while in England, the corresponding ratio is approximately one bed to 300 population" (GOI, 1946).

The situation in 1991, over forty years later, is little different; although the number of hospital beds has increased to about 22,000, the bed: population ratio remains the same due to a concurrent increase in the population.

However, the last four decades stand out as a period of immense activity in the field of planning and research in mental health care. The scenario has changed from a few isolated efforts to establish the magnitude of the problems during the early 1960s, to one of active efforts to reach beyond the confines of traditional psychiatry during the 1980s.

The place assigned to mental health in the public health programmes was modest during the first two decades. In the mid-1940s (Bhore, 1946), Col. M. Taylor's report called for improvements in seventeen mental hospitals and the establishment of seven new institutions within the following ten years. In addition, the need for training of medical and ancillary mental health personnel was emphasized. A visible result in the first decade after Independence (1950s) was the setting up of the All India Institute of mental health (AIIMH) at Bangalore for the training of psychiatrists, psychologists and psychiatric nurses. The Mudaliar committee reviewed the situation in 1962, which envisaged that within the next ten years psychiatric units would be set up in all district hospitals. Although almost thirty years have elapsed since, a majority of district hospitals in the country (with the exception of Kerala, Karnataka and Tamilnadu) do not have such units. The failure to meet targets is also visible in the dearth of departments of psychiatry in medical colleges.

Active thinking in this area marked the decade of 1970s. Concern for organizing mental health services was expressed in national and regional forums. Notable among these are the Indian psychiatric Society's seminars/workshops held at different places. The WHO- SEARO, New Delhi, organized a number of

meetings to consider this issue (WHO 1971,1974). Another reflection of this concern was the choice of mental health as the subject of four presidential addresses (Bagadia 1971)[20], (Jayaram 1972; Vidya Sagar 1973; Deb Sikdar 1974). All these efforts raised hopes of a possible breakthrough in this area and the development of mental health activities at the national level.

Of the concerns expressed and the suggestions made, two views emerged: first, the recognition by all that trained mental health professionals alone would be inadequate to meet the growing needs; and second, the need to develop services beyond mental health institutions. This was expressed clearly in a number of ways. Two examples will be illustrative of these points:

> *Even if all the five-year plan efforts in the field of health were only geared to increasing the number of psychiatric doctors, it.... would be impossible to provide an adequate number of hospital beds and mental specialists even in the next 50 to 1000 years... even if the training facilities in the country are doubled and trebled, which is not easy, it could still require nearly 100 years to provide an adequate number of psychiatrists for working in the curative field* (IPS 1964).
>
> *One of the most important elements in the delivery of health care in India is the primary health centre. Up to now PHCs have not been developed to their full potential, but as trained staff and supplies become available, they will become increasingly important elements in the delivery of health care, and as soon as possible the opportunity should be taken to provide mental health care at and from these*

[20] Bagadia, V.N., Presidential Address, Indian Psychiatric Society Conference, Madurai (1971).

centres, through the multidisciplinary team and by the use of other available staff, such as government medical officers, nurses, family planning workers and basic health workers, who have undergone suitable training (WHO1971).

It is significant to note that in a number of centres around the country, efforts were directed during the second half of the 1970s to operationalize these suggestions in the form of pilot community mental health programmes. During the 1980s the National Mental Health Programme of India was formulated, with emphasis on integration of mental health care, improvement in mental hospitals, enhanced training in medical colleges and initiatives from the voluntary sector.

PSYCHIATRIC FACILITIES

To date, the mental health institutional infrastructure in India consists primarily of mental hospitals alone. There are 42 institutions in the country, with a total bed capacity of about 22,000 beds. This too is grossly inadequate when compared globally. For example, Holland with a population of 15 million has more than the total number of beds for mental patients in India. The cities of Tokyo and New York each have more psychiatric beds than are available in the whole country. In addition, about one third of mental hospital beds are located in four hospitals in Maharashtra. There are no mental hospitals in the states of Haryana, Himachal Pradesh, Manipur, Meghalaya, Arunachal Pradesh, Mizoram and the Union Territories of Andaman and Nicobar Islands, Chandigarh, Pondicherry and Lakshadweep. Of the existing beds in mental hospitals, more

than 50 per cent of the patients occupy them for a longer period than the likely need for them. Furthermore, a very low level of professional staffs as well as extremely limited facilities for rehabilitation and specialized care characterizes these hospitals.

During the last ten years the unsatisfactory conditions of mental hospitals has been the subject of public interest litigation at Ranchi, Trivandrum, Delhi and Pune. Although one still hears such observations as: patients are made to lose all sense of human dignity; they are treated not better than cattle, etc., there have been positive developments in the hospitals at Trivendrum, Ranchi, Delhi and Pune. The demand for better services in the institutions is, in a sense, an important reflection of the growing awareness of the general public and the changed perception of these hospitals as treatment centres rather than centres for custodial care alone.

With regard to mental health manpower and training facilities, there were only a handful of psychiatrists and no recognized facility for training psychiatrist within the country at the time of Independence, the first effort was the establishment of AIIMH at Bangalore in 1954. From January 1955, diploma courses in psychological medicine were started. At present, about three-dozen centres provide training for DPM and MD courses. It is estimated that over 150 psychiatrists qualify annually and there are currently about 1,500 psychiatrists in the country.

Training facilities for clinical psychologists are available at Ranchi, Bihar and Bangalore, and there are about 400 to 500 clinical psychologists working in

the country. Training facilities for psychiatric social workers are currently available in Bangalore alone, and only twelve professionals are trained annually. Psychiatric nurses are trained at Bangalore and Ranchi, which offer a diploma course of duration of ten months. At Delhi, Bangalore and Chandigarh, a two years (M.Sc.) postgraduate course in psychiatric is available. The total number of psychiatric nurses in the country is estimated to be 500.

COMMUNITY PSYCHIATRY APPROACH

In India mental illness is viewed as a curse and mental treatment is perceived to be confinement in a lunatic asylum. This results in the inhuman treatment of patients by society and neglect by the mental health services. Half the available bed capacity-which is less than 1/30th of a bed per thousand population- is blocked by patients who have either been cured or no longer require hospitalisation, but have been neglected by their relatives. The modern psychiatric approach tends to fail, as their methods of delivery of services are largely unsuited, with limited specialist manpower and material resources.

The range and intensity of mental ailments is much broader than is fathomed by the common mind. According to the Directorate General of Health, roughly 10 millions people are afflicted with serious mental health disorders. Figure for neurosis and psychiatric disorder are two to three times higher. New cases of serious mental disorders are estimated at 35 per thousand. Mental retardation is estimated at 0.5 percent to 1 percent of all children. One to 2 percent of all children suffer form learning and behavioural disorders. Alcohol and drug related

problems reveal an alarming growth. A staggering 60 to 70 million people in India require mental health care. However, the infrastructure and trained personnel required to cope with this demand are sadly lacking.

The psychiatric approach has hitherto been deeply rooted in Western cultures. There is tendency to focus clinically on mental illness rather than humanely on mental health. Many mental hospitals are essentially custodial rather than therapeutic institutions, and are no different from prisons.

In the West, the humane approach to managing the mentally ill had begun in the late 18th century with the efforts of Phillippe Pinel, superintendent of two large asylums in Paris where the mentally ill, mentally retarded and criminals are chained and housed. Pinel liberated the mental patients from their chains and initiated a humane approach. The recent trend in psychiatric care, however, is to synthesize the humane ideas of Pinel with Freudian Psychoanalysis. The discovery of chlorpromazine and a series of other psychotropic drugs and the consequent de-institutionalisation in the 1950s brought about what is termed as a community psychiatry movement.

Till the 1960s, mental health services in India were centered in the mental hospitals though a breakthrough was made in terms of research, training and overall quality of services. In 1957, the veteran psychiatrist Vidya Sagar transformed the Amritsar Mental Hospital into a centre of humane and liberal treatment. He involved the relatives of the patients in looking after them. They were invited to stay with them and in the process were familiarized with the principles of mental health, which they could then take back to the community.

The first step in the non-institutional management of the mentally ill in India was the setting up of general hospital psychiatry units. Initially they were established in general hospitals attached to medical colleges but later psychiatric units came up in both governmental as well as private or missionary general hospitals. Currently, in most states, the general hospital psychiatry units are situated in the state capitals or other big cities, but in at least two states (Kerala and TamilNadu) every hospital at the district headquarters has a psychiatric unit.

The introduction and expansion of psychiatric care in general hospitals has brought about a change of outlook, both from the professional and public points of view, in terms of general public acceptance, as well as training of mental health professionals and research workers.

The new approach has a number of advantages over traditional mental hospitals. For instance, general hospital facilities are more acceptable and easily approachable. Families can visit and relatives can stay with the patients. There is no stigma attached and there are no legal restrictions on admissions or treatment; and proximity to other medical facilities ensures thorough physical investigations and early detection of associated physical problems. This method of treatment, because of limited patient facilities, has brought in ambulatory care and has broken the myth that mental illnesses can be treated only in closed mental hospitals. Hospital based psychiatry is thus being replaced by a larger community based mental health movement.

Although services for the mentally ill considerably improved over the past three decades, most of these services were available in urban areas, catering to a

small proportion of the needy population. There was a need to evolve cost-effective alternative approaches of mental health care, which would be decentralized and integrated with general health care to provide basic mental health care. During the mid-1970s, two centres in the country - Department of psychiatry at the Postgraduate Institute of Medical Education and Research at Chandigarh and the National Institute of mental Health and Neurosciences, Bangalore, initiated pilot programmes on community-based mental health care.

The basic approach of the programme is to integrate mental health with the existing primary health care services by training the existing personnel, i.e., the doctors and the multipurpose workers, in public mental health care. With the inclusion of mental health in primary health care, the multipurpose health workers are now trained for early recognition of all severe mental disorders and epilepsy in the community; referral of the identified patients to the primary health centres; regular follow-up of such patients in the community with feedback given to the doctors at the PHC; education and the motivation of the patients' families and neighbours to look after them with sensitivity; and management of psychiatric emergencies when the doctor is not available. The PHC doctors are trained to diagnose and manage severe mental disorders, both acute and severe; refer difficult cases for specialist opinion to district hospitals and receive them back for further follow up; and supervise and guide the multipurpose workers.

Following the feasibility exercises, pilot training programmes for PHC personnel, regular training programmes for different categories of personnel, and

the development of manuals are taking place at NIMHANS. Follow-up has been extremely positive. However, the need for an adequate supply of drugs for long term management and careful monitoring were seen to be necessary.

Mental health has traditionally received the least priority in nation and state health planning. Health planners, administrators and medical professionals are unaware of the widespread morbidity caused by mental illnesses. The wide-ranging misconceptions have resulted in poor demand for modern services and under utilization of the limited available services. To fulfil the requirements of mental health care, the National Mental Health Programme (NMHP) proposes to train medical health officers to manage cases at the periphery and enable them to identify mental illness and follow up the treatment recommended by trained specialists who periodically visit remotely located centres. With the help of health workers, social workers and volunteers, the people are sought to be educated on mental illness and a greater awareness is generated among general practitioners, the patients, their relatives and local social workers.

The psychiatry approach, which offers the answer to the widespread malaise of mental illnesses, thus has the additional advantage that it can relate to the Indian context. Despite the breakdown of social ties and norms, the family and society remains the pivot of Indian social structure. Through their participation and with the provision of essential health services and requisite know-how, mental health services can show promising.results.

PROBLEMS IN EXISTING MENTAL HEALTH SERVICES AND NEEDS

There has been a strong influence of the mental health movements in the west on the development of mental health movement in the country. The transferability of these models to our own setting needs to be examined and there is a need to develop culturally appropriate treatment strategies so as to make it more acceptable to the community.

Variability is the most challenging issue here. A standardised form of care is lacking. There is variability in care, approach, and vision and in availability and allocation of resources. This kind of variability is not only between institutions but also occurs within the same institution itself. Looking at what is useful is self-scrutiny and external scrutiny, public awareness and conscious of their rights.

Different systems of mental health care are available here: folk healing, Ayurveda, Unani, Homeopathy, Allopathy, naturopathy etc. It is estimated that folk healers cater considerable proportion of cases and they are available at the rate one per thousand. One of the major drawbacks is that there is no systematic effort to analyse their data and the evaluation of benefits and risks. Ayurvedic system is rich with its elaborate phenomenology and culturally appropriate hygienic measures for the promotion of mental health, but at the same time there have been no organised studies available evaluating the efficacy of Ayurvedic system of treatment. The same is the case with homeopathy and Unani systems of mental health care.

Modern medicine of mental health care is mainly in the settings of mental health hospitals, general hospitals and private nursing homes. They are different in terms of facilities, hygienic conditions, record keeping, admission and discharge policies. Usually patients are discharged within a period of 2-8 weeks and one can imagine the situation where rehabilitation services in the community are totally lacking. The subhuman conditions in the mental hospital facilities are gross violation of human rights and there is an urgent need to improve the quality of mental health services in the mental hospital setting.

Lack of properly qualified and trained mental health personnel and the peculiar nature of the work has been one of the major impediments in discharging quality mental health care. The care of interdisciplinary coordination has been striking. Not only there has been an uneven growth in the status and manpower development of different professionals but also there is a lack of integration of services of different mental health professional such as psychiatrists, psychologists and psychiatric social workers. To a large extent, each professional group has developed its own 'area' excluding others at times competition with other professionals.

Management guidelines are essential to improve the quality of care. There are no set guidelines followed in the management of mentally ill.

Documentation is nil, inadequate or incomplete without which it will be difficult to make proper evaluation of the treatment programme.

Wide variability in undergraduate and postgraduate training especially in the duration of training, supervision, student involvement and examination is one of the areas, which requires immediate attention.

Lack of properly designed epidemiological and evaluative research has been a major drawback in organising programmes and setting up policies. Since we do not have epidemiological data, we have to make use of the available data from the community information systems, and epidemiological data to be generated for all the major mental health problems at the national and state levels.

The leadership from the non-medical mental health professionals in terms of developing non-medical models for issues of rehabilitation, drug dependence, child mental health related areas have been far from satisfactory. These issues cannot be left as it is, as future development has to include a large component of non-medical models and interventions. Specific and focused efforts have to generate this leadership as well as involvements of these professionals.

There are number of innovative initiatives taken by private sector. The notable is crisis intervention, rehabilitation of the mentally ill, cases of the elderly, street children, etc. However, most of these have been at the local levels with small-scale experiences without adequate evaluation. It is very important that the NGO development is given greater importance both for its growth, direction and for its place in the over all mental health care programmes.

What is obvious from the preceding discussion is that the since colonial times the development of mental institutions in India was guided by motives and underlying assumptions suitable to the government of the time. The colonial

governments preoccupations were generally an outcome of the need to provide some form of mental treatment for itself whether it was the military or later the British administrators. There was no attempt to understand or to formulate a policy or develop an institution, which would take care of the masses. Naturally the method of treatment followed concepts and ideas suitable to the Europeans and hence the emphasis was on western methods of analysing the problem and treating it. Although there were some experts who also tried to analyse the problem from the viewpoint of masses, no definitive follow-up actions were taken. After independence there was an attempt to understand the problem from a people's perspective approach, which are reflective in various committee report and recommendations. These initiatives and recommendations led to some fruitful developments and also the extension of the mental services to areas more accessible to the masses. Also there was a shift in the approach towards mental health, which took into account the specifities of the Indian subcontinent. The next chapter takes a look at the various reports and recommendations that ultimately lead to the formation of a National Mental Health Policy (1982).

CHAPTER - IV

MENTAL HEALTH PROGRAMME AND POLICY IMPLICATIONS

MENTAL HEALTH: PROGRAMME AND POLICY IMPLICATIONS

INTRODUCTION

The physical and mental health of an individual is inter-related and no health programme can be considered complete without adequate provision for the treatment of mental ill 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 minimum of discomforts to others. He will not allow himself to be overwhelmed by the stresses and strains inseparable from ordinary existence. In this context, 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.

WHAT ARE MENTAL HEALTH POLICIES?

Mental health policies are statements by governments or health authorities that aim to formulate clear and relevant objectives for the prevention, treatment, care and rehabilitation related to mental disorders.

- To reduce the number of people who develop mental health problems
- To assist those with mental disorders improve their overall quality of life
- To eliminate the stigma associated with having mental or emotional problems
- To provide effective interventions to all in need

- To promote ongoing research into the causes and treatment of mental disorders

Why are mental health policies important?

Mental health policies are important because they coordinate, through a common vision and plan, all programmes and services related to mental health. Without this type of organization, mental disorders are likely to be treated in an inefficient and fragmented manner.

What are the main elements of a comprehensive mental health policy?

Mental health policies touch upon many aspects of health systems, such as how funds should be distributed across different types of services, and what sort of medications and other supplies should be made available. All mental health policies are anchored by four guiding principles:

Access: The right to obtain treatment should depend on need for services, not ability to pay or geographic location.

Equity: Mental health care resources should be distributed fairly across the population at large.

Effectiveness: Mental health services should do what they are intended to do: improve health status.

Efficiency: resources should be distributed in such a way as to maximize health gains to society.

POLICIES IN INDIA

BHORE COMMITTEE REPORT (1946)

Before Independence there were no clear strategies for the care of mentally ill. The approach was largely to build 'asylums' which were for custodial care rather than therapeutic or rehabilitation centres. The colonial Government in 1943 under the chairmanship of Sir Joseph Bhore set up the Health Survey and Development Committee[21]. Pre -Independence situation according to Bhore Committee: "Even if the proportion of mental patients is taken as two per 1,000 population in India, hospital accommodation should be available for at least 8,00,000 mental patients, as against the existing provision of a little over 10,000 beds for the country as a whole. In India, the ratio of one bed to about 40,000 population, while in England, the corresponding ratio is approximately one bed to 300 population."(GOI, 1946)

This committee's recommendation provided an almost revolutionary alternative to the existing system in the country. The guiding principle of the committee were: (1) no individual should fail to secure adequate medical care because of the inability to pay for it; (2) health programmes must, from the beginning, lay special emphasis on preventive work; (3) the need is urgent for providing as much medical and preventive care as possible to the vast rural population of the country because they receive medical attention of the most meagre descriptional though they pay the heaviest toll when famine and pestilence sweep through the land (4) the doctors of the future should be a social

[21] Government of India Report (1946): *Report of the Health Survey and Development Committee*, Delhi, Manager of Publications.

physician attracting the people and guiding them to healthier and happier life. The major recommendation was for the setting up of infrastructures of rural areas with primary health centres as the main focus.

The Report made various recommendations to improve mental health services in India. In putting forward proposal and recommendations the committee viewed that the most important step to be taken is the formulation of a mental health programme for the country after preliminary investigations of the mental health needs. The committee also proposed that 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 needs 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 objectives in view the committee made following recommendations for the short-term programme. The committee's proposal for Mental Health care were:

- The creation of mental health organizations as part of the establishments under the Director General of Health Services at the centre and of the Provincial Directors of Health Services;
- The improvement of the existing 17 mental hospitals in British India and establishing two new institutions during the first five years, and of five more during the next five years;

- The provision of facilities for training in mental health for medical men in India and abroad, and for ancillary personnel in India, and
- The establishment of a department of Mental Health in the proposed All-India Medical Institute.

MUDALIYAR COMMITTEE REPORT (1962)

The Mudaliar Committee[22] reviewed the progress made in mental health, subsequent to the Bhore Committee, over a period of nearly two decades, in the following words: "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 against the total need of the number of beds available in mental hospitals in India is only 15000. There is hardly any provision for the education of mental defectives. Provision for the treatment of psychosomatic diseases in general hospitals is inadequate."(GOI 1962)[23].

The recommendations were made in three heads, viz., general, training, and research. In the curative field, the committee recommended the setting up of in-patient and outpatient departments at lay hospitals, independent psychiatric and mental health clinics, and institutions for the mentally ill.

The Committee also stressed the need for training mental health personnel, orienting professional groups (like Paediatrician, school teachers, nurses and administrators) in mental health care and orienting medical and health personal in mental health.

[22] Government of India, Report of Health Survey and Planning Committee, pp. 87-88 (1962).
[23] Mudaliar, A.L., "Health Survey and Planning Committee", Government of India, 1962, New Delhi.

SRIVASTAVA COMMITTEE (1974)

Active thinking in the area of mental health marked the decade of the seventies. The document plans for immediate action does not contain any specific proposals for developing mental health programmes. One of the important outcomes of Srivastava Committee's recommendation was the Community Health Volunteer (CHV) Scheme. The training of the CHVs contained a component for mental health. One of the twelve chapters in the CHV manual was also devoted to the recognition and management of mental health emergencies and problems. The Committee recommended that one-hour (out of the total training of 200 hours of community health workers) be devoted to mental health.

ALMA ATA CONFERENCE (1978)

This was the international conference in which India took an active part, has come to be recognised as the turning point in the organisation of health services. The term "Health For All" has become the focus of much activity and reorientation of the health programmes around the globe. In view of this the inclusion of Mental Health as part of primary health care by this conference as one of the eight essential components of primary health care is significant. " Education concerning prevailing problems and the method of identifying, preventing and controlling them: promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation- maternal and child health care including family planning; immunisation against major infectious diseases;

appropriate treatment of common diseases and injuries; PROMOTION OF MENTAL HEALTH and provision of essential psychotropic substances."

PAI COMMITTEE REPORT (1979)

Pai Committee report[24] emphasised the need for improving the existing conditions of three Mental Hospitals of the Kerala State. The committee observes, " In the wake of the increasing urbanisation and the clamour for competition, stresses and strains of modern life the incidence of psychological and psychiatric problems are on the increase. Advances have also been made in the understanding as well as the treatment of the diseases... The status of the mental hospitals should be raised so as to serve not only as a curative institution but also a centre for training and research... In all District Hospitals Psychiatric Units with both inpatient and outpatient facilities should be available." An out patient cubicle and 15 beds in the Intermediate hospital and a treatment room for carrying out special forms of therapy have been recommended.

NATIONAL HEALTH POLICY (1983)

The National Health Policy[25] was formulated and adopted in 1983 providing comprehensive framework for planning, implementation and monitoring of health services. Successive plans have evolved and implemented intervention programmes to achieve the goals set in the National Health Policy.

[24] Draft Mental Health Policy for Kerala State (1990): Government of Kerala.
[25] Government of India, National Health Policy, MOHFW, New Delhi, 1983.

In 1983, the National health policy suggested that a "special well-coordinated programme should be launched to provide mental health care as well as medical care, and also the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, infirm and the aged." (GOI 1983)

KRISHNAMOORTHY COMMISSION (1983)

On 15th March 1983 V. Krishna Moorthy was appointed by the Government of Kerala to conduct an enquiry into the working of Mental Hospitals of the State. Krishna Moorthy observed that revolutionary changes are taking place in the area of mental health care both at conceptual and the operational levels. It is essential that we should formulate our strategy for tackling the mental health problem in keeping up with these changing trends and ideas in the field. The utility of continuing the existing institutions of mental health and the methods of treatment, in their present form should be subjected to a thorough re-examination. Of course, any radical change is likely to be strongly resisted because as observed by Leonard. J. Robert L. Leopold (Social Problems: A Modern Approach). Institutions' tend to perpetuate themselves in order to fill needs other than those for which they were designed. ...All too often decision to preserve existing institution is made for the sake of people other than the patients." This institutional form of resistance to change, which has recently been described as " organisational sclerosis" has first to be overcome by the policy makers, who should take care to bring to bear on the issues involved lucid and original ways of thinking and problem solving methods. The first step in this

direction would be changing the concept of monolith mental care centres and to establish three-tier institutional set up consisting of: (a) Acute treatment units (b) intermediate care units and (c) long term care units.

Commenting on the implementation of the National Mental Health programme, Krishna Moorthy points out that the mental health care would get decentralised and it would expand to cover the whole country. The new functional infrastructure, which would be created for the scheme, can also be utilised for community oriented rehabilitation work and for the follow up care of the discharged mental patients would help to reduce the number of admissions to mental hospitals and the incidence of chronocity. With effective field work and educational programmes the mental health field staff can enhance the social acceptability of the cured mental patients. The programme may therefore be implemented with full vigour in the State. He also recommends that while implementing the scheme the following proposals may be taken into account.

1. The names of the discharged mental patients and others identified as mental patients may be registered in each primary health centre and identity card issued to them. The cardholder may be given prescribed medicines and drugs in free of cost price. Pending finalisation of arrangements thorough primary health centres the free supply of medicines may be arranged through District and Taluk Hospitals.
2. Mental Health Centres may be established in District Hospitals for periodic check up of discharged patients and to suggest a further course of treatment if any, necessary.

3. The field staff of National Mental Health programme may be entrusted with the task of collecting and reporting accurate data regarding mental health problems in the State. Arrangements may be made at the State level to collect and process the data and to publish them periodically"

FIVE-YEAR PLANS (1950-1984)

The Five-Year plans provide a glimpse of the importance attached to the mental health services in the overall development of the country as well as the measures taken to organise services. The impression one gets on reading the plan documents and the fund allocation presents a picture of relative low importance to mental health services.

TABLE.1: OUTLAYS FOR"MENTAL HEALTH" IN FIVE-YEAR PLANS

First Five Year Plan:	Rs. 0.094 crorers
Second Five Year Plan:	N.A.
Third Five Year Plan:	Rs. 0.25 crores
Fourth Five Year Plan:	
Mental Health	Rs. 2.00 crores
Estb. Of Psych. Clinics	Rs. 0.50 crores
Fifth Five Year Plan:	
A I M H, Bangalore	Rs. 0.50 crores
Estb. Psych. Clinics	Rs. 1.00 crores

(Source: ICHI Report)

SIXTH FIVE-YEAR PLAN

The Sixth plan in its planned targets to be achieved in the next twenty years proposed to identify and provide urgent treatment to those with mental disorders as follows: " under the heading of Mental Health, 20% population coverage is expected by 1985, 50% by 1990 and 75% by the year 2000 A.D. This refers to the case detection and treatment." In addition, the proposed plan included 64.23 lakhs for control of drug abuses in the category of new schemes and 8.30 lakhs for NIMHANS, Bangalore.

NATIONAL MENTAL HEALTH PROGRAMME (1982)

The National Mental Health Programme[26] (Government of India 1982) is the outcome of the developments in providing mental health care through different methods as well as overall goals of health care goals in general.

TABLE.II: COMITTEES AND ITS RECOMMENDATIONS

Committees	Recommendations
Bhore Committee Report (1946)	• The creation of mental health organizations as part of the establishments under the Director General of Health Services at the centre and of the Provincial Directors of Health Services; • The improvement of the existing 17 mental hospitals in British India and establishing two new institutions during the first five years, and of five more during the next five years; • The provision of facilities for training in mental health for medical men in India and abroad, and for ancillary personnel in India, and • The establishment of a department of Mental Health in the proposed All-India Medical Institute.

[26] See next chapter, " NMHP and Jahangirpur Experience of DMHP".

Mudaliar Committee (1962)	• The recommendations were made in three heads, viz., general, training, and research. • In the curative field, the committee recommended the setting up of in-patient and outpatient departments at lay hospitals, independent psychiatric and mental health clinics, and institutions for the mentally ill. • The Committee also stressed the need for training mental health personnel, orienting professional groups (like Paediatrician, school teachers, nurses and administrators) in mental health care and orienting medical and health personal in mental health.
Srivastava Committee (1974)	• The document plans for immediate action does not contain any specific proposals for developing mental health programmes. • One of the important outcomes of Srivastava Committee's recommendation was the Community Health Volunteer (CHV) Scheme. The training of the CHVs contained a component for mental health. One of the twelve chapters in the CHV manual was also devoted to the recognition and management of mental health emergencies and problems. • The Committee recommended that one-hour (out of the total training of 200 hours of community health workers) be devoted to mental health.
National Mental Health Programme (1982)	• To ensure the availability and accessibility of minimum mental health care for all in the foreseeable future, particularly the most vulnerable and unprivileged sections of the population. • To encourage the application of mental health knowledge in general health care and social development. • To promote community participation in developing mental health services, and to stimulate efforts towards self help in the community. • The specific approaches suggested for the implementation of NMHP are: a) diffusion of mental health skills to the periphery of the health service system, b) appropriate appointment of tasks in mental health care, c) equitable and balanced territorial distribution of resources, d) integration of basic mental health care within general health services, e) linkages to community development.
National Health Policy (1983)	• It suggested that a "special well-coordinated programme should be launched to provide mental health care as well as medical care, and also the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, infirm and the aged." (GOI 1983)

District Mental Health programme (1996)	• To provide sustainable basic mental health services to the community and to integrate these services with other health services. • Early detection and treatment of patients within the community itself. • To see that patients and their relatives do not have to travel long distances to go to hospitals or nursing home in cities. • To take the pressure off from mental hospitals. • To reduce the stigma attached towards mental illness through change of attitude and public education. • To treat and rehabilitate mental patients discharged from the mental hospital within the community. (b) Brief description of the scheme: • The state will set in motion the process of finding suitable personnel for manning the District Mental Health Team. They can take in service candidates who are willing to serve in this pilot project and provide them the necessary training in the identified institution. • Catchment Area will be the patients from the district itself and adjoining areas. • District Mental Health Team will be expected to provide service to the needy mentally ill patients and their families as follows: Daily out patient service, ten bedded in service facilities, referral service, liaison with Primary Health Center, provide follow up service & also community survey if feasible. Also remove stigma of mental illness by creating awareness in the community.

OTHER DEVELOPMENTS

Another recent development is the drug dependence control programme developed since 1986. This was a follow up of the acceptance of the Narcotics drugs and Psychotropic Substances (NDPD) Act 1985, and the growing prevalence of the use of 'hard' drugs like heroin. The salient features of the programme are:

1. Setting up of de-addiction centres;
2. Training of personnel;
3. Support to voluntary agencies for de-addiction care;

4. Monitoring the use of drugs in the country-special centres has been set up at Delhi, Chandigarh, Bangalore and Pond cherry for the purpose. The development of services for the mentally retarded has gradually moved away from the area of mental health. In fact, the Mental Health Act (1987) excludes mentally retarded persons from its ambit. A National Institute for mentally handicapped was set up in 1984. The current policy is to train in-service teachers, develop training and educational materials and provide legislative and other support for the mentally handicapped individuals. The Person with Disabilities Act[27] was enacted in 1995.

Health policies and programmes have significant role in shaping health services system and care. In this chapter an attempt is made to review the mental health programmes and policy since independence. It is evident from the report of all committees that in the field of mental health, our achievements are not satisfactory. Although all the committee reports emphasise the need to improve the mental health services with its various recommendations, there is no serious attempt to improve mental health services in India. In this context, the National Mental Health Programme (1982) was a major development in providing mental health care through different methods as well as overall goals of health care in general. Since 1996, no major steps were taken for the implementation of NMHP. Pressure from various agencies led to the formation of District Mental Health Programme (DMHP) as pilot projects. At present, it is operational in 22

[27] Government of India, " The Persons with Disabilities Act", Ministry of Social Justice and Empowerment, 1995, New Delhi.

districts of 20 states. In the next chapter, an attempt has been made to understand and analyse the implementation of District Mental Health Programme under National Mental Health Programme.

CHAPTER - V

NMHP AND JAHANGIRPURI

EXPERIENCE OF DMHP

NMHP AND JAHANGIRPURI EXPERIENCES OF DMHP

NATIONAL MENTAL HEALTH PROGRAMME

The National Mental Health Programme (GOI 1982)[28] is the outcome of the various initiatives taken to provide mental health care through different methods as well as overall goals of health care in general. It aims at providing mental health care to the population utilizing the available resources.

It is estimated that 10 to 15% of the population suffer from some form of mental health problem. Qualified professionals providing mental health care are few and the outreach of services in rural area is very low. The Government of India initiated the National Mental Health Programme in 1982 with the objective of improving mental health services at all levels of health care (primary, secondary and tertiary) for early recognition, adequate treatment and rehabilitation of patients with mental health problems within the community and in the hospitals. However, the Programme did not make much headway either in the Seventh or Eighth Plan. Mental Hospitals are in poor shape. The States have not provided sufficient funds for mentally ill requiring inpatient treatment. The Supreme Court has directed the Centre and the States to make necessary provision for these hospitals so that the inmates do get humane and appropriate care. (Source: Ninth Five-Year Plan, Government of India)

[28] Government of India (1982): *National Mental Health Programme for India*, Ministry of Health and Family Welfare, Government of India, New Delhi.

The Central Council of Health and Family welfare recommended that: (1) mental health must form an integral part of the total health programme and such should be included in all national policies and programmes in the field of education and social welfare and (2) raising the importance of mental health in the course/ curricula for various levels of health professionals, suitable action should be taken to strengthen the mental health education component. A committee under the chairmanship of Dr. G. N. Narayana Reddy, Director NIMHANS, Bangalore submitted a plan for the implementation of the NMHP. The salient features of the Plan are:

1. Programme of community mental health at primary health care level in states/ Union territories.
2. Setting up of regional centres for community mental health.
3. Formation of National Advisory group on mental health.
4. Task force on mental health.
5. Prevention of mental illness and promotion of mental health.
6. Integration of multipurpose training schools in NMHP.
7. Involvement of voluntary agencies in mental health.
8. Mental health education for undergraduates.
9. Evaluation of community mental health programmes.
10. Preparation of manuals and records.
11. Training programmes for mental hospital staffs.

An out come of these recommendations was the order of 22nd September 1987 issued by the Government, which outlined the pattern of assistance for NMHP during the Seventh Five Year Plan to the states.

The Objectives of the programmes are:

- To ensure the availability and accessibility of minimum mental health care for all in the foreseeable future, particularly the most vulnerable and unprivileged sections of the population.
- To encourage the application of mental health knowledge in general health care and social development.
- To promote community participation in developing mental health services, and to stimulate efforts towards self help in the community.
- The specific approaches suggested for the implementation of NMHP are: a) diffusion of mental health skills to the periphery of the health service system, b) appropriate appointment of tasks in mental health care, c) equitable and balanced territorial distribution of resources, d) integration of basic mental health care within general health services, e) linkages to community development.

The Central Council of Health and Family Welfare has recommended that mental health should form an integral part of the total health programme, and should be included in all National policies and programmes on health, education and social welfare.

The Central Council of Health & Family Welfare reviewed the progress and resolved that the National Mental Health Programme should be accorded due priority and full-scale operational support (including social, political, professional, administrative and financial back up) are provided.

The National Mental Health Programme was started in 1982. During the Eighth Plan, NIMHANS developed a District Mental Health Care model in Bellary district with the following aims:

1. To provide sustainable basic mental health services to the community and to integrate these services with other health services;
2. Early detection and prompt treatment of patients;
3. To provide domiciliary mental health care and to reduce patient load in mental hospital;
4. Community education to reduce the stigma attached to mental illness;
5. To treat and rehabilitate patient's mental problems within their family setting.

It is proposed that during the Ninth Plan period the experience gained in implementing mental health care both in Central and State Sector will be utilised to provide sustainable mental health services at primary and secondary care levels and to build up community support for domiciliary care. IEC (information, education and communication) on mental health especially prevention of stress-related disorders through promotion of healthy lifestyle and operational research

studies for effective implementation of preventive, promotive and curative programmes in mental health through existing health infrastructure will receive due attention.

As decided in the meeting of the Central Council of Health in 1995 and as recommended by the Workshop of all the Health Administrators of the Country held in February, 1996, the District Mental Health Programme was launched in 1996-97 in four Districts, one each in Andhra Pradesh, Assam, Rajasthan and TamilNadu with a grant assistance of Rs. 22.5 Lakhs each. A budgetary allocation of Rs. 28.00 crores has been made during the Ninth Five Year Plan for the National Mental health programme.

The Programme envisages a community based approach to the problem, which includes (i) Training of the mental health team at the identified nodal institute within the State, (ii) Increase awareness in the case necessity about mental health problems, (iii) Provide services for early detection and treatment of mental illness in the community itself with both OPD and indoor treatment and follow –up of discharge cases, and (iv) provide valuable data and experience at the level of community in the State and Centre for future planning, improvement in services and research. The National Institute of Mental Health and Neurosciences, Bangalore is providing the training to the Trainers at the State level regularly under the National Mental health Programme.

The District Mental Health programme was extended to seven Districts in 1997-98, five more Districts in 1998 and six more Districts in 1999-2000. Thus this programme is under implementation in 22 Districts in 20 States.

(Source: Ministry of Health & Family Welfare.)

DISTRICT MENTAL HEALTH PROGRAMME

(Under National Mental Health programme 1996-97)

District Mental health Programme was successfully developed by NIMHANS, Bangalore in Bellary district of Karnataka near Bangalore, it is conceived as a model and adopted by the states for implementation.

(a) Objectives of the programme are:

- To provide sustainable basic mental health services to the community and to integrate these services with other health services.
- Early detection and treatment of patients within the community itself.
- To see that patients and their relatives do not have to travel long distances to go to hospitals or nursing home in cities.
- To take the pressure off from mental hospitals.
- To reduce the stigma attached towards mental illness through change of attitude and public education.
- To treat and rehabilitate mental patients discharged from the mental hospital within the community.

(b) Brief description of the scheme:

1. The state will set in motion the process of finding suitable personnel for manning the District Mental Health Team. They can take in service candidates who are willing to serve in this pilot project and provide them the necessary training in the identified institution.

2. Catchment Area will be the patients from the district itself and adjoining areas.
3. District Mental Health Team will be expected to provide service to the needy mentally ill patients and their families as follows:

   Daily out patient service, ten bedded in service facilities, referral service, liaison with Primary Health Center, provide follow up service & also community survey if feasible. Also remove stigma of mental illness by creating awareness in the community.

Currently the programme is under implementation in 22 districts in 20 states as follows:

STATE	DISTRICT	NODAL INSTITUTE
Andhra Pradesh	Medak	Instt. of Mental Health, Hyderabad
Assam	Nagaon	Guwahati Medical College
Assam	Gopalpara	Guwahati Medical College
Rajasthan	Seekar	SMS Medical College, Jaipur
Tamil Nadu	Trichi	Institute of Mental Health, Chennai
Arunachal Pradesh	Naharlagum	Govt. Hospital, Naharlagum
Haryana	Kurukshetra	Pt. B. D. Sharma PGIMS, Rohtak
Himachal Pradesh	Bilaspur	I. G. Medical College, Shimla
Punjab	Muktsar	Medical College, Amritsar
Madhya Pradesh	Durg	Mansik Arogyashala, Gwalior
Maharashtra	Raigrad	Institute of Mental Health, Pune
Uttar Pradesh	Kanpur	K G Medical College, Lucknow

Kerala	Thiruvananthpuram	Mental Health Centre, Tvm.
Kerala	Thrissur	Mental Health Centre, Thrissur
West Bengal	Bankura	State Mental Health authority
Gugrat	Navsari	Civil Hospital, Navsari
Goa	South Goa	
Daman Diu (UT)		
Mizoram	Aizwal	District Hospital, Aizwal
Chandigarh (UT)	District Hospital	
Manipur	Imphal East	State Mental Health Authority
Delhi	Chhatarpur	IHBAS, Shahdara, N.Delhi

DMHP JAHANGIRPURI

The District Mental Health Programme is being implemented as a pilot project, in Chhatarpur district (on Paper). The allocation for five years is by the central government for the programme is Rs 1.5 crore. This includes training, recruitment of staff, provision of medicines and IEC activities, etc. The nodal agency is Institute of Human Behaviour and Allied Sciences, Shahadara, New Delhi. In place of Chhatarpur District the programme was started in Jahangirpuri, at Babu Jagjiwan Ram Memorial Hospital, where IHBAS Community Outreach Unit, saying that Pradhan of Chhatrpur district was not ready for such programmes. However from December 2000, they have also started a unit of DMHP at Chhatarpur. Under the programme, a psychiatrist and social worker is posted at BJRM Hospital, Jahangirpuri, Delhi and psychiatric services are

implemented. But for the purpose of the present study only Jahangirpuri area was covered as the Chhatarpur programme was started in December 2001. A brief note on methodology follows.

METHODOLOGY

The study was done using observation technique (Psychiatric OPD at BJRMH) and nine in-depth case studies with patients visiting the psychiatrist. In observation, emphasis was on service delivery, doctor-patient relationship, infrastructure availability and problems in service delivery in the background of DMHP guidelines and objectives of DMHP and NMHP. Informal interviews were also done with 25 patients and 25 family members (care givers/ Family members) about the services available at BJRMH and their understanding and perception of mental health and illnesses.

SOURCES OF DATA

Both primary and secondary sources were used to gather information about the services rendered. Initially information was gathered through Ministry about the programme and its objective. Further information was collected from different studies and research papers from various sources. Information were collected from the field by administering case studies on selected eight patients and informal interviews with local people, patients and their family members, and service providers (Doctor and social worker).

SAMPLE AND SAMPLING

For the purpose of study nine patients visiting psychiatric OPD were selected. The basis of selection was their diagnosis by psychiatrist and their informed consent for case study. The informal interviews were done with patients and family members selected randomly waiting for their turn about the services and their perception of mental illness and health.

TOOLS OF DATA COLLETION

Structured and unstructured interview schedule and observation technique were mainly used to collect the information for the study. Apart from those, secondary data from various sources and in some cases informal unstructured interview was also carried out.

(A) Observation Technique: This was followed throughout the study from the services point of view to see services rendered by OPD keeping in background DMHP guidelines, local needs, and infrastructure availability. During home visit of patients for case study, observations were made of their living conditions and other demographic and socio cultural factors.

(B) Case study method: As this study is mainly based on the qualitative data, case study method has been administered with patients. Within the case study quantitative information were also gathered like monthly income etc. In case study, the area of emphasis were personal information, personal history, demographic information of

family, family tree, family history, substance abuse, patients perception of the problem, family members/ caregivers perception of the problem/ illness, place of living, migration, major stresses, information about the community outreach programme/ DMHP, details of previous medical interventions (in context of type of practitioners/ cost/ satisfaction), need for mental health services, suggestions to improve the existing facilities, problem with present facilities, patients and family members perception of services and mental health and illnesses (for detail please refer to appendix-II).

(C) Interview: Informal interviews were done with patients and family members waiting for their turn at psychiatric OPD about the services, facilities available and their perception of mental health and need.

For interviewing service providers (Doctor and Social worker) same method was followed.

Both, the case studies and the informal interview with patients and family members gave valuable insights about the patients' and family members perception of mental health conditions and services available. The informal interviews helped in exploring processes, relationships and its consequences in greater detail. During the interviews, people were willing to reveal more about themselves and their way of life and problems. For instance, it became clear that they had great difficulty discussing the mental health issues due to different reasons, like stigma, ignorance and their own understanding of mental illnesses.

In fact, for many people the concepts of 'mental health' and 'madness' were so interrelated that it was almost impossible to distinguish between the two. Some key results of the study are presented here. Studies have identified several areas and issues that is important from DMHP and Community mental health services point of view:

PROFILE OF JAHANGIRPURI RESETTLEMENT COLONY

The nature of this colony is a mix of JJ Slum and refugee resettlement colony. The colony was earlier meant for refugees from Pakistan and Punjab who were supposed to resettle there. There are 11 blocks in the colony with plotted housing scheme. But as time passed, these Plots have gone to the others in exchange of money. Plots allocated to refugees had been sold to other Jhuggi dwellers and migrants from other slum thus the original plot owners disappeared in majority of the cases. The colony not only comprised of plot housing only, in addition, there are Jhuggi Jhopris in between the blocks, known as JJ clusters. People living in these JJ clusters are mainly migrants from Bihar, UP and other states, who came here in search of job and better opportunity. They are basically from the labour class having informal means of work characterised by daily wages and lack of social security etc.

The colony is overcrowded and the population density is quite high where five to six people are living in one room (10X12' ft). The services of basic amenities are inappropriate. There are common toilets for both males and females. This creates problem of availability and become unsafe for human

habitation. In addition, overcrowded public utilities often face the problem of maintenance and sustenance of public utility.

In Jahangirpuri, the squatter (Jhuggis) settlement is very poor and crowded. Dwellings are small — on an average about 2.5m wide and about 3m deep. A few people have a second floor, usually reached by an outside ladder. The streets are irregular in width. Most are wide enough for a rickshaw to pass through, but some are only wide enough for pack animal. There are some small open spaces on the streets — usually at the end of culs-de- sac — but there are a few more formal community spaces, such as temple courtyards. Drainage is a problem. The site is relatively flat, and is on the edge of a swamp. Many of the open drains are blocked. They are cleaned twice a week, but get full of household waste. In some places streets have been paved with bricks; this raises their level above the floor level of the houses, with obvious consequences during heavy rain.

OCCUPATIONAL STRUCTURE

The Jahangirpuri resettlement colony with population from varying parts of the country has adopted different occupations. There are people working in Govt. Service, Pvt. Service, sales, production, labour, Self-employment, and Petty business. Basically the population is involved in informal sector of activities for bare survival. The plethora of occupations; some of them are traditional and new skilled are – business, Petty shop, sabji vendor, Driver, Mechanic, Safai, Brush maker, factory worker, rickshaw puller, Construction worker, house maid etc.

INCOME

The qualitative data based on case study shows that due to a large number of informal sectors, occupational distribution among the resettlement dwellers there is a great variation in the level of income. Level of income as economic stratification has been playing pivotal role in determining the issue of access to basic amenities and health services.

FAMILY SIZE

Family size has strong relationship with the economic status of the family. It has impact on the per capita expenditure of the family. Due to large number of family in the community, people could not meet the bare necessities, education of children, cost of medical care, ability to pay for accessing basic services and health care services.

STATUS OF DMHP IN JAHANGIRPURI: A PRELIMENARY REPORT

The study in Jahangirpuri was undertaken with an objective to understand the development of mental health services in India and to see the implementation of District Mental Health Programme under the National Mental Health Programme (1982) as a decentralised model of mental health care in India.

In this study, a modest attempt is made to examine and analyse the findings of the study and implementation of DMHP, its shortcomings and other associated factors.

The findings of the study, which are based on interviews, give preliminary insights into the functioning of DMHP. Case studies are given in the appendix.

The following section is based primarily on case studies; interviews with patients, family members and service providers and, the findings arrived at on the basis of study conducted.

The psychiatric OPD is situated at Babu Jagjiwan Ram Memorial Hospital in a single room in the general ward of the hospital. There is no signboard where the service is presently given. The board is still at same place where the service was available earlier. This leads to lots of running around for the illiterate population in trying to locate the doctor or the room where the service is being given. The room allotted for the purpose is very small. However the room is used for treatment of patients as well as for distribution of medicine by the social worker. The resident doctor coming from IHBAS to assist the doctor also uses the same room. With so many officials operating from the same room and even some of the waiting patients in the room the patient being treated finds it difficult to share his/her problems with the doctor.

Presently the service is available once a week on Wednesdays, 10AM to 2 PM whereas the programme specifies daily OPD service. Consequently there is lot of overcrowding on Wednesdays and most often the number of patients is 40 to 45 per day. Considering the problem faced by the patients the doctor is helpful enough to see them all and not return the patients. This affects the quality of treatment, as the doctor is not able to allocate adequate time to each and every patient. Even the doctor corroborated the facts and felt constrained and suggested

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the extension of the OPD service on a daily basis. Due to the non-availability of daily OPD services, the programme is not accessible to majority of the working population. As has been mentioned earlier most of the inhabitants of the area are engaged in petty activities like vending, rickshaw pullers, masons or daily wage labourers or government servants. It is difficult for most of them to miss out on their daily bread earning activities and a need was expressed to make the service available either in the evening or on Sundays (Case study – 5).

Here it is important to note the fact that although patients are satisfied with the doctor and his behaviour, there are problems faced by patient periodically that are related to the doctor and services. The present emphasis of service is only curative, where as patients' needs are not only curative. At times they need guidance and counselling to adjust with families and other rehabilitative measures. This is presently not possible due to crowding and it is practically impossible for the doctor to give time to patients. In that sense the services available and guidelines to run a DMHP as a pilot project has inherent loopholes that should be taken care of in future planning and policy development. Although from the beginning there is emphasis on comprehensive approach and teamwork in the field of mental health including professionals like clinical psychologist, physician and other professionals, whereas services available are run only by a psychiatrist and a social worker. Even at the programme level, the psychiatrist and social worker were giving only curative services against the broader objective of the DMHP. The social worker is supposed to take care of the social aspects of mental health problems, which includes; case history taking, giving

insight on the sociological causes of the problem to the psychiatrist, home visits, rehabilitative measures and follow up at the community level. It is his duty to arrange and organise the community mental health awareness programmes along with other measures, which will enhance the coping mechanism of the community. But unfortunately, the social worker is doing the work of distributing medicines thereby not utilising the creative space, which is given to him. In fact, the reason for this unprofessional function of the social worker is due to the faulty implementation of the DMHP by the nodal institute.

The sole objective of providing a social worker is to develop a community based approach towards the problem. The social worker is supposed to look into the social aspects of the problems through counselling and regular interaction. He is also supposed to look into the social problems which can either create conditions leading to mental problems or help in accentuating them. A proper study of these could also be beneficial to the doctor in diagnosing the patient better and such valuable data and experience can also help the government and policy makers in future planning and improvement in services and reach. The social worker is supposed to be the formal as well as informal link with the community. Contrary to the role expected of him the social worker here (Jahangirpuri) was mostly engaged in distribution of medicines. There was no effort to build a community based approach to the problem nor was there any effort to educate the community about the various aspects of prevention and promotion of mental health problems.

It is evident from case studies that at present there is no emphasis on awareness programme, which is not difficult, keeping in mind the area covered by the programme. In the case studies and in interviews it was repeatedly stressed that most of the patients came to know about the services through neighbours, fellow patients or family members of the patients with whom they have personal contact or relation. Most of the patients are not aware of DMHP and a large number of them have an idea that this psychiatric unit is a part of Babu Jagjiwan Ram Memorial Hospital.

It was found in case studies that there is a substantial section of the population, which visit various spiritual healers, priests and mystics for their problems. There is a growing need to take cognisance of this and if possible identify and develop methods to bring them back in the ambit of the mental health system. It is quite evident from case study- 1 and 7 that patients are taking treatment at psychiatric OPD and simultaneously they are under treatment of spiritual healers and they have a belief on both. Even in case study –1 patient reported that her epilepsy is under control due to the medicine that she is taking prescribed by psychiatrist and other problems like of *Devi Aana* are under control due to spiritual healing of Usha Mata.

On the basis of the this study it can be reasonably established that since it's inception, the DMHP was not found to be sensitive enough to these cultural variations, needs and cultural intricacies.

Another significant finding that came out in the case studies (Case study 1 & 7) is the doctor's refusal to take into cognisance that the patients usually visit the

shamans, priests and other indigenous practitioners. Preference for these practitioners has its roots in diverse social factors which affect the general being of the patient and his family. Whereas the case history taken by the doctor does not record this fact and, as a consequence, the whole focus is narrowed down to a technicist (read curative) approach to the problem of mental health. Thus, the much rhetorical emphasis on the issues of awareness, prevention and other supportive mechanisms professed in the programme is structurally excluded from the actual working out of the programme. This may not be entirely intentional rather, an outcome of the scant resource allocation which derails the whole programme. The policymakers and planners should take these shortcomings into account and an appropriate methodology or scheme of things can be evolved.

While the programme outline suggests the availability of a ten bedded in-service facility, the actual position is that there is a ten bedded facility available at the nodal institute IHBAS which is located at least 25 kms away from the Jahangirpuri area. Many patients and caregivers expressed the necessity of an in-service bed facility. The main objective of the programme was expressed as the availability of essential mental health services near the abode of the patients but in actual the referral facility as well as the bed facility is far away from the service centre. Moreover no effort has been made to provide mental health facilities with a holistic approach, which is the basic principle of any mental health programme.

Jahangirpuri area is basically a resettlement colony and Jhuggi Jhopri cluster. Although this area is not served by a comprehensive health scheme, the present

hospital from where this programme is being run is a big relief for the residents of this area. The biggest advantage is the availability of all the health related services at one place. It is convenient for the other doctors also and any mental health related problem is immediately referred to the service centre of the programme.

Problems in implementation of program

The DMHP was started in Jahangirpuri in place of Chhatarpur. The institute has its own reasons to start the programme at Jahangirpuri. The institute was having a Community Outreach Programme and under that programme they were running once a week psychiatric OPD at Babu Jagjiwan Ram Memorial Hospital at Jahangirpuri. So it was easy for them to start DMHP at Jahangirpuri itself and with money allocated for the programme they appointed a Psychiatrist, a social worker and a driver for the programme. Here it is important to note the fact that the nodal institute was running a programme under community outreach programme and providing services to masses. I do not find a reason to start DMHP programme in Jahangirpuri itself whereas there are a large number of other areas are there in Delhi where no such services are available. Once the DMHP programme was launched, the COP (Community Outreach Programme) doctors were replaced by a psychiatrist and social worker appointed for DMHP. When the psychiatrist was inquired about the programme he was not aware of the objectives of the programme. Although, he was very helpful and without his help this study would not have become possible.

The institute on the other hand expresses its inability to do anything about it-citing the non-release of adequate funding by the government and non-availability of adequate infrastructure facilities provided by the govt. authorities. The multitude of implementing agencies and their individual constraints not only serves as a bottleneck for the adequate implementation of the programme but also limits the effectiveness and the reach of the programme. There is no mechanism provided in the programme for the proper coordination of the various agencies involved in the programme.

While the primary objective of the DMHP was to operate a community mental health programme in the defined catchment area, the other programme components included training lay volunteers to detect and manage mental disorders, operating a mental health service system in the area, planning and implementing an intervention programme for the identified mentally ill, integration of mental health with primary health care infrastructure in the area, and conducting periodic awareness programmes in the community.

The document on the implementation of the DMHP not only provides the objectives of the programme but also provides detailed guidelines for implementing it. It states at the outset 'the state will set in motion the process of finding suitable personnel for manning the district mental health team. They can take in service candidates who are willing to serve in this pilot project and provide them the necessary training in the identified institution.' Although the doctor concerned is a trained psychiatrist, there has been no attempt to give him any specialised training. A workshop was however organised by the nodal

institute but no attempt was made to accommodate the community leaders and the local NGO's working in that area. It has been clearly mentioned in the programme manual that the training programme in identified institutions will include 'workers up to the grass root level- doctors, nurses, social workers, clinical psychologists, non professionals like panchayat leaders, ANM's, teachers, anganwadi workers'. It is worth noting that there are anganwadi workers present in this area and some of them even showed concern for the cause. However the need was felt by both the patients as well as the caregivers to make it wider in approach so that they also are made a part of it. The doctor is professionally qualified for the job and the patients and the caregivers seemed satisfied by his treatment.

One of the significant departures from the existing mental health policies in other states or areas which the NMHP took cognisance of was the effect of the role of awareness of mental health problems in the community and the role the community can play in preventing mental health problems and promoting good mental health. The emphasis is on making the community equipped to handle such cases and if possible try and contribute to the overall objective of 'mental health for all'. Keeping this objective in mind the DMHP proposed the following as its objectives:

1. Early detection and treatment of patients within the community itself.
2. To reduce the stigma attached towards mental illness through change of attitude and public education.

3. To treat and rehabilitate mental patients discharged from the mental hospital within the community.

The above objectives were to be achieved through regular training programmes. Such training and awareness programmes could well educate and then equip the community to help early identification and detection of the patient and the involvement of the community in treating the patients. It has often been observed that the worst stumbling block for the effective treatment of the mentally ill is the kind of treatment they receive at the hands of the community. Most often they are treated as outcasts. Appropriate public education could help solve this problem and in fact can persuade the community in being an active participant in the overall treatment of the patients. The community can also be made receptive to those patients who have been successfully treated. There is always this possibility that such patients if not received well by the community can develop mental problems once again or their earlier problems can relapse.

The above report can be summarised as follows:

Problems in services available:

1. Presently service is available only once a week.
2. The present emphasis of service is only curative, whereas patients' needs are not only curative.

3. There is no provision for guidance and counselling. It is found that at times patients and family members need guidance and counselling to adjust with illness.
4. Since at present the programme is available only on Wednesdays the clinic is overcrowded.
5. Due to crowding doctor is not able to give adequate time to each patient.
6. Service available is run by a psychiatrist and a social worker. There is no comprehensive approach and teamwork by including other professionals like clinical psychologist, physician, etc.
7. The social worker is only distributing medicines. The professional skills and his training as mental health personnel are not utilized properly.
8. There is no coordination between the facilities and various agencies, especially NGOs working in the area.
9. There is no integration of mental health care with primary health care.
10. No attempt is made to include the community leaders, workers at the grass root level such as, ANM's, anganwadi workers and the local NGOs working in the area in training programs organised by the nodal institute.
11. Service is not accessible to a majority of the working population.
12. There is no signboard where the service is presently provided. The board is still at the same place where the service was earlier available.

13. The clinic is situated in one room occupied by doctor, social worker, patients and the same is used for treatment for patients as well as distribution of medicines by social worker. Even the resident doctor coming from IHBAS to assist the doctor also uses the same room.
14. There is no provision for early detection and treatment of patients within the community. Presently services are available to those visiting psychiatric OPD themselves.
15. There is no awareness programme to reduce the stigma attached towards mental illness through change of attitude and public education.
16. There is no provision to treat and rehabilitate mentally ill patients discharged from the mental hospitals within the community.
17. There is no effort to undertake community surveys on mental illnesses and other associated factors, although it is feasible.
18. At times some medicines are not available and patients have to buy them from market and there is no provision for reimbursement.

Suggestions to improve the services:

Following suggestions were made by the patients and family members to improve the services:

1. The service should be available daily. In case of psychiatric emergency, people do not know where to go and how to intervene. The other problem is with working people, who do not get time to

visit Psychiatric OPD because service is available only on Wednesdays. If service is available daily they can also utilise the services on weekends.

2. There should be provision for diagnostic test within the hospital premises or in Jahangirpuri itself, because at present they have to go to nodal institute, IHBAS, Shahadara for the tests.
3. At present there is no counselling service for patient and family members where they can discuss their day-to-day problems like adjustment with patient and information about other services available, rehabilitative programmes etc.
4. There should be a lady doctor because at times female patients have problems in sharing personal information with male doctors.
5. There should be a separate room where confidentiality can be maintained because at present the setting is very crowded where other patients are also present waiting behind for their turn. This creates problems in communication between the doctor and the patients.
6. One of the suggestions was to introduce an awareness programme to remove the stigma of mental illness from the community.

CHAPTER -VI

CONCLUDING OBSERVATIONS

CONCLUDING OBSERVATIONS

Mental health is an integral component of health through which a person realizes his or her own cognitive, affective and relational abilities. With a balanced mental disposition, one is more effective in coping with the stresses of the life, can work productively and fruitfully, and is better able to make a positive contribution to his or her community.

The development of mental health programmes in India is still at an embryonic stage. Perhaps this is an advantage for the development of mental health programme as it is occurring at a time when the emphasis is on community care and utilization of community resources. This could help us avoid the problems of too much institutionalisation in the field.

The above discussion clearly signifies that mental health is an important component of health and development of the human society. Despite various recommendations and policies, the development of mental health services has been uneven. Since Independence various committees have recommended policies to conduct epidemiological survey to generate base-line epidemiological data and information system for the development of mental health services. But till date we are dependent on estimates that vary regionally and mostly generated on the basis of hospital admissions and discharge. A similar lag has been noticed in the implementation of the Mental Health act, in spite of having been accepted by the parliament in 1987 and it had become operational only since April 1993.

It is necessary on the part of public health personnel to conduct research in bringing out the epidemiological basis for such programmes. Responsibilities

also lie with the social scientists to influence the government and public health work in order to have a broader view and better understanding for the problems related to mental health. In the Indian context, no proper research has been done to see the ways in which culture and religion influence mental illnesses and health. It is also clear that mental illness is a significant cause of disability in India, which has been largely ignored, in health related development activities. The impact of economic structural adjustment in impoverishing people, the breakdown of traditional community and family relationships caused by urban migration, and the myriad adverse effects of newer diseases like AIDS are likely to cause a greater impact on people's psycho-social health. In addition, these programmes do not incorporate proper preventive measures and even curative and rehabilitative services provided are inadequate in terms of the estimated needs.

The absence of a central organization for mental health has been a serious constraint in post Independence planning in India. The District Mental Health Programme was developed by NIMHANS, Bangalore in Bellary District of Karnataka near Bangalore and it was adopted as a model by the States for implementation of DMHP. It is interesting to note that the NMHP was started in 1982, but till March 1996, 20 out of twenty five states have not set up the State Mental Health Authority. At present also most of the states have not set up the State Mental Health Authority that was one of the most important guidelines for the implementation of NMHP to run the programme. Without realising this and not emphasising creation of state mental health authorities, the decision of policy

makers and government to start DMHP is not going to serve any purpose. The DMHP as pilot project under the NMHP is presently implemented in 22 districts of 25 States. It is shocking that NMHP was accepted in 1982 and its proper implementation started in 1996 at country level as a pilot project. Even the selection of district is also surprising. There is no district selected from Bihar and other states of India especially in the northern and north eastern states where primary level mental health services are still a dream, But they have selected one district each in states like Kerala and Tamilnadu, where every districts in these two states have a district psychiatric units already functioning. Rather the same money and effort could have been utilised to spread the same programme to areas where it is needed the most.

The programme was started in 1999-2000 under the guidance of the nodal institute, Institute of Human Behaviour and Allied Sciences, Shahadara. Although the programme was started in 1999-2000, it started functioning in Jahangirpuri in place of Chhatarpur from August 2000. The proposed district for starting the programme was Chhatarpur, although it is not a district. The programme was started at Jahangirpuri area, which is a part of South Delhi and it is also not a district. In this regard, when nodal institute was inquired about the reasons for this change the Institute replied that it started the programme in Jahangirpuri because the Pradhan of Chhatarpur was not ready for such programme and according to Pradhan there was no need for such services. The programme was extended to Chhatarpur from December 2000. A point to note is the absence of any guidelines for selecting a district. In our country, district is the

functional unit of governance with associated hierarchies and structures. If we are having district mental health programme it should be under the District head and there should be specified guidelines to run the programme. Decision to run district mental health programme under the guidance of Nodal Institutions is conceptually wrong because there is no planned development of mental health institutions considering the needs of the country, and in some states there is not a single mental health institute resulting in uneven distribution of "mental health institute" across the country. In this context, it is not possible to run DMHP at country level under the guidance of Nodal Institutions.

Any programme which targets people's need and their progress should start from the bottom. In other words, for a successful implementation of any programme the approach should be 'top down'. It has been copiously proved that the reliance on the 'top to bottom' approach is responsible for the failure of most of such programmes. Since independence we are looking at the West for guidance and modalities in mental health services and mental health care. And whatever the estimates we have of mental health problem in India is based on the estimates given by West and International institutes. Although we have some scanty estimate of mental health problems in some cities that are based on hospital admission but most of them have overlooked the fact that large population of the country has no or little access to basic health services. Further the shocking fact is that policy makers whose memory was good enough to include disabilities and its categories in 2001 census have excluded mental health

problems, thereby the policy makers have once again shown their insensitiveness to mental health problems.

The development of support materials and models at the district level facility for initiating and coordinating the large-scale expansion of the mental health problem is a serious problem. These programmes lack in-built evaluation mechanism, having no space for continuous research and community participation at the functional level.

There are number of new issues that have come up in the country with implication for mental health. The most notable are alcohol policies, violence in society, the growing population of elderly persons, urbanization, mental health of women, disaster care, migrants and refugees, street children, and stress at the work place. These new problems pose serious challenges to existing mental health services and infrastructure. It is also doubtful given the status of DMHP whether the existing program can take care of such a complex mental health scenario.

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APPENDIX

APPENDIX – I

CASE STUDIES

CASE STUDIES:

CASE-1:

The patient is a 21 years old unmarried female. She is Khatri Punjabi religious girl. She is second born in her family. She is class IX Pass because she was not able to appear in her class Xth examination due to her illness. Presently she is house-girl, at times she helps her sister in her tuition-work. She has done beautician course and embroidery course. At times she does beautician work if clients visit her place for that purpose. By and large with these works she manage Rs. 200-300/- per month.

In her family, there are six members including father, mother, two brothers, and a sister. Her father is fifty years old, class 5th pass small businessman doing furniture repair work, earning Rs.3000/- per month. Her mother is forty years old class eighth pass housewife. She has a year elder brother class IX pass doing marketing work earning around Rs.1500/- per month. She has a year younger, twenty years old sister, who is a student of B.A. (IInd year). Her younger brother is fifteen years old, class Xth student.

Patient is a religious girl having firm belief in God and Saints. She does fast on Mondays as religious practice. Her family members are also religious believing in God and Sadhvi Usha Mata.

Patient suffered from chicken pox, when she was two and half years old and for that she was admitted for ten twelve days. From last three-four years she is a patient of epilepsy. Presently she hasn't any problem because epileptic fits are

under control and she is under medication. Doctor has prescribed her to take medicines regularly for three years.

Where as the patients perception is concerned she thinks about her disease that why it happened to her but she didn't able to find any reason for that. Where as family members perceptions are concerned they attribute it to luck or chance.

I felt very good after meeting this patient because I found most of things that are coming up are new for me from medical facilities and service point of view. In her medical record she was taking treatment for epilepsy but in my finding based on my case study and interview with her, I found that she has some other problems that even doctor is not aware of it like, she is also suffering from *BHUT AANA, DEVI AANA* and for that she is seeing different Baba's and traditional healers and Ojha's around the country and her family members have spent more than lacks of Rupees on it. Even for her treatment she spent three months in Jammu, Six months in Himachal Pradesh, simultaneously she has other problems that are according to her is very personnel and doctor is not aware of it like at times she urinates on bed since childhood that is continued till date.

<u>CASE-2:</u>

The patient is a twenty one year old unmarried female. She is Kohli Punjabi religious girl. She is third born in her family. She is class Xth pass, and she was not able to pursue her further studies because she wanted to go for nursing course but she didn't get the admission because of her English. Presently she is a house girl.

In her family, there are five members including father mother and two brothers. Her father is fifty-three years old, Intermediate pass having a small shop of electric goods repair and motor winding, earning Rs. 1500/- per month. Earlier he was an Otto rickshaw driver. Her mother is forty-five years old class eighth pass Basti-Sevika earning Rs. 500/- per month. She has three years elder bother, class twelfth pass, earlier he was working with his father, presently teaching at Navjyoti, an NGO earning Rs. 500/- per month. Her younger brother is eleven years old class seventh student.

Patient lives at Jahangirpuri in a one room Jhuggi of 10'x 10' and a small kitchen. She is originally from Itawa (U.P.). His grandfather migrated to Delhi before independence. Since then they are living in Delhi at different places. They are living at Jahangirpuri since 1984.

Presently the patient is taking treatment for *Anxiety Disorder*. In her family one of his father's brother was having mental problem, earlier he was in armed forces presently he is working as postmaster. His problem started in his teens.

Patient's perception of his disease and causes are loneliness and she feels the problem started after her elder sister marriage. At times she feels angry and agitated. She perspires profusely and her palms are often clammy. She feels often inadequate and depressed, sustained muscle tension and she complains of excessive sweating and heart palpitation, muscular tension, especially in the neck

and back. She is not very clear about linkages between her problem and surrounding environment.

She came to know about the Community outreach programme/ DMHP through BJRMH and she is getting treatment for depression since July 2000. About the need for mental health services patients think that there is a need, problems are there and there is need to improve the services by daily OPD. However, patient is satisfied with the treatment she is getting.

Family members perceives reason behind her problems are related to her mother's constant anxiety about family income, and her braked education, loneliness due to elder sister marriage and her over expectations like she wants to become self dependent she want job.

CASE-3:

The patient is a forty-eight years old married woman. She is a *Saini* (Hindu), religious woman. She class tenth pass housewife.

In her family there are five members including herself, husband two sons and daughter in law. Her husband is class tenth pass fifty-two years old, owner of General (Kirana) store having income of Rs. 3000/- per month. Her elder son is twenty-five years old, class tenth pass, presently unemployed. Her younger son is fourteen years old mentally retarded epilepsy patient. Her daughter in law is twenty years old class twelfth pass housewife doing tuitions at home and earning Rs. 500/- per month. Patient is originally from Bulandshahar, U.P. and they

migrated to Delhi in search of job. Presently she lives in resettlement colony at Jahangirpuri having two room (10'X12'' ft), kitchen and bathroom.

The patient is suffering from depression since last ten years. She complains of anxiety, sleep disturbances that include insomnia and nightmares. She perspires profusely. Patients' perception of her problem is due to her younger child problem she feels stressed about his future and care. When the younger child was two and half years old she came to know that he is not a normal child, since then she is suffering from depression and anxiety and tension about her younger child future. Besides other reasons of her constant anxiety and depression are family income and her elder son. Her elder son is married and he failed in class twelfth presently unemployed. Previously she was taking treatment at Bada Hindu Rao hospital and Pant Hospital but there wasn't relief.

Where as need for mental health services are concerned they feel that everywhere these services should be available. In their own gali (street), there are three patients who need these services. For improving existing services there suggestion is to increase the OPD services for five days week. They also need provision of govt rehabilitative services. Their complains are that they are not getting standardised drugs. Present facilities are by and large good initiative but its time taking and crowded.

CASE-4:

Patient is a fourteen years old unmarried male. He is a *Saini, Kastkar* (Hindu), illiterate. He is mentally retarded suffering from epilepsy.

In his family there are five members including himself, Father, Mother, elder brother and sister in law. His father is class tenth pass fifty-two years old, owner of General (Kirana) store having income of Rs. 3000/- per month. His mother is class tenth pass housewife. His elder brother is twenty-five years old, class tenth pass, presently unemployed. His daughter in law is twenty years old class twelfth pass housewife doing tuitions at home and earning Rs. 500/- per month. Patient is originally from Bulandshahar, U.P. and they migrated to Delhi in search of job. Presently he lives in resettlement colony at Jahangirpuri having two room (10'X12'' ft), kitchen and bathroom.

The patient is suffering from mental retardation since last eleven years. Epilepsy fits are started three years back for which he is taking medication at COP/DMHP/BJRMH. Patients' family members perception of his problem are due to his birth problem, patient is incubator child having minor head injury during birth. Patient is dependent on caregiver for taking bath and putting cloths and essential basic living skills and needs. Patient even can't recognise the real value of money and it denomination. He goes school for vocational training and candle making, but there is no improvement. Her mother is also a patient of depression since last twelve-thirteen years and for that she is on medication.

Earlier patient was taking treatment at G.B. Pant Hospital. Since last one year he is taking treatment at COP/DMHP/BJRMH. Primarily patients was diagnosed as having developmental growth problem and mental retardation and for that his

family member consulted various Private practitioners hospitals and G.B. Pant hospital before coming to DMHP.

Where as need for mental health services are concerned they feel that everywhere these services should be available. In their own gali (street), there are three patients who need these services. For improving existing services there suggestion is to increase the OPD services for five days week. They also need provision of govt rehabilitative services. Their complains are that they are not getting standardised drugs. Present facilities are by and large good initiative but its time taking and crowded.

CASE-5:

Patient is fifty years old married, Srivastava, Kayastha (Hindu) male. Earlier, he was doing Suitcase repairing work near Lal-Qila. Since 1985, he is having sound and speaker repairing work and small shop in Jahangirpuri earning Rs. 3500/- per month.

In his family there are five members including him, wife and three sons. His wife is forty-five years old class sixth pass house wife. His eldest son is twenty-two years old class third pass doing suit case repair work at Lal Qila earning around Rs. 3000/-. His second son is twenty years old class two pass doing speaker-repairing work at Jahangirpuri with his father. His third son is eighteen years old class third pass doing speaker-repairing work at Lal Qila. He has two daughters and both are married living with their in-laws. They are originally from UP but migrated to Delhi before independence and born and brought up in Delhi.

From last Fifteen years they are living in Jahangirpuri. They have their own Pucca house and five rooms of 8'x10'ft.

Patient is diagnosed as a patient of Bipolar affective disorder and alcohol abuse and for that he is under medication. In patient family there isn't family history of alcohol abuse and bipolar r disorder. Patient is alcoholic having daily Whisky or Desi whatever available. Patient is not having any major stress or tension, all his sons are settled in business and earning. Patient is under medication since last one year at DMHP and they came to know about it through neighbour. Before that they are taking was taking consultation at G B Pant Hospital. G.B. pant hospital was far so they are not going regularly and besides there are transportation cost are there.

Patient perception about his problem is concerned he denied that he is alcoholic and he said that earlier he was taking but now he has left it few years back. Patients complain about headache He does not like crowded place and sounds (shor-sharaba). Where as family members perception of his problem is concerned, he is burden to family and its reputation and his behaviours are irrational. They complain of patient dialling 100 No. Calling police and making false allegations against family members that family members are beating him, Pure ghar me mar pit karte hain tosdfod karte hain. Now a day he is cool due to medicine but whenever he does not take medicines again stars the same doing all these things since last ten years. He creates scene with neighbours.

CASE-6:

Patient is eleven-year old unmarried girl studying class fifth standard. She is Koli Hindu girl. She is first born in her family.

In her family five members are there including herself. Her father is thirty five year old illiterate (Can sign) sewing master working from home and earning Rs. 3000/- per month. Her mother is thirty years old class eighth pass simple housewife. She has two younger brothers, one, eight years old studying in class Ist and second is one year old. Her family is living in one room (8x10 ft) and kitchen at jahangirpur Jhuggi with common toilet. Patient is originally from Gwalior. Her father is in Delhi since 1982-83. He migrated to Delhi for employment and better remuneration.

Patient is diagnosed for complex partial seizure. There is no family history of any mental disorder. Whereas Patient perception of problem and causes are concerned she complains of headache, she feels her head is moving (Chakkar Ana) feels pain in hand and feet. She doesn't know why it happened to her. She is not aware of seizure. The problem started in May 1999 at Gwalior at her maternal Grandfather place. Family members perception of her problem is that it happened all of sudden in May 1999 in Gwalior. Patient complained that she is feeling Chakkar followed by seizure followed by second seizure next day. They don't know why it happened to her.

Patient father came to know about the DMHP through one of the compounder of hospital who is patients' father client. Treatment started in may 1999 at Gwalior under Dr. Anil Sharma. He prescribed a full medical check up

and after that prescribed year-long medication. They shifted to DMHP because of its closeness from their house and free treatment. They feel that there is a need for such services. They are by and large satisfied. They are happy that they have such type of facility in their locality. For improvement of services their suggestion is that to extend the services to seven day a week and they want more facilities for check up. Presently for check up they have to go to Institute of Human Behaviour and allied sciences. They are not aware of the programme. Besides, there is no measure problem with the services available. Doctor is good and understanding. Besides they complained of crowding and they have to wait for the Wednesdays and in emergency there are no mental health services available.

CASE-7:

Patient is thirty years old married house wife. She is class eighth pass Halwai, Hindu religious woman.

In her family there are five members including her. Her husband is forty years old class ninth pass sewing master earning around Rs 000/- per month. Her first-born is a daughter. She is fourteen years old, class Ninth student. Her eldest son is eleven years old student of class Sixth. Her younger son is Nine years old student of class fourth. Patient is in Delhi since last three years. They are living at jahangirpuri, since last two years having one room and a kitchen.

Patient is diagnosed for Generalised Anxiety disorder and presently he is under medication. In her family, from father side her brother is suffering from

mental problem. Patients recall that her problem started when she was pregnant second time, she felt anxious fear (Chakkar ana, Ghabarana, unconsciousness). Her present problem is unconsciousness, tension and chakkar ana. At times she also feels hallucination. She does not know why it happened to her, but she thinks it may be due to weakness. For her treatment earlier she visited Balaji in Rajasthan for traditional healing. Before that she visited various doctors in home town Bhagalpur, Patna and in Delhi. In between she also visited various Bhagat and Ojha's. She also visited AIIMS Psychiatric Unit for her treatment and from there she came to know about DMHP. About the present services, she is satisfied but she feels there is need to extend daily services for six days a week or three days a week at least. Her complain is that in emergency we don't have any specialise service in case of unconsciousness and fits and other situations.

CASE-8:

Patient is a fifty years old married class fifth pass housewife. She is Bhumihar, Hindu religious women.

In her family there are six members including her. Her husband is fifty-two years old Government servant with MCD earning Rs. 4500/- per month. She has a one son and two daughters. Both the daughters are married living with their in-laws. Her son is thirty years old, class tenth pass, married, working in a export factory as worker earning around Rs. 1500/- per month. He daughter in law is twenty-five years old class twelfth pass housewife. She has two grand daughters of age five years and five months. They are living atjahangirpuri settlement

colony having two rooms and bathroom (common with land lord). Patient is not living regularly in Delhi; quite often she visits her home place Muzzaffarpur, Bihar. From last six months she is in Delhi. Patient is originally from Muzzaffarpur, Bihar. They came to Delhi because of her husband Job who is working in MCD, Delhi.

Patient is diagnosed for mild depression with headache for that she is under medication since last two month under supervision of DMHP Community outreach centre. Whereas patient's perception of her problem is concerned she thinks its due to home affairs and house hold tensions, money problem, her son is not having proper employment. One of the recent accidents in her family that is a major setback to her and her family members are death of her grand son. Major stresses are money matters and house. At her hometown she wants to build a house. She came to know about DMHP through hospital staff. Previously she ha snot gone under any medical intervention for her present problem. She is visiting DMHP since last two months and by and large she is satisfied. About the services she thinks that there is a need of such type of services in community and she referred lot of other patients who need intervention. She also wants the extension of services for other mental problems and rehabilitative programs for mentally retarded.

CASE-9:

Patient is eighty years old, married, retired peon from ordinance depot, Delhi. He is religious Dua, Punjabi. He is getting pension of Rs. 1600/- per month.

In his family eight members are there including himself. His wife is seventy years old illiterate housewife. His son is thirty-three years old illiterate peon at ordinance factory, Delhi getting Rs. 5000/- per month. His daughter in law is thirty years old class eighth pass housewife. His eldest grand daughter is ten years old student of class fifth. His grand son is seven years old class two student and youngest granddaughter is two years old only. He has six daughters and all are married living with their in laws. Originally they are from Pakistan (Dera), migrated to Agra in 1947 due to partition and during 1947-49 lived at various places like Alwar, Muktasar and Kot kapura. From Agra they migrated to Delhi in 1985 and presently they are living in Jahangirpuri resettlement colony having two rooms (10 X 12' ft) and a kitchen.

Patient is diagnosed as patient of Dilusional para Psychosis. In his family there isn't any history of mental illnesses. Patient is taking Gutka and tobacco and occasionally drinks alcohol. In Pakistan Patient was doing agricultural work. After migration, he came to India and worked as a fruit vendor at Agra then joined ordinance Factory at Agra as a peon. His father was killed in 1947 partition.

APPENDIX – II

INTERVIEW SCHEDULE

APPENDIX-II

INTERVIEW SCHEDULE
(CASE STUDY FORMAT)

Date :

Case No. :

Problem :

Name :

Address :

Father's / Husband name :

Date of Birth :

Age :

Sex :

Marital Status :

Cast :

Education :

Occupation:

Income (Monthly/ Annually) :

Religion :

Personal History:

Demographic Information of family:

Name of family member	Relationship with respondent	Age	Sex	Education	Occupation	Income

Family Tree:

Family History:
(Mental Health and other related problems)

Substance Abuse:

Patients Perception of the Problem / causes:

Family members/ care-giver perception of the problem/causes:

Place of living: (In context of crowding/ space availability)

Migration:
(When/ Original Place / Causes of migration/ i/ii/iii generation of migrants)

Major Stresses:

From where did they get information about Community Outreach programme/ District Mental Health Programme:

Details of previous medical interventions:
(in context of type of practitioners/ Cost and Satisfaction):

Need for Mental Health Services:

Suggestions to improve the existing facilities:

Problems with present facilities:

Patients' perception:

(Mental Illness; Seizures; Unconsciousness; High Grade Fever; Head injury; Major Physical Illness; Substance abuse; Psychological Stresses; Developmental milestones; Educational Performance; Occupational problems; Sexual / Marital Problems; Interpersonal problems)

Family Member/ Care-Givers' perception:

(Mental Illness; Seizures; Unconsciousness; High Grade Fever; Head injury; Major Physical Illness; Substance abuse; Psychological Stresses; Developmental milestones; Educational Performance; Occupational problems; Sexual / Marital Problems; Interpersonal problems)