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Mental Health in U.P. - Last Fifty Years

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Uttar Pradesh is bigger than many countries of the world, both geographically and in population. This state consists of large Indo-Gangetic plains with Hindi as the basic language though the dialect differs in different parts. Primarily it is an agricultural society, but urbanization is happening amazingly fast. The cultural background is largely uniform over the state. The society is stable. Unfortunately, mental health growth has not been as robust as in some other parts of the country.The reason for this poor development is not difficult to seek. Most mental health institutions were developed in the south or eastern part of the country; therefore, not many from this state could join them.The first post-graduate teaching program came into existence in the K.G's Medical College (KGMC) in 1971. The state did not consider the mental health of primary importance till recently. The priorities were communicable diseases and malnutrition.

HISTORY

My first encounter with an individual with mental illness was in the year 1954 when I saw a young man tied in ropes on a railway platform. This man was loudly abusing, and a crowd had gathered around him. I was fifteen-year-old and did not know what the issue was. I was told that this person is being taken to Agra for treatment. This experience was totally forgotten till I became a psychiatrist in 1965 and I could appreciate the pain of mental illness. After completing my training from All India Institute of Mental Health, Bangalore in 1965, I applied for a job in U. P. Health Services. I requested the director to allow me to work only in the area of mental health. I was informed that you are being appointed as a medical officer, and you can be posted anywhere.Why am I relating these incidents? This is to show that this state was not explicitly geared to develop mental health care. Similar scenes of the mentally ill lying uncared for at home and in the streets can still be seen. Even now, psychiatrists are posted as medical officers and are expected to perform duties as medical officers. They lose contact with their specialty and become ineffective both as medical officers as well as psychiatrists. There is an acute shortage of psychiatrists in the state, and we are not using even the available resources appropriately.

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I joined the Department of Medicine as a lecturer in psychiatry(KGMC) in 1969. The department already had two faculty members in psychiatry. Later in 1971, an independent Department of psychiatry was carved from the department of medicine, and post-graduate training in psychiatry started. The availability of mental health training or services was very few at that time. There were three medical colleges owned by the state govt and two university-owned colleges in Varanasi and Aligarh. Psychiatric facilities were available only at Lucknow and Varanasi. There were three mental hospitals in Agra, Bareilly, and Varanasi. Except for Agra, all others were managed by non-psychiatrist. A couple of retired psychiatrists from mental hospitals were in private practice. The number of psychiatrists could not reach double figures.

The Indian Psychiatric Society asked me to organize the central zone. This zone consisted of U. P. and Madhya Pradesh. The total number in the two states was not more than twenty, and the whole conference was held in a small room. The situation has entirely changed now.

PRESENT SITUATION

The real change occurred after psychiatric post-graduation started in Lucknow. Soon after, Varanasi and Aligarh, and Agra also started post-graduate programs. Many new govt medical colleges and private medical colleges are providing post-graduate training currently.

This rapid development has led to another group of problems. There were not many trained post-graduate teachers in psychiatry. Institutions tried to fulfill the requirement of teachers by different kind of manipulations that is affecting training programs. The development of any specialty depends on the ability of persons joining it. There were three distinct phases. The first phase was in the sixties when those interested in specialty traveled long distances to do specialization. The second phase started in the seventies and continued for nearly twenty years when psychiatry was the last choice during post-graduate selections. Many senior teachers actively discouraged bright students from taking psychiatry as they felt that this specialty would not provide them the type of returns they deserved. Things started changing around 1990 when quite a few bright students started opting for psychiatry. This description does not mean that there were periods when no bright students joined psychiatry, but the ratio of the mixture had changed over a period.There are around 180 members of the Indian Psychiatric Society, and there must be another fifty who are not members, but even these numbers are too few for this state.

From its inception, psychiatry had been riddled with a conflict between biologically versus the psychologically oriented group. Though everyone accepts the multi-factorial causation of mental illnesses, the emphasis still varies. We in India have another important variable, the indigenous methods of treatments and religion-based therapies like yoga. The young clinicians are confused and often provide contradictory signals. They will prescribe a large number of medicines, provide rudimentary psychological help, and recommend yoga. Such advice produces conflict in patients' minds and caregivers and often results in treatment failure. Psychiatry is an evidence-based specialty, and we should practice methods that have sound evidence. Drug treatment for various illnesses has reasonable evidence; similar evidence is also available about certain specific psychotherapies. The limitation is that these psychotherapies can be practiced by people who have been trained. Therapies like Yoga, Ayurveda, Unani are being tried by some, but there is no consensus. Till such times the consensus develops, one should refrain from using them as therapeutic tools, but they can be used as general mental health measures as per the patient's belief system. But one must clearly specify the reason for such advice. A young man shows repetitive bouts of anxiety in tough situations. If he or his family believes that prayer to god or any other such practice helps, there is no harm in trying it in the right earnest for some time. If it does not work, we revert to accepted methods. Combining the two from the start will confuse the psychiatrist as he will not know what worked.

LAW AND MENTAL HEALTH

MHCA 2017 is progressive and right based legislation, and Chapter 5 of the Act (Sec 18-28) is fully devoted to the rights of persons with mental illness (PMI). Section 28 of the Act describes the "Right to access mental healthcare," which will be universally available. The section states that "Every person shall have a right to access mental health care and treatment" from mental health services run or funded by the appropriate government, and the government shall make sufficient provision as may be necessary, for a range of services required by PMI. Suppose the government fails to provide the right to access mental health care to everyone. In that case, it is the government's responsibility to reimburse the costs of treatment according to the section. The range of services includes outpatient and inpatient services, free essential medicines, halfway home, sheltered accommodation, services for support of family persons of PMI, hospital, home, community-based rehabilitation services, and child and old age mental health services. Mental health services are to be integrated with the general health services at all levels, such as primary, secondary, and tertiary levels (C.L.Narayan).*Similar is the situation about The Rights of Persons with Disabilities (RPwD) Act-2016. None of the facilities envisaged in the act are available to persons with mental illness. I think it is time to encourage the mentally sick and their relatives to go to courts to avail of these facilities as provided by law.

The ground reality is that mental health service does not exist in the state. There is a district mental health program that is largely funded by the center. Mentally ill have no access to treatment near their place of stay. There are no rehabilitative services. Medicines are provided in the district mental health program and in some government hospitals. How adequate are they need to be examined? There is a need to develop a systematic mental health care program for the whole state where the sick should be able to get treatment near their homes, and rehabilitation

should be built. District mental health programs could be the nucleus for state mental health services. The district mental health program should have a twenty-bed unit in each district. This should include acute care, long term care, and rehabilitation. Patients coming from different parts of the districts should be referred back to their primary health care unit, and the follow-up treatment should be done by local health personnel. This will provide hands down training to medical officers and sensitize them to the mentally ill's needs.

FUTURE

The future of psychiatry in U.P. will largely depend on how psychiatry's current leadership faces the challenges. I have the following suggestions to make.

Emphasize the teaching of psychiatry both at the under-graduate and post-graduate levels. We must follow the curriculum developed by the medical council of India. This curriculum has many deficiencies, and repetitive representations could resolve these. No individual or institution should diverge from the accepted curriculum; this will bring uniformity. Many distinguished clinicians may have developed new techniques or new knowledge, but these should not be part of the curriculum till accepted by the medical council. Many teaching institutions have a shortage of staff; this could be overcome by developing guest faculty for areas where sufficient expertise does not exist in the department. Students needto be exposed to different settings, like mental hospitals, rehabilitation centers, prisons, and research settings, not as tourists but as clinical duties.

The clinical services should be developed to provide comprehensive care for acute patients, chronic patients, and psycho-social emergencies. A partnership between private psychiatrists and state mental health services should develop.

Uttar Pradesh state branch of IPS should take the initiative to develop apsychiatric journal in Hindi, which is likely to find acceptance in the whole of Hindi heartland, *e.g.*, U. P., M. P., Bihar, Rajasthan, Chhattisgarh, Jharkhand Uttarakhand, etc. Original thinking can only develop in one's native language. Most of us have been trained to translate all native concepts into a foreign language, which often takes away the concept's vital ingredient. I have emphasized it many times earlier, but re-emphasis is required to develop expertise in psycho-social management and measurements. We also need to develop primary data on psycho-social issues particular to our area.

I wish the new journal and the branch a bright future.