MENTAL HOSPITALS IN INDIA

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ABSTRACT

This review traces the history of the mental hospital movement, initially on the world stage, and later in India. in relation to advances in psychiatric care. Mental hospitals have played a significant role in the evolution of psychiatry to its present status.

The earliest hospital in India were established during the British colonial rule. They served as a means to isolate mentally ill persons from the societal mainstream and provide treatments that were in vogue at the time. Following India's independence, there has been a trend towards establishing general hospital psychiatry units and deinstitutionalization, while at the same time improving conditions in the existing mental hospitals.

Since 1947, a series of workshops of superintendents was conducted to review the prevailing situations in mental hospitals and to propose recommendations to improve the same. Implementation of the Mental Health Act, 1987, and grovernmental focus upon mental hospital reform have paved way for a more specific and futuristic role for mental hospitals in planning psychiatric services for the new millenium. especially for severe mental illnesses.

Key words : Mental hospital, NMHP, Indian Lunacy Act, Mental Healt Act

The occurrence of mental illnesses has been identified and documented since Hippocratic times. Descriptions of temperaments and mental illnesses abound in literature - albeit under different names. So also, treatments have been described for these disorders from antiquity. The mental hospital movement represents a major process in the evolution of psychiatry. The earliest predecessor of mental hospitals on record was a Greek sanctuary at Epidauros, which consisted of temples, gymnasia, bathing pavilions and spacious grounds with trees and statues of deities and physicians, and tablets inscribed with accounts of cures (Menninger. 1995).

The fourth century AD witnessed the establishment of institutions solely for the mentally ill in Byzantium and Jerusalem (Menninger,1995). Thereafter, Christian and Mohammedan religious orders established places of refuge for the mentally ill and patients were treated by a variety of procedures with a religious coloring.

The first major modern mental hospital to be established was the Bethlem hospital in London in 1247. Since then, mental hospitals have played a major role in shaping the evolution of psychiatry to its current status.

MENTAL HOSPITALS AND THE EVOLUTION OF PSYCHIATRY

The history of mental hospitals as they evolved is valuable in understanding the growth of psychiatry. One of the earliest records of institutions for management of mentally ill persons can be traced back to the sixth century to Greece, as mentioned earlier. Other institutions have also been identified at Jerusalem and Byzantium in the 4th century AD. For the next 10 centuries the management of mentally ill persons was controlled by the Christian and Islamic religious orders, with priests being the therapists. During this period. mental

illnesses were considered to be incarnations of evil forces and this reflected upon the treatment given to patients also.

The first modern mental hospitals for 'lunatics' were founded from the 13th century onwards in Europe. These were established primarily for isolation treatment and protection of mentally ill persons. The Bethlem hospital was founded in London in 1247 and began to accept patients in 1377. Hospitals were established in Spain and France in the 15th century. By the late 18th century, the condition of mentally ill patients in these institutions was one of neglect, restraint and abuse. Poor clothing, unhygienic conditions, poor nutrition, restricted movements due to chaining of hands/feet and lack of stimulation. The Bedlam of London (Bethlem hospital) even publicity displayed mentally ill patients for public amusement. These poor conditions were largely contributed to by scarcity of funds, lack of interest among the ruling aristocracy and over-crowding of mental hospitals.

In the late eighteenth century and early nineteenth century, Pinel revolutionized care of the mentally ill by liberating over 50 patients from the Bicetre in France. He propagated a humane approach for the care for the mentally ill. Around the same time the York retreat was established by William Tuke in order to provide a kind, tolerant and humane approach towards the mentally ill. This 'moral treatment' of patients emphasized on open wards settings, pleasant surroundings, minimal restraint, regular activity and a familial relationship between the healers and the patients. Hospitals based on this approach were also setup in the United States and claimed impressive cure rates. Mentally ill persons who were previously being cared for in Jails were freed by the efforts of Dorothea Dix. She proposed setting up of State run hospitals for treatment of the mentally ill based upon Pinel's moral approach (Menninger,1995).

Thereafter, State run hospitals were established in most states of the United States in the 19th century and were designed to provide moral treatment in non-urban settings as urbanization was presumed to have an etiological roll in mental illnesses. They emphasized upon silence orderliness and regular routines as having therapeutic value for mental illness with time, however, these gave way to strict regimentation and control and declare demarcation of the staff from patients. Once again, as years passed, inmate population increased beyond accomodation capacities, funds diminished and interest in mental hospitals and their maintenance waned -- thus giving way to dirty, overcrowded and unhygienic conditions with 'encompassing tendencies' (Jones,1993). Goffman described four characteristics of these institutions as batch living, binary management, inmate role and institutional perspective These conditions prevailed till the mid 1950s, which saw the emergence of two major forces which influenced the evolution of psychiatry. The first was the development of specific drugs like chlorpromazine for treatment of mental illnesses -- thus providing a ray of hope for their cure. the second was the rise of the antipsychiatry movement led by the likes of Goffman, Szaz, Maine, and others. These movements along with the economic recession prevailing at the time were motivating factors for deinstitutionalization of mentally ill persons and the evolution of the community psychiatry concept (Jones,1993).

The historical overview highlights what may be called the 'swinging pendulum' 'phenomenon' of mental health care. The driving force behind this phenomenon has been the felt need to provide a human care for the mentally ill. Hospitals were initially established in the 13th to 15th centuries for this purpose With time the impetus was lost and redundacy set in leading to poor patient care. This prompted pinel to librate patients from these hospitals and propagate his 'moral treatment' in form of open wards, regular exercise and a human approach. Hospitals were again established in the 19th century for proper care of the large number of mentally ill as propagated by Dorothea Dix. in the US. Once again, redundancy set in as conditions deteriorated in these hospitals too over the next century thus giving way to deinstitutionalization and community care. Of

late, a number of professionals in US and Europe have raised doubts about the efficiency of the community in taking care of mentally ill. Concern has also been raised about the plight of deinstitutionalized and homeless mentally ill in many countries (Elpers,1995; Cohen,1994; Lamb,1994) this might be a prodrome for the next swing of the pendulum towards institutionalization.

Thus, institutionalization and deinstitutionalization-- both seem to be alternating with each other in an attempt tp provide 'proper' care for the mentally ill.

MENTAL HOSPITALS IN INDIA - A HISTORICAL PERSPECTIVE

The earliest record of institutions for the care of mentally ill in India can be traced back to the reign of Md. Khilji in the 15th century. There existed at that time, such an institution at Dhar, near Mandu in Madhya Pradesh (Varma,1953). Even before this period, mentally ill persons have been described as being cared for in various temples and religious institutions in South India (Somasundaram,1973). Mental hospitals (or asylums as they were called) were entirely a British conception. Therefore, the evolution of mental hospitals in India was greatly influenced by British psychiatry and catered mostly to European soldiers posted in India at the time. Sharma has described five phases in the development of mental hospitals in India in his book on Mental Hospitals (Sharma,1990). These five phases were greatly influenced by the prevailing geo-political situations at the time.

The first phase extended from the last 18th century to the mid 19th century. During this period, Lord Cornwallis was the Governor General of India (1786-1793). This period saw the establishment of the first mental hospitals in India. Surgeon Kenderline started one of the first asylums in India in Calcutta in 1787. In 1795, a lunatic asylum was established at Monghyr, in Bihar for insane soldiers. The first mental hospital in South India was opened at Kilpauk, Madras in 1794. The guiding principle behind these asylums was to separate mentally ill persons

from the mainstream of society. During this period, excited patients were treated with opium, given hot baths and sometimes, leeches were applied to suck their blood. Music was also used as mode of therapy to calm down patients in some hospitals (Sharma,1990).

The second phase in the development of mental hospitals extended from the mid 19th century to the late 19th century. This period was significant for the enactment of the first Lunacy Act (also called act no.36) in the year 1858. This act gave guidelines for establishment of asylums as will as admission procedures. During this period, new asylums were built at Patna, Dacca, Calcutta, Berhampur, Cuttack, Waltair, Trichinapally, Colaba, Poona, Dharwar, Ahmedabad, Ratnagiri, Hyderabad (Sind), Jabalpur, Banaras, Agra, Bareilly and Lahore. despite establishing so many asylums, the number of lunatics admitted to these institutions was very large and increased further in the following years. Consequently, there was deterioration in the public health and hygiene of the hospital. By the end of the second phase, most of these buildings were in a bad state, in constant need of repair and renovation.

This deterioration in the state of mental hospitals was a cause of great concern both in India and abroad. This heralded the third phase of development of mental hospitals lasting the first quarter of the 20th century. All asylums that were hitherto under the charge of the Inspector general of Police were put under the charge of Civil Surgeons. Also, specialists in Psychiatry were appointed to these hospitals The year 1918 saw the establishment of a Central European Hospital (now called the Central Institute of Psychiatry) at Ranchi by Col. Berkeley Hill for European Mentally ill patients.

The fourth phase extended from 1920 till the time of independence in 1947. During this period, efforts were made to raise the standard of treatment and care in mental hospitals. Also, 'asylums' were renamed as 'mental hospitals' in 1920. The importance of occupational therapy and rehabilitation was stressed. The 'Bhore committee' which was set up in 1946, surveyed

mental hospitals and made appropriate suggestions for the future. At that time, there were at least 19 mental hospitals with bed strength of 10181. The Health Survey and Development Committee report submitted by Col. Moore Taylor in 1946 reported a numerical and professional inadequacy and suggested a focus on training of personnel and students in psychiatry, promotion of occupational and diversionary therapies, and separate child psychiatry units. Also, the report recommended that the 'walls of ignorance, superstition and suspicion be torn down so as to establish a friendly relationship with the community'. The committee suggested improvisation and modernization of most hospitals, attachment to medical colleges, and establishment of proper mental health (Taylor,1946)

The final phase of development of mental hospitals came after India's independence in 1947. In view of the poor conditions prevailing in most mental hospitals, along with inadequate resources, and a trend toward deinstitutionalization in the international arena, the government of India has focussed upon the creation of General Hospital Psychiatric Units rather than building more mental hospitals. there has also been an emphasis on improving conditions in existing hospitals, while at the same time encouraging outpatient care through general hospital psychiatry units.

Since independence, the numbers of mental hospitals in India have increased from 31 to 45 (Sharma,1990). The number of patients treated in these institutions has increased manifold as compared to before independence. Of late there has been a surge of interest in community based programs for managing mental illness on part of the government of India. While hospital psychiatry units and community based mental health initiative are effective in identification and treatment of most minor & less severe forms of illnesses, there still exist a large number of patients who require long term inpatient care (sometimes in restrained settings) in mental hospitals. These patients are mostly those with more severe forms of illness, poor social supports, significant family and societal burden. These constitute nearly 1% of the population at any point of time. And it is for these patients that the need for mental hospitals will remain for a fairly long period of time.

MENTAL HOSPITALS IN INDIA : RECOMMENDATIONS AND CURRENT STATUS

Attempts have been made to survey the functioning of mental hospitals by organizing a series of conferences/workshops of superintendents of mental hospitals. These were held in Agra (1960), Ranchi (1986), Bangalore (1988), Delhi (1995) and Bangalore (1999). The existing state of mental hospitals was reviewed in each of these conferences and recommendations were proposed towards their impovement. The first conference in Agra higlighted the poor standards in most existing hospitals and suggested remodeling/ modernization of buildings, improvement of treatment facilities, provision of adequate staff, development of psychiatric wards in all general hspitals, a revised system of maintenance of hospital records.

The Ranchi workshop highlighted the large size, wide catchment areas and paucity of funds and staff as contributing to mental hospitals functioning as 'mere' custodial settings. Therefore, it recommended that the bed strength of existing hospitals be restricted to 400, psychiatric training units (25-50 beds) be established at district level, no new mental hospitals be opened (unless minimum standards are met) and the roles of mental hospitals. psychiatrists and other staff be redefined in keeping with the objectives of the National Mental Health Program (NMHP). It also recommended that daily outpatient services and 24 hour emergency services, special services for children and elderly be established in addition to provision of adequate and modern diagnostic facilities. establishment of detoxification centres and community based treatment programs to supplement occupational and rehabilition services. regarding the staffing pattern. The workshop suggested that there should be 8 psychiatrists, 20 medical officers/junior residents, 2 occupational

therapists, 1 clinical psychologist, 2 psychiatric social workers and 35 nurses for every 100 patients in addition to 20 attendants, 10 clerks, 8 records personnel, 1 dietician, 10 security staff, 3 drivers and 5 pharmacists (Sharma,1990).

The Bangalore conference in 1988 concluded that mental hospitals should function as active therapeutic centres providing mental health srvices and should become centres for community mental health services. Also, service manuals, job descriptions and periodic orientation courses were suggested so as to enhance the knowledge, skills and the 'right' attitude to mental health problems was also recommended (NMHP Progress report,1989). The Delhi conference in 1995 also made similar recommendations as the previous ones and suggested use of mental health related nomenclature so as to reduce stigma (Sharma & Chadda,1996).

The most recent of ths series of conferences/workshops was held at NIMHANS, Bangalore in 1999. Recommendations were drafted to ensure minimum standards of care in mental hospitals and are summarized as under (Circulated at the National Workshop for Medical Superintendents for assuring minimum standards of care in mental Hospitals held at NIMHANS, Bangalore in February,1999).

Infrstructure : Prison like structure to be changed so as to provide a therapeutic ambience.

Inpatient facilities : all cells to be abolished. There must be a maximum of 20 beds per ward. Separate cots and mattresses for each patient, with at least 3 feet distance between cots.

Facilities for a hygienic therapeutic environment (with specific recommendations regarding the linen, plates, water supply and electricity, toilets and bathrooms, etc.).

There should be one nursing station in each ward to record daily observations and give beside medication.

Recommended staff : patient ratio for nurses is 1:3 (teaching hospitals), 1:5 (non-teaching), for ward aides is 1:5, for sweepers is 1:10 and for barbers on contract basis.

Medical personnel must see patients at least once in three days.

Supportive services : Kitchen and dietary services.

Outpatient services : Daily outpatient services with round the clock emergency services must be available. Free drugs, short stay wards, basic investigations, modified ECT services are also recommended. There should be at least 2 doctors and 2 nurses, one psychologist and one social worker available at all times.

Rehabilitation services : This includes structuring of ward activities, emphasis on work habit, supervised personal care and grooming, and recreation/socialization facilities in each ward. There should also be a separate rehabilitation centre with one instructor for 10-15 patients in each section (encouraging day care).

Records : Separate files for all patients, regular notes during inpatient stay, and printed admission forms (in keeping with the Mental health Act,1987) are recommended.

Liaison services : Regular visits to jails and other correctional institutions, liaison with general hospital services and a panel of medical specialists for consultation (for associated medical problems) are recommended.

Monitoring mechanism for functioning of all hospitals : A brief overview of the above revels that recommendations of all the five conferences/workshops are essentially similar. This suggests that the problems in mental hospitals are persisting despite repeated recommendations regarding the improvisation of services. Excepting perhaps NIMHANS, Bangalore and a few select other institutions, these recommendations have not been fully implemented in most hospitals.

There were about 10000 beds in mental hospitals for a population of 400 millions at the time of India's independence. Over the last 50 years, the population has increased by nearly two and half times, while the number of beds have incresed to only about 21000 (Murthy,1992). Thus, the psychiatric bed ratio has remained more or less constant at 1 bed for 5000 population. the prevalence of severe mental morbidity in India ranges from 3 to 10 per 1000,

which is more than five times the bed strength available (Murthy,1992).

The respective state governments are presently managing all mental hospitals. These hospitals run regular outpatient services catering to large catchment areas. The inpatient facilities are closed settings consisting of primitive prison like cells or (the more recent) closed wards. In addition, some of these hospitals also have open wards where the patient is admitted along with a relative or attendant and given treatment. Problems like inadequate water supply and frequent power cuts are still existing in most hospitals.

Many hospitals have more inpatients than the actual bed strength sanctioned. This contributed to overcrowding and considerable strain on the already limited resources and other ward staff. Psychologists, social workers and occupational therapists exist only in few hospitals. Most of the hospitals are affiliated to medical colleges and have post graduate training courses (MD and DPM). Few like the NIMHANS at Bangalore and Central Institute of Psychiatry at Ranchi also have training courses for clinical psychology, social work and psychiatric nursing. The government provides free medicines and other treatment facilities like ECTs at most of these hospitals. Special clinics for epilepsy, lithium clinics, deaddiction units and child and adolescent psychiatry clinics are also run by some of these hospitals. Many hospitals also have activity community psychiatry programs and run satellite clinics in nearby districts.

In summary, mental hospitals in India are structurally geared to provide comprehensive mental health care to the needful. However, aftercare and rehabilitation of patients into the mainstream of society continue to remain tenuous issues in the care of mentally ill. This is especially because of inconsistent follow up rates, poor education of patients regarding illnesses and poor compliance with medications. The paucity of aftercare and rehabilitation facilities is a major drawback of our mental health care delivery system and contributes largely to the often observed 'revolving door' phenomenon among hospital patients.

A major effort at studying the current state of mental hospitals was initiated by the National Human Rights Commission recently. Many hospitals consist of very old and dilapipated buildings, which are in dire need of constant renovation and repair. Facilities for patients in closed wards/cells are scarce - these include such basic amenities as adequate water, sanitation, food provided (in terms of quantity and quality), and beds and mattresses. Further, the actual inpatient number often exceeded the sanctioned bed strength, there is overcrowding and attendant poor hygiene in the wards. Also, the structural organization of the closed cells and wards is primarily custodial in nature-- thus curtailing the patients fundamental right to freedom of movement. Ward environment are often dichotomized resulting in risk of violence most hospitals are grossly understaffed in terms of the number of doctors, nurses and ward staff posted. There is also a tendency to post relatively less competent staff to mental hospitals (based on the erroneous belive that care of mentally ill is less demanding than other specialities). There are also not enough trained clinical psychologists and psychiatric social workers in mental hospitals. This is primary due to paucity of these professionals as well as to lack of enough facilities to train these professionals and improper utilization of available personnel.

Most of the current problems can be traced to a certain extent, to insufficient budgetary provisions. Also contributory is the often-evident step-motherly and indifferent attitude of health departments and other medical specialities towarsd psychiatry and psychiatrists. So also the administration of mental hospital is mostly done by clinicians who do not have any formal training in administration as such. This aspect of administration has been much debated with respect to the pros and cons of having clinicans in administrative posts. While clinicans have an in depth understanding of the problems existing in a mental hospital, this fact in itself does not make them the best persons to administer it. This debate is still far from resolved and requires a very detailed analysis of the

situation for a deffinitive stance to be taken.

All the above mentioned drawbacks not withstanding, mental hospitals still form the crux of mental health care delivery system in India, while general hospital psychiatric units and community based approaches provide treatment and enhance public awareness regarding minor mental illnesses. Hence attention must be paid to the structural and functional aspects of these hospitals so as to provide the best possible care to our mentally ill.

The implementation of the Mental Health Act,1987 has regulated the functioning of mental hospitals to a great extent. The act has provisions for admission and discharge procedures, rights of the mentally ill patients, procedures for establishing psychiatric hospitals and monitoring agencies to monitor their functioning. These are a great advancement over the Indian Lunacy Act of 1913, which had different yardsticks for hospitals catering to different populations.

FUTURE DIRECTIONS

Mental hospitals, general hospital psychiatric units and communiy based clinics are important 'agents' for delivery of mental health sevices. All these agents serve important purpose of different levels of severity of illness and care provided. Despite the recent trend towards deinstitutionalization and closure of mental hospitals in many parts of the world, it is unlikely that any other modality will be able to replace mental hospitals in the foreseeable future. Mental hospitals, with all their inherent flaws and drawbacks, are powerful institution for proper care of a subset of mentally ill persons specially those with severe forms of illness and poor familial/social supports.

The future, therefore, probably lies in improving the structural and functional aspects of mental hospitals in India. These might include increasing the budgetary provisions for hospitals and an attempt at changing the bureaucratic attitude towards mental hospitals in general. Greater administrative autonomy would be one of the steps to be taken to improve functioning of mental hospitals by reducing bureaucratic and

procedural delays. Also, there is a need for 'need based decision making' strategies, thereby cutting down on administrative delays. These would themselves result in improvements in the hospital infrastructure and facilities provided for patients In addition, expansion of training facilities for mental health professionals, especially, for clinical psychologist, psychiatric social workers and psychiatric nurses would provide the necessary intellectual resources for a multidisciplinary approach to treat mental illnesses. Also, the last word is yet to said, as to whether the clinician or a hospital administrator is the best person to administer mental hospitals.

The changing role of mental hospitals also needs to be reconsidered. This is because earlier, hospitals were primarily used to sequester 'dangerous' lunatics form the society. With the advancement of our knowledge regarding mental illnesses, mental hospitals need to take a more expanded role in the community - not only as treatment centres, but also as facilitators of social awareness and training of personnel to meet community mental health needs. Mental hospitals also have a tremendous potential for psychiatry and brain research, which is one of the final frontiers of human knowledge - and is as yet relatively untapped. The National Mental Health Programme, envisages a wider role for mental hospitals in treatment of patients. They are expected to be the nerve centres providing specialist care at a teritiary level with links to peripheral areas.

In conclusion, mental hospitals are an indispensable component of India's mental health program there are certain deficits in the functioning of these hospitals as of now and need to be rectified so as to fit in to the newer role that has been envisaged for them in the nation's mental health policies. Also minimal standards need to be maintained to provide adequate care for the mentally ill.

The current trend is towards decentralization of services for the mentally ill, but a properly integrated mental health care system is yet to be formulated. Till such a time, mental hospitals shall be required to continue to

play a significant role in the management of psychiatric morbidity. Many significant changes towards improvement have occured in the last few decades with increase in psychiatric awareness, manpower and facilities. However, more needs to be done in terms of training programs, budgetary allocation and a proactive bureaucracy in order to fulfill the roles that have been planned for mental hospitals in the nation's mental health program.

Leon Disenberg has aptly summarized the present status of mental hsopitals as follows - 'although the use of institutions for long term care can be minimised by providing alternatives in the community, they will continue to be necessary. The quality of the institutional environment is a major determinant of the way the patients function. It is, therefore, important to subject institutions to regular evaluation and to improve their architectural design and the content of work programs where necessary'.

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