LETTERS TO EDITOR

LET US LEARN THE RIGHT LESSONS FROM ERWADI

Sir,

The horrific tragedy at Erwadi has kindled some long over-due discussion (IJP, Vol.43: No.4, 2001) on the plight of chronic psychotics in our society.

The specific questions to be addressed are:
1. Why do 'patient-care facilities' like the ones at Erwadi come up at all?
2. Could mere strong-arm tactics like forcible closing down of these places, whenever there is a hue and cry in the media solve this vexed problem?

Now a little history:
Henderson and Batchelor (1962) tells about four distinct periods in the history of psychiatry from the end of eighteenth century, namely:
1. The period of humane reforms
2. The period of introduction of non-restraint
3. The hospital period and finally,
4. The social and community period.

Mental health care all over the world has attained the present overall acceptable level, thanks to the progress made during each one of these four periods. Pinel quite poignantly inaugurated humane reforms in 1794. During the subsequent periods the legacy of Pinel was carried forward. After Conolly's authoritative book in 1856, 'The Treatment of the Insane without Mechanical Restraint', mechanical fetters ceased to have any place in the practice of psychiatry.

A 'hospital period' had its beginnings all over the developed world from early twentieth century. In this era ideals in humane reforms as well as abolition of restraints were translated to action. Every single aspect of mental hospitals was influenced by the two previous periods: In their architecture, administration, staffing, social milieu, everything. Old mental hospitals were extensively reconstructed. Many new ones with patient-friendly ambience were built. Laws like the National Health Service Act (1948) in England, ensured that government funds were made available for a mammoth infrastructure development, quite liberally. With even hairdressers and chiropodists added to the staff of mental hospitals, inmates were assured of a dignified life, like everybody else.

Mental hospitals were no more viewed as bad places, as they used to be. The mentally sick and their families could now trust these places to get the needed support and care. On the minus side, the census in mental hospitals went up steeply. It was in this context the 'social and community period' commenced. The doors of mental hospitals were opened and a whole lot of outreach services developed. The emphasis was on providing better alternatives, so that hospital admission could be minimized.

Querido's 'Psychiatric Consultative Bureau' in Amsterdam started in the early years of Community era, is a classic example. The Bureau provided 24 hour service of psychiatrists, social workers, etc to assist the family doctor in the home-treatment of disturbed mental patients. It arranged admission to a mental hospital or other appropriate facility as per needs. In addition the Bureau worked in close association with public assistance departments and also took an active part in rehabilitation.

The history of around two hundred years is recalled here, as it has some relevant lessons for us in the current Indian scenario.

The type of care system developed by Querido served the purpose of preventing admission to mental hospital as far as possible, but at the same time arranged admission whenever that was needed. It also facilitated the early discharge of patients by organizing good after care services.

In India the concept of Community Psychiatry did not blossom as an extension service from properly developed mental hospitals. Nor has Indian Psychiatry gone through the earlier three periods of humane reforms, introduction of non-restraints and the hospital
period. This legacy has given us our share of woes. Infrastructure development did not take place. Also enough attention was not paid to bringing in humane concerns into our day to day hospital practices.

Things did not change even after independence. Not even proper repairs were done for those century-old dreadful cages, where our patients lived! State governments, whom the Constitution assigned the responsibility to provide health care never bothered to build and maintain proper mental hospitals. Nor did the central government do anything, even though the matter involved serious human rights issues. Today it is not fashionable, even to talk about mental hospitals! Many a stalwart of Indian Psychiatry who did their best to provide good quality care for their patients in mental hospital against heavy odds, are all now forgotten!

As for psychiatrists working in mental hospital today, many of them are totally demoralized. They have learned to live with all those glaring shortcomings in their institutions like jail like high walls, leaking roofs, broken doors and all-round squalor. When patients are condemned to live with no access to drinking water and have just open drains as their toilet facility, their doctors are supposed to look the other way, lest they offend their State Government!

Recently the National Human Rights Commission (1999) has viewed that mental hospitals in India are 'places where the rights of the mentally ill are grossly violated'. In Kerala the Honourable High Court is directly overseeing the working of government mental hospitals. The court has appointed committees for this, taking special care not to include any psychiatrists the learned view is that psychiatrists have nothing to contribute, in the business of managing mental hospital! May be some even think that psychiatrists are part of the problem!

Why do we have a situation like this nearly two decades after the arrival of our National Mental Health Programme? Did we get influenced too much by an American model of the Kennedy era, where they spent huge federal funds and developed many Community Mental Health Centers that functioned quite independent of mental hospitals?

The naive belief of our policy makers and health administrators these days is that in modern psychiatry there is no need for any mental hospital! So much so, if a Medical Superintendent demands funds to modernize his Mental Hospital, lay health administrators and politicians will view him as old-fashioned!

A recent document by the WHO, the world Health Report 2001, has taken up mental health for their special attention. But it is unfortunate that they have failed to address the issue of unwanted psychotics, in poor countries. Statements like 'mental health services should be provided in the community rather than in mental hospitals', are all quite fine in the case of developed countries, where they already have enough of decent mental hospitals. But what about poor countries where they practically have no facility that could be justifiable called by the name mental hospital? The WHO report gives the example of Australia. But even after their large-scale down sizing, mental hospital bed population ratio in Australia would be many times that of the 'notional' beds that we have in a country like India!

The model developed in USA, where they had too many mental hospital beds is obviously not suitable for us with our meager number of miserably maintained mental hospital beds. Bhaskaran (1991) has observed that 'In spite of our heroic efforts at treatment and rehabilitation a section of our psychiatric patients will not be able to remain and function in the community... and will need indefinite and even lifelong custodial care'. With widespread poverty, illiteracy and superstitions, scientific treatments may never reach large sections among the needy. Ultimately it will be the Government's responsibility to take care of all these persons. What a body like WHO must do in this regard is to issue recommendation that would mandate the
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governments in developing and poor countries, to take up the guardianship of these people. Patients must not be allowed to perish in the present fashion. Protection of basic human rights of even the weakest is the responsibility of all nations.

A civilized society must have enough number of good mental hospitals located at places in the reach of the poorest. These hospitals should provide amenities and services consistent with universal human rights concerns as well as scientific psychiatry. They could be nodal centers to co-ordinate all the mental health services, including rehabilitation programs in a defined geographical area. Today even in USA, they talk more about Public Psychiatry, rather than Community Psychiatry, meaning thereby, institutional setting must be made available as per actual public needs!

Many psychiatrists these days are keen to redefine their professional role as that of a medical specialist. Always in the midst of high-tech gadgets and prescribing new molecules, that they believe, work wonders! They are reluctant to face the stark reality that even with the best of treatment a small proportion of patients fail to respond. With higher life expectancy for all, the number of these non-responders is bound to increase. Where will these "treatment failures" end up?

Sreenivasa Murthy (2001) has estimated that in India inpatient care is available only to about 10% of the very ill mental patients. But what about others? State support has to be provided for the remaining 90% with a network of well thought of institutional settings. On one end of a broad spectrum of treatment settings a total-care institution, whether you call it mental hospital or by any other name, also has to be there.

Many poor people seek admission in places like Erwadi, as they have nowhere else to go. What else they could do, when the few available Government Hospitals virtually shut their doors and institutions in the private sector are unaffordable?

Since the late eighties Kerala has a mushrooming of custodial institutions, manned by untrained persons to 'take care' of chronic mental patients. Many of these Erwadi-like places have very poor patient care standards. It is indeed a sad irony that unhealthy trends are taking roots in the highly literate Kerala, close to the heels of our National Mental Health Programme!

Agarwal (1998) has reported about a poor family, in its utter helplessness sending a severely psychotic daughter to the thick forest quite ceremoniously, dressed in saffron and all! Our society indeed has many more terribly innocent ways to cope up with the tragedy of severe mental illness in the family!

If Erwadi is not to be repeated, we must take a fresh, close look at our National Mental Health Programme. It may be modified or even re-drawn, if found necessary. In allocating resources for mental health care, there should be a proper prioritization. The fiscal requirement to rebuild our existing mental hospitals and to build new ones for the actual needs of a country inhabited by over hundred crores has to be realistically worked out. The central Government has to create a fund for this. They must not take cover under a mere technical stand that the constitution and the Mental Health Act has placed this responsibility on the states. State Governments would not be able to take up this huge challenge. Even though they have competent experts in their cadre, they do not have the necessary economic resources.

Improving the quality of treatment, upgrading mental health education etc. are all steps in the right direction, that are absolutely necessary to prevent chronicity among psychotics, as Selvaraj & Kuruvilla (2001) have emphasized. But despite all these there is a need to have more number of well-maintained mental hospitals. Trivedi (2001) is quite hopeful about the great Indian family system, in coping up the problems of chronic psychoses. But let us remember that even that has its threshold of tolerance for aberrant or violent behaviour, especially when the family is poor. Our failure to strengthen Mental Hospitals that are meant for
the most disturbed psychotics from the desperately helpless and poor families is not in tune with the great humane traditions of Psychiatry.

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JAMES T. ANTONY, Consultant Psychiatrist, Poothole Road, Trissur-4, Kerala (email: jamesantony@vsnl.com).