Human rights initiatives in mental health care in India: historical perspectives

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Introduction

> *"All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood."*
>
> [United Nations Universal Declaration of Human Rights]

Human rights encompass the "basic rights and freedoms to which all humans are entitled". This covers a broad range of rights related to civil and political issues, such as the right to life and liberty, freedom of expression, right to equality before the law and social, cultural and economic rights, including the right to participate in culture, the right to food, the right to work, and the right to education. The importance of human rights also reflects the progress that has been achieved by mankind in many of the above mentioned spheres. Undoubtedly, these advances have occurred due to a better understanding of the evolution of the human brain and mind. It is critical that the rights of human beings in the event of an "unsound" mind or mental illness are contextualised and examined with careful consideration.

Mental illness is a unique problem in that it affects the very basic faculty of human beings and can pose potential adverse impacts on both the suffering person as well as others. Thus, in the context of psychiatric disorders, while rights of mentally ill people should ensure them their due privileges in the community, it should also ensure protection against infringement of the rights of others (1).

Rights of the Mentally Ill

The rights of the mentally ill include the following (2):

- The fundamental rights as their fellow citizens, including the right to a decent life, as normal and full as possible.
- Legal safeguards against abuse
- Right to appeal
- Right to necessary treatment in the least restrictive set up and as far as possible to be treated and cared for in the community
- Right to rehabilitation
- Right to personal autonomy, privacy, freedom of communication
- Right to education
- Right to training
- Right to economic and social security
- Right to family and community life
- Right to employment
- Right for protection against exploitation and discriminatory, abusive or degrading treatment
- Right for assistance, including legal, for protecting their rights

Human Rights and Indian Psychiatry

Major phases and revolutions have been described in relation to the history of psychiatry (3). The initial phases were predominated by the belief that sin and witchcraft were responsible for mental illness; mentally ill people were restricted to jails and asylums. Later, specific theoretical schools explaining the pathogenesis of psychiatric disorders from their respective perspectives created an impact in psychiatry. Further developments were related to the initiation and consolidation of community psychiatry that led to the integration of mental health care in the community.

While the historical roots of Indian psychiatry have been traced to periods as early as that of King Ashoka (3), spirituality has always been a pervading factor in understanding as well as treating psychiatric disorders in India. It

is noteworthy that descriptions of mental health have given consideration towards human rights even in earlier days of modern psychiatry in India (3). This chapter attempts to review the various historical perspectives with relevance to the human rights initiatives in mental health care in India.

The Bengal Enquiry (1818)

One of the earliest descriptions referring to human right issues of the mentally ill was reported in the Bengal Enquiry of 1818 (2). This followed the select committee revelations on the regulations of psychiatric care in England in 1816. The enquiry indicated that the mental health care settings were sub-optimal – "the buildings are low and damp and not half-large enough for the number of patients, to which must be attributed the numerous deaths which occur". Inadequacies were observed in various domains like food supplies, staff handling of the mentally ill persons, issues related to restraining unmanageable patients and many other similar aspects. The recommendations suggested that the asylum had to ensure humane and caring behaviour of the staff towards the patients; also, with relevance to restraints, it was emphasised that "un-necessary coercion should never be used and that heavy iron chains should not be applied except in extreme cases where light leg chains may be used".

Some specific descriptions of the asylum followed: The asylum at Murshidabad was regarded as wholly unfit, the building altogether a wretched place even in its best state. The Rasapagla asylum in Calcutta was described in a worse situation. The asylum at Patna was said to labour under disadvantages greater even than those pointed out existed in Murshidabad. It was erected on a low ground close to the breeding ground of miasmas and was provided with poor quality water. This probably resulted in a high death rate of 52%. There was overcrowding in the Bareilly asylum, 105 patients were accommodated in 29 cells, with four persons often confined in a cell not bigger than 80 sq. feet. The Benares asylum was "*on a scale so contracted and insufficient and in appearance bore more resemblance to a prison than of an asylum for lunatics*"(2).

Diet supplies were also noted to be insufficient. Significant lacunae were observed in the handling of mentally ill persons in these asylums. Ernst summarised the 1818 inquiry as leading to "*only moderate control of gross abuses, rectification of the institution's physical defects whenever*

practicable, and strongly expressed avowals to humane and moral treatment, proper gender segregation and classification of lunatics".

Investigations into the state of 'Native Lunatics in Bengal' (1840)

The second evaluation pertaining to mental health care issues was reportedly the investigation on the state of native lunatics in Bengal in 1840. This followed the suspicions of the European Superintendents' alleged corrupt practices as well as the highly divergent cure and death rates in the asylums. The summary of the findings emphasised the varying quality of conditions, influence of each superintendent's individual style of functioning, management and their individual commitment to patient care.

Consequent to this enquiry, the asylums in Benares, Delhi and Bareilly were condemned to be re-built. Around this time, it appeared compelling that basic amenities like diet and other factors like occupation for patients and the interest of the treating doctors were all vitally important. It was a paradoxical observation that at around the same time, surgeon Paton in Delhi was practicing what he considered a very effective approach of enforcing discipline and industriousness through 'food restriction' as punishment, which was reflected in a not altogether favourable cure; on the contrary, it resulted in increased death rates.

An overview of these early inquiries suggested that while they focussed on the responsibilities of the administrators, the Indian assistants and the role of the head keepers were never attached attention in the English documentation of Indian asylums (2).

Developments during the early 1900s

This period was described as the 'third phase' of development during which time the mental hospitals that were till then under the charge of the Inspector General of Police, came under the charge of civil surgeons. The posting of specialist psychiatrists as full time officers in these asylums became a requirement. The centralised supervision of all asylums was planned in 1906 and was implemented formally under the Indian Lunacy Act of 1912.

Berkeley Hill, the then Superintendent of the Central European Hospital at Ranchi made a significant contribution to an attitudinal change towards

these institutions. He persuaded the government to change the names of the lunatic asylums to mental hospitals. Also, he highlighted the need to involve social scientists with the care of the psychiatric patients and the first efforts to train psychiatrists and psychiatric nursing personnel began during this period.

An Association of the Medical Superintendents of mental hospitals was also established and a manual for superintendents of mental hospitals was formulated in 1930. This manual described the procedures for care, administration, and treatments, as well as the roles of different levels of staff.

Mapother's Report of 1938

The Mapother's report is considered as a significant step in elucidating the needs of the mental hospitals in India (2). This report compared the state of psychiatric services in London and India. The contrasting perspectives of the mental health scenario were evident in this report. While the psychiatric bed ratio was 1:200 in London, the same was 1:30,000 in India. Five out of 8 beds for medical diseases were for the psychiatrically ill in London, in contrast to 1 out of 7 in India.

There was significant overcrowding noted in the mental hospitals. For example, Yerawada had 29% overcrowding and Madras had 93% overcrowding. Due to overcrowding, there was an annual death rate of 123 / 1000 in Agra mental hospital. Mapother cited that "*indifference was stated commonly as a reason but this must be fought against*". He was very critical of the medical services in India, "*the Indians have been unable to exercise the authority to enforce change … the only thing they knew is to lock up the worst patients*".

Mapother was extremely critical of the state of the mental health hospitals and compared them on a scale of "badness". According to him, "*most mental hospitals are desolate wastes, based on the conception that the insane are indifferent to ugliness and are destructive*". Mapother mentioned Madras as the 'best' of the 'typical' mental hospitals in India. He described the mental hospital in Pune as 'inspired by the public work department concept of lunatic', with 'open air cages'. He advocated a comprehensive programme for re-organizing mental health services in India.

The re-organisation programme suggested by Mapother comprised the following:

- Admission Procedures:
  - Brief detention / observation exists but no short admission beds;
  - Voluntary admission exists but no beds in public wards.
  - India is not ready for non-volitional order on account of corruption.
  - Every case should be seen by a magistrate before and after admission for detention.
  - Certification for detention should be limited to experts with recognised qualifications.
- Visiting Committees needed to be set up.
- Deputy to Public Health Commission with knowledge of psychiatry to be appointed
- Institutional facilities to include:
  - Increase in beds irrespective of all pressures
  - Specialised services especially for the criminal, mentally retarded and involuntary patients
  - Classes of service to include – psychiatric clinic in Government hospitals and beds for mentally ill persons
  - Short treatments lasting for 1 month
- Improvements of conditions for chronic patients
- Increase in undergraduate education in mental health
- Diplomas to be started
- Teachers / researchers to have a stint of training abroad
- Well-trained staff and mental health nurses required
- Need to introduce social workers in mental hospitals
- Organised occupation of patients and training of those who supervise them is crucial
- Survey and public propaganda as to the true incidence of mental illness and whether certain illnesses could be prevented.

Moore Taylor's Report

In 1946, Col. Moore Taylor, Superintendent of the European Mental Hospital at Ranchi and member of the Health Survey and Development Committee (Bhore Committee) was asked to survey mental hospitals and his report was based on his observations of 19 mental hospitals. His observations and recommendations were summarised as follows: "the majority of mental hospitals in India are out of date, and are designed for detention and safe custody without regard to curative treatment. The conditions of many hospitals in India today are disgraceful and have the makings of a major public scandal".

Many of Taylor's observations concurred with the earlier observations by Mapother. The following were the recommendations of the Moore Taylor's Report (2):

- Qualified and trained psychiatrists to head mental hospitals;
- Need for adequate staffing;
- Post-graduate training courses with adequate emphasis on prophylaxis and prevention in line with the principles of modern preventive medicine;
- Uniformity in undergraduate training in psychiatry;
- Mental hospitals should be teaching institutions and attached to medical colleges;
- Need for a mental health service, with improvement in the status, pay and conditions of service of the medical staff, with increased opportunities for purely professional work;
- Urgent necessity for better trained nurses;
- Increase in the number and quality of ward personnel;
- Theoretical and practical instructions for both nurses and ward personnel;
- Need for a more systematic and better conceived plan of work therapy and diversional therapy;
- Special homes for patients with physical problems (medical or nursing) under the supervision of the Medical Services (It was

observed by Moore Taylor that more than 50% of the patients in mental hospitals could be cared for in such homes);

- Need for outdoor clinics in mental hospitals;
- Services addressing mental health issues in schools, child guidance clinics, juvenile homes and remand homes;
- Psychiatry should not be segregated, but form links with other medical specialties. Nonetheless, Taylor cautioned that to open psychiatric units in general hospitals before there are trained personnel to conduct them would be sub-optimal. Once this was achieved the general hospital could bear its share of mental illness treatment and prevention activities;
- Need to create goodwill about mental hospitals by "*letting the community know that the mental hospital has a real service to be given; convincing people that they need what it has to offer; making it easily obtainable; making people glad they can have what the institution has to offer*".

The onus of improvement of mental health services was placed on the government. Taylor mentioned that "*this is a suitable time for Government to take stock, overhaul resources, and rechart the course for the next 30 years*".

Bhore and Mudaliar Committees

The description as well as the recommendations of the Bhore Committee have been summarised in the compilation – *Mental Health – An Indian Perspective* (4). The Bhore Committee divided mental ill-health conditions into two groups, i) mental disorder and ii) mental deficiency. *Mental disorder may be either inherited or acquired, and very often is both. No age is exempt from mental disorder although the types may be different at different age periods. A large proportion of them are amenable to modern methods of treatment. Mental deficiency is ascribed, on the other hand, to a hereditary or congenital taint or to some accident or illness occurring just before or soon after birth.*

The Bhore Committee commented that the present position in India is extremely unsatisfactory. It mentioned that chronic starvation or under-nutrition, tropical fevers, anaemia and frequent childbirth in women who are unfit for motherhood are responsible for the large numbers of mental breakdown in India. The report estimated the requirement of beds for

mentally ill at that time to be about 800,000. Only a little over 10,000 beds were then available for these patients. Given the deficiencies of mental health care in India, the Bhore Committee came out with the following proposals which can be summarised as below (4).

The Bhore Committee recommendations (1940) for mental health, based on Moore Taylor's report, called for improvements in mental hospitals and the need for medical and ancillary mental health personnel. It was also instrumental in the formation of the National Institute of Mental Health and Neurosciences (then known as the All-India Institute of Mental Health) in Bangalore.

The committee suggested that the most important step to be taken was the formulation of a mental health programme for the country after a preliminary investigation of the needs of individual provinces. "*Such a programme should aim at providing for the community, in successive stages, a modern mental health service embracing both its preventive and curative aspects. As a part of the implementation of such a programme two of the most urgent 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 mind, the following recommendations were made by the Bhore Committee for a short-term programme (4):

a) Creation of mental health organization as part of the establishments under the Director General of Health Services at the Centre and of the Provincial Directors of Health Services;

b) Improvement of the existing 17 mental hospitals in British India and the establishment of two new institutions during the first five years and of five more during the next five years;

c) Provision of facilities for training in mental health for medical men in India and abroad and for ancillary personnel in India; and

d) Establishment of a Department of Mental Health in the proposed All-India Medical Institute.

Importantly, there had been a mention about the promotion of positive mental health, "*the pursuit of which requires the harmonious development of man's physical, emotional and intellectual equipment*". The Bhore Committee recommended that apart from provision for the

prevention and cure of specific forms of ill-health, physical and mental, many of the proposals by the Committee, for example, those dealing with health and physical education, the social aspects of programmes for mothers and children, for the school going population and for industrial workers, the removal of slums and the creation of parks and other facilities for promoting community life should also help to raise the level of mental health in the community.

The Mudaliar Committee envisaged the development of psychiatric units in all district hospitals in the subsequent ten years. The Medical Council of India mandates the setting up of Departments of Psychiatry at all medical colleges.

Medical Superintendents' Workshops: Summary of the proceedings

Four workshops on the improvement of mental hospitals in the country were conducted over a period of 30 years between 1960 and 1990. These included the first conference of Superintendents of Mental Hospitals in India held in November 1960 at Agra, WHO workshop on "Mental Hospitals in India: Present Status, resources and future needs" at Ranchi in February, 1986, Workshop on Mental Hospitals in India held as part of the NMHP implementation at NIMHANS, Bangalore in March 1988, and a WHO workshop on Future Role of Mental Hospitals in Mental Health Care in India held at IHBAS, New Delhi in December 1990.

The following were the themes of focus at all these workshops:

- Improvement of living conditions;
- Improvement of hospital infrastructure and function;
- Definition of role of various personnel;
- Training of staff in mental hospital;
- Provision of outpatient and emergency services;
- Provision of daycare and rehabilitation services;
- Extended role of mental hospitals in teaching and training;
- Need for special services (child, old age, drug and alcohol, criminal mentally ill);

- Need for development of GHPUs;
- Need for development of alternative services and linkage in the community for mental health care;
- Undergraduate and postgraduate training and refresher courses in psychiatry for other professionals;
- Mechanisms for internal and external monitoring.

While the workshops were well attended and these above-mentioned recommendations were formulated by mental health professionals, only a few of them had resulted in visible changes (2).

Quality Assurance Project in Mental Health

While the last few decades of the 20th century witnessed significant growth of private psychiatric institutions for the mentally ill, general hospital psychiatry, initiation of the National Mental Health Programme with focus on community psychiatry as well as the enactment of the Mental Health Act of 1987, the issues related to the care of the mentally ill with relevance to human rights needed comprehensive review. There was a need to be proactive in ensuring that the basic rights of the mentally ill were protected. Also, there was a need for the standards of mental health care to be reviewed. This led to conceptualisation and implementation of the project on quality assurance in mental health care (2). The details of this project are discussed in further chapters.

Minimum standards of care in mental hospitals

The Central Mental Health Authority recommended the development and implementation of a set of minimum standards of care in all the mental hospitals in the country. Guidelines for minimum standards of care were prepared after consultative meetings of medical superintendents and state health secretaries in February and June 1999 (5).

The National Mental Health Programme

The National Mental Health Programme which was initiated in 1982 (6), was re-energised in 1996 and the District Mental Health Programme was initiated in different states in a phased manner. Under the 11th Five Year Plan, this programme was restrategised and strengthened based on guidelines formulated at a national consultative meeting held in 2006 (7). This is detailed in subsequent chapters.

Conclusion

Review of the historical perspectives on human rights initiatives in mental health suggests that there has been a continued emphasis on ensuring the ensuring the provison of human rights of the mentally ill. While these reports highlighted the inadequacies in the older and existing mental health setup, they have suggested important recommendations to correct these lacunae.

References

1. Human Rights and Mental Illness. Report of the National Inquiry into the Human Rights of People with Mental Illness. Volumes I & II. Australian Government Publishing Service, Canberra 1993.
2. Quality Assurance in Mental Health. National Human Rights Commission, India 1999.
3. Parkar SR, Dawani VS, Apte JS. History of Psychiatry in India. Journal of Postgraduate Medicine 2001; 47:73-76.
4. Agarwal SP (Ed). Mental Health – An Indian Perspective 1946–2003. Directorate General of Health Services. Ministry of Health and Family Welfare, New Delhi 2004.
5. National Institute of Mental Health and Neuro Sciences. Minimum standards of care in mental hospitals. Recommendation and report of the national workshop for medical superintendents of mental hospitals and state health secretaries. NIMHANS 2000; NIMHANS publication No.39.
6. Government of India. National Mental Health Programme 1982.

National Institute of Mental Health and Neuro Sciences. Report of the national consultative meeting of mental health professionals for implementation of DMHP as per 11th Five Year Plan. NIMHANS 2006.