

Mental Illness in India

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ABSTRACT

The armed territorial conflicts, terror activities, and filing economies in several countries are breeding mental health issues. Mental illness, shrouded by stigma is the elephant in the room here which is finally acknowledged by the society and the policy makers. Both the military as well as the civilian society are affected. The rigours of military life and the daily anxiety of civilian society, both appear to be leading to mental health issues in defence personnel and the civilians. In India, with limited medical resources, the situation is even grim. In this review paper, the focus remains on the issues of mental health and mental illness, which have recently come to the fore on account of many national happenings in last few years. The paper explores the extant literature on mental illness in India and outlines the meaning of mental illness, discusses the legislations and Government's programmes and initiatives regarding the promotion of mental health. The issue of mental health is discussed in light of rising suicide incidence in our soldiers which is a cause of concern. The paper culminates with the suggestions for further research and remedial measures.

Keywords: Mental disorder; Mental health; Soldiers; Military; Defence forces

"Mental illness is nothing to be ashamed of, but stigma and bias shame us all."

-Bill Clinton

1. INTRODUCTION

The famous painting *The Scream* by Edward Munch (1893) is the symbolic representation of the universal anxiety of the modern human⁶. It is one of the most recognizable works of art. The painting conveys a meaning to every viewer, the overpowering exasperation. The agonised figure in the painting is reduced to a garbed skull shrieking in the throes of emotional crisis. It shakes one to the core and the scream from the painting resonates in sync with the silent yet powerful scream emanating from the viewer's soul.

The current state of affairs all over the world marked by violence and strife has a deleterious effect on mental health of people. In the crisis-strewn world of today, trauma and sudden loss are frequent happenings all over the globe. War, conflicts, deaths, bombings, rapes, murders, domestic violence, muggings and robberies on the street are a few of the terrible things that we witness and/or experience due to which the mental health is in jeopardy. The psychological consequences such as mood and anxiety disorders, substance abuse, general psychological distress etc. ensue along with impairment in social functioning. World Health Organisation (WHO) in 2005, during European Ministerial Conference on Mental Health endorsed the statement 'No health without mental health'. But the historical divide between the practice and the policy between physical health and mental health exists even today. The upshot is a

global tragedy that we are witnessing: a legacy of the neglect and sidelining of mental health²³. Mental health is defined by WHO as, 'a state of well being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work with productively and fruitfully, and is able to make a contribution to his or her community'³³.

According to the World Bank report (1993), the Disability-Adjusted Life Year (DALY) loss due to neuro-psychiatric disorders is higher than that with diarrhea, malaria, worm infestations and tuberculosis when taken individually. It has been estimated that DALYs loss because of mental disorders will represent 15 per cent of the global burden of diseases by the year 2020. The disability-adjusted life year (DALY) developed in 1990s is the measure of overall disease burden, in the form of the number of years lost due to ill-health, disability or early death. It is a way of comparing the overall health and life expectancy of different countries. In 2013, 31 million years of healthy life were lost to mental health in India. Estimates suggest that by 2025, 38.1 million years of healthy life are expected to be lost to mental illness in India i.e. a 23 per cent increase. WHO data (Mental Health Atlas, 2014) indicates that in some low income countries, the treatment gap for mental disorders as compared with physical disorders can be higher than even 90 per cent. It is for the first time that world leaders at UN have acknowledged the promotion of mental health and well-being, and the prevention and treatment of substance abuse, as health priorities while charting the global development agenda. The happy ending is the inclusion of mental health and substance

abuse in the Sustainable Development Agenda adopted at the United Nations General Assembly in September 2015. The Agenda envisions the world as a better place 'where physical, mental and social well-being are assured' in the years to come which is in line with the WHO definition of health. World leaders appear committed to 'prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development'³².

The Mental Health Care Bill, 2016 is passed by Upper House. World mental health day, 10th October was observed this year with the theme 'Psychological First Aid'. According to a recent study 'Mental Health and Integration' done by The Economist Intelligence Unit with the purpose of assessing the degree of commitment of 15 Asia-Pacific countries to integrating those with mental illness into their communities, India has ranked 11th, with 29.5 points while New Zealand topped the list with 94 points. Public health services in India are often insufficient, inaccessible and of poor quality. No wonder that mental health has been sidelined. In India, there are just 43 government-funded mental hospitals and 0.3 psychiatrists per 1,00,000 people, and even fewer psychologists. Plus less than one percent of the total health budget is spent on mental health³¹. The prevalence of mental illness warranting intervention by a mental health professional is estimated to be 20 per cent in India¹⁴. The social burden of the stigma attached with mental illness when coupled with the disproportionate emotional, physical, mental and economic burden of the medical treatment makes a deadly cocktail for the individual with mental illness and his/her family.

According to Dr D. Ram, Director of Central Institute of Psychiatry, 13 per cent of the Indian population suffers from acute mental illness and mental health professionals are not depressingly low in number in India. He added that for the first time a mental health survey was conducted on a large scale in 12 states covering almost 60 per cent of population to ascertaining the incident of mental illness at national level. The report indicated that 10.6 per cent population from age 18 and above suffered mental illness (Times of India, October 22, 2016). According to Dr Nimesh Desai, Director of the Institute of Human Behaviour and Allied Sciences (IHBAS), "Mental disorders can be grouped into two broad categories- severe mental disorder, such as schizophrenia and bipolar disorder, and common mental disorder (CMD) such as depression and anxiety". He says that the percentage of prevalence of severe mental disorders do not vary much across time, history, cultures and countries because these have a genetic basis. On the other hand, the percentage prevalence of CMDs varies according to the psychological atmosphere and social milieu where one is placed (Hindustan Times, July 12, 2015).

The stigma that comes with mental illness deters the individuals from seeking help and is not only confined to the patients of mental illness but also to their families/caregivers. This type of stigma is called as courtesy or associative stigma and it comes to the caregivers just by virtue of being associated with the individual with mental illness¹⁷. Caregivers report depressive symptoms when they are subjected to stigma¹⁵.

2. CULTURAL ASPECT OF MENTAL ILLNESS

The term 'culture' is an abstraction comprising the total way of life of a group of human beings¹³. Culture exerts a significant impact not only on the prevalence of mental illnesses but also on people's reaction to those mental illnesses in that culture. India's multicultural and traditional society follows a pluralistic approach to healthcare. There are systems of healthcare other than modern medicine such as Ayurveda, Unani medicine, Naturopathy and Homoeopathy prevalent in the society. Sometimes people ascribe supernatural cause to the illness. They approach religious and traditional healers for help in disease and disorder, especially in case of mental illness²⁴.

In India, it has been estimated that twenty percent of mental illness warrants intervention by a mental health professional. Interesting to note that the prevalence of mental disorders in India is very low compared to the western world¹⁴. This is may be due in part to inadequacy in the epidemiological studies, genetic reasons or because of cultural differences in that in India, good family support, cultural factors, lifestyle and better coping skills and comfortable environment deter mental illness²². Some cultures regard brief reactive disorder and possession trance as mental disorders while some societies consider these as exalted states. Researchers found that schizophrenia is more prevalent in inner cities and urban areas as compared to countryside²⁰.

There are certain psychiatric syndromes that are limited to certain specific cultures and are called culture specific or culture bound syndromes. These are considered a disorder only within a specific society or culture and have no objective biochemical basis or structural alterations of body organs or functions⁴. In Indian subcontinent, following are some of culture specific syndromes:

- *Dhat*: Nocturnal emissions in males
- Possession syndrome: Diagnosable under dissociative disorders
- Culture bound suicide: *Sati* (self-immolation by a widow on her husband's funeral pyre, *Jouhar* (suicide committed by a woman when faced by prospect of dis-honour from another man (usually a conquering king), *Santhara/Sallekhana* (involves voluntarily giving up life by fasting unto death over a period of time for religious reasons to attain God/ *Moksha*)
- Koro: Seen in Northeastern states like Assam, exhibited by both the sexes, and involves a fear of genitalia retracting into abdomen leading ultimately to death
- Mass hysteria: hundreds to thousands of people start to believe and behave in a manner in which they ordinarily won't

Trivedi²⁵, *et al.* discussed health care needs of women in India and suggested that mental health needs should be customised in accordance with the local needs and cultural sanctions. In a study conducted by Pawar¹⁹, *et al.* 90 per cent of patients of mental illness admitted to having experienced stigma, and 86 per cent admitted to having experienced discrimination with females reporting more discrimination than males. The participants experienced stigma irrespective of their age, mental status, rank or education. Caregivers of people with mental illness as well as the members of general

population perceived stigma and felt blamed by the community. A number of public policy and judicial enactments in India have tried to address the issue of stigma attached to the mental illnesses and the rights of people with mental¹⁰.

3. MENTAL ILLNESS IN DEFENCE FORCES

Armed forces guard the nation from external enemy as well as they assist the civil administration when a natural calamity befalls and/or an internal conflict raises its head. The selection procedure of defence services ensures that only the physically and mentally robust are recruited and the military training makes them battle worthy by instilling discipline and esprit de corps in them. Armed forces personnel are exposed to various kinds of stress on account of unique nature of their duties and services that involve being away from family for long periods being in life-threatening combat situations and deployment in extreme weather conditions. The stress arising from these stress have no parallel in civilian life as much threat to life and well being accompanies this job²¹. Globally, the prevalence of a mental disorder has been noticed to be around 45 per cent in troops after deployment¹¹. The untreated mental health problems have a negative impact on wellbeing and operational effectiveness of the forces in combat situations⁹. Researchers reveal that fear of being stigmatised and lack of trust/confidence in mental health providers are major barriers to seeking help in armed personnel^{7,8}.

Minister of Defence, India in 2015 revealed that at least 413 defence personnel have committed suicide since 2012. 334 cases were reported from the army alone during the period. The Air force was next with 67 suicides and the Navy reported 12 such incidents. During the same time period, eight incidents of fratricide in the army were reported. The air force reported one such incident, while Navy reported none. Occupational hazards, domestic issues, finance related problems, perceived grievances, personal issues, mental built and the inability to withstand stress were cited as the major reasons for such incidents. He added that a substantial number of officers (from military only) have been trained to provide psychological counselling to the defence personnel and their families (The Hindu, 11 December, 2015). During the years 2003 to 2007, 635 cases were reported of suicide including attempted suicides; and 67 cases of fratricidal killings in the three services of Armed Forces. Between 2007 and 2010, 208 soldiers were killed actions against militants, while 368 soldiers committed suicide*.

Talking of paramilitary forces, women constitute less than two percent but account for 40 per cent of total number of suicides in these forces. The rate of suicides for women is way above the suicide rate in general population, where it is 7.1 per lakh according to the data from National Crimes Record Bureau (NCRB) and the Bureau of Police Research & Development (BPRD).

In 2014, Central Armed Police Forces (CAPF) 175 personnel committed suicide. The cause-wise analysis reveals that 25.7 per cent of suicides were due to 'marriage related issues', 10.3 per cent were due to 'family problems' and 8.6 per cent were due to 'services related issues' while 49.1 per cent suicides were due to unspecified 'other causes'. The state-wise

data reveals that 45.7 per cent suicides were reported in Madhya Pradesh, 20 per cent in Telangana and 10.3 per cent in Jammu & Kashmir. These three states account for 76 per cent of total suicides. In Jammu & Kashmir, maximum suicides reported were from 'service related issues' category accounting for 73.3 per cent of total such suicides in CAPF in the country (Times of India, 23 July, 2015).

Koshy¹², writes that Kashmir is one of the most militarised zones in the world. The long standing, ongoing conflict takes a heavy toll on the mental health of armed forces deployed in the region. This prompted New Delhi to take measures to curb the distress among the forces. The Defence Ministry has included Yoga as one of the measures to reduce stress levels in India controlled Kashmir. In high altitude regions, isolation may be a reason of stress while deployment in insurgency areas, the threat comes from one's own countrymen, may also be a cause of distress for some.

A threat to the basic instinct of survival in the combat situations and during the deployment in conflict ridden areas can be an ordeal not only physically, but mentally also. The stresses of barrack life sometimes end up pushing the vulnerable ones over the edge which in turn in some instances results in suicide, fratricide or nervous breakdown. Research evidence from an American sample suggests that poor mental and physical health has been observed in active duty military personnel as compared to veterans and reserve personnel³.

Based on the recommendations of Defence Institute of Psychological Research (DIPR)³⁵, a number of remedial measures to deal with stress are implemented in the Army in field as well in peace areas. Liberalised leave policy, deployment of psychological counselors in counter insurgency areas, stress management training programmes, rotation of units and individuals to minimise exposure to stress, periodical review, monitoring and analysis of stress related incidents, disseminations of reading materials on stress management in appropriate languages are some of the measures taken along with the introduction of training capsules on relaxation techniques including Yoga and Pranayam. In their 21st Report, the Standing Committee on Defence (2009-2010) recommended, 'The Committee understand that the demand on the personnel of Indian Armed Forces have been increasing over the years due to changing operational commitments of diverse nature. At the same time, they are required to meet aspirations of their family members for a good quality life on account of rapidly changing socio-economic conditions in the society.'

Another study conducted by DIPR³⁶, the three main operational stressors found were the fear of torture, uncertain environment, and domestic stresses. These stressors are responsible for most of the psychological issues in armed forces. It was found that middle rank officers were more stressed as compared to soldiers and Junior Commissioned Officers (JCO). In traumatised troops, mental disorders such as post traumatic stress disorder (PTSD) have been observed, which lead to various somatic symptoms. The magnitude of the problem is down played by sounding the plea that the overall psychiatric morbidity in the Armed Forces is less than the national figures.

4. MENTAL HEALTH INITIATIVES IN INDIA

In 1887, Nellie Bly, earned acclaim for going undercover as a mental illness patient and admitting herself to a mental asylum in New York. Her ten day stint with starvation to brutality and sexual assault in the asylum made its way into one of the most notable journalistic exposes of the time and her book led to various reforms at the institution. We cannot boast of any such incidents at our journalists hands. Delhi Commission for Women (DCW) conducted a surprise visit to *Asha Kiran* complex which houses government run homes for people with mental disability in Delhi. The whole system was found to be in a deplorable state with nude inmates roaming the wards, some inmates crawling on the floor, floors covered in fecal matter and blood as women are not provided sanitary materials, up to four women sharing one bed, and children sleeping on the floor in cold with no mattresses because of bed-wetting.

Indian Lunacy Act of 1912 totally revamped the mental health services and their administration in India (Banerjee, 2001). With the law being enacted, the so called mental hospitals that resembled the prisons in their administration, became free and came under central supervision. It was acknowledged that specialists such as psychiatrists are needed to treat the patients with mental illness. However, the law viewed the mentally ill as potentially dangerous and the need to protect the public from the mentally ill was of paramount importance.

The National Mental Health Program (NMHP) was launched by the Government of India in 1982 with the objectives:

- (a) To ensure the availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population;
- (b) To encourage the application of mental health knowledge in general healthcare and in social development and
- (c) To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

In IX Five Year Plan, the District Mental Health Program (DMHP) was launched under NMHP in the year 1996 with the objectives of early detection and treatment, training of general physicians for diagnosis of mental illness, public awareness generation and lastly, record keeping.

In 2003, NMHP was re-strategised by extending DMHP to 100 districts, up-gradation of psychiatry wings of government medical colleges and hospitals, modernisation of state mental hospitals and by use of information, education and communication along with monitoring and evaluation.

The mental health plan was again revised in 2009 and includes:

- (a) Timelines for the implementation of the mental health plan
- (b) Funding allocation for the implementation of half or more of the items in the mental health plan
- (c) Shift of services and resources from mental hospitals to community mental health facilities and
- (d) Integration of mental health services into primary care.

In April, 1993 Mental Health Act 1987 (MHA) came into force officially. The Mental Health Act of 1987 was only

a slight improvement from the Indian Lunacy Act (1912). Woefully speaking, it upheld the regressive provisions of the colonial Act such as, 'to protect society from the presence of mentally ill persons who have become or might become a danger or nuisance to others'. Thus, the 1987 Act also focused on institutionalisation of the individuals with mentally illness.

The National Trust for the Welfare of Persons with Autism, Cerebral Palsy was established in 1999. It is a statutory body of the Ministry of Social Justice and Empowerment, Government of India, set up under the 'National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities' Act (Act 44 of 1999) with the purpose of providing for the appointment of legal guardians for the people with these disabilities. The Mental Health Act of 1987 only covers persons with mental illness. Therefore, the National Trust Act was founded to take care of the legal and social issues confronting persons with the above disabilities.

In October 2007, the need for a comprehensive law on mental health was first realised when the United Nations Convention on the Rights of Persons with Disabilities was ratified by India. The Convention provides that the States which ratify it should enact laws and other measures to improve disability rights, and also abolish legislation, customs and practices that discriminate against persons with disabilities.

The first-ever National Mental Health Policy was launched on 10 October, 2014 with an aim to provide universal psychiatric care to the Indian population, 20 per cent of which is expected to suffer from some form of mental illness by the year 2020. The first of its kind policy insisted on an increase in funds to provide accessible and affordable care to the ones suffering from mental illness. The policy also called for training the mental health professionals ranging from community-based counselors to specialised psychiatrists. 'Mental Health Action Plan 365' was also announced which spells out the specific roles of the central government, the state governments, local bodies and civil society organisations in the year to follow.

In January 2014, the Reserve Bank of India (RBI) guidelines raised the question that is fraught with issues- the guardianship of persons with disabilities. RBI issued guidelines which were in concordance with the Mental Health Act, 1987, to accept legal guardianship certificates for the purpose of operating bank accounts of persons with disabilities. Several people with mental illness have a genuine argument that why cannot they decide on what to do with their money. The central bank later clarified that it is not mandatory for every mentally ill person to insist on a guardianship certificate when submissions from several organisations working with rights of persons with disabilities poured in.

Mental Health Care Bill, 2016 passed by Upper House is a progressive, ambitious and watershed legislation to address the issue of mental illness and related concerns. Upon the ratification of the United Nations Convention on the Rights of Persons with Disabilities in 2007, the reform in health sector was much needed. It comes as a delight that for the first time in the history of mental health legislation in India, 'mental illness' is comprehensively defined as: 'A substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise

reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub-normality of intelligence’.

The Bill will replace the archaic 1987 Act if passed by Lower House and assented by the President. The Bill provides a certain degree of autonomy to the persons living with mental illness. A substantial portion of the Bill revolves around ways to protect, promote and fulfill their rights ‘during delivery of mental health care services’. Plus it lays stress on bringing the mental health services on a par with those available in the general health system. The Bill provides for the formation of Central and State Mental Health Authorities and a Mental Health Review Commission. The provision of Advanced Directive under the Bill is a welcome move. One more positive aspect of the Bill is the de-criminalisation of attempt to suicide which is otherwise a punishable offence under Section 309 of Indian Penal Code. The Bill mandates the insurance companies to provide medical insurance to persons with mental illness as in the case of physical illnesses. The banning of the use of electroconvulsive therapy (ECT) for minors and without anesthesia for adults is another key feature of the Bill.

The Rights of Persons with Disabilities Act, 2016 received the President’s assent in December, 2016 to give effect to the United Nations Convention on the Rights of Persons with Disabilities. This law replaced the PwD Act which was enacted in 1995. The new law has increased the number of disabilities from 7 to 21 and has listed some neurological/mental conditions such as intellectual disability, autism spectrum disorder, mental illness, and Parkinson’s disease in the list of disabilities. This law provides for reservation in higher education, government jobs, and in allocation of land for the persons with the benchmark disabilities.

5. CONCLUSION

In order to contain the concerns of the rising behavioural or psychiatric disorders both in the military and the civilian society, various steps need to be taken, 1st of these being the admission of the fact that the mental health is in jeopardy due to stress and strain of modern life. Evolutionary, human beings were not designed to deal with these stresses that we are facing today owing to demanding jobs/lack of jobs, interpersonal conflicts at workplace and in the family, terrorism, internal conflicts in the countries and others.

In the civilian society, what we need to address first is the stigma associated with mental illness. The society needs to understand that mental illness is not a matter of shame and warrants help just like physical illness. Second, an awareness program is warranted to increase public’s awareness surrounding mental health issues. The decriminalisation of suicide by Mental Health Care Bill 2016 is a welcome move.

In armed forces, blaming mental illness on ‘domestic issues’ would take us nowhere. The behavioural problems in the soldiers should be dealt not through punishment or red ink entries but with the help of counseling and/or medical care. There is a strong need to inoculate officers with stress management training. Psychological counselors must be inducted in the

armed forces on the lines of ITBP. The counseling services can be sought from civilian psychologists on a part-time basis.

The masses need to be made aware of the mental illnesses and be sensitised towards the agony accompanying these. We need to develop a culture of respect and understanding as opposite to a culture of stigma and shame. In this, the principal challenge lies at the workplace. The individuals, who need help, don’t seek help in a fear of being mocked and/or laid off. There is a pressing need to conduct the large scale empirical researches to assess mental health status of people in both civilian and military set up and to ascertain the causes of malfunction. Being forewarned, is being forearmed they say.

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