Chapter 1

Introduction:

An Overview of Psychiatry
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CHAPTER 1: INTRODUCTION ON PSYCHIATRY

1.1 *Etymology:*

German physician, anatomist and physiologist Johann Christian Reil\(^1\) (1759 – 1813) coined the word psychiatry. The term "Psychiatrie" derived from Greek roots meaning ‘mind healing’ refers to the medical science that deals with the study, diagnosis, treatment, and prevention of mental disorders. These disorders may affect persons of all ages, and may involve either intellectual or emotional processes, verbal or non-verbal behaviour. They may result from disturbances in biological function, or from the adverse influence of psychological or socio-cultural factors.

1.2 *Definitions:*

a) Psychiatry is the branch of medicine that deals with the recognition, treatment and prevention of mental abnormalities and disorders. It deals with illnesses that predominantly affect a

\(^1\) Johann Christian Reil. Available in [www.whonamedit.com/doctor.cfm/1176.html](http://www.whonamedit.com/doctor.cfm/1176.html) (Visited on 05.10.02)
person’s mental life and behaviour, i.e., his feelings, his thinking, his behaviour and social relationships.\textsuperscript{2}

b) Psychiatry is the medical speciality concerned with the study, diagnosis, treatment and prevention of behaviour disorders.\textsuperscript{3}

1.3 Psychiatrist - definition of the term:

a) Physician specialising in the diagnosis and treatment of mental disorders. The properly trained psychiatrist can provide a comprehensive evaluation from a psychiatric point of view, a medical differential diagnosis, treatment planning, and multiple therapeutic and health-enhancing interventions.\textsuperscript{4}

b) Psychiatry and neurology\textsuperscript{5}:

One versed in the branch of medicine that deals with the prevention, diagnosis, and treatment of mental and emotional disorders. Although with the development of behavioural neurology there is increasing overlap between the medical specialities of psychiatry and neurology, it may generally be said that psychiatry

\textsuperscript{2}L. A Rees, Short textbook of psychiatry. 3\textsuperscript{rd} ed. (London: ELBS, 1982), 159.

\textsuperscript{3}Campbell’s psychiatric dictionary, ed. by Campbell, R J. 8\textsuperscript{th} ed. (Kolkata: O.U.P., 2004).

\textsuperscript{4}Lexicon of psychiatry, neurology and the neurosciences, ed. by Ayd, F J. (New Delhi: B I Waverly, 1995).

\textsuperscript{5}Edward Henry Reynolds and Michael R. Trimble, ed.s. The bridge between neurology and psychiatry (Edinburgh: Churchill Livingstone, 1989), 97-99.
is concerned with disturbances in emotion, thinking, perceiving, and behaviour, whereas neurology is concerned with disorders of identifiable parts of the nervous system. It has been suggested that a psychiatrist is a non-invasive neurologist. A psychiatrist is a physician who has had advanced training in the diagnosis and treatment of mental disorders.  

1.4 Psychiatry - scope and importance

In 1995, Dr. Leon Eisenberg and others completed a report on world mental health. It outlines the problem of interrelations of health problems, such as depression, heart, lung diseases, sexually-transmitted diseases, on the one hand, and of psychosocial pathologies, such as violence, alcoholism, abuse of women and children, and underlying social conditions such as war, poverty, and discrimination, on the other. They form self-perpetuating spirals. Thus Psychiatry is a worldwide public health problem.

There is need to stress the fact that mental health is as important as physical health to the overall well being of individuals,

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families, societies, and communities. Advances in neurosciences and behavioural medicine have shown that like many physical illnesses, mental and behavioural disorders are the result of a complex interaction between biological, physiological and social factors.

For the first time, the subject of the *World Health Report*\(^8\) (2001) (titled: “Mental Health: New Understanding, New Hopes”) is Mental Health. Dr. G. H. Brundtland, Director-General of World Health Organisation (WHO), has accorded high priority to mental health since taking over the leadership of World Health Organisation in June 1998. More than hundred psychiatrists and related professionals from all over the world took part in the compilation of the report. Information on the development of national health programs and available resources was collected for the report using a simple questionnaire, which has become Project Atlas concerning about 185 countries.

This report contains the following important divisions: i) The public approach to mental health; ii) Burden of mental health and behavioural disorders; iii) Solving mental health problems; iv)

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Mental health policy and service provision; and vi) The way forward – containing 10 recommendations.

1.5 **Incidence rate:**

Mental disorders are common affecting 20-25% of all people at some time during their life. At any one point of time 1—15% of the population suffer from one or other mental disorder. In addition 20% of patient seeking treatment at the primary health care facilities has disorders account for 12.3% of the disability adjusted life years lost due to all diseases and injuries.

1.6 **Divisions:**

Divisions of The field of Psychiatry are diverse and extensive. Age wise, there are special branches dealing with children (Child Psychiatry), with adults (Adult Psychiatry) and old age (psychogeriatrics).

Besides these, there are special branches like Forensic Psychiatry dealing with medico-legal aspects, Social Psychiatry that includes all environmental factors, including epidemiology, etc.
1.7 Classification and Subject Headings of mental disorders:

International Classification of Diseases, 10th edition (ICD-10) by WHO and Diagnostic and Statistical Manual, 4th edition (DSM- 4) by American Psychiatric Association are two international schemes well accepted by the psychiatric community.

Relevant thesaurus terms are available in Medical Subject Headings (MeSH) and the Thesaurus of Psychological Index Terms (TPIT).

1.7.1 Attempts of Classification of mental disorders in Ancient India-

The practice of classifying mental disorders has been prevalent since ancient times, as is evident in the ancient Indian text like Charaka Samhita and Sushruta Samhita which date back to 3rd century BC. Both these texts have chapters on insanity (unmad). Many psychiatrists have attempted to equate some of the conditions described therein to the modern psychiatric diagnostic terms with uncertain results.
1.8 History of Psychiatry in the world:

Psychiatry has to cross a path full of twists to be recognised as a medical discipline. Initially, it was in the purview of the church as it was thought that mental disorders were due to witchcraft, evil, loss of patients’ souls to the devil – it was the time when hundreds of mental patients were burnt to death.\(^9\) Psychiatry has been defined as the oldest art in medicine and the nest science. It is the oldest art because mental disorders were among the first types of illness to be recognised. The oldest prescription in existence is from Egyptian medicine and calls for ‘the exhibition of green stone as a fumigator against hysteria’.\(^10\)

Ancient medicine, both Egyptian and Greek, considered all disease to be caused by evil spirits or demons and similar concepts continued in Europe with regard to mental disorders throughout the middle ages.

**Hippocrates** (460 – 377 B.C.) replaced demonical concepts by a theory and practice of medicine based on observation and

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natural causes. He regarded mental illnesses in much the same light as he did physical illnesses. He considered that mentally ill patients needed to be investigated to discover the causes of the illness in order that these should be dealt with as effectively as possible.

The theories of disease causation of Hippocrates and Galen regarded disease to be due to a disturbance in the body of the distribution of the four humours – black bile, yellow bile, blood and phlegm. We still pay tribute to these by the use of words like melancholia, cholera, sanguine and phlegmatic. These ideas were prevalent even to the days of Shakespeare which is apparent in many of his writings.

In the middle ages, despite the enlightened teachings of the Hippocrates and Galen, beliefs that mental illness was evil-reincarnated were responsible for cruelty to the mentally ill, who were flogged and ill-treated in order to drive out demons and evil spirits. Witch hunting occurred on a large scale in the fifteenth century and many supposed witches were put to death because they were believed to be possessed by evil spirits.
Three bright spots of lights in that age of darkness were i) a humane and caring hospital at Mount Cassino in Italy (6th Century), ii) a hospital in Lyons (6th Century) and iii) another hospital in Paris (7th Century). These hospitals treated mental patients in a caring and understanding way.\textsuperscript{11}

Development of modern trends in psychiatric care and treatment

It will be convenient to consider the Development of modern trends in psychiatric care under the following headings:

A. Hospital care, including social and legal aspects
B. The development of psychological methods of treatment
C. The development of the organic or biological approach to psychiatric illness
D. The development of drug treatment in psychiatry

A. Hospital care, including social and legal aspects:

One of the most important dates in the history of psychiatry is 1795, which marks the inauguration of the humane treatment of the mentally ill by Pinel in Paris.

\textsuperscript{11} A. Clare, Psychiatry in dissent (London: Tavistock, 1987), 32-37.
Pinel gave patients increased liberty and provided them with work and activities in the hospital. Previously, they had been restrained and sometimes chained and were noisy, destructive and disturbed but, when freed and given work to do, their behaviour dramatically improved and an air of tranquillity prevailed throughout the hospital.

Rush in America continued this important social reform and Conolly and Tuke in England and these pioneers are the real founders of modern social psychiatry.

The work of Tuke in York and Connolly in Hanwell, Middlesex, not only started the movement for more humane treatment for the mentally ill in this country but also influenced public opinion to regard mentally disordered people as being ill and not criminals or possessed by devils, and the society had a duty to provide medical treatment as well as providing humane care.

In Britain, a large number of mental hospitals were built during the nineteenth century. In 1890, the Lunacy Act was passed, which imposed on local authorities the duty of providing mental hospital accommodation. The Act made Certification and a judicial order a prerequisite for admission to public mental hospitals.
The effect of this was that persons with early or mild degrees of mental illness were excluded from treatment, as Certification was only invoked when the behaviour or the medical condition of the person made admission to hospital imperative.

The Maudsley Hospital, by a special Act of Parliament, was allowed to admit patients on a voluntary basis in the early 1920s. Subsequently, in 1930 the Mental Treatment Act enabled all mental hospitals to take voluntary patients.

This Act had far-reaching consequences; patients now sought admission at a much earlier stage of the illness, with the result that recovery and discharge rates improved. There was also a rapid development of out-patient clinic services to enable patients to be seen prior to admission and to be followed up after discharge.

The most striking change in social and legal provisions for psychiatric illness was the Mental Health Act of 1959 of United Kingdom that, in many ways, constituted a revolutionary change in psychiatric care. The Act abolished Certification and also did away with the distinction, from the legal viewpoint, between mental and general hospitals. Patients can now be admitted informally to psychiatric hospitals, just as they can go to general hospitals. Compulsory admission, when necessary for observation or
treatment, is not a judicial procedure but based on medical recommendations. The Act lays much greater emphasis on the care of a patient in the community, with increased opportunities for treatment of psychiatric illnesses at outpatient clinics, day hospitals and in the patients’ home. The **Mental Health Act 1983** provides more safeguards for detained patients and protection of staff.

The Department of Health and Social Security proposes closing down many of the older mental hospitals and establishing large psychiatric units at general hospitals that will serve specific catchments areas.

**B. The development of psychological methods of treatment:**

Paracelsus, in the fifteenth century, put forward the view that health and illness were controlled by astral bodies such as the stars and the moon. The term lunacy is a relic of these theories that allege that mentally ill people are affected by the moon.

From this developed the concept of animal magnetism and Mesmer believed that ill health was due to a disturbance in the dye of a fluid which was called animal magnetism.
Patients treated on the basis of this theory often went into a trance-like state, which was in fact identical with what we now know to be hypnosis. Charcot and others later used hypnosis therapeutically. Charcot believed that hypnosis and suggestion were the keys to psychiatric treatment.

Freud started using hypnosis to treat psychiatric patients but later dispensed with it, as he found it was unnecessary and often created undesirable dependence on the part of the patient. He replaced it by his method of free association. This became the foundation of psychoanalysis, which proved to have far-reaching influences on thinking and attitudes as well as providing a method of treatment for certain psychiatric disorders and laid the basis of modern dynamic psychiatry.

**C. The Organic or Biological Approach:**

The Organic or Biological Approach takes into account to physical factors in mental illness and initiated somatic treatment methods. Morgagni started it in the 18th century. He took mental illness as an organic disease. Later other persons and mainly some
neuro-psychiatrists paved the way for a biological, constitutional and organic type of psychiatry.

As a result, a number of treatments were introduced:

- Wagner von Jauregg – Malarial therapy for general paresis
- Klaesi – prolonged Arcosis therapy
- Sakel – Insulin coma therapy
- Meduna – Cardazol convulsive therapy
- Moniz – Lobotomy – 1936
- Cerletti and Bini – Electroconvulsive therapy

**D. The Development of Drug Treatment:**

Herbal treatment was used for mental patients since the days of Hippocrates or before. It was described in Burton’s Anatomy of Melancholy. Chloral hydrate was introduced into medicine in 1869 and Fisher synthesized the first barbiturate in 1903.

The past few decades saw tremendous development in the drug research and treatment. Specially, the invention of psychotropics drugs has transformed the field of psychiatric treatment.
The field of psychopharmacology (study of drugs) is now in a state of flux and showing rapid growth.

To provide quality care and to disseminate knowledge\textsuperscript{12}, National \textbf{Committee for Mental Hygiene} was established in the USA in \textbf{1909}. This was followed by the formation of a \textbf{Mental Hygiene Council in the UK in 1923}.

Dr. Leon Eisenberg\textsuperscript{13} (1922- ), child psychiatrist and medical educator invented a number of "firsts" in medicine and psychiatry. He has major contribution in child psychiatry, autism, and the controversies around autism, RCTs, social medicine, global health, affirmative action, and evidence-based psychiatry.

\textbf{Mental Health Act of 1959} has taken care of major considerations like social, administrative and legal aspects.

\textbf{1.9 History of psychiatry in India with special reference to West Bengal}

\textsuperscript{13} Leon Eisenberg. URL: http://en.wikipedia.org/wiki/Leon_Eisenberg.htm (Visited on 05.10.02)
**Ancient & Medieval India**

Institutions like Takshashila, Nalanda and Vikramasila were few and far between. Hence to obtain information about early Indian psychiatric practice we have to depend mostly on Sanskrit verse into which all the-then knowledge had to be condensed. Descriptions of different types of mental illness are found in ancient Indian medical and religious texts.

Behaviour and characteristics of personalities and mental disorders were named after certain supernatural beings like Brahma, Indra, Varuna, Kuber, Ganesha, Pretas, Sarpas, etc.

**Ayurveda:**

It is believed that Ayurveda was born in the Jeyati period (3000 – 2750 BC) out of the efforts of Aryans to condense and correlate the existing medical knowledge of the pre-Aryan era. Ayurveda is the science of life. It studies man as a whole keeping in

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view his social, spiritual, seasonal and religious environment. It studies at length the diet, work, rest and sleep. The studies of scriptures, a sense of purity, love for truth, proper sex hygiene have all a place in it. It has eight branches of which Bhut-Vidya (Psychiatry) is one.¹⁵

**Bhut-Vidya (Psychiatry):**

Bhut-Vidya is not demonology as Atreya lays down at the outset – Neither Gods, neither the Gandharvas, neither goblins nor demons nor aught else, torment the man who is not tormented of himself.

Personality was divided into three groups: Sattic (i.e., highly intellectual & moral temperament), Rajasik (emotional, passionate and impulsive) and Tamasik (mentally subnormal). Each was defined as the unsettled condition of the mind, understanding, consciousness, perception, memory, intelligence, character, behaviour and conduct. These were caused by three humours (vayu, pitta, kapha) or by sudden fear from or influence of certain mythological gods or demons.

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Western Medicine was introduced in India by the Portuguese rulers of Goa; no mental hospital was established by them. The first medical school in India was established in 1824\(^{16}\) in pre-independent India which later renamed as Calcutta Medical College in 1835.

**Psychiatry in India\(^{17}\):**

The proceedings of the Calcutta Medical Board\(^{18}\) dated April 3, 1787 indicate that a mental hospital was in existence at Calcutta at that time which was established by Dr. G. M. Kenderdine, a surgeon of the East India Company. Since he was suspended from service for 7 years, the Board rejected his prayer for permission to admit patients sponsored by the government.

In 1787 a government sponsored hospital was established near Presidency General Hospital (now IPGMER, Calcutta) under the

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supervision of Dr. William Dick, a Surgeon of the East India Company, on monthly salary of Rs. 200/-. After the retirement of Dr. Dick (in 1818) this hospital gradually deteriorated in the standard of its service. The Government was forced to close it down in 1821. Mr. Beardsmore, a Headkeeper of this hospital, had already opened a private hospital in 1817 behind the boundary wall of Presidency General Hospital at Bhowanipur, Calcutta. All these three hospitals were meant exclusively for white mental patients.

In Madras, a mental hospital was established in 1794 which incidentally is probably the oldest existing hospital of its kind in India today.

The first Lunacy Act enacted in India for the establishment of mental hospitals and their management came into force in 1858 (Act XXXVI of 1858). During the subsequent two decades at least six mental hospitals were in existence in Eastern India alone. They were European Lunatic Asylum at Bhowanipur (established in 1817) one each at Patna, Dacca (i.e. Dhaka, the capital of Bangladesh), Dulanda (Calcutta), Berhampore and Cuttack. The mental hospital at Dacca was shifted to Tezpur in 1876, soon after Assam was separated from Bengal in 1874.
The number of mental hospitals gradually grew in other parts of India as well. By 1865 six mental hospitals were established in Western India- at Colaba, Poona, Dharwar, Ahmedabad, Ratnagir and Hyderabad (Sind, now in Pakistan).

In South India, Two hospitals – one each at Waltair and Tiruchirapalli – were established in 1871. In 1871, a hospital meant for both the Europeans and Indians, lodged in separate wards, was established in Madras (Chennai).

In the Central Provinces, two hospitals were opened, one each at Jabalpur and Berar (Elichpur) in 1866.

In North India, mental hospital was established at Benaras (Varanasi) in 1854, one at Agra in 1858 and another at Bereilly in 1862. Punjab, however, had its mental hospital as early as 1840, during the reign of Maharaja Ranjit Singh, i.e. before the territory was finally taken over by the British East India Company in 1849.
MORAL TREATMENT – THE REMOVAL OF CHAINS

It has been documented that the Arabs established many flourishing medical schools and mental hospitals in Baghdad, Damascus and Cairo between 8th century and 13th century. The enlightened treatment received by the patients in those hospitals and the relaxed atmosphere inside them remained unsurpassed in Europe for many centuries.

The concepts of humanism and freedom of the individual permeated the social fabric of Europe after the French Revolution. Enlightenment in the form of removal of chains and other mechanical restraints from the mental patients were observed in France, England, Italy and Belgium in the last decade of the 18th century.

Mental hospitals were being built during this period in India and efforts were made to introduce this concept of humane or moral treatment in Indian mental hospitals. Though written records are scarce, it is generally agreed that value of simple interventions and kind treatment was recognized as the rule of the hospitals. Hard data are more easily available from 1821 when government sponsored patients were admitted in private hospitals meant for the
Europeans only. For the European patients non-restraint had been established as the rule by the mid-fifties of the 19th century. Reports of hospital superintendents show that in the hospitals for native patients restraints were resorted to even in 1870’s, though the same reports concede that native patients were as a rule, quieter than the European ones. This contradiction was explained by the fact that European patients considered it insulting to be restrained by native keepers. If restraint was essential in a given situation, it had to be done by a European Keeper; if European keepers were not available, restraint was not to be done.

FOOD AND DIVISIONS

European patients were divided into class-I and Class-II on the basis of their social status. Patients of Division-I lived in separate rooms and dined together on one table. Disturbed patients were kept in a high security building. They were supervised by European or Anglo-Indian staff only. They were given spicy food. Fish and flow with seasonal fruits, jelly, cheese and pudding were supplied. They had to pay Rs. 100/- per month. Diet for Division-II was also good, but details are not known. They had to pay Rs. 50/- month.
For the **native patients** the **food was poor**. One rupee was spent for the daily diet of sixteen patients since 1844. Before that date the allocation of money was 3 paise per patient per day. There was no division between patients on social status. But the kitchens for the Hindus and Muslims were separate. Before 1844, in a day the native patients used to get only one meal that consisted of rice, pulses and occasional fish or meat. Needless to say, the morbidity and mortality rates were high. Dr. F. P. Strong, the then Civil Surgeon of 24 Parganas, who was in-charge of the native mental hospital, increased the allocation of money, and added fish or meat to their daily diet which was served twice a day. This information is contained in the annual report of the native mental hospital for 1844 which was founded in 1816 at Russa Pagla on the southern outskirts of Calcutta. This is, incidentally, the first mental hospital meant for the native patients (Bengal Presidency Native Insane Hospital). By 1842 this hospital became “filthy, crowded, defaced and broken”.

**OVERCROWDING, SANITATION AND BEDS**

The Government built another mental hospital at Dullunda (at the site where the Police Training School now stands). This place is
about 300 meters to the south West of IPGMER, Calcutta. In 1847 patients from Russa Pagla Hospital were transferred to the Dullunda Hospital. The accommodation was for 150 patients. But the number of patients swelled to 350 by 1871. NCL’s and Criminal Lunatics were also lodged in this hospital.

The annual report for 1872 shows wooden platforms were provided for patients of Dacca Asylum so that they need not sleep on the floor. This step was taken to reduce the rates of morbidity and mortality by medical illnesses. After few years separate sleeping arrangement was made in Punjab for the prevention of physical and sexual abuse of mental patients by one another. At the native hospital at Russa Pagla patients were allowed to sleep on bamboo frame constructed by them. The floor of the old, damp, dilapidated building was considered by the authority to be unsuitable for the purpose. By implication, patients had to sleep on the floor, physical and sexual abuse by one another was common and death rate high.

**REMOVAL OF PATIENTS TO ENGLAND**

In the early 19th century experts and administrators believed that the tropical climate was one of the causes of mental disorders
among the Europeans living in India. Accordingly European patients were sent to England for treatment, if they did not improve within six months of their admission in a mental hospital in India. This practice began in 1818 and continued till 1891. The passage money and other expenses were paid by the East India Company as a loan to be repaid by the recovered patient. Doubts were expressed about the utility of this practice by Dr. John Macpherson in 1854. But his views were ignored. In 1866 Sir Charles Wood, the then Secretary of State for India (The British Crown took over the administration of India in 1858) expressed strong reservation about the wisdom and cost effectiveness of this practice. A strange incident hastened the pace of events. In the same year five native mental patients were sent to England for treatment at government expenses by mistake. Needless to say, the government took strong exception to this gross violation of rules. Stringent rules and regulations were framed to regulate the selection of patients. Gradually the flow of patients was reduced to trickles till the “Royal India Asylum” at Ealing (Where these patients were used to be lodged from 1870 onwards) was closed down on December 31, 1891.
DRUGS AND OTHER PHYSICAL METHODS

The role of drugs in the management of patients in the mental hospitals of colonial period was insignificant. Little is known about the methods of treatment followed in the mental hospitals of late 18th century. Reports of early 19th century suggest that doctors believed that a comfortable meal was the best sedative and exercise the best hypnotic. Around 1855 morphine and other opiates were in use along with a hot bath. Blood-letting as a method of treatment was used sparingly. If ever used, it was done by the use of leech and not by vene section. For chronic patients blisters were created on different parts of the body, especially on the nape of the neck. Doctors knew that blisters had no intrinsic value as a modality of treatment. It diverted the patient’s attention to physical symptoms and thereby helped reduction of mental anguish. Report of Bengal Asylums for 1862 shows that this method of treatment was used for control of excitement and sleep disturbance along with a mustard poultice applied to the stomach. Potassium Bromide was used for epilepsy. Dr. Smith of Lahore Asylum considered digitalis to be useful at times.
Dr. A. J. Payne, the Superintendent of both the European Lunatic Asylum and the Dullunda Native Hospital used drugs very rarely. A few pegs of rum were, according to him, good medicine for excited patients (Report of 1873).

In the last quarter of 19th century “current electricity” was frequently used in the native asylum at Dullunda by Dr. Payne, the then Superintendent of that asylum. He reports (Report of 1873) that the use of electric treatment yields surprising results. This treatment is, however, different from modern method of ECT invented by Cerletti and Bini in 1938. In the older variety (i.e. what was used in the late 19th century) it was static electricity. The Gadget was touched at different parts of the body. It was a very painful experience. The use of this method was topped subsequently on the ground that the machine was primitive and imperfect. It is noteworthy that Dr. Payne was the Superintendent of nearby European hospital as well. But he never used this method of treatment on his European patients.

**OCCUPATIONAL THERAPY**

Labour, as therapeutic modality, was practiced widely in native hospitals with great success. But in the hospitals for
Europeans it was not introduced with enthusiasm. Dr. Theodore Cantor, Superintendent of European Asylum at Bhowanipur, Calcutta, was of the view that outdoor work in the tropical sun might be harmful for the Europeans. Moreover, he noted that patients of his hospital spent the whole day doing nothing; still they refused to participate in any work outside their rooms (Report of 1873). Attitude of the Superintendents often was a deciding factor. It was, however, emphasized in government orders that occupational therapy must not be coercive in nature. It is a part of the treatment of each patient and must be tailor-made for his need and aptitude. While knitting, sewing and weaving were taken up easily by the female patients in both European and native hospitals, occupational therapy involving outdoor activity was, as a rule, scorned by the European male patients. In the native asylum at Russa Pagla, till its closure in 1847, and at Dullunda since 1847, on the other hand, inmates usually came from the families of cultivators and labourers. They readily joined the occupational therapy sessions. The nature of the job earmarked for them was cultivation and preparing ropes and other products by jute. The standard of their work was so good that the hospital sole their products in open market with a profit margin of over six thousand
rupees in one year (Report on 1873). Clay modelling and dressmaking were also introduced at Dullunda Hospital. Dr. Francis P. Strong of Russa hospital took great pains in encouraging the patients to take up occupational therapy as a mode of their treatment. His work was continued at Dullunda hospital by Dr. Payne, as it brought money to the hospital. Dr. Payne was perceived as ill-disposed to native patients. Dr. Theodore Cantor, his predecessor, proposed that they might learn the 3R’s. But Dr. Payne shot down this proposal on the plea that literature had no place in the life of these natives and that the expenditure on salaries of teachers would be a sheer wastage of money (Report of 1863).

OTHER DEVELOPMENTS

Arrangement for entertainment was made for the patients at times. But shortage of rooms, even in European mental hospitals, stood in the way of its proper and regular use. As per the 1862 Report, Dacca Asylum made arrangement for Indian musical instruments and indoor games after the evening meals. Some patients were allowed to attend local festivals with their keepers. At the native asylum at Russa Pagla patients were allowed to perform
dance and music including Indian instrumental music (flute, cymbal). They were given the indulgence to smoke tobacco, chew betel leaf and play cards. The authorities did understand the value of entertainment and harmless habits in the life of the patients. But vagaries of whims of Superintendents and lack of adequate facilities in the hospitals often stood in the way of implementation of their instructions.

In late 1860’s and early 1870’s Dacca Asylum broke new ground when it decided to board out patients to the families of respectable person of the town. The aim was to avoid the ill-effect of overcrowding on the process of recovery and to permit the patients to adjust with family life in a foster home before their discharge. Doctors used to visit them in their foster homes for assessment of their mental state. The head of the family received Rs. 5/- as subsidy per month. This system did not last long as the head of the family was held responsible for escape of the patient. The emphasis on moral treatment in mental hospitals of 19th century India was a reflection of pious wishes of our rulers. The picture of what was actually realized was different.
During the early part of the 20th century, with the growing social and political awareness of the educated section of the Community, the plight of the mental patients incarcerated in these hospitals got adverse publicity in the media and ultimately in the British Parliament. Consequently the Government took certain major decisions for the improvement of the management of mental hospitals. In 1906 ideas were afloat for the supervision of these hospitals by a central authority. The Government decided that the mental hospitals which were till then controlled by the inspector General of Prisons, would be under the overall charge of Civil Surgeons (i.e. CMOH of modern times). This is a fundamental change in the management of mental hospitals. The next most important change was the recognition of the role of specialists in the treatment of mental patients. Psychiatrists were appointed as full-time officers in mental hospitals.

The enactment of the **Indian Lunacy Act in 1912** had probably the most far-reaching consequence and impact on the whole system of mental health service and administration in India during the following seventy five years. Under this new legislation the central supervision of all mental hospitals became a reality. The Central lunatic asylum for European patients was established under
this Act, only to be closed down after the establishment of the Ranchi asylum in 1918.

As a result of the sustained efforts of Col. Berkeley Hill, the Superintendent of Central European Asylum at Ranchi, the term “Asylum” was removed from the Government records in 1922 and all asylums in India were renamed as Mental Hospital. The stigma of asylums was sought to be reduced by this change in nomenclature. He worked hard to bring about many other changes for the betterment of mental hospitals. How far he succeeded can be assessed from his on statement. In 1924 he wrote these words in a paper published in the Journal of Mental Science (British Journal of Psychiatry of today). “There is a Persian saying that there is no greater anguish known among mankind than to have many thoughts at heart and no power of deed. This particular form of anguish must be well-known to most medical superintendents of mental hospitals”.

The condition of the mental hospitals rapidly deteriorated during the following two decades. The “Bhore Committee” Report (1946) states that there were at least 19 mental hospitals with bed strength of 10,181. The majority of these hospitals were quite out
of date and were designed for detention and safe custody without regard for curative treatment. Here was a gross inadequacy in the medical personnel, both numerically and in specialized qualifications. The Report recommended that these hospitals should be modernized. The modernized mental hospitals should meet both the needs of the community and the medical colleges. And these should form part of any scheme for reconstruction or expansion. The inadequacy of nursing staff and attendants did not escape the notice of the Committee. Besides making other recommendations, it observed that the Indian Lunacy Act, 1912 had outlived its utility.

The spadework done by the Bhore Committee for the qualitative and quantitative improvement of mental hospitals was not forgotten. There was a steady rise in the number of mental hospitals in free India, in 1947 there were 31 of such institutions and in 1987 it rose to 45. Efforts were also taken to improve the conditions existing in those hospitals.

But it must be conceded that the emphasis shifted from the mental hospitals to the creation of psychiatric departments of teaching hospitals. As a result, mental hospitals continued to
languish in the backyard of negligence in financing staff pattern, floor space in relation to patient population and the quality of care.

The initial psychiatric system was a copy of the British system. It was more custodial rather than therapeutic in nature with stigmatisation and segregation of the patient so as to ensure the safety of common people from the hands of these so-called dangerous people.

An attitudinal change started from the early 20\textsuperscript{th} century and gained momentum in the early 50s.

\textbf{1. Indian Association for Mental Hygiene\textsuperscript{19} (1928):}

Twentieth century saw the birth of a movement in the USA and then in the UK to improve mental illness awareness and care. As a consequence, \textbf{National Committee for Mental Hygiene (1909)} was formed in the \textbf{USA and Mental Hygiene Council (1923)} in the \textbf{UK}.

India under British rule followed the British lead and formed the Indian Association for Mental Hygiene came at Simla on 23rd

\textsuperscript{19} Quarterly Bulletin of the Indian Association for Mental Hygiene, no.5 (January 1930):31- 37, no. 21 (January, 1934):18, no. 22 (April, 1934):2-4.
August 1928 led by Lt. Col. Owen Berkeley of European Lunatic Asylum (now Central Institute of Psychiatry, Ranchi).

It aimed to do

- Knowledge dissemination
- Organization of meetings, seminars and popular lectures
- Establishment of a library
- Publication of a quarterly Bulletin
- Formation of treatment centres

In the field of mental illnesses and allied areas.

2. *Indian Psychoanalytical Society (1922)*

Founder President and the then head of Department of Psychology, Calcutta University was Dr. Girindra Sekhar Bose.

3. *Indian Association for Mental Hygiene, Calcutta Chapter (1929):*

Dr. Girindra Sekhar Bose started the Calcutta Chapter with five members. By the beginning of 1933, its membership rose to 264.
**Activities:**

- a monthly popular lecture by a leading scholar which became a weekly event
- a home for the Mentally Retarded in 24th April 1932
  The name ‘Bodhana Niketan’ was given by Rabindranath Tagore
- a psychiatric outpatient clinic in a general hospital

The Bengal Government objected to allot space and electricity for it in the state-run Calcutta Medical College. The non-government Carmichael Medical College agreed to provide free space and electricity and lent some furniture while the expenses for the clinic were to be paid by the Association.

Dr. Bose made an advance of Rs. 867.50/- to defray the cost of furnishing the Clinic and purchasing some essential instruments. Thus the stage was set for opening the doors of the first psychiatric OPD clinic in a general hospital in India.
Dr. Gauranga Banerjee\textsuperscript{20} (Ex-Professor & Head, Unit of Psychiatry, NRS Medical College, and Kolkata, India) writes about the clinic:

‘The working hours of the Clinic were between 8-00 A.M. and 10-00 A.M. on every Tuesday and Thursday. The MO-in-Charge was Dr. Girindra Sekhar Bose. He had two other Medical Officers to assist him. They were Dr. Bhupati Mohan Ghosh and Dr. Kamakhya Charan Mukherjee. All the members of the staff worked on honorary basis. The sole exception was a part-time bearer who received a monthly pay of Rs. 2/- (Rupees Two only).

Though the OPD clinic was opened on 1st May, 1933 the first patient was registered on the following day i.e. 2nd May, 1933. The original case record of this patient is still preserved and displayed on the wall of the chamber of the Head of the Dept. of Psychiatry of R.G. Kar Medical College.

It is on record that 174 new cases attended the clinic during the first year of its existence. It is gratifying to note that this clinic is not only the first of its kind but is still one of the most

\begin{itemize}
\item Gauranga Banerjee, First psychiatric clinic in a general hospital in India in Website: www.indianpsychiatry.com (Visited on: 22.10.2003).
\end{itemize}
thriving centres of service, teaching and research in Psychiatry in Kolkata.’

Dr. Girindra Sekhar Basu in his book ‘Swapna’ first introduced a modern outlook in Bengal Psychiatry. He was a believer of the Freudian school of thought. More recently, Dr. D. N. Ganguly brought some Pavlovian flavour in the psychiatric thoughts.

Prof. Dr. Gorachand Boral\(^2\) & \(^2\) gives some important glimpses:

<table>
<thead>
<tr>
<th>Year</th>
<th>Establishment</th>
<th>Location</th>
<th>In-charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1787</td>
<td>Lunatic Asylum for Europeans</td>
<td>Calcutta</td>
<td>Dr. G. M. Nendeln (a medical doctor)</td>
</tr>
<tr>
<td>1817</td>
<td>Govt. Home for Mentally Diseased</td>
<td>Calcutta</td>
<td>Mr. Beardsmore</td>
</tr>
<tr>
<td></td>
<td>A Private Asylum for Europeans</td>
<td>Calcutta</td>
<td>Mr. Beardsmore; Turned into Govt. owned:</td>
</tr>
</tbody>
</table>

\(^{2}\) Gora Chand Boral, Glimpses of the history of psychiatry in West Bengal (Kolkata: Institute of Psychiatry, 1997).

<table>
<thead>
<tr>
<th>Year</th>
<th>Type</th>
<th>Location</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1874</td>
<td>Lunatic Asylum</td>
<td>Maidapur</td>
<td>Later closed down</td>
</tr>
<tr>
<td>1874</td>
<td>Lunatic Asylum</td>
<td>Dallanda</td>
<td>Later closed down</td>
</tr>
<tr>
<td>1874</td>
<td>Lunatic Asylum</td>
<td>Berhampore</td>
<td></td>
</tr>
<tr>
<td>1918</td>
<td>Central Lunatic Asylum</td>
<td>Ranchi</td>
<td>for Europeans</td>
</tr>
<tr>
<td>1922</td>
<td>Indian Psychoanalytical Society</td>
<td>Calcutta</td>
<td>President: Dr. Girindrasekhar Bose</td>
</tr>
<tr>
<td>1925</td>
<td>Ranchi Manasik Arogyasala</td>
<td>Ranchi</td>
<td>for Indians</td>
</tr>
<tr>
<td>1929</td>
<td>Indian Association for Mental Hygiene, Calcutta Chapter</td>
<td>Calcutta</td>
<td>President: Dr. Girindrasekhar Bose</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
<td>Location</td>
<td>Details</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1932</td>
<td>The Mental Hospital Society</td>
<td>Calcutta</td>
<td>President: Manmathnath Mukherjee, Secretary: Dr. Haranath Basu</td>
</tr>
<tr>
<td>01.05.33</td>
<td>The first deptt. of psychiatry with outpatient facility in a general hospital in India</td>
<td>the then Carmichael Medical College, Calcutta</td>
<td>Now known as R. G. Kar Medical College</td>
</tr>
<tr>
<td>1935</td>
<td>Bangiya Unmad Ashram</td>
<td>Lilooah, near Calcutta</td>
<td>Later shifted to Dum Dum, Calcutta</td>
</tr>
<tr>
<td>1938</td>
<td>A Mental Hospital</td>
<td>North Calcutta</td>
<td>Beginning of the Mankundu Hospital</td>
</tr>
<tr>
<td>08.02.1940</td>
<td>Lumbini Park Mental Hospital</td>
<td>House donated by Rajsekh Dar Bose at Tiljala, Indian</td>
<td>Psychoanalytical Society (made govt. since</td>
</tr>
</tbody>
</table>
The first department of psychiatry with outpatient facility in a general hospital in India was opened on 1st May 1933 at the then Carmichael Medical College (now known as R. G. Kar Medical College), Kolkata. Five years after this event, in 1938, the outpatient facility of Department of Psychiatry of J.J. Hospital, Mumbai was opened.

A department of Neurology and Psychiatry was established in the Calcutta Medical College in 1939 by an order of the Government of Bengal.

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**General hospital psychiatry in India**

The first department of psychiatry with outpatient facility in a general hospital in India was opened on 1st May 1933 at the then Carmichael Medical College (now known as R. G. Kar Medical College), Kolkata. Five years after this event, in 1938, the outpatient facility of Department of Psychiatry of J.J. Hospital, Mumbai was opened. A department of Neurology and Psychiatry was established in the Calcutta Medical College in 1939 by an order of the Government of Bengal.

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## Medical Colleges in West Bengal with Psychiatric Units

<table>
<thead>
<tr>
<th>Date</th>
<th>Development</th>
<th>College/Institute</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.05.33</td>
<td>The first department of psychiatry with outpatient facility in a general hospital in India</td>
<td>the then Carmichael Medical College, Calcutta</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Now known as R. G. Kar Medical College</td>
<td></td>
</tr>
<tr>
<td>1939</td>
<td>Psychiatric Unit</td>
<td>Medical College and Hospital, Calcutta</td>
<td></td>
</tr>
<tr>
<td>1960</td>
<td>Psychiatric Unit</td>
<td>National Medical College and Hospital, Calcutta</td>
<td></td>
</tr>
<tr>
<td>1962</td>
<td>Psychiatric Unit</td>
<td>Sir Nilratan Sarkar Medical College and Hospital, Calcutta</td>
<td></td>
</tr>
</tbody>
</table>

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24 Gora Chand Boral, Glimpses of the history of psychiatry in West Bengal (Kolkata: Institute of Psychiatry, 1997).
1970 | Psychiatric Unit | Bankura Sammilani Medical College | Bankura
1970 | Psychiatric Unit | Burdwan Medical College | Burdwan
1972 | Bhowanipore Mental Observation Ward incorporated into Institute of Postgraduate Medical Education and Research | Calcutta
1976 | Psychiatric Unit | North Bengal University Medical College |

There are **other general hospitals with psychiatric units**:

- B. R. Singh Hospital
- The Garden Reach Hospital
- The Ramkrishna Mission Seva Pratisthan Hospital
- The Marwari Hospital
- Kumar P. N. Roy Group of Hospitals
- The Durgapur Steel Hospital
The Goenka Hospital (The University College of Medicine, Calcutta)

Except these, there are some facilities available at districts like Midnapore, Jalpaiguri, Bankura, Burdwan, etc.

**Psychiatry: Teaching**

The University of Calcutta started the ‘Department in Psychological Medicine’ in 1959-60. Initially, only diploma course (DPM) was offered. Later it stared to offer courses like MD in Psychiatry and also research facilities.

The Birth of *Indian Psychiatric Society*:

The premier body of the Indian psychiatrists the *Indian Psychiatric Society* came as a result of strenuous efforts by Dr. Nagendranath De (a co-organiser of *Indian Psychoanalytical Society* with Dr. Girindrasekhar Bose) in 1948. He was the President of the society and instrumental behind the publication of its journal which now known as the ‘Indian Journal of Psychiatry’. The first issue came out with Dr. De as its editor.

**Historicizing Indian psychiatry**

According to AMIT RANJAN BASU, a mental health historian, the historical endeavour to map Indian psychiatry has largely
remained linear, positivistic and evolutionary. Whether it starts from the ancient times or modern, it shows our past as a tale of victory for the western science, without questioning the borrowed paradigm. The use of historical methods for serious enquiry of psychiatry has been ignored. Emergence of a new genre of historicism that is critical of both colonialism and psychiatry as a universal science has raised hopes to critically review the emergence of psychiatric knowledge.

Foucault’s work on history of madness attempted to record the history of both concepts and institutions.25 It took into account both subjective and objective view of things.

Following this unconventional method, Ashis Nandy26 did a study on the psychology of colonialism by comparing have and have-nots in India. Frantz Fanon’s27 did a comparable important work on psychological effect of colonialism in Algeria where he said, “This colonialism colonizes minds in addition to


bodies and releases forces within colonized societies to alter their cultural priorities once for all’.

Girindrasekhar Basu was the first psychoanalyst outside the western world. Nandy’s work\textsuperscript{28,29} attracted scholarly attention towards him. Kakar\textsuperscript{30} also has observed how Girindrasekhar has modified the Freudian version of psychoanalysis through his innovative practice. Basu\textsuperscript{31} followed up Nandy’s analyses on Girindrasekhar.

Indian Medical Gazette\textsuperscript{32} wrote the following on ‘Lunatic Asylums’: "It is not, however, till within recent years that we find proper arrangements for the due care of the insane and for the teaching and training of the asylum attendants. We have on previous occasions referred to the changes which are about to take place in the management of the asylums of India, and with the new century we have every reason to expect that a new era is dawning

\textsuperscript{28} A. Nandy, The savage Freud and other essays on possible and retrievable selves (Delhi: Oxford University Press, 1995).
\textsuperscript{30} S. Kakar, “Encounters of the psychological kind: Freud, Jung and India” in Culture and psyche: Selected essays, 20–32 (Delhi: Oxford University Press, 1997).
\textsuperscript{32} [Editorial], “Medical progress in India during the past century”, Indian Medical Gazette 35 (1901):21–25.
for the insane in India."

Lodge Patch\textsuperscript{33} reviewed the development of Punjab Mental Hospital from 1840 to 1930. Like other British persons he wanted to transform from their ignorance and superstition Indians through custodial care in asylums.

Berkeley-Hill\textsuperscript{34} described the internal contradictions of colonial administration as a hindrance towards scientific development of Indian psychiatry in a chapter on ‘Ranchi European Mental Hospital’ in his autobiography.

He took charge in October, 1919 and on the 24th October, 1934 when he handed over the charge of the Ranchi European Mental Hospital, it had become under him the finest mental hospital in Asia, and a great deal finer than many mental hospitals in Europe." Berkeley-Hill was a founder member of the Indian Psychoanalytical Association and a prolific writer. But his writings\textsuperscript{35} strongly supported colonial ideology and he used psychoanalysis as a tool of governance.

\textsuperscript{33} Patch CJ Lodge, A critical review of the Punjab Mental Hospitals from 1840–1930 (Lahore: Punjab Govt Record Office Publications, 1931).
\textsuperscript{34} O Berkeley-Hill. All too human: an unconventional autobiography (London: Peter Davies, 1939).
\textsuperscript{35} O Berkeley-Hill, Collected papers (Calcutta: The Book Co., 1933).
Girindrasekhar Bose’s article\textsuperscript{36} was written as a scientific review of the past 25 years’ work done in psychology than as a historical narrative. All present a view of Indian psychiatry that is becoming modern and civilized, emerging out of the status of a ‘savage’ society.

Varma\textsuperscript{37} wrote a long article on the history of psychiatry in India and Pakistan in the Indian Journal of Neurology and Psychiatry (later Indian Journal of Psychiatry) in its fourth year of publication. Varma was the first Assistant Superintendent of the Indian Mental Hospital at Kanke, Ranchi. He wrote a comprehensive chronological account of the changes brought in the Indian psychiatric institutions in Bengal, Bihar, Orissa, Madras, Calicut, Waltair, Mysore, Bombay, Sindh, Assam, Central Provinces, Punjab and Amritsar.

Venkoba Rao\textsuperscript{38} deliberated on the ancient Indian

\textsuperscript{36} G Bose, “Progress of psychology in India in the past twenty-five years” in The progress of science in India during the past twenty-five years, ed. B Prasad, 336–52 (Calcutta: Indian Science Congress Association; 1938).


thoughts on psychiatry in his presidential address at the Annual Conference of the Indian Psychiatric Society. He attempted to relocate our psychiatric past from the pre-Vedic period to the post-Vedic Ayurvedic treatises, to show that it is in continuation with a uniform pattern all over the world.

Rao\textsuperscript{39} also talk about the sacred Hindu text Gita in relation to mental sciences and rediscover parallels with western psychiatry. He did not doubt that the atma and kaya duality of Gita can be different from a Descartian mind/body split, which is foundational to modern philosophy and cognitive science. He has also ignored Girindrasekhar\textsuperscript{40} Bose’s significant contributions to Indian philosophy.

\textbf{1.10 State of Mental Health Care in West Bengal: some government statistics}

The government-supported mental health care system is inaccessible or unavailable to many of the mental health patients

\textsuperscript{39} Ibid
and care seekers, due to lack of adequate resources and ineffective mobilization of existing resources. Sometimes, government-supported mental hospitals and mental health centres in West Bengal are over-crowded, and cannot deliver satisfying results in treatment of mental disorders and mental diseases. In terms of patient doctor ratio, patient counsellor ratio, and availability of indoor beds per thousand patients in government-supported mental hospitals and health centres across West Bengal, these indicators are much less than that of other areas of health care system.

**Mental Health Indicators in West Bengal**

In India, it is estimation that about 5% of population suffers from various psychological disorders, such as depression, neurotic disorders, stress related disorders and adjustment disorders. About 1 percent of population suffers from serious mental disorders such as psychotic disorders and 0.5% of the population may be in need of active treatment of a serious mental disorders. As per WHO guidelines, union Government has initiated efforts to diagnose the mentally ill patients at the early stage and treat them through general healthcare delivery system. The union government of India supplements the efforts of the state
governments in promoting mental healthcare in the states through the National Mental Health Programme. The District Mental Health Programme under the National Mental Health Programme launched in 1996-97 on a pilot basis. In order to provide increased access and better quality of mental healthcare, the National Mental Health Programme during the 10th five year plan envisages the expansion of District Mental Health Programme to cover 100 districts in the country, strengthening about 37 government mental health institutes and psychiatric departments of 75 medical colleges, undertaking IEC (Information Education and Communication), research and training activities. So far, 94 districts have been covered under the District Mental Health Programme, psychiatric wing of 9 medical colleges and one mental health institute have been upgraded. Out of a total outlay for Central Sectoral Health Programmes during the 10th five year plan, about 1.5% has been allocated towards National Mental Health Programme\textsuperscript{41}. Bankura District implemented first District Mental Health Programme in West Bengal. Almost all district hospitals of West Bengal have psychiatric wings to provide the mental healthcare.

Table 1 and Figure 1 depict the share of specialized hospitals in the state of West Bengal. It shows that mental hospitals cover about 9.17% of total specialized hospitals which may be considered as adequate as compared to other specialized areas of healthcare. Table 1 and Figure 2 depict the share of inpatient beds for specific diseases in hospitals in West Bengal. It shows that indoor beds for mental healthcare cover about 15.93% (including reserve beds in a mental hospital Ranchi) of total number of specialized beds which is adequate as compared to other specialized areas of healthcare\textsuperscript{42}. Table 2 depicts the distribution of hospitalization cases by major causes in government-funded district hospitals in West Bengal, where patients with diarrhoeal diseases ranked first with 19.31 percent. The patients with mental and behavioural disorders ranked fifteenth with 2.4 percent and patients with maternal hypertension ranked twentieth with 1.32 percent\textsuperscript{43}. The treatment for mental and behavioural disorders in inpatient departments across the government hospital is very marginal as compared to the affected people. This gap is supplemented by the


\textsuperscript{43} Ibid
private mental hospitals, mental healthcare centres run by voluntary societies and NGOs, although statistics on the non-government initiatives in mental healthcare are not readily available, systematically collected and disseminated.

On the other hand the Table 3 and Figure 3 show that the sharp increasing of population served per bed in West Bengal, due to almost static nature of number of beds in any healthcare system and exponential growth of population. Table 4 depicts that the population served per doctor and per nurse has slide decreasing trend which indicates access to health professionals has slide increasing trend due to the strengthening of capacities of medical colleges and nursing schools, and other reasons.

The government supported specialized mental health hospitals in West Bengal having inpatient care facilities are:

- Calcutta Pavlov Hospital, Kolkata
- Lumbini Park Mental Hospital, Kolkata
- Institute of Psychiatry, Kolkata
- Mental Hospital, Behrampore
- Institute for Mental Care, Purulia
- Mankundu Mental Hospital
• Central Institute of Psychiatry, Ranchi (with reserve beds for patients from West Bengal)\(^4\).

Government hospitals in districts and medical colleges also have mental healthcare wings for the treatment of mental and behavioural disorders, although lacking modern facilities, proper rehabilitation schemes, and most of the times overcrowded. Many times the supporting staff of these hospitals are not sensitized enough to provide efficient services to the care seekers\(^5\).


Specialised Hospitals in West Bengal as on 31.12.2004

- Maternity: 40.37%
- Infectious Diseases: 21.10%
- Mental: 9.17%
- Children: 5.50%
- Others: 10.09%
- Leprosy: 9.17%
- Cancer: 4.59%

Figure 1: Share of Specialized Hospitals in West Bengal

Specialised Beds in West Bengal as on 31.12.2004

- Infectious Diseases: 45.06%
- Mental: 15.93%
- Maternity: 11.97%
- Leprosy: 11.62%
- Others: 7.39%
- Cancer: 4.19%
- Children: 3.85%

Figure 2: Share of Beds for Specific Diseases in West Bengal
Table 1: Share of Beds and Specialized Hospitals in West Bengal

<table>
<thead>
<tr>
<th>Type of Disease</th>
<th>No. of Specialized Beds</th>
<th>No. of Specialized Hospitals*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental and Behavioural Disorders</td>
<td>2013</td>
<td>10</td>
</tr>
<tr>
<td>Cancer</td>
<td>529</td>
<td>5</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>5693</td>
<td>23</td>
</tr>
<tr>
<td>Leprosy</td>
<td>1468</td>
<td>10</td>
</tr>
<tr>
<td>Maternity</td>
<td>1512</td>
<td>44</td>
</tr>
<tr>
<td>Children</td>
<td>486</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>934</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12635</strong></td>
<td><strong>109</strong></td>
</tr>
</tbody>
</table>

*Hospitals include State, Central, Local Body and Voluntary Organisations

Table 2: Distribution of Hospitalized Cases by Major Causes in District Hospitals in West Bengal

<table>
<thead>
<tr>
<th>Rank</th>
<th>Type of Disease</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diarrhoeal diseases</td>
<td>19.31</td>
</tr>
<tr>
<td>2</td>
<td>Cerebro Vascular / Cardio Vascular diseases</td>
<td>11.13</td>
</tr>
<tr>
<td>3</td>
<td>Respiratory Infections</td>
<td>7.1</td>
</tr>
<tr>
<td>4</td>
<td>Poisoning</td>
<td>5.21</td>
</tr>
<tr>
<td>5</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>5.05</td>
</tr>
<tr>
<td>6</td>
<td>Obstructive Labour</td>
<td>4.75</td>
</tr>
<tr>
<td>7</td>
<td>Road Traffic Accident</td>
<td>4.14</td>
</tr>
<tr>
<td>8</td>
<td>Malignant Neoplasm</td>
<td>3.8</td>
</tr>
<tr>
<td>9</td>
<td>Haemorrhage (Maternal)</td>
<td>3.56</td>
</tr>
<tr>
<td>10</td>
<td>Abortions</td>
<td>3.38</td>
</tr>
<tr>
<td>11</td>
<td>Diabetes Mellitus</td>
<td>3.03</td>
</tr>
<tr>
<td>12</td>
<td>Injuries due to Falls and Fire</td>
<td>2.94</td>
</tr>
<tr>
<td>13</td>
<td>Anaemia</td>
<td>2.81</td>
</tr>
<tr>
<td>14</td>
<td>Asthma</td>
<td>2.5</td>
</tr>
<tr>
<td>15</td>
<td>Mental and Behavioural Disorders</td>
<td>2.4</td>
</tr>
<tr>
<td>16</td>
<td>Tuberculosis</td>
<td>2.25</td>
</tr>
<tr>
<td>17</td>
<td>Cataract</td>
<td>1.88</td>
</tr>
<tr>
<td>18</td>
<td>Peptic Ulcer</td>
<td>1.81</td>
</tr>
<tr>
<td>19</td>
<td>Eclampsia</td>
<td>1.57</td>
</tr>
<tr>
<td>20</td>
<td>Hypertension (Maternal)</td>
<td>1.32</td>
</tr>
<tr>
<td>21</td>
<td>Meningitis</td>
<td>1.16</td>
</tr>
<tr>
<td>22</td>
<td>Others</td>
<td>8.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Population Served per Bed in West Bengal, 1987-2004

Figure 3: Population Served per Bed in West Bengal

Table 3: Population Served per Bed in West Bengal, 1987-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Population served per bed*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>936</td>
</tr>
<tr>
<td>1988</td>
<td>950</td>
</tr>
<tr>
<td>1989</td>
<td>964</td>
</tr>
<tr>
<td>1990</td>
<td>1011</td>
</tr>
<tr>
<td>1991</td>
<td>1022</td>
</tr>
<tr>
<td>1992</td>
<td>1047</td>
</tr>
<tr>
<td>1993</td>
<td>1069</td>
</tr>
<tr>
<td>1994</td>
<td>1092</td>
</tr>
<tr>
<td>1995</td>
<td>1107</td>
</tr>
<tr>
<td>1996</td>
<td>1112</td>
</tr>
<tr>
<td>1997</td>
<td>1126</td>
</tr>
<tr>
<td>1998</td>
<td>1154</td>
</tr>
<tr>
<td>1999</td>
<td>1173</td>
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<tr>
<td>2000</td>
<td>1130</td>
</tr>
<tr>
<td>2001</td>
<td>1136</td>
</tr>
<tr>
<td>2002</td>
<td>1146</td>
</tr>
<tr>
<td>2003</td>
<td>1166</td>
</tr>
<tr>
<td>2004</td>
<td>1186</td>
</tr>
</tbody>
</table>

*Figure computed on the basis of Hospital beds under management of State Government, Central Government, Local Bodies and Public Undertakings.
Table 4: Population Served per Doctor and per Nurse in West Bengal, 1981-2003

<table>
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<th>Year</th>
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1.11 State of Mental Health Care in West Bengal: role of NGOs

World Health Organization\textsuperscript{46} (WHO) in its Mental Health Policy and Service Guidance Package - Organization of Services for Mental Health module declares “Mental health care should be provided through general health services and community settings. Large and centralized psychiatric institutions need to be replaced by other more appropriate mental health services”. Many voluntary mental healthcare organizations across the state of West Bengal follow this motto of WHO. They also follow a sustainable model, involving local communities in mental healthcare and rehabilitation. This section deals with the innovative approaches by these nongovernmental organizations, nature of involvement of the community and extension of mental healthcare systems to the unreached people.

Some societies have engaged themselves in awareness campaigns on different mental health related issues, like,

examination-related stress, mental stress, mental disorders, suicide, dementia, Alzheimer disease, Schizophrenia disease, etc. whereas some other societies have engaged themselves in care giving. Some care giving NGOs and societies are running outdoor clinics, day-care centres and indoor clinics at the grassroots level with the public-private participation model. Training programmes for the caregivers are also being organized by the NGOs and voluntary societies to help the mental health patients and their kith and kin.

In West Bengal a number of specialized NGOs and voluntary societies were formed by the dedicated people from diverse background, ranging from renowned psychiatrists, psychologists, social workers, cured mental health patients, caregivers and families of care seekers. The ten voluntary societies and NGOs in West Bengal profiled below work in different areas of mental healthcare, integrate research, training and service delivery, and collaborate actively with other sectors of health and social welfare systems.
a) MANAS - An Experience in Community Psychiatry-

Twenty six years old NGO MANAS practises ‘in-community’ participative kind of environment where patients, carers and medical/paramedical and non-medical volunteers will actively participate in the treatment process. Members include people from different spheres of life including psychiatrists, psychologists, psychiatric social workers, information scientists, etc. It does not take funds from any governmental or non-governmental, national or international agency – only from people who are actively involved and committed to its cause.

MANAS tries to coordinate the different families towards building up of a long-term residence for the chronically ill mental patients. To fulfil this need, MANAS bought 14 bighas of land at Madanpur (near Teghari) in Nadia district. Outdoor clinics are being operated there for the last 13 years or so.

Since its inception, MANAS conducts one psychiatry outdoor clinic at a school in Park Circus, Kolkata where apart from this outdoor, a recreation club for patients, families, volunteers and friends run simultaneously. It gives a sense of openness to the treatment process and wipe out some of the social
taboo and inhibitions associated with mental illness from the heads of patients and others.

MANAS organizes an annual picnic on its land at Teghari, Nadia where ponds, cultivated lands (belonging to MANAS and cultivated by patients and other members) and a **canteen run by chronically ill** patients lend a flavour of community psychiatry.

b) **Mon Foundation: A Social Outreach Initiative**

This 15 years old organization is mainly run by mental health professionals and has a concentration of psychiatrists, psychologists, social workers, and information scientists.

Mon Foundation works for the benefits and rehabilitation of differently-abled persons. A team of mental health professionals are working with the objective of conducting training, research and promotional activities to bring about awareness on mental health and other related areas concerning children. It has resource base about six psychiatrists, four counsellors, one psychiatric social worker and one information scientist. It has a full-fledged office with several computers and
office staff and several other members from different legs of the society.

Mon Foundation also involves with school mental health programme in association with Child Relief and You (CRY). For the last 9 years, Foundation is giving life skills training to the school children of four districts in West Bengal (Kolkata, Purulia, Purba Medinipur, and South 24 Parganas) and in one district in Orissa (Boudh district). A number of teachers of nearby schools and CRY-supported organizations have been trained in identification and intervention of psychological and psychosocial problems among students. A research study is being conducted till date on 1500 students to assess the prevalence of psychological and psychosocial problems among children.

Mon Foundation maintains two core groups to implement different mental health related programmes. A teachers’ Core Group has formed to develop life-skill modules, publish the Mon Newsletter and to develop the advocacy policy on student mental health issues. Students’ Core Group with 10-16 members has also built up to involve students in this crucial issue which culminated in their writing up a booklet on ‘how to study?’.
Mon Foundation organizes seminars and training workshops time to time to share its experiences, disseminate research findings, and awareness-raising. An annual seminar is arranged with eminent persons from different fields as speakers to intensify the cross-discipline information flow. Small lecture sessions are also arranged on alternate Wednesdays (the usual meeting day of members and/or like-minded in the Mon office) on topics bearing relevance with the mental health action scenario. Mon Foundation also lends this platform to the students and interns of mental healthcare. Every year students of J.D. Birla Institute of Home Science (affiliated to Jadavpur University, Kolkata), and MSW students of Vidyasagar University undergo training in Mon Foundation. Mon organized training on mental health issues for the state resource persons and about 2100 primary teachers from four districts jointly with West Bengal Board of Primary Education. Mon also provided training to the doctors participating in the ‘Adolescent Mental Health Program’ conducted jointly with World Health Organization (WHO), Government of India’s Department of Maternal and Child Health and All India Institute of Hygiene and Public Health.
As books on mental health issues are rarely available, Mon tried to cover this gap by publishing nine booklets on mental illness, depression, trust, schizophrenia, students’ mental health, problem of the adolescents, etc. Last three of them are already exhausted proving the need of this type of awareness raising books in simple, jargon-free language. Foundation also collaborated with ‘Save the Children Fund, U.K.’ in bringing out a life skills training manual for the National Child Labour Project (NCLP) schools. Mon also organizes free medical camps in the nearby localities time to time.

c) ANJALI: An Integrating Initiative

Established in 2000, ANJALI prefers to call itself a human rights organization in the mental healthcare sector that uses government infrastructure (mental hospitals along with its doctors and other facilities) and inputs its own guidelines, counsellors, therapists, etc. to rehabilitate the long-term staying cured patients of the government hospitals. ANJALI works as an advocacy group and also organizes human rights sensitization program and mental health awareness programme for common people.
Its activities are supported by Dorabjee Tata Trust, Action Aid India, and Ratan Tata Trust. ANJALI does not have psychiatrists as it uses the doctor-base of the hospitals it currently works. The resource base of ANJALI consists of four psychologists/counsellors, four psychiatric social workers, three vocational trainers and twenty two therapists.

ANJALI uses novel therapeutic techniques, some of which are unique and innovative. **Green Therapy** is a unique kind of therapy which uses gardening work to nurture a creative zeal that really involves the participating patients and this pro-nature activity provides an opportunity to the in-house patients to enjoy some outdoor activity and inhale some fresh air which is a rarity in their state-hospital-owned life. Other therapies include Audio-Author therapy, Music therapy, etc.

The vocational trainers equip the patients with different skills, such as, **block printing, incense-stick making, and sewing** which will give them some sort of occupation along with greater coordination of motor and brain functions – at least ANJALI thinks and believes so. The money earned from these products is used for some finer things which **these patients** require but not
usually get since their families rarely (if any) visit them. This is one burning problem for all state-run government hospitals that have inpatient facility and in this crucial sector ANJALI tries to lend it’s helping hand and tries to humanize the mental health scenario in West Bengal (and India) in terms of increased understanding, awareness, care and treatment.

ANJALI is now working with all patients in three mental hospitals: **Lumbini Park Mental Hospital, Calcutta Pavlov Hospital (both in Kolkata) and Beh rampore Mental Hospital in Murshidabad** district of West Bengal. In the last 5 years of their existence, they have integrated more than hundred patients with their proper place in society.

ANJALI undertakes following activities for the mental health patients:

i) **Life skills training**: It trains the patients to be capable of doing their day-to-day activities independently. This lessens their helplessness and need of taking help from others.

ii) **Creative therapy**: Songs, plays and other such things are performed to or by them so as to hone their imaginative and creative faculties.
iii) **Recreation & relaxation therapy**: Provided with games, cultural functions, picnics and other such activity which give them some enjoyable leisure moments.

iv) **Occupational therapy**: Patients are trained in different occupations so that they can earn little something and this makes them feel less of a burden to the family/society.

v) **Economic empowerment**: It organizes marketing outlets of the products created by them and money thus earned is used for betterment of societal goals of ANJALI. It also tries to seek out suitable placements for reintegrated patients.

vi) **Organizing shelter**: Old age homes, short stay homes are arranged for the recovered patients who have nowhere to go back to.

vii) Family counselling & follow up: There are patients who have no family to return to. This may be for different reasons: unwillingness on the part of families to take back because of social taboos or fear of instability, economic hardships debarring the family to take up added burden, just plain callousness, etc. ANJALI takes a positive step in solving probable conflicts and confusion by creating an atmosphere of mutual trust and dependence. Follow ups are done
regularly to monitor the reintegration process and to decrease the chance of relapse.

viii) **Cognitive therapy**: To nurture the intellectual capabilities, ANJALI helps them to learn some basic accounting, language & other skills that lessens their dependence on others in day to day life.

ix) **‘Lattu’ or the Youth advocacy leadership**: Youths can be the best torchbearers for rights sensitization in the field of mental health which is the most important issue for ANJALI. Without a steady flow of young activists dedicating their quality time for ANJALI’s causes – the pace of the mental health movement could not be sustained. Hence ANJALI has this program intended for the general youth – creating their awareness, leadership-capability with respect to the work to be done in the mental health sector.

d) **Forum for Mental Health Movement: An Umbrella Organization**-

Established in December 1992 as an umbrella organization of mental healthcare organizations in West Bengal, Forum for Mental Health Movement became a common platform for mental healthcare activists, care seekers and care
givers. This forum consists of representatives of 30 plus member organizations. Its mission is to:

- coordinate amongst mental healthcare organizations;
- provide resource base;
- encourage information and resource sharing within the group;
- organize regular monthly meets among Forum-members;
- organize seminars/workshop/conferences/training programmes;
- organize academic discussions;
- celebrate World Mental Health Week;
- undertake outstation consultancies;
- undertake advocacy and referral services; and
- Get as many similar organizations under the umbrella as possible.

Being a pressure group, the main areas of this Forum are initiation, advocacy, campaigning, networking, information education and communication (IEC) of new ideas through publications; monitoring and evaluating of government policies and existing environment; and, exchanging of ideas and solutions.
e) **ANTARA - A Whole Village (Antaragram) for the Mentally Affected**

Established in **1971**, ANTARA (http://www.antaraonline.org) is one of the **oldest NGOs** to work in the field of mental healthcare in West Bengal. This is still very active and vibrating in a **ten acre campus** in the suburban areas of Kolkata. Antara Society was founded to embalm the anxious, worried, depressed and war-torn West Bengal people and East Bengal refugees. **Destitute people** are **served free of cost** here while **other patients pay highly subsidized**, nominal charges. It is particularly focused in the fields of **mental illness, drug addiction and alcoholism**. ANTARA runs **psychiatric outdoor clinic, chemical dependency clinic, child guidance clinic, general medical clinic** and **tuberculosis clinic** throughout the week. Average number of mental patients treated **per week** is about **1400**. **Number of beds** available in the inpatient department is about **200** including 36 for drug addicts & alcoholism. ANTARA also has day care facility for the recovering mental patients. Its **Counselling and Guidance Clinic** is available to cater to the demands of the depressed persons, alcoholic and other patients.
ANTARA provides shelter, care, treatment and rehabilitation to the destitute & very poor persons suffering from mental disorders, including drug addiction & alcoholism. It has 36 beds each for male and female patients and also a group home for the mentally impaired. It organizes annual 'Mental Health Fair' in which awareness stalls, displays and demonstrations by different sister organizations and like-minded people, sale of ANTARA products (made by patients) and other usual fair-like phenomenon included. Surprisingly, it has become an attraction for neighbouring people as well as a place for the like-minded organizations to showcase their ideas, products and activities. This fair also offers a platform for intermingling and experience-sharing thereby strengthening the common bond and enforcing the motivation of the mental health activists.

ANTARA runs Work Therapy Projects, Antara Infotech Vocational Training Centre, and a number of training programmes on psychiatric social work, psychiatric nursing, orientation courses for professional and lay people, mental health programmes for school going children, and computer training courses for patients. These courses are recognized by Jadavpur
University and they bridge the gap for a much felt need of the
dearth of trained mental health workers.

ANTARA has a range of community facilities such as
recreation centres, library, reading room, community mess, and
residential quarters for the staff to provide the mentally afflicted a
better cultural and intellectual atmosphere to live in.

ANTARA has developed a full-fledged comprehensive
programme and infrastructure for the treatment of all types of
psychiatric disorders and substance abuse. ANTARA serves a
number of care seekers from south and other parts of West
Bengal, other Indian States and also from Bangladesh. In
addition to our services for psychiatric illness and substance abuse,
it provides general medical facilities too.

Every service from ANTARA is centred at Antaragram,
which is located at a village in the district of South 24 Parganas.
Antaragram includes five inpatient wards, consisting two wards
(one each for men and women) for persons suffering from acute
psychiatric disorder; two wards (one each for men and women) for
rehabilitation; and a ward for men with substance addiction to
receive treatment & subsequent rehabilitation. It also has outreach outpatient departments in Kolkata City and distant villages for the convenience of the public.

The ANTARA Community comprises of staff, trainees, recovering inmates and the families of residential staff is the uniqueness of Antaragram. Apart from giving the patients a homely atmosphere, the Community Members ensure 24-hours care to inmates. The Community shares common mess, observes National Days and festivals. Annual sports, cultural competitions, get-togethers, picnics, etc. are organized periodically. Along with outpatient and inpatient treatment facilities, ANTARA has developed a well equipped Occupational Therapy System at Antaragram.

For the last few years, ANTARA is providing outpatient treatment facilities for children with special needs in its Antara Child Guidance Clinic (ACGC). ACGC consists of psychiatrists, clinical psychologists, psychiatric social workers, and special educators. Clinical Profiles of children covered includes (i) children with depression, stress reactions, conversion reaction, psychosis, conduct and behavioural problems; (ii) children with scholastic backwardness, learning disabilities, attention deficit hyperactive
disorder (ADHD); (iii) children with mental retardation along with behavioural problems, autism, and other development disorders. ACGC follows a comprehensive treatment process. In this process, the intake officer (a psychiatric social worker) decides whether the child needs admitted treatment. Then other professionals in the team do a detailed work up. After the psychiatric and physical examinations, a detailed management plan is chalked out. Then referrals are made for required assessments, such as, psychological, intelligence quotient (IQ) and emotional quotient (EQ). Various therapies like Behaviour Therapy, Cognitive Therapy, Supportive Therapy, Skill Training, Social Skill Training, etc. are taken up by the concerned therapists and trainers. ACGC imparts training to the parents, if necessary, since they take up the same task at home. ACGC also conducts family meeting every month to develop a self-help group of parents.

In addition to the services in the mental healthcare area, ANTARA promotes general health services in the local village communities through special programmes, such as nutritional supplements, growth monitoring and health education to the mothers and children of the nearby communities. It is supported by
the Catholic Relief Services, India. About 300 families in the nearby community get the advantage of this service. This service has got two aspects named Safe Motherhood and Child Survival.

ANTARA is also associated with a **School Programme** that extends its activities to students in schools and colleges in neighbouring four districts of West Bengal, namely Kolkata, Howrah, North and South 24 Parganas Districts. This school programme is mainly to impart awareness about mental health, mental illness, dangers of substance addiction, and also to uproot many of the wrong concepts about mentally ill persons.

**f) ARDSI Kolkata – Caring the People with Alzheimer’s and Other Dementia-Related Diseases**

Established in **September 1999**, Alzheimer’s and Related Disorders Society of India, Kolkata Chapter (ARDSI Kolkata) [www.ardsikolkata.org] disseminates information about the disease and care giving tips to the victims of the disease and to their family members. Used to be associated with old age only, these group of diseases are now catching up the young also as early as 40s. About 3.2 million are affected in India and will
increase with the increasing longevity of human race. We should give a serious thought on the very few organisations like this which are dealing with this non-glamorous but much-needed area. ARDSI Kolkata consists of caregivers as well as psychiatrists, neurologists, psychologists, social workers and other volunteers. It tries to support caregivers by providing advice and information. It organizes public awareness campaigns and provides day and respite care services. The light behind the scene of ARDSI Kolkata is an 80 plus young lady Mrs. Choudhury, the mother of a patient who founded this Chapter. If someone is caring for someone with dementia there are many ways the ARDSI Kolkata can help. Counselling family on caring for dementia person is one of its main activities. Knowing where to turn to for support or how best to approach medical services for a diagnosis or ongoing help can be confusing and difficult. ARDSI Kolkata offers help with these services. It also arranges a carers’ support group meeting once a month. This meeting give carers a chance to meet other people in similar situations to share thoughts, feelings, and experiences. The meetings are relaxed and informal. It provides quality dementia care training for professionals interested in providing dementia care for any settings and helps families deal with day to day care giving
by supporting homecare needs. ARDSI Kolkata plans to extend its future activities in the following areas: newsletter printing, establish help-lines, support respite care, run a day care.

**g) Anadaniketan: A Home Away From Home**

In 1988, National and state awards winner for the welfare of the disabled persons Dr. Haramohan Sinha founded this organization in a village (Khjurdihi, near Katwa) in the Bardhaman district. Its facilities include: home for the mentally ill persons, special school for mentally retarded, outdoor clinic, library, cancer detection and management centre, ambulance service, guest house, vocational training centre, hostel for boys and girls, RCI recognised training courses on special education, community workers' training programme, continuing rehabilitation education programme, etc.

**h) Paripurnata: A Half-Way Home**

Paripurnata is a short stay home for women who have been committed to the hospital for mental illness, Pavlov Institute. The women are nurtured by Paripurnata, which provides them with life-livelihood skills and helps to rehabilitate them back into their families /communities. Paripurnata maintains a
three year supervision of the women rehabilitated. It is also working with communities to reduce the need for mentally ill persons to be institutionalized. The aim is to create an early detection mechanism that will work as a preventive against mental illness. Its motto is to return a person in his/her wholeness of human being while returning him/her to her original background. It started with 6 women residents in the first year, increasing to 12 in the 3rd year. The stay will be for 9 months, after that a financial assistance will be provided to the families to lessen their economic burden. Paripurnata team consists of psychiatrists, psycho-therapists, counsellors, social workers, house mothers, volunteers, even the cook and the gardener. It runs by a governing body and a working committee consisting of high level persons from the top rank of the social strata to advice and monitor.

i) Sailendranath Guha Thakurata Institute (Sangati)-

Sailendranath Guha Thakurata Institute (Sangati) is a society, engaged in social, educational research and vocational studies. Its target clientele is mentally retarded children. Its facilities include: day care centre, educational & vocational training
facility; counselling, psychological assessment and parental training. Sangati conducts research, provides occupational therapy and physiotherapy. Sangati also provides vocational training on computer applications, art & craft, entrepreneurship development, and talent development.

j) **Pavlov Institute**-

Pavlov Institute, Kolkata [www.pavlovinstitute.co.in, www.gipspace.com] is working in the area of mental health and allied subjects for more than fifty years following the scientific principles of the great Russian physiologist I. P. Pavlov, under the guidance of **Dr. Dhirendranath Ganguly**, an eminent person in Indian Psychiatry. The motto of Pavlov Institute is to provide comprehensive, professionally faultless and socially just psychiatry services. The present facilities of the Institute include: (i) a regular **psychiatric clinic** at the heart of the city of Kolkata. Qualified psychiatrists and psychologist are available there seven days a week for general counselling, psychotherapy, parent’s guidance clinic, family therapy, career guidance, couple therapy, family counselling, etc; (ii) **research project and rehabilitation programme** in substance-abuse disorder, community psychiatry
and correctional psychiatry; (iii) a branch clinic named Sangbed at Sodepur, in the North 24 Parganas district of West Bengal. Five qualified neuro-psychiatrists attend this thriving clinic on various days offering psychotherapy, counselling and psychometric services. The institute publishes a Bengali magazine *Manabmon* and a journal *Psyche and Society*. Pavlov Institute has three goals before it. Firstly, to develop a properly equipped research network geared towards conducting an in-depth study of the integration of psychosomatic nature of human illness. Secondly, the centres, while fully utilizing the benefits of modern medico-technical progress, will try its best to unburden the patients of those unnecessary trapping—both diagnostic and therapeutic, which have become the trademark of conventional treatment; thirdly, to inculcate in doctors and paramedics a spirit of dedicated service to the suffering humanity, particularly those who have very little to fall upon. Pavlov Institute is going to establish an integrated hospital complex having state-of-the-art indoor and outdoor facilities. The institute plans to introduce certified training courses on counselling, psychiatric nursing and continued medical education in psychiatry; and rehabilitation and parents-guidance centres.
Other than above-mentioned voluntary societies and non-governmental organizations, there are many other initiatives at the grassroots level in rural and urban West Bengal working towards supplementing the huge gap of demand and supply in mental healthcare. We must mention names of some other initiatives in West Bengal, such as Antar Darshan, Antarik, Baulmon Society, Institute for Motivation and Self Employment (IMSE), Diksha, Sachetana, Sanglap: counselling unit, SEVAK, Purbasha, Institute of Psychological and Educational Research (IPER), Manovikas Kendra Rehabilitation and Research Institute for the Handicapped (MRIH), National Institute of Behavioural Sciences (NIBS), Turning Point, Society for Mental Health Care, Dulal Smriti Samsad, Dana, Dishari: City Health and Welfare Association, Shubho Uttaran, Sahamarmi, Samikshani, Setu. These organizations are working either in a specific area of mental healthcare such as suicide, or for a specific group of people, such as mentally challenged persons.

The mental health movement in West Bengal has gained momentum after the establishment of a network of
voluntary societies and non-governmental organizations across the state. These initiatives also deal with socially sensitive issues, such as, handling of persons with severe mental retardation, involvement of community in rehabilitation of cured mental patients, mental stress due to peer pressure, and so on. Most of the organizations generate their funds from the society itself, rather seeking support from the external donor agencies or government. This helps in their long-term sustainability and enhancing their morale. The government healthcare systems need to be fine-tuned in line of the initiatives of NGOs, so that existing infrastructure can be utilized optimally with involving the stakeholders.

These NGO activities supplement, not substitute, the state-run mental healthcare system. This unique symbiotic relationship of public-private joint ventures may lead the way to a balanced mental health scenario in the state of West Bengal.
**Conclusion:**

To conclude with Eisenberg’s (2000) words: “the unique role of psychiatry will be its contribution to a new paradigm: brain/mindfulness, integrating neurobiology with behaviour in its social context. That is the intellectual challenge ahead.”

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47 Leon Eisenberg, “Is psychiatry more mindful or brainier than it was a decade ago?” *British Journal of Psychiatry* 176 (2000): 1-5.