Pills that swallow policy:
Clinical ethnography of a community mental health program in northern India

Transcultural Psychiatry

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Abstract

India's National Mental Health Program (NMHP) was initiated in 1982 with objectives of promoting community participation and accessible mental health services. A key component involves Central government calculation and funding for psycho-tropic medication. Based on clinical ethnography of a community psychiatry program in north India, this paper traces the biosocial journey of psycho-tropic pills from the Centre to the Periphery. As the pill journeys from the Ministry of Health to the clinic, its symbolic meaning transforms from an emphasis on accessibility and participation to administration of 'treatment'. At its final destination of delivery in the rural health centre, the pill becomes central to professional monologues on compliance that mute the voices of patients and families. Additionally, popular perceptions of government medication as weak and unreliable create an ambivalent public attitude towards psychiatric services. Instead of embodying participation and access, the pill achieves the opposite: silencing community voices, re-enforcing existing barriers to care, and relying on pharmacological solutions for psycho-social problems. The symbolic inscription of NMHP policies on the pill fail because these are contested by more powerful meanings generated from local social and cultural contexts. The authors argue this understanding is critical for development of training and policy that can more effectively address local mental health concerns in rural India. The paper concludes with an outline of potential areas and approaches to interrogate well meaning mental health programs that alienate the very people it is meant to serve.

Key words: Community Psychiatry, India, Psycho-tropic medication, Mental Health Policy, Clinical Ethnography.

Introduction

India is considered a leader among low-income countries in developing national policies on community mental health services (Cohen, A., 2001). The country's policies have emphasized strategies to address challenging human and financial resources, and servicing dispersed and remote populations of a very large and diverse country. These approaches include an explicit focus on integration and treatment of mental illness in primary health care, community participation in the development of services, and forging links between mental health and social development (Government of India, 1982).

In actuality, the practice of community psychiatry in India is a focus on pharmacological treatment of psychiatric disorders. Community participation and psycho-social approaches although enshrined in policy are not actualised in practice. This paper teases out the dynamics of why this has come about and contend that psychotropic medication has become the essence and embodiment of India's community mental health policy. In this paper, 'the pill' is used as a trope for understanding the actualization of mental health policy. Tracing the biosocial journey of the pill from policy makers in Delhi to patients in a village in the state of Uttar Pradesh State, the paper contends that the practice of community psychiatry is an administrative psychiatry focused on effective distribution of psychotropic medication. The 'pill', initially embodying ideas of accessibility and participation achieves the opposite: silencing community voices, re-enforcing existing barriers to care, and relying on pharmacological solutions to psychosocial concerns.

This paper is part of research examining the cultural relevance of community mental health in India. It includes consideration of the relationship between policy, clinical services, and local communities. The issues highlighted are not intended to generalize about the state of services for the whole country. Rather it seeks to

consider the specificities of implementation at a chosen field site in the context of mental health policies and the health bureaucracy. Nevertheless, some of the findings are emblematic of the problems affecting the delivery of community psychiatric services in rural India in general.[i] Data is based on eight-teen months of clinical ethnographic field work conducted by the first author, at a government community mental health program and a village in Kanpur district, Uttar Pradesh State; interviews with Indian mental health professionals and policy makers; and analysis of relevant policy and research documents[ii]. Kanpur was chosen as a field site for several reasons. When this research commenced, it was the only community psychiatry program operating in the state of Uttar Pradesh and one of the longest operating programs in northern India. This fit well with the research objectives of examining a functioning program. The first author's extensive cultural knowledge of the region over several years, and personal and academic links with Kanpur, facilitated this work. The second author is also familiar with the social geography of the area, and has been educated there for over ten years. Both authors are fluent in spoken and written Hindi, the local language spoken in North India. Additionally, the second author's medical psychiatric training, clinical teaching and research experience in mental health in India, complements and contextualises the fieldwork observation and analysis. Local supervision and ethical aspects of the research were established prior to the commencement of this study.

The Kanpur program (known as the District Mental Health Program) was unique in some respects. Data from the Kanpur city out-patient clinic (from November 1998 to December 2003) indicated that 48% of patients were diagnosed with depression while 11% were diagnosed with psychosis[iii]. This suggested a deviation from national objectives which explicitly focus on serious mental disorders.

The other program for which some comparable data[iv] is publicly available, in Thiruvanthapuram district, Kerala state, reports approximately 30% of patients with a diagnosis of schizophrenia between 1999 to 2004 (DMHP Thiruvananthapuram, 2004)[v]. The clinical vignettes presented in this paper reflect the focus of the Kanpur program on common mental disorders. The main difference between those presenting with serious mental disorders and common mental disorders, is that the former often did not access the clinic[vi]. Nevertheless, for those that reached the clinic, the 'story of the pill' was quite similar to those diagnosed with common mental disorders.

During fieldwork, the role of psychotropic medication emerged as a central theme amongst mental health policy makers, clinicians and the general public. It is for this reason that the authors deploy the journey of 'the pill' as a conduit metaphor for appreciating the processes through which central policies both connect and reach the periphery (Lakoff, G. & Johnson, M., 1980). This device serves to illuminate the social, cultural and political processes that shape and actualize policy. The paper will proceed by analyzing the role of the pill at successive stages in its journey from the centre to the periphery: from the bureaucrats in New Delhi to the village via the local rural clinic.

I. The 'policy' pill

In 2002, the Government of India unveiled a 're-strategized' National Mental Health Program. This shift in policy followed a recognition that previous efforts to implement the earlier 1982 Program had met with limited success (Kapur, R. L., 2004; Agarwal, S. P., Ichhpujani, R. L., Shrivastava, S., & Goel, D. S., 2004; Weiss, Mitchell G., Isaac, Mohan, Parkar, Shubhangi R., Chowdhury, Arabinda N., & Raguram, R., 2001). These national policy changes took place in the context of wider

international developments in the field including the publication of two influential reports and new evidence highlighting the global burden of mental disorders (Desjarlais, R., Eisenberg, L, Good, B., & Kleinman, A., 1996; World Health Organization, 2001).

The new Indian policy initiatives in 2002 departed rather significantly from the original National Mental Health Program (NMHP) unveiled in 1982. The latter emphasized access to services and community participation[vii] with a focus on serious mental disorders (Government of India, 1982; WHO Expert Committee on Mental Health, 1975). The new policy favored provision and distribution of psychotropic medication, and was supported by a steep budget increase of Indian Rupees 16.2 billion (US$345 million). A senior health bureaucrat, an architect of the new policy, explained:

> "This [budget increase] involved advocacy but the methods, which I adopted, were unorthodox….I worked out the cost of treating psychiatric conditions using the retail prices in Delhi…I was somehow able to convince the top people then that mental health interventions..."

In a policy environment emphasizing outcomes, 'the pill' had the requisite appeal to garner funding:

> "I was only referring to pharmacological interventions because you see as far as the health care system is concerned it is only drugs and treatment you see there's no question of psychotherapy and treatment of psychosocial....because if you get involved in that those things they may be scientifically correct but.....
>
> So I said you cannot have a cheaper public health intervention and the results are phenomenal…so this...some how appealed to them..."

This new NMHP sought to down-play and distance itself from previous strategies. The same senior health bureaucrat commented:

"The Bellary model [an earlier model for delivering mental health services at

> the district level] ……. is unevaluated. It has become a holy cow which no one dares questions and there were major problems in that.....there were major dysfunctional aspects…and because it became a holy cow so we could not question it, we adopted it lock, stock and barrel and this is responsible for many of the problems we are facing now.
>
> We have [now] modified it without specifying or saying it in so many words because it's a holy cow you can't touch it. So what we have done is that we have put it aside because no one really knows what is the Bellary model so.…we are on safe ground. So whatever we do we can say it conforms to that model."

This signified an abandonment of some of the key principles of the NMHP, in favor of allowing state governments to 'innovate':

> "…This thing can succeed only if the states are prepared to innovate and that is why whenever they ask me how do we go about it I say: take the funds, do what you want with it, only achieve the results, which we want to achieve. How you go about it we are not going to look into it. Give us a utilization certificate and we will release the next year's funds."

Additionally, the new policy of 2002 redefined the relationship between psychotropic medication and mental health policy. Previously the 1982 policy placed a singular emphasis on access to treatment including community participation, integration of mental health with primary care, psychotropic medication and psychosocial approaches. The new policy is however deliberately ambiguous. Whilst not explicitly rejecting key aspects of the old policy, it implicitly emphasizes medication. Yet it is unclear about how community participation, integration of mental health with primary care and psycho-social interventions inter-link within the new approach[viii].

The absence of published literature that contests or resists this change from the 'old' 1982 policy to the 'new' 2002 policy is striking. Consultations on the re-strategized NMHP ('new' policy) did take place "…with various stakeholders…" (Agarwal, S. P., Ichhpujani, R. L., Shrivastava, S., & Goel, D. S., 2004), but there is no indication of who was involved in this process and what resulted from it. Although, there have been several critiques of generic mental health policy (Kapur, R. L., 2004; Mondal, P., 1995; Murthy, R. S., 2004; Nizamie, S. Haque & Desarkar, Pushpal,

2005), these have not been substantiated with empirical data[ix]. A national evaluation of district mental health programs (DMHPs) was conducted in 2002 but is not available in the public domain (Basic Needs India, 2004). Two programs in the southern Indian States of Kerala and Tamil Nadu have websites detailing services and providing annual reports, though these do not constitute formal evaluations (Arunkumar, T. S. & Vijayachandran, S. K., 2008; Government of Tamil Nadu, 2008). It is notable that there has been a singular absence of professional and popular comment on the shift of emphasis in the re-strategized NMHP. Thus, the 'pill' devoid of any resistance or critique becomes central to the new mental health policy, geared up to be advanced through the bureaucratic structures of the state government.

In India, implementation of health services is undertaken by state governments with the central government providing overall direction, technical assistance and some funding (Misra, R., Chatterjee, R., & Rao, S., 2003). The singular emphasis of mental health policy on psychotropic medication was re-enforced by multiple layers of administrative structures at the state level in Uttar Pradesh,. The District Mental Health Program in Kanpur was initially funded by the central government as a pilot project with the stipulation that it would be taken over by the state government after five years[x]. Responsibility for implementation was given by the state government to the head of the Department of Psychiatry in a government medical university[xi] who was designated as the 'Nodal Officer'. The Department appointed a mental health team at Kanpur (110 km away) based in the local district hospital.

Within these administrative structures, there were divergent understandings of mental health priorities and varying levels of commitment to the Program. In the State Ministry of Health, an Indian Administrative Services (IAS) officer responsible

for mental health services stated that that there was "….no state planning" for mental health and that it was "just there" in policy but not really a priority. This same officer stated that the purpose of the DMHP was "*to provide counselling to those suffering from mental illness…from the patient's perspective."* This would appear to be very closely linked to NMHP ideals of community participation. It was perhaps a distant and idealistic view reflecting the position of the Indian Administrative Services at the apex of the country's civil service hierarchy. In contrast, within the local Department of Psychiatry there was frustration with the state government's commitment. A senior academic psychiatrist commented:

> "According to them [bureaucrats], this [mental health] is something which is not very significant, it's not one of their priorities…….It varies from official to official. You see, sometimes officials are very sympathetic, they're considerate, they promise you things and they also do things according to your wish. At other times, they may not be very supportive, they may not listen to you or they may do things so late that it's not keeping with your own time table. There is a doctor who is designated the medical officer. It's a high rank in the medical hierarchy and then the secretariat is there, the administrative service is there. They look after these things. But I believe they are very busy and they have no time for these things. Sometimes we have a good response, at other times not very good."

However, even within the Department, priority given to the Program often depended on the inclinations of the particular Nodal Officer. The post had been held by several psychiatrists with varying levels of interest in the program. Additionally, the distance between the project area and the Department of Psychiatry resulted in a degree of isolation for the project team and a sense they were not receiving due attention. These factors led to various administrative problems which hindered implementation in Kanpur. They include difficulties in the release of salaries from the state government, intermittent supplies and poor quality of psychotropic medication.

In a setting lacking clear administrative responsibilities and priorities, 'the pill' became an important bureaucratic tool for implementation, and perceived as a

‘common minimum’ that could be acceptable for both bureaucrats and health professionals. ‘Common Minimum’ is a term used in Indian political coalitions to refer to the most basic acceptable agenda for a government (Jha, Prem Shankar, 2004; Pant, Pushpesh, 2004; Pai, Sudha, 1996) It is an ‘implementable’ program that balances the needs of a range of stakeholders. The ‘pill’ is a common minimum, a known entity and good fit within the dominant biomedical structure and practice. Such bureaucratic structures and justification serve to reify the ‘pill’ as central to the delivery of care at the rural clinic.

In the rural clinic, the pill interfaces with local culture where its acceptability is challenged by the power of local social moral worlds. Clinicians running such rural clinics, and faced with intractable problems of their patients, retreat into a monologue on compliance with medication. As a result, the pill accentuates the gap between the Centre and the Periphery, reframes the policy as pill, and creates newer boundaries between professionals and patients.

II. Compliance with medication: the pill as a boundary marker

Two vignettes that follow illustrate challenges at the rural clinic[xii]:

1) Lata

I first met Lata, a 45 year old woman, while driving out of the local mental health clinic with the team. Just as we were crossing the railway track to enter the highway someone came running after the jeep. The driver stopped the jeep. Lata smiled at the psychiatrist and explained that she was late. Looking at her percha (prescription slip) he asked her when she had last been to the clinic and whether she was taking her medicines. He admonished her for not coming to the clinic and pretending to be angry, said that next time he won’t dispense

medication if she doesn't attend regularly. It was several months later when I met Lata in the village and got to know her and her family that I learned she suffered from 'headaches'. Her problem had started when she had been hit on the head with a piece of wood during a fire. Over the one year that I interacted with her, she would attend the clinic every few months. Each time she would go, the doctor would reproach her for not coming regularly. One of her main concerns was whether she would be able to get free medication. Often she would ask me to intercede on her behalf to obtain medication. I understood that her irregular attendance at the clinic related primarily to her inability to negotiate a visit to the doctor within the constrained economics of the family. I noted that she was more likely to attend the clinic when her husband accompanied. Lata also told me that she would 'forget' about the clinic day as she would get involved in some pressing agricultural tasks. She would attribute this 'forgetting' to being a 'dehatin' (a pejorative way of referring to a villager).

2) The Team's journey into the village

The mental health team's jeep seating the psychiatrist, the social worker, the psychologist and an assistant (known as a peon) and driven by the team driver leaves Kanpur city for a rural health centre at around 8 AM. A box of medicines, patient case records and a case register are carefully stored in the jeep. After a long journey lasting between 2 – 2 ½ hours, along a dusty highway, sometimes on dirt roads, and riddled with long traffic jams, punctured tires and engine problems, the team reaches the health centre located at the edge of

the nearest town. As the jeep enters the compound, one is a struck by the fact that the place appears deserted. A single doctor sits out on the lawn at the head of a table, a few patients mill around. Near the Doctors' residences, a few patients hang about and some nurses and other health staff stand outside the Health Centre. The Health Centre is a typical two story government pinkish colored building. The scenario changes as we proceed towards the out-patient entrance. Several motor-cycles and bikes are parked, 10-15 people are sitting outside on the low concrete boundary, a few people are milling inside the building and on the steps. There is an air of anticipation and people chat in small groups. As the jeep turns in and parks, some stand around it and greet the doctor. A local relative of the doctor greets him and they exchange a few words. The doctor greets a young male patient by patting him on the shoulder; he smiles and is clearly pleased. Others move inside, anxious to register and obtain a 'number' to secure their place in the queue. If it's a summer day, the team moves into one of the offices on the ground floor. In the winter, they sit outside in the sun. A member of the mental health team asks the health centre staff to get some chairs. These are rusty rackety types. Often enough chairs are not available and patients have to stand or sit on small stools. The psychiatrist sits at the desk while the social worker and psychologist are set up in separate positions; one of them volunteers the task of filling in patient registers while the other conducts interviews with newly registered patients. The assistant brings in the box of medicines, begins collecting the perchas (prescription slips) of the patients and

places them before the doctor. Usually the electricity supply is not functioning. The team and patients sweat it out. Patients and family members begin crowding the entrance to the consulting room. The Peon (door attendant) and the Jeep Driver carry out 'crowd control'. Outside the room, patients and their family members stand around waiting. There is often confusion among new patients about where to go. Other patients guide them. On the external walls, a board states the services available. Inside the room, hand drawn maps pasted on the walls, indicate the health centre's catchment area and bar charts highlighting targets for particular physical diseases. After several hours of work, the team packs up and leaves. Everyone is silent on the drive back. Exhausted and hungry, they return to Kanpur city by mid-afternoon.

Both these vignettes are social dramas that highlight the incongruencies and commonalities between the clinic structure and patients' realities. For example, patients and clinicians appear to operate along different social calendars. Whilst the clinic staff rely upon western linear clock time, most villagers prioritize their needs within the harsh and changing reality of rural life. Additionally, there are important differences in the way '*illaj'* (treatment) is conceptualized. Although the pill appeals to both staff and patients, their interpretations differ. These cannot be explored by the clinicians, as the nature of social space at the clinic only allows for a limited level of interaction. The disjuncture in the clinic space, however, also arises from the different social realities of urban mental health professionals and rural people. The

following section examines the nature of these divides, and their accentuation through clinical interaction.

The social divide commences with the professionals' 'journey' to the village. Typically these visits are referred by mental health professionals as 'going to the community'. This phrase illustrates a particular and rather peculiar conceptualization of community. For the visiting urban based professionals, rural health centres are a site for interacting with the 'community'. They provide both a physical space and a conceptual framework for accessing the inaccessible village. 'Community' is a geographically defined space, and its relationship with providers defined through the lens of 'cases'. Thus, it is viewed as a site of disease and pathology. It is within an epidemiological and geographical understanding of community that the pill as medicine assumes significance in the clinic. It becomes the primary clinical intervention. The clinical and cultural consequences of this will be discussed in the next section. In the village, the health centre is not viewed as part of the community. Despite being called a 'Community Health Centre', it is geographically located at the edge of the area it serves. Thus, within the popular imagination it exists outside or on the edge of the community: a place that is inaccessible to most rural people (Jain, S. & Jadhav, S., 2008).

Inside the clinic, tablets are central to the interaction between the 'team' and the 'community'. Patients and family members, professionals and policy makers re-emphasize the value of the pill. The clinic itself resembles a noisy grocery shop where medications become *the most* sought after commodity. Indeed, patient attendance would drop when free medications were not available.

During field work at District Mental Health Program (DMHP) clinics in Kanpur, the first author was frustrated by his inability to gain insight into the lives and

experiences of patients and their families. The authors argue this relates to the dominance of 'the pill' both symbolically and in everyday discourse in the clinic. This leads to an effective muting of the voices of patients and families, and their social worlds.

The emphasis by health staff, during the clinical encounter is on *lakshan* or symptoms. New referrals to the clinic have their history initially elicited by a psychiatric social worker or a psychologist, following which the patient waits to see the psychiatrist. These written accounts of patient history largely focus on the *lakshan* of the patient and omit the social context of the patient's lives. An excerpt adapted from field notes illustrates two clinical interactions:

Case 1
A 30 year old man came to the clinic with a male friend. He reported symptoms of *tension* and *ghabrahat* (translated by clinicians as anxiousness or fear). The psychologist asked about questions about his symptoms – Did he sleep well? Did he fell anxious? Although he had been ill for a number of years, at no point were the reasons for his *ghabrahat* explored nor his social circumstances elicited.

Case 2
A Muslim woman in her mid-40s reported to the clinic and was seen by a female social worker. During the interview, the woman was asked: "*kya dikath hai*?" (What is your problem?).

Holding her head the patient responded: "*Sar dard*" (Head-ache). She then went on to provide a physical description of her problems, talking about having vomited and having pain in her eyes. In her narrative she continued to emphasize her headaches saying: "*Saar ka jadha dikath hai*" (My head ache is the main problem). She also said she experienced *uljahn* (loosely and incorrectly translated by clinicians into English as restlessness or anxiety).

The Social worker responded: "*kya uljahn paree?*". (What is the *uljahn* about?)

The woman responded "*voh baita bimar hai uska*" (my son at home who is sick).

The social worker did not follow up on this issue and went on to the next item on her form.

The completed forms in English language are then forwarded to the psychiatrist. The psychiatrist then asks the patients and family some further questions followed by a prescription.

The interview was thus oriented to eliciting de-contextualised and discrete list of symptoms in order for the doctor to make a diagnosis. The social worker explained her role was to take down details about the patient's complaint so that the doctor can save time. She was unaware that her history taking was framing local suffering in English and crafted in the language of biomedicine; and how patient 'symptoms' were in effect, a co-constructed activity.

Once the patient obtains the medication (either from a private store or from the government pharmacy), the medicines are brought back to the staff to be verified against the prescription. The patient is given instructions on how to take the medication. Outside the clinic, patients compare medications they have received. The verification of medication and instructions on their use is an important ritual in the clinic. For the staff it serves to enforce compliance. For patients and families, it helps alleviate doubts about their medication. This process is analogous to the blessing of the *prasad* (offering) in a Hindu temple: the medicine is an offering that needs to be 'blessed' by the doctor (Jadhav, S., 1994)

Similarly, there was a great deal of administrative activity and contestation around the pill. A ledger book was used to meticulously note the details of free medication. The allocation of free medications was a point of discussion between the patients and the team, with some patients insisting on being given free medication. When medication was scarce, it was allocated on the basis of need as assessed by the Team. Most patients received some free medication, often having to obtain part of the prescription from private pharmacies. Some patients, generally women with poor access to money, would either not buy the pills; or if purchased, ration the dose to last longer.

The power that the pill held for many patients was apparent from frequent occurrences where patients reached the clinic as the Team was leaving. They would rush towards the doctor's jeep and implore him to write a prescription. Once such incident is recorded in the ethnographer's field notes:

> As we were leaving and had sat in the car, tea was served to us. Then a patient appeared at the car window – an old woman with her son. The male mental health professional admonished them for being late, becoming a bit angry and telling them that the team had come on time and therefore had to leave on time. Later when it turned out this woman had not been back to the clinic in a long time, he again got angry telling her that they wasted fuel to come here; and that they couldn't visit the clinic each month.
>
> The woman had been suffering from some anxiety and lack of sleep. I asked her if she came from far…it didn't seem that far. The professional then said to me that these people take their medications for a few days then get better and stop. He then asked her a few questions and renewed the prescription. Apparently she still had some of these medications at home. He advised her to check the expiry date – it didn't look like she understood, he then told her to get some literate person to ensure that the tablets were still good. The prescription was written in English.
>
> As we were departing, she said something about one of the medications being '*garam*' (hot). The professional told her that it isn't *garam*. [This however appeared to be the reason for her reluctance to come back.]

This vignette together with earlier examples, underscore the importance of the pill as central to patient-professional interaction. Indeed, almost all clinic dialogues centre on compliance with medication. This dialogue about compliance is scripted in four sequential elements:

I. A general statement by the professional about the importance of regular medication.

II. A defence by the patient and family member that they will follow the instructions. Alternatively an admission, often with an excuse, of having stopped the medication.

III. A more emotionally charged rejoinder by the professional restating the first script, and reinforced by a sub-script: the patient won't get better if the medication is stopped.

IV. This is followed up by a statement from someone else on the team, such as the jeep driver, reaffirming the professionals decree (such as 'don't be your own doctor').

In these uneven dialogues[xiii], the pill also serves as a boundary marker that distinguishes professional identities of various team members. This boundary separates those who can or cannot prescribe. A mental health professional, who did not have the licence to prescribe, said *'my job satisfaction would improve if I could prescribe*'. This desire was shaped by the overwhelming and rather appealing biomedical focus of the clinic. Additionally, he didn't feel comfortable practising hospital based taught skills of his own profession. Moreover, the distinct professional identities of social workers and clinical psychologists were rarely acknowledged by the public. They were often regarded as 'assistant doctors' and a part of the doctor's entourage.

The pill also emphasizes the distinct worlds of patients and professionals. These distinctions are located along multiple dimensions – urban versus rural, educated versus uneducated, and responsible versus irresponsible. Thus patients who don't attend the clinic or are non compliant with medication were viewed as 'irresponsible' (rural, uneducated) as opposed to the 'responsible' (urban, educated) professional. In this scenario, rejection of 'the pill' by patients is tantamount to a rejection of the mental health professional, including her expert tools and remedies. Conversely, clinicians view patients' non-compliance as antithetical to progress and

advancement. The patients are thus construed as backward, uneducated, and irresponsible.

This divide between professionals and communities is related both to the nature of professional mental health training and the use of language in the clinic. The knowledge base of mental health and training priorities are largely determined in Euro-American contexts. Local training is often a watered-down version of western psychiatry lacking grounding in local social and cultural concerns. Specifically, principles basic to clinical training, namely self awareness and reflection about how their own social class and theory shape suffering are conspicuously absent (Jadhav, S., 1996). Thus professional training does not equip them with an ability to integrate an understanding of local context into their work. This is reflected in the use of language in the clinic; both the concrete use of the English language and the experience-distant professional language used to record and formulate distress. At a concrete level in the case record, suffering is defined in words that alienate the mental health professional from the actual experience of suffering. Clinical exchanges necessarily use experience-distant language that allows the professional to frame patient experiences in a particular way. The problem is that this language frames the problem in biomedical terms. Clinicians appear reluctant to interpret suffering in the stated ways of patients and their families. Consequently when well-intentioned interventions are rejected by the public, clinicians feel frustrated. This frustration is projected onto patients. Non-compliance with medication and non-attendance at the clinic is attributed to ignorance of the patients and their families.

When asked about the main obstacles for community psychiatric services, many professionals stated that the public was unsupportive. Field work data would suggest the opposite: people were aware of services and assisted others through

informal mechanisms such as providing advice about specific doctors, and accompanying friends and relatives to attend a clinic. From the community's perspective, the clinic did not comply with their needs: for example, people's own views about the nature, location and timing of services. The final section will examine some aspects of villager's views of government mental health services and their power to render them ineffective.

III. '*Sarkari Davai'* (government medicine): community reactions to government services

Village responses to psychotropic medication are difficult to fit into a straightforward or coherent theory. Perceptions and use of the pill have to be understood in terms of class, caste, gender, agriculture and the local political economy. In brief, the authors argue that the 'pill' is constrained by the social, political and economic context of rural life. The pill is not necessarily transformative; rather it is acted upon by local structures of the village. These dynamics are illustrated by considering the disjuncture between the meanings of a local pattern of distress, *uljhan,* and the clinic's response to this.

In visits to the DMHP clinic, the patients were observed to use specific idioms to refer to their problems. One of these idioms was *uljhan*. If a patient used this pattern of distress, the staff member eliciting the case history would enter the term *uljhan* under the symptoms section of the case record. In most cases the structure of the clinic did not allow time to probe the nature and causes of the *uljhan*. The clinic staff interpreted this local idiom either as an anxiety or a depressive disorder so as to ensure a goodness of fit with ICD-10 diagnostic categories, and prescribed appropriate anti-depressant medication. Whilst this section will briefly summarize the

popular and professional understandings of *uljhan* amongst subjects from the present study site*, a* separate paper will detail the ethno-semantics of *uljhan.*

In brief, *uljhan* is a local form of suffering, with two distinct dimensions. In the first it is part of a continuum of states leading to a person becoming *pagal* (completely mad). *Uljhan* is linked both to social interaction and to the body. A person experiencing *uljhan* would feel *chir-chira paan* (annoyance) about a particular situation or person and an inability to *bardash* (tolerate) others. In the body, *uljhan* is also linked to *gussa* (anger) and *kamzoree* (weakness) and both are linked to *khoon jal raha* (burning of blood). A person having *uljhan* can progress along a continuum towards *mind disturbed* which is a *rog* (illness) and a less severe form of *pagal* (mad).

The second form of *uljhan* deals with day to day concerns and a worry about socio-economic concerns, especially money. *Uljhan*, in this context, refers to unfulfilled economic social ambitions and desires. The *uljhan* is resolved when these are fulfilled. In a general sense, it also serves as boundary marking economic and social divides. Thus, ‘dominant’ castes would claim greater *uljhan* than lower castes because they had greater responsibilities. Conversely, Dalits (formerly ‘untouchable caste’) would say that ‘dominant’ caste groups did not experience *uljhan* because they were well off. Similarly, informants revealed that *all rural people have uljhan* in contrast to their urban counterparts. Generally, it was noted that people had less desires and needs in previous times, and that the current cash-crop environment had increased desires leading to *parivaric tension* (family tensions) which was linked to *uljhan*.

The case of Raj, a 33 year old electrician, illustrates aspects of *uljhan:*

Raj was given a diagnosis of depression in the local psychiatric clinic in late 2003. He was the main earning member of the family which consisted of his mother, 2 married brothers, their wives and children, and one unmarried brother. They lived in a mud house which contained an outer room where they slept and inner court yard and another room.

As a student he would experience chir-chira paan (irritability) and would not eat for days and get angry. This cleared up and he became an apprentice for four years. Since 1997 he had set up his own store in the nearby town. His recent problems had developed following a visit to a cold-storage facility. There had been a leak of ammonia gas and he developed a 'permanent' cold and continued to smell the gas. He also said he experienced uljhan – "kaam mai maan nahi lagtha tha" (I was not interested in my work). He said if someone was talking to him – "kisse sai bath karna tho bharee paan lagtha tha" (talking to others became difficult). He linked uljhan to chir-chira paan and said that when he had chir-chira paan he could not bardash (tolerate) what other people would be saying. His brother then described how he would be unable to sit in a group like we were sitting now.

He and others related his problem to the delicate nature of his electrical work ('mahin kam karnai sai') and that he had to sit for 10-12 hours. Others said that he was the 'thinking' person in the family (despite not being the eldest) and since starting his store he had assumed greater responsibility (zimidari).

He had seen many private doctors to get medication for his 'cold'– but with no improvement he went to see this psychiatrist. The medication, he said, made him feel 15 years younger. Over the year, he reported feeling better.

And most times it appeared he did not attend the clinic. In April 2005, he was still taking the medication but only once a week. The doctor had reduced the 'power' but he figured out himself that skipping a dosage didn't cause problems and concluded he only needed it once a week.

Raj was well respected in the village for his skills as an electrician and generally had a happy disposition though there was always an air of worry on his face and as he told me himself one day 'hum to jeevan katrahai hai' (I am just passing the days of life). This was a frequently used phrase among men in the village. It reflected a sense of despondency about the course of village life that included a complex web of economic, family and social tensions.

Raj's experiences with the psychiatric services were reflective of a wider experience amongst those that presented at the clinic with a 'common mental disorder'. The clinic addressed his specific manifestations of *uljhan* – i.e. the symptoms they chose to hear – by editing his local idiom into a category analogous to a more universal construct of anxiety and depression, stripped of its cultural meanings and translated from Hindi into English. (*ibid.*). Raj reduced his medication once the basic symptoms had left him, but his *uljhan* persisted because of continuing social concerns that embodied his presenting idiom. Thus, the healing power of the 'pill' including the clinic and mental health policy in the village is limited and constrained by its inability to engage with existential problems on the ground.

The relative power of different medication was implicitly recognized by villagers who distinguished between 'strong' and 'weak' tablets. Medication dispensed from government health centers was generally categorized as 'weak', while that from 'private' doctors were seen as 'strong' or 'good'. This concrete

meaning had some basis in reality as often the ‘private’ doctors, many of whom did not have professional qualifications, would prescribe allopathic medication incorrectly. Also, general (not psychotropic) medications from government health centers were often diverted to the private sector, leaving only a limited range of medications at these centers.

Thus, the ‘weak’ categorization of government medication reflected the ‘weak’ nature of these services. While there is no evidence that villagers viewed psychotropic medications as ‘weak’, the authors contend that these ‘pills’ are rendered ‘weak’ in a cultural sense by the villagers precisely because the clinic is unable to address their social cultural problems. The result is that patients do not comply with treatment. Metaphorically, the nation’s rather patronizing community mental health policy fails because the pills have swallowed the policy.

IV. Discussion

The paper raises several sets of questions about the content and operationalisation of mental health programs. First, are the issues around compliance and the dominance of bio-medicine, universal to most psychiatric settings across nations? What are the specificities of the north Indian setting? Although compliance is a universal issue, the culture of community psychiatry in northern India has been shaped by its local political economy. Research literature on state-society relations in northern India has demonstrated how a range of social groups utilize the state to advance economic and political interests (Harriss, John, 2006). The state is not simply the dispenser of social welfare programs and jobs, but rather is acted upon by groups to advance their interests. This literature suggests a dynamic relationship between the state and the population, rather than the state as a

top-down deliverer of goods and services. The implication is that whatever the state offers is contested by social and caste groups to leverage access to jobs, services and other benefits to serve particular interests.

Community psychiatry operates in this setting as yet another government service that can be manipulated to serve individual and group interests. Perhaps patient compliance to treatment may not be due to patient negligence or illiteracy as suggested by health professionals. Rather, it appears to be predicated upon a local cultural logic that facilitates engagement with a range of governmental public services. In this consumerist approach, people make explicit choices about health care that are contingent upon maximizing benefits (Harford 2008). Such an explanation may obscure varying levels of socio-economic power. While some 'non-compliance' was due to choice, this also depends on the ability of the consumer to access alternative providers. Some people just don't reach the clinic. In either case, engagement with patients, families, and local communities are pre-requisites for subsequent health education including 'compliance' with treatment.

A second set of questions relates to the reasons behind the failures of the National Mental Health Program. Why is it that technically sound and multi-faceted programs metamorphose into singular interventions? Is it the bureaucratic imperative to simplify and find a basic minimum? Or does the pill have an underlying appeal or power beyond that of well-meaning policy makers and health professionals?

Development policy researchers assert that development practice is not driven by good policy but rather is the product of organizational cultures and multi-layered relationships. Consequently, development workers strive to maintain coherent representations of policy as it is in their interests to do so (Mosse, D., 2004). The National Mental Health Program is technically a 'good' policy, however in practice it

fails to achieve its objectives. The idea of integrating mental health in primary care has long been the main strategy propagated by the World Health Organization and governments for extending mental health services in low-income countries. A WHO evaluation of the strategy suggests that "…in the absence of adequate data on the effectiveness of specific intervention for specific conditions, the success of existing primary care mental health programmes is difficult to assess." (Cohen, A., 2001:30). The author concludes however that given resource constraints, "…integration is the only realistic option." (pp.30). Similarly, a recent review of community mental health services in low and middle-income countries suggests that there are several gaps in existing evaluations. These include limited evaluations of a) cost-effectiveness, b) programs in rural areas and c) outcomes in bipolar disorders and panic disorders (Wiley-Exley, Elizabeth, 2007).

A plausible explanation for the failure of the National Mental Health programme could be the disjuncture between the stated policy objectives and that which is actually implemented. Indeed, an historical analysis of the failures of public health in India suggests a mismatch between the multiple "ambitions" of planners and the reality of poor infrastructure and resource constraints. This mismatch resulted in a reliance on programmes targeted to specific diseases ('vertical' programs) and technologically oriented interventions, largely supported by foreign aid (Amrith, 2007). Taken together, both the analyses of public health and of development policy, argues for an additional insight into the failure of community mental health in India: that the transformation of a complex strategy into a singular intervention results from the power of the 'pill' to balance multiple functions and interests. Despite poor outcomes and limited evidence, mental health professionals and bureaucrats maintain fidelity to a dominant health model while implementing

something quite different. This dichotomy between policy and practice could relate to a calculated ‘hedging’ by professionals as they respond to the sometimes contradictory global ‘rationalities’ they seek to implement and the discordant realities of local rural lives in India.

Psychiatric professionals in northern India operate in a national and international professional environment dominated by biological approaches to psychiatry. An ethnographic study at two psychiatric hospitals in North India found that psychiatrists rely predominantly on multiple prescriptions and ECT (Nunley, Michael, 1996). The author suggests that this is due to an ‘epidemic’ view of psychiatric disorders among psychiatrists and the need to “sell” psychiatry within society and to their medical colleagues. This argument is re-enforced by pharmaceutical interests that are in a circular relationship with bio-medical approaches. A pharmaceutical representative in Kanpur explained how his company funded the majority of private psychiatrists in the area and their families to attend an international psychiatric meeting in 2005. The representative stated that the ‘payback’ for the company came through a promise by the psychiatrist to prescribe a certain amount of their products. This dominance of pharmacology is counter posed by the largely unproven strategies of the national mental health program and the WHO which emphasize concepts of decentralization, integration and community participation. The picture is further complicated by the poor state of primary health care services (Bajpai, N. & Goyal, S., 2004). In such a scenario, reliance on the ‘pill’ is the only ‘effective’ and ‘proven’ alternative[xiv]. Thus, the implementation of a *biologically oriented psychiatry* appeals to health professionals as both a way to achieve desired professional outcomes (e.g. satisfied patients, income, and credibility among peers) and cements linkages with the dominant discourses of

international psychiatry. This allows health policy planners in New Delhi to claim their own official 'compliance' and 'adherence' with international public health strategies. In short, this process of replication and mirroring along a chain that links Geneva, New Delhi and the Clinic is a cultural dynamic that directly impacts on the rural patient population.

It appears that the 'pill' also acts as a 'cover' for various interests. In the realm of policy, it represents progress and reform and has an ability to garner new funding. Conversely in the clinic it provides a deeply entrenched biomedical rationale, a way of sidestepping more fundamental issues relating to development and social family dynamics[xv]. It provides a 'cover' legitimated by popular demand that allows mental health professionals to avoid addressing issues for which they have neither adequate training nor resources. The recourse to psychotropic medication is therefore not a creative response to resource constraints but rather reflects the constrained choices that mental health programs and their implementers face.

For villagers, the popularity of the 'pill' may serve a similar function, i.e. their response to the inability of the health centre to address fundamental aspects of their suffering. This might suggest that state institutions in India do not "…have the normative support necessary for their reliable, effective functioning" because their underlying western logic is neither understood nor respected on the ground (Saberwal,1996). Returning to the village, this fits well with the local situation in Kanpur of a poorly functioning and marginal community health centre. Contrasted is a nearby *dargah (*Muslim shrine) that attracts Hindus and Muslims because it offers healing for physical and mental distress within an acceptable meta-physical framework. This healing site unlike the health centre, functions in the 'centre' of the community and with public support. This is not to assert that biomedicine lacks

acceptance within the village nor that the *dargah* is efficacious. Indeed, the ‘pill’ holds both symbolic and curative power in popular Indian conceptions of illness. Thus, whilst the health centre as a state institution may not command ‘respect’ on the ground, we suggest that the underlying technology of the ‘pill’ is popular in many quarters. Indeed, both biomedical and community mental health care flourish in the private (registered and unregistered) sectors of Kanpur district.

The community psychiatry program reported here, functions within the health centre. As the paper has described, aspects of the clinical interactions lead to a ritualized interaction that edit out the social realities of patients’ lives. Lacking the cultural and social capital to effectively engage with the health services, patients resort to placing medication at the core of their interaction with mental health professionals. Just as ‘non-compliance’ with treatment may be an adaptive strategy to dealing with state services, so too patient acceptance of the pill may be seen as a ‘rational’ choice within constrained circumstances.

Finally, what are the practical implications of this paper for mental health services in northern India? Earlier in the discussion, this paper questioned the relevance of ‘technical fixes’ as outcomes of well-meaning policies. It is clear that a great deal of re-thinking is necessary before considering an instant solution in the form of alternative policies and models. Indeed the paper cautions against a magical quick fix that can be offered. Within the rural clinic setting there appears to be a stalemate of sorts. It has certain dynamism and earnestness characterizes the work of mental health professionals. Yet it is unable to respond to local problems. This paper is not intended to provide ready to use solutions though the data suggests some possible avenues to move beyond this impasse, and address both professional conceptualizations and local suffering. These could be grouped into

three areas: a better understanding of communities, appropriate training of professionals, and encouragement of multiple models for mental health services.

The paper contends that community voices and concerns are silenced in the clinical setting and marginalized within the development of mental health programs. This would suggest the need for dialogue with communities on mental health issues and would require a shift away from the monologues of compliance towards dialogues that address wider issues. There are structural factors which impede such a dialogue. Among these is the training of mental health professionals in India. This training, as discussed earlier, often alienates professionals from ground realities. Overcoming these difficulties requires a fundamental re-configuration of health education and clinical training in graduate and post-graduate schools. In brief, this includes providing mental health professionals with: 1. *Awareness* of how their own social cultural background shape their professional training, identity, and interactions; 2. *Recognition* that significant aspects of current psychiatric theory and policy is culturally alien in India (Jadhav, Sushrut, 2004); 3. *Knowledge* and relevance of a culturally embodied health and illness paradigm (Scheper-Hughes, Nancy & Lock, Margaret M., 1987); and 4. *Skills* to negotiate such cultural differences, commencing with locally valid clinical practice that could then be embodied into policy (Jadhav, S., Littlewood, R., & Raguram, R., 1999).

This may not necessarily be an impossible task. Over the past three decades, the new cross-cultural psychiatry (Kleinman, Arthur, 1977; Kleinman, Arthur, 1980; Kleinman, A., 1987; Littlewood, Roland, 1980; Littlewood, R., 1990) has consistently critiqued the theory and practice of western psychiatry and offered a range of paradigms to accomplish these (Bibeau, Gilles, 1997; Chakraborty, Ajita, 1990; Chowdhury, A. N., Chowdhury, S., & Chakraborty, A., 1999; Jadhav, S., 2000;

Jadhav, S., 2005; Kirmayer, Laurence J., 1989; Kirmayer, Laurence J., 2006). Such changes in training of professionals and effective dialogue with communities could create enabling conditions for the flourishing of multiple models of mental health care. There have been several pioneering initiatives in India that highlight development of services in response to challenges that are particular to each setting. Although this paper does not intend an exhaustive review of these, some innovations merit attention. For example: 1) The Banyan, a charismatic non-governmental organization, developed at Chennai in response to the plight of homeless mentally ill women (http://thebanyan.org/). 2) Eco-Psychiatry, a theoretical and service framework that addresses the mental health consequences of local ecological problems in the Sunderban region of West Bengal (Chowdhury et al., 1999). 3) Asha Gram Mental Health Program, which focuses on a community based rehabilitation model for mental illness in a remote tribal region of Madhya Pradesh. (Chatterjee, Chatterjee & Jain, 2003). 4) The Psychiatric Centre in Miraj, Maharashtra that utilised over two decades of group meetings with patients and families, leading to the development of a text book predicated on local suffering; and in a manner that is accessible for both carers, patients and professionals (Rukadikar, A., and Rukadikar, M., 2007). Such texts offer potential blueprints for development of services that might more effectively address local concerns and inform policy. 5) Bapu Trust in Pune, Maharashtra, that addresses gender and mental health concerns through advocacy, service development and research (www.camhindia.org).

V. Conclusion

This paper traces the journey of India's National Mental Health Program from conception to actualization. 'The pill' is deployed as a metaphorical vehicle for tracking the dissemination of policy from centre to the periphery. Ironically, this rather

abstract ‘pill as metaphor’ turns itself into a concrete but ineffective ‘pill as medicine’, towards the end of its journey. By detailing how powerful meanings generated from local social-cultural contexts can thwart and render impotent well intentioned efforts of health professionals, the paper helps appreciate the dynamics underpinning the failure of India’s current National Mental Health Program. The social lives of medication appear to work against its own pharmacological properties. The authors assert these insights are critical to the future development of effective policies and services that intend to address mental health problems in rural India. Specifically, they point to the necessity for: a) cultural understanding of communities by mental health professionals and health planners; b) training of mental health professionals so as to enable a more equal and effective dialogue with patients and families; and c) social and political space that would facilitate and encourage the development of multiple models of mental health care.

In closing, the authors propose that this paper be read as an evolving statement that merits further research on additional critical issues which have not been possible within the scope of this research. Some of the topics that demand further enquiry include a study of the 1) rapidly shifting indigenous folk models of mental health and illness, 2) re-invention and commodisation of traditional healing systems and their remedies, 3) impact of globalization on re-enforcing and shifting existing social boundaries between the centre and periphery, & 4) generation of newer marginal groups and attendant mental distress within urban metropolitan spaces of the country. An enquiry that extends into such spheres demands a multi-disciplinary approach that itself has so far received scant attention. This is possible if current inflexible boundaries between bio-medicine and social sciences can be made porous. These concerns will also help to further interrogate how India’s official

‘mental healthcare system inherently marginalizes the very people it is meant to serve through its myopic methods’ (Gaitonde, Rakhal, 2008),

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[i] Although this paper critiques existing policy and services, this is no way belies the dedication and sincerity of those involved in conceptualizing, operationalizing and delivering mental health services in India. Here, the ethnographer's position is unique in allowing the luxury of a critique that is written in a western academic space. This constrasts with the day to day struggles of those placed in a position to implement services in rural India under complex and challenging circumstances. The authors consider both positions useful.

[ii] Approximately 25% of field work time was spent with the local community psychiatry team, 65% living in a village where the team provided services and 10% interviewing professionals and policy makers. Research with the team involved participant observation at clinics, training sessions and social activities and formal and informal interviews. There were three aspects to the field work in the village. One, involvement and observation of the daily activities of village life (including agricultural activity, festivals, funerals, trading, healing rituals and marriages). Two, interactions and informal interviews with a range of informants. These included healers, local doctors, village council members, store keepers, politicians, and people with health problems. Third, observations and interactions at specific sites in and around the village. These included a local *Dargah* (Islamic shrine and healing centre), the local government health centres and the homes of patients of the community psychiatry program. Interviews with professionals and policy makers involved informants within state and central government, non-governmental organizations and mental health professionals at several sites.

[iii] In the seven rural health centres covered by the program, 155 patients were seen in the period August, 1999 to December 2003. The diagnostic breakdown of the patients was as follows: Depression – 67.4%; Psychosis – 10.3%; Substance abuse – 1.2%; Epilepsy – 10%; Mental retardation – 2.7%; other – 8.3%.

[iv] The Kanpur and Thuruvananthapuram data are not directly comparable as different diagnostic categories have been used.

[v] A DMHP in Madurai, Tamil Nadu reports some data on patient diagnostic breakdown (www.cbhi-hsprod.nic.in/files/PROD78/DMHP-Madurai.ppt). However the time-frame of the data is not clear. It would appear the program received 1020 patients. Out of these 137 (13.4%) received a diagnosis of 'acute psychosis', 290 (28.4%) a diagnosis of 'anxiety disorder' and 130 (12.7%) a diagnosis of 'mood disorder'. Similarly, some data is reported for a DMHP in Trichy, Tamil Nadu State. (http://www.tnhealth.org/dmhpt.htm) but the time frame is not clear though it appears to refer to 2000-01. The data indicates a total of 715 new patients of which 14.7% were given a diagnosis of schizophrenia and 22% a diagnosis of depression.

[vi] The reasons for this relate to a fatigue among care-givers, previous experience with poor treatment outcomes, internal family and community dynamics (including stigma, issues about inheritance, and gender), and explanatory models that diverge from bio-medicine. These issues will be detailed in a separate paper.

[vii] The National Mental Health Program has its official origins in a seminal World Health Organization 1975 report on mental health services in developing countries (WHO Expert Committee on Mental Health, 1975). The report strongly argued for training primary health care staff to identify, treat and follow-up persons with mental illness in the community. This report also advocated community participation, decentralization and integration of mental health knowledge in social development activities. Following two widely reported experiments in India, this approach became part of official government policy in the early 1980s (Government of India, 1982). In

subsequent years, the National Mental Health Program was further operationalized through a District Mental Health Program (DMHP).

[viii] In an interesting about turn, it was recently reported that the Indian government is 're-vamping' it's National Mental Health Program to focus on training of MBBS doctors to deal with mental health problems. This would appear to be a return to earlier policies and is in part a response to increasing suicide rates. The Minister of Health stated: "I do confess that the national mental health programme of my ministry is not performing well. I am worried and we are in the process of reviewing the programme." (Sinha, Kounteya, 2007; India Abroad News Service, 2007)

[ix] A brief study of a District Mental Health Program in Delhi (Kumar, Anant, 2005) is a singular exception.

[x] After five years, the state government refused to take over funding following which Central funding was renewed.

[xi] Chhatrapati Shahuji Maharaj Medical University, Lucknow (Capital of Uttar Pradesh State), formely known as King George Medical College, Lucknow.

[xii] Field notes.

[xiii] The scenario takes on the flavour of a judicial court in which the onus is on patients ('accused') to prove themselves 'not guilty' of an alleged offence.

[xiv] The clinical efficacy of psychotropic medication versus psychotherapy and other non-medication based interventions such as yoga have been considered in the literature with somewhat inconclusive results. A recent clinical trial in Goa, India compared the efficacy of psychotropic medication with psychotherapy (Patel, Vikram et al., 2003). It found no significant differences after 12-month follow-up. A systematic review of five studies sought to compare the efficacy of yoga in depression (Pilkington, Karen, Kirkwood, Graham, Rampes, Hagen, & Richardson, Janet, 2005). The authors of the review conclude that yoga has potential benefit but requires further investigation on the aspects of yoga that are most effective and for which levels of severity of depression.

[xv] We are grateful to an anonymous reviewer for suggesting these two points.