MENTAL ILLNESS
Mental Illness refers to different types of mental disorders which include disorders of thought, mood or behavior, causing distress and an inability to function fully.

The inability could be in the psychological, social, occupational or interpersonal domains. Persons having mental illness may have trouble handling daily activities, family responsibilities, relationships, or in discharging responsibilities at work or in school. Their problems could be in more than one area of their functions.

Signs and Symptoms

There is no clear-cut dividing line between mental health and mental illness. The signs of common mental illnesses include depressed or irritable mood, anxious affect, diminished interest, insomnia or hypersomnia, psychomotor retardation/agitation, fatigue, feelings of worthlessness, diminished ability to think, delusions, thoughts of death, hallucinations—visual or auditory, incoherent speech, neglect of personal hygiene, lack of emotions, angry outbursts, social isolation, persistent feeling of being watched, etc. Signs and symptoms occur on a continuum, from mild to severe.

Definition

The ICD-10 (WHO, 1992) defines mental disorders as: ‘the existence of a clinically recognizable set of symptoms or behavior, associated in most cases with distress and with interference with personal functions’ (p. 2).

The DSM-IV (APA, 1994) classification gives a fuller definition: a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering, pain or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one.

Etiology

For most mental illnesses, the etiology is not fully clear. However, from epidemiological and other research, we know that the causes are multifactorial. Various biological, psychological and socio-cultural factors determine both the vulnerability to psychopathology and the form that pathology may take.

Irrespective of its original cause, mental illness must currently be considered a manifestation of a behavioral or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and the society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.
Chapter 2
Historical Perspective

The Discipline of Clinical Psychology

From its very inception, Clinical Psychology as a vibrant profession has grown with the academic, research and clinical work of Dr. Girindrasekar Bose in the early 1920s to current state (Prabhu, 1976; 2001a; 2001b; 2004). Even though, there were various advances, the actual development emerged with the establishment, in 1954, of the All India Institute of Mental Health (presently, National Institute of Mental Health and Neurosciences (NIMHANS)) in Bangalore and the commencement of a formal, fulltime training program there in clinical psychology in the year 1956.

The need of associating psychologists in the diagnosis and management of mentally ill was first recognized/implemented in the 1920s at the European Mental Hospital [presently Central Institute of Psychiatry (CIP)], Ranchi, but the emphasis on the therapeutic role of the clinical psychologist was mainly due to the work of Dr. Bose. His immense interest in the dynamic school of thought led to the use of a variety of techniques/approaches and psycho-analytical concepts such as dream analysis, free association, repression, hypnosis, yoga, etc., in his day-to-day clinical work.

The first half of the 20th century is a golden era of psychology in India with Dr. Bose and his colleagues providing the much needed impetus to a strong therapeutic orientation (Prabhu, 2004).

The NIMHANS and CIP which came into existence in the middle of the 20th century, extended the intervention components in the clinical psychology training and practice. Over the years, several contemporary psycho-social methods of interventions were introduced into clinical practice at these institutes, although emphasis and extent of exposure varied between the two centers. Since these two training centers existed in mental hospital settings, the predominant exposure of the trainees was to the problems of the mentally ill and the severely disturbed. The exposure to minor mental illnesses, psycho-social aberrations, health psychology and psycho-social dimensions of primary health conditions was limited. The trainees at these centers did not receive the attention needed to function as a specialist, independently within the framework of the profession so that they could develop an appropriate professional identity. This was due to the several limitations inherent in the training setting (Prabhu, 2001). Together, about 20 candidates per annum, were trained at these two centers. However, with the dawn of the new century, there were changes.

The Road Traversed

Impressive progress has been made, particularly in the last three decades, both in basic as well as in application research in different areas of clinical psychology. This growth has brought in significant changes in the health field as well as in society and expanded the scope of clinical psychology to a much broader extent than previously thought.
Advances in technology played a major role in bringing about these changes. For example, the computer provided a better analogy for cognitive theories as well as providing a powerful tool for experimental research. As the information age began to unfold, there was an increase in the number of research outlets. The expanding scientific literature allowed researchers to focus on specific and/or specialized problems.

In the light of these recent research contributions made in the field of Clinical Psychology, three major misconceptions about clinical psychology can be dispelled (Belloch and Olabarría, 1994).

(1) Historically, the therapeutic interventions were quite non-specific to various disorders and did not have a close connection with basic research. During the last three decades, this scenario has changed dramatically. Today clinical psychologists engage in basic research designed to elucidate the physiological and cognitive mechanisms of mental and organic disorders. These developments are exemplified in recent research, *inter alia*, on the cognitive evaluation of body sensations and cognitive schema in anxiety and depressive disorders, panic disorder, post-traumatic stress disorder, delusion disorders, somatization disorders, personality disorders (which are always thought as treatment refractory), has led to specific and highly effective short-term psychological interventions.

(2) Clinical psychology was linked with the study of emotional disorders such as anxiety or depression. Modern clinical psychology, however, can make substantial contributions to the theory and treatment of medical disorders, such as, infertility, dermatological conditions, respiratory disorders, gastrointestinal and bowel diseases, and cardiovascular diseases. For example, evidence provided suggests that decreasing interpersonal stress by couple therapy is an effective treatment for organically healthy infertile men, that biofeedback may be a laudable treatment for epilepsy, tension/vascular headache, and that behavioral processes are important for the etiology and management of chronic hypertension, one of the risk factors for CV diseases, and various other systemic diseases. All these developments have resulted in the emergence of a new field of expertise, one that covers certain aspects which traditionally belonged to clinical psychology, such as, diagnostic and assessment functions, psychological treatment, etc. and other aspects that require new types of socio-technical qualifications and contributions. These aspects involve interdisciplinary work in and with the community, in health promotion and prevention, receiving/giving support for specialized services in hospitals, working with other experts in Primary Care Centers, engaging and supporting the network of Social Services, utilization of new psychological instruments and equipment to deal with chronic conditions. All of this has developed from an interdisciplinary point of view, where “the team is not simply the sum or juxtaposition of professionals with different skills, but a working group with a high degree of
functional expertise, a result of the integration of the professionals’ contributions to achieve those goals” (cf. Belloch and Olabarría, 1994).

This way, placing itself within the framework of health organizations and referencing to a Health Care model, clinical psychology has cleared its path for creating new areas of action as a consequence of technical and social responsibility. This may be the beginning of the institutionalizing different working tasks or bureaucratization of clinical psychology within the health system.

We must emphasize that the public network of mental health services is the main career path for clinical psychologists, though this is not the only one. Mentioning their active contribution to new fields is in order. Some of these are: Care for primary health problems, in their day-to-day tasks associated with their hospital services, such as, the efforts and research work involving oncology, psychosomatic disorders, pain, pre- and post-surgery psychoprophylaxis, in their work with chronic illness, such as, diabetes, asthma, hemophilia, HIV/AIDS, head-injury, dementia, a plethora of skin disorders and so on. These interdisciplinary, but specific work show an increase in the acknowledged outcome.

Integrated public services are provided at the Primary Health Care level, where support and coordination of professionals is extremely important. Thus, clinical psychologists have taken over more duties to overcome the traditional division between comprehensive health care (and subsequent treatment of general health problems) and what is known as mental health care. This kind of work has helped to detect psychopathological cases, to organize follow-up and simultaneously easing and improving referral procedures.

Clinical psychologists also contribute through teaching psychological and interpersonal skills to professionals in a general health setting to help them manage health problems, change patients’ habits/life style. In general, the clinical psychologists promote health in the community, in small groups and in individuals.

(3) The discipline of Clinical Psychology is not restricted to the study and treatment of psychological problems, such as, low self-esteem or shyness, as demonstrated by recent research. Psychological intervention is highly effective in the treatment of severe mental disorders as well. Family education and treatment prevent relapse in the schizophrenics. That Cognitive Behavior Therapy (CBT) is effective in the treatment of disorders, such as, anxiety, panic, obsessive-compulsive disorders and in dispelling delusion associated with life-long disability, have also been supported through research.

Role of the RCI

The consequential benefits the establishment of the Rehabilitation Council of India (RCI) are: Clinical Psychology has been recognized as one of the core specialities within the mental health sector
giving it a professional identity, fostering inter- and intra-professional interaction and groups who work together as a team as well as with their own clients and field of work.

Clinical Psychology gained comparability with regard to other post-graduate degree holders of health disciplines.

**Training Programs**

The RCI was empowered with the required statutory authority for standardizing and monitoring training course for clinical psychologists, for granting recognition to institutions running the recognized courses, and for maintaining a central register for qualified clinical psychologists. Professional interaction among the clinical psychologists and decision making process as and when deemed necessary was also facilitated.

The amended RCI Act in 2000 gave the RCI the additional responsibility of promoting research in rehabilitation and special education.

More importantly, the RCI developed a core competency model for internship program in Clinical Psychology for the first time in 2001. The regulations of the M.Phil Clinical Psychology training program outlined the professional scope, and the nature and core areas of the clinical psychologists’ work.
Chapter 3

Magnitude of the Problem

In India, over 25 million people suffer from mental illness. Lack of economic resource together with lack of professionals in the field has made the scenario bleak.

Prevalence of Mental Illness

The epidemiological surveys in many countries indicate that mental disorders are quite common among the general population worldwide. Generally, the prevalence of all mental disorders varies between 10 and 15 per cent of the general population. Studies have estimated lifetime prevalence of mental disorders among adults to range from 12.2 to 48.6%.

The WHO has estimated that approximately 450 million individuals worldwide suffer from neuropsychiatric disorders in their lifetime.

A large number of epidemiological surveys have shown the prevalence rates of mental morbidity in rural and urban areas ranging from 9.5 to 370/1000 in India (Suresh, et al., 2007). This is comparable to global rates.

The wide variations observed have been attributed to a lack of definition providing a clear boundary between psychopathology and normality, a difficulty faced in operationalizing “clinical significance” and “medical necessity”.

Type

Approximately 33% of the number of years lived with disability (YLD), are due to neuropsychiatric conditions. Of the 10 leading causes of YLD in the world, inclusive of all ages, four are psychiatric conditions, with unipolar depression being the leading cause.

Among individuals aged 15 to 44 years, panic disorder, drug use disorders, and obsessive compulsive disorder (OCD) were in the top 20 disorders (Robert, et al., 2004).

Among the mental health problems, depression and anxiety disorders are the most prevalent, followed by substance use disorders among adults.

Among children the most common are attention deficit and conduct disorders.

India has a high rate of suicides - 89,000 persons committed suicide in 1995, increasing to 96,000 in 1997 and 104,000 in 1998, which is a 25% increase over the previous year (WHO, 2001a).

Age

High prevalence rates from 10 to 15 per cent among school-age children have been shown. A recent epidemiological study sponsored by ICMR (Mehta, 2004) indicated the overall prevalence of mental-behavioral disorders in children to be 12.5%, a finding in agreement with an earlier report (Mehta, 1990) of a prevalence rate of 12-13% in school children.

Young adults, aged 15-44 years, the most economically productive section of the community,
is the most affected. It is projected that developing countries, such as India, will see the most substantial increases in the burden of mental disorders in the next two decades. It is estimated that mental disorders accounted for 12% of disability adjusted life years (DALY) in the year 2000, and 13% in the year 2001 (WHO, 2002).

Projections suggest that the health burden due to mental disorders will increase to 15% of DALY by 2020 (Murray and Lopez, 1996).

Reducing the stigma, affordable treatment opportunities, low cost centers, psycho-education, social rehabilitation, vocational training may be effective solutions for reducing the burden.
Chapter 4
Assessment of Mental Illness and Patient Care

Tools/Techniques Employed

The screening scales or instruments employed in a majority of the epidemiological studies conducted in India, *inter alia*, include Mental Health Screening Questionnaire, Questionnaire for the Assessment of Psychiatric State of the Family, Indian Psychiatric Survey Schedule, Social Functioning Questionnaire, Psychiatric Screening Questionnaire, Psychiatric Health Questionnaire, Case Record Schedule, Rapid Psychiatric Examination Schedule (Suresh, 2007).

Facilities for the Care of the Mentally Ill

In spite of the high burden of mental disorders which is approximately a sixth of all health-related disabilities, and despite the fact that a significant portion of this burden can be reduced by primary and secondary prevention, most people in India do not have access to mental health care. This can be attributed to the inadequate infrastructure including lack of adequate human resources. When available, treatment is based on a purely medical model focusing on the provision of drugs and ECT. There is a dearth of facilities for providing psycho- and psycho-social therapies, counseling, and rehabilitation services.

It is well accepted that mental health care is multidisciplinary, involving such professionals as psychologists, psychiatric nurses and psychiatric social workers. However, such multidisciplinary care is limited to only a few centers in our country.

Bed-strength in Hospitals

India has 0.25 mental health beds per 10,000 population, approximately 20,000 beds in mental hospitals and 3,000 beds in general hospitals for psychiatric patients. Of these, the vast majority (0.20) occupied by chronic patients requiring long stay, are not accessible to the general population.

Patient Care

*Family and Community Involvement*

Family burden is a complex problem that seriously affects the treatment of chronic mentally ill patients.

The Indian family is a source of strength when it comes to mental illness, but the family structure, composition, attitudes, obligations, and values are changing. In fact, there is a total change in the sociology of the Indian family. Families, the primary caregivers, are feeling the strain in a country without a welfare system.

The recent deinstitutionalization process has reduced the length of hospital stays and steadily promoted family/community care of the mentally ill. Studies suggest that more than 65 per cent of the discharged patients return to their families. The emotional and economic strain experienced when a relative discharged from a mental hospital returns home is a burden on the family.

The critical phase of deinstitutionalization, i.e., providing adequate and accessible community
alternatives to hospitalization has not progressed satisfactorily. Thus, quality of life and well-being of chronic and severely mentally ill who are discharged from the hospital has not improved as much as it should have within the philosophy of deinstitutionalization (Amool, 2005).

Mental health literacy needs to be built strongly in the community to scale up the utilization of available mental health services. Over 90% of the mentally ill are cared for within their communities, by their families without even receiving a diagnosis.

On the credit side, India has a community mental health program that consists of integrating basic mental healthcare into general healthcare services. The objectives could be:

- training the primary healthcare personnel in mental healthcare,
- providing them with adequate neuropsychiatric drugs in primary care settings,
- supervising primary healthcare staff, and
- establishing a psychiatric unit at the district level.

**Treatment**

Many people are still unaware that there are effective treatments for many mental disorders. For example, nearly 50–60% of persons with depression will recover with treatment in three to eight months; with schizophrenia, a combination of regular medication, family education and support can reduce the relapse rate from 50% to 10%.

India has 0.4 psychiatrists, 0.04 psychiatric nurses, 0.02 psychologists and 0.02 social workers per 100,000 population (WHO, 2001b). At the most, only 10% receive active psychiatric care as against 30 million requiring mental health care. Approximately, 2,50,000 new psychiatric cases manifest each year. Most turn to faith healers or temples first. Stigma, discrimination and neglect prevent care and treatment. Thus, even the available services for mental disorders are being poorly utilized. Nearly two-thirds of persons with known mental disorders never seek help from health professionals. Instead, they resort to harmful practices, visit faith healers and delay treatment till the condition deteriorates which compels them to seek treatment from established government institutions.

**WHO Recommendations**

Evidence shows that adequate prevention and treatment of mental disorders can reduce the suicide rates, irrespective of whether such interventions are directed at individuals, families, schools or other sections of the general community (WHO, 2001c).

If access to mental healthcare is to be improved, mental healthcare must be provided at the community and primary level.

To address the treatment gap, the WHO (2001d) has outlined the following ten recommendations:

1. Mental health treatment should be accessible in primary care.
2. Psychotropic drugs need to be readily available.
3. Care should be shifted away from institutions and towards community facilities.
4. The public should be educated about mental health.
5. Families, communities and consumers should be involved in advocacy, policy-making and forming self-help groups.
6. National mental health programs should be established.
7. The training of mental health professionals should be increased and improved.
8. Links with other governmental and non-governmental institutions should be increased.
9. Mental health systems should be monitored using quality indicators.
10. More support should be provided for research.

Though the quality of the care in mental hospitals has improved tremendously from the colonial times, infrastructure and other facilities are considered still inadequate (Banerjee, 2001).

*The WHO has warned that many countries will be unable to cope with a predicted boom in mental illness over the next decade. According to WHO, “If we don’t deal with Mental Illness, there is a burden not only on the Mentally Ill, on their families, their communities, there is an economic burden if we don’t take care of people who need their care and treatment.”*
Chapter 5

Manpower Development

Historical Perspective

The first training program in clinical psychology in India was established at the All India Institute of Mental Health [(presently, National Institute of Mental Health and Neurosciences (NIMHANS)], Bangalore, in the year 1956. Subsequently, the training program was replicated at the Hospital for Mental Disease [(presently, Central Institute of Psychiatry (CIP)], Ranchi, in 1962.

In 1951, a training program in clinical psychology came up at the Benares Hindu University, but it exited the professional scene without making an impact.

Nomenclature

The nomenclature of the clinical psychology training program changed several times from the original DMP (Diploma in Medical Psychology) to the current M.Phil in Clinical Psychology more for various extrinsic reasons than for any issues related to the content of the course itself. However, from the outset it has been a post master’s 2-year, fulltime, regular and structured training program with emphasis on acquiring professional praxis through supervised internship. Since, the trainees received financial support, the course had a built-in demand to provide routine clinical services at both indoor and outdoor facilities.

Current Scenario

For nearly half a century, the National Institute of Mental Heath and Neurosciences, Bangalore and the Central Institute of Psychiatry, Ranchi were the only training centers in clinical psychology in the country. Attempts at starting and sustaining training programs in Clinical Psychology made in Kolkata, Ahmedabad, Varanasi and Bangalore being unsuccessful, there was a mismatch between the acute demand for the limited seats available at the two centers due to a growing interest in clinical psychology.

Centers for Training in Clinical Psychology

However, with the dawn of the 21st century, things started looking up. Today, training in clinical psychology is being offered at 10 recognized centers across the country with an annual intake of over 90 trainees.

Five of the ten training centers found their locations in a medical setting, four in the traditional mental hospital setting, and one has been started by an NGO catering to rehabilitation needs of various disabled populations.

RCI Involvement

Registration/Requirements

The degree holders from above centers qualify for enrolment on the RCI professional register thereby increasing the available qualified manpower.

Enrolled professionals are entitled to: (a) hold office (by whatever designation called) in
government or in any institution maintained by appropriate authority, (b) practice anywhere in India, (c) sign or authenticate any certificate required by any law, (d) give any evidence in any court as an expert under section 45 of the Indian Evidence Act of 1872 (The Gazette of India, Part II, Section 1, dated Sept. 1992).

Any person who acts in contravention shall be liable for punishment (which includes imprisonment for a term, up to one year or with fine). Every center which grants the recognized degree/certificate such as M.Phil (Clinical Psychology) is required to furnish all the necessary information, such as, content of the course, examination pattern, requisites for obtaining qualification, etc., required by the RCI, from time to time.

In view of the above statutes, any graduate or post-graduate degree in Clinical Psychology other than M.Phil in Clinical Psychology, as outlined by the RCI, from any center other than those listed below, is currently not recognized for purposes of enrolment on the register.

Not relevant to the practice of clinical psychology are such claims as: Taught M.A./M. Sc. psychology without direct patient contact, supervised clinical internship, and hands-on training in interventional work pertinent to a wide variety of clinical problems.

A Ph.D. in clinical psychology (after a Master’s degree in Psychology) involves neither a widespread exposure to clinical situations as in M.Phil training, nor a mandatory examination—theory and practical/clinical—to ensure acquisition of specified levels of competency. Hence, candidates with a Ph.D. degree, without completing the two-year clinical internship (as in M.Phil in Clinical Psychology), are considered ineligible to register as clinical psychologists effective from March 2007, notwithstanding the topic of the dissertation which may relate to a clinical area.

Clinical internship of a two-year duration completed which involves supervised, hands-on training, in a variety of clinical situations, subsequent to a post-graduate degree in psychology has been prescribed by the RCI as the minimum required qualification to register as a professional clinical psychologist in India.

The details of the centers currently recognized as per the notification (Gazette of India, New Delhi, dated November 1, 2006) are as follows:

1. Central Institute of Psychiatry, Kanke, Ranchi – 834 006 (Jharkhand)
2. Manipal University (formerly MAHE), Manipal – 576 104 (Karnataka)
3. Sri Ramachandra University, (formerly SRMC), Porur, Chennai – 600 116 (Tamil Nadu)
4. Ranchi Institute of Neuro Psychiatry & Allied Sciences, Kanke, Ranchi – 834 006 (Jharkhand)
5. Department of Psychology, University of Calcutta, Acharya Prafulla Chandra Road, Kolkata – 700 009 (West Bengal)
6. Sweekar Rehabilitation Institute, Upkar Circle, Picket, Secunderabad – 500 003 (Andhra Pradesh)

Subsequent to above notification, the following institutes have been approved:

7. Institute of Human Behavior and Allied Sciences, Jhilmil, Dilshad Garden, Delhi – 110 095
8) Department of Clinical Psychology, Amity Institute of Behavioral & Allied Sciences, NOIDA (Uttar Pradesh)
9) Institute of Mental Health and Hospital, Billochpura, Agra – 282 002 (Uttar Pradesh)
10) Regional Institute of Medical Sciences, Lamphel, Imphal – 795 004 (Manipur)

Inspection by RCI

The RCI is authorized to appoint requisite inspectors to any University or Institution anywhere in India, where education for professional practice is given, or to attend any examination held by the University or Institution (ibid).

Short Term Courses/Workshops/Seminars

Some committed/interested candidates who could not get enrolled for M.Phil training program carried on with their mission of serving the mentally ill, contributing in one way or the other in the service domains very closely connected to Clinical Psychology.

Some clinical psychology departments, including those in premier institutes, organize short-term courses aimed at imparting knowledge in assessment and interventions, to those not formally qualified, in such areas as marital therapy, behavior therapy, cognitive therapy, sex therapy, neuropsychological assessment/rehabilitation, etc. However, such short-term courses, of one to two weeks’ duration, are found wanting in hands-on experience under a competent supervisor and also in the assessment of the participants’ proficiency. These limitations are understandable given the time constraints for interaction.

Many senior and superannuated professionals also organize workshops and seminars, of varying durations, through university departments or NGOs on issues such as assessment, using projective and non-projective tests, counseling, therapy techniques, etc., for those not formally trained. Such programs also suffer from the lacunae mentioned above.

Those with Experience

Competent and resourceful participants do pick up the necessary techniques and skills at the short term programs. Coupled with their field/practical experience, they practice in the field of clinical psychology with such competency as those trained formally. They make good, partially at least, the short fall in available human-resources. Denying registration/enrollment to such candidates, as per the current rule is viewed as unfair by the RCI.

Discrepancies

India is well placed as far as trained manpower in general health services is concerned, trained mental health personnel are limited, and mostly based in urban areas.

Compared to the number of psychiatrists, most countries have between two and three times as many psychologists, social workers and psychiatric nurses. In India, it is estimated that there are more psychiatrists in active clinical practice than there are trained psychiatric nurses, clinical psychologists and psychiatric social workers. No systematic efforts are being made to address this distortion, by either the professional organizations or by the Government.

Bridge Course by RCI

Therefore, a bridge program called
Certification Course in Clinical Psychology for in-service candidates was offered by the RCI in the year 2003.

Entry requirements are: the candidate at the time of entry to the course should be working full-time with the mentally ill and be able to produce an experience certificate (an endorsement on the nature and quantum of work done) by a registered clinical psychologist (who is a two-year M.Phil degree holder from a recognized center, enrolled already under the category – clinical psychologist) stating that he/she has put in more than 5 years of service in the field (which means certifying clinical psychologist should have more than five years of experience post-qualification, i.e., post - M.Phil), following the award of post-graduate degree in psychology (fulltime/regular M.A./M.Sc. with a minimum of 55% marks in aggregate). Application/prospectus can be obtained, free of cost, from any of the training centers listed in this section.

The objectives of the program are:

1. Updating with relevant theories as applicable to clinical practice.
2. Imparting supervised hands-on experience in various domains related to clinical psychology practice.

This course, of 6 months' duration, is run in a few recognized centers which have regular, fulltime, qualified/registered clinical psychologists to provide the necessary input and supervised practical experience and which have adequate clinical material and infrastructures required for imparting academic training/degree.

On successful completion of the training as per the prescribed curricula, the candidates have to appear for theory/clinical exam conducted by the respective universities. With registration by the RCI, the successful candidates, become eligible to perform as responsible professionals in clinical psychology. Such candidates however, cannot function as faculty members in departments conducting M.Phil clinical psychology training programs.

**Training Centers for Bridge Course**

(Center code – 002/05)
The Professor and Head
Department of Clinical Psychology
Kasturba Medical College
Manipur University
Manipal – 576 104 (Karnataka)

(Center code – 003/05)
The Director (Admn.)
Regional Institute of Medical Sciences
Lamphelpat
Imphal – 795 004 (Manipur)

(Center code – 004/05)
The Executive Director and Chairman
“Digdarshika”
Red Cross Bhawan Campus
Shivaji Nagar, Bhopal – 462 016

(Center code – 005/05)
The Director
“Saarthak”
24, Hauz Khas Village
New Delhi – 110 016

Though there is an upward trend, the number of professionals currently available is no match to the number required to meet the ever growing demands in the field. Efforts are being made towards increasing the number of centers that can impart the M.Phil level training.
Chapter 6

Government and NGOs

District Mental Health Program

The objectives of the District Mental Health Program (DMHP) are:

- to ensure availability and accessibility with ease, of mental health care for the needy,
- to integrate mental health care with general health services, and
- to promote community participation and to increase awareness.

The DMHP was first launched in 1996-97 in one district each in the States of Andhra Pradesh, Assam, Rajasthan and Tamil Nadu. Currently, the program is being implemented in 22 districts in the country and covers around 40 million people, which is approximately 5% of the population. It is planned that this program would be extended to 100 districts (The Ministry is planning to cover 400 districts in the next three years and all 600 districts in due course under National mental Health Programme. But even if successful, it will still only cover 150 million people, or approximately 15% of the country’s population.

Some of the drawbacks of implementing this program are:

- these efforts have been linked to charismatic leaders rather than the structural and enduring changes of the health system, and
- these programs have been limited to an area in the country or to a particular mode of service provision which makes it difficult to replicate or transport to another area in the country.

Thus, the issue to be addressed on priority in the country is accessibility. Policy interventions are needed to increase access to appropriate and quality mental health services by the needy.

Wherever modern health services are available, people do avail them even though they tend to seek out religious and traditional healers for relief of their problems, whether general or mental health related.

Mental Health Policy

The policy was initially formulated in 1982. Since the primary health facilities are relatively well developed in India, it was recommended that care for mental health must form an integral part of the total health program and as such should be included in national policies and programs related to health, education and social welfare.

The national mental health program was adopted as the mental health policy. The objectives of the national mental health program are:

1. To ensure availability and accessibility of minimum mental health care for all, particularly to the most vulnerable and under-privileged sections of the population in the foreseeable future.

2. To encourage application of mental health knowledge in general health care and in social development.
(3) To promote community participation in mental health service development and to stimulate efforts towards self help in the community.

From 1982 to 1995, the program was run as a pilot program. The program is currently being implemented in twenty-two districts in the country and it is to be extended to cover 100 districts within a stipulated time.

The following approaches have been adopted by the program:

(1) Integration of basic mental health care into general mental health care services.
(2) Training of primary health care personnel in the aspects of mental health care.
(3) Provision of adequate neuro-psychiatric drugs in peripheral health care institutions.
(4) Support and supervision of trained primary health care personnel.
(5) Establishment of a psychiatric unit at the district level.
(6) Encouraging community participation.

Mental Health Legislation

A number of public policy and judicial enactments have tried to address the issues of stigma attached to mental illness and the rights of the mentally ill.

The Mental Health Act, 1987 with a focus to improve the quality of services/care and protect the rights of mentally ill has replaced the Indian Lunacy Act of 1912. The new Act has been a very important milestone in the development of modern psychiatric services in the country.

The Mental Health Act, 1987 has provided new definitions, simplified procedures for admission and discharge. It has also introduced licensing of psychiatric hospitals, separated the mental health authorities at the State and the Central levels. Facilities for children and persons with addiction have been bifurcated and human rights of the mentally ill has been promoted.

There are also Acts relevant to marriage and divorce, Juvenile Justice Act, Persons with Disabilities Act and legal provisions related to suicide and attempted suicide. The State Governments took a long lead time to establish mental health authority and to implement this Act.

Budgetary Provisions

According to a WHO report, 28% of nations have no specified budget for mental health. About one-third of the people live in countries which invest less than 1% of their total health budget in mental health services. India spends just 0.83% of its total health budget on mental health (WHO 2001b), in spite of the fact that the budgetary support for the National Mental Health Program (NMHP, 1982) has been increased nearly seven-fold to Rs.1900 million in the Tenth Five Year Plan, up from Rs. 280 million during the Ninth Plan (Khandelwal et al. 2004). This quantum accretion in the resource base is being utilized as under:

<table>
<thead>
<tr>
<th>(In Rs.)</th>
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<tbody>
<tr>
<td>District Mental Health Program</td>
<td>Rs. 633 million</td>
</tr>
<tr>
<td>Modernization of Mental Hospitals</td>
<td>Rs. 742 million</td>
</tr>
<tr>
<td>Strengthening of Medical Colleges</td>
<td>Rs. 375 million</td>
</tr>
<tr>
<td>IEC initiatives</td>
<td>Rs. 100 million</td>
</tr>
<tr>
<td>Research and Training</td>
<td>Rs. 50 million</td>
</tr>
</tbody>
</table>

This allocation is small as compared to 10 - 18% in other countries.

Issues Related to Mentally Ill Women

The recent national seminar organized by the National Commission for Women highlighted the
difficulties in the lives of the mentally ill women who face stigma, discrimination and deprivation of homes.

The Commission’s effort towards drawing up a holistic plan with participation from NGOs for the care and welfare of women has been viewed as an important step in the right direction.

A study conducted in Delhi with a population of 70 million showed nearly 2,500 mentally ill women, devoid of hopes, virtually on the street. Extrapolating for the whole nation, the country will have nearly 150,000 mentally-ill, destitute women.

The Commission along with the government departments, State Women’s Commissions and NGOs need to collaborate for establishing rehabilitation centers, after-care homes and halfway homes across the country year after year. Such program should be inclusive of counseling and the welfare of the affected, the children and the family.

**Linking of Services—Mental Health and General Health**

Since trained manpower in general health services is available in the country to a greater extent, the development of mental health services including manpower has been linked with general health services and primary health care.

Training opportunities for various kinds of mental health personnel are gradually increasing in various academic institutions in the country.

Of recent, there has been a major initiative in the growth of private psychiatric services to fill a vacuum that the public mental health services have been slow to address. A number of non-governmental organizations have also initiated rehabilitation programs, school mental health programs and underlining human rights of the mentally ill.

Despite all these efforts leading to some progress, much needs to be done towards training, research, and providing clinical services to promote mental health in all sections of the society.

**Role of Non-governmental Organizations**

Patel and Tara (2003) give an excellent account of non-governmental organizations (NGOs) working in various areas of mental health in different parts of the country. In addition, NGOs also play a significant role in influencing policy matters.

The NGO perspective on health is that it is an integral component of community development and good health is the result of a complex interaction of social, economic, biological and psychological factors. Thus, bio-medically oriented, hospital based solutions alone are insufficient to ensure sustainable health change in a community. For example, NGOs often work both in clinical and non-clinical sectors which exercise a profound influence on child and adult mental health, such as women’s empowerment and non-formal education. Community-based child guidance and development services are the focus of some NGOs. For example, Action for Autism in New Delhi and the Maharashtra Dyslexia Association, Mumbai, focus on specific disorders of childhood and adolescents. Whereas, NGOs like Sangath and Manas in Goa, Saarthak and Samadhan in New Delhi, Samikshini in Kolkata provide multi-disciplinary services for a range of childhood and adult mental health problems.
Chapter 7
Vision for the Future

Thoughts for Future Growth

In the absence of a certification authority till recently in the country, the clinical psychologists’ role as a full-fledged professional went unrecognized among their peers with consequent limitations to their effectiveness in treatment setting(s).

In India, smaller psychiatric units in general hospitals or NGOs often employ a single clinical psychologist and thus many of them practice in “pockets of isolation”. In addition, for too long, clinical psychologists have not been held accountable in clarifying the treatment principles and the evidence for both efficacy and effectiveness. Therapists are allowed to freely explore a wide variety of treatment approaches as long as no harm is done. This “benign neglect” led to practices nearly as varied as the number of settings, leaving little incentive for practitioners to develop the necessary skills to objectively evaluate their own services.

However, current legislation has brought about the accountability hitherto lacking which will have important ramifications for professional practices. With the rapid global change in psychiatric health care, clinical psychologists of this country will have to upgrade their skills which are central to their professional practice. They will have to gain greater trust of the public as well as the professional community.

The field of clinical psychology has “rediscovered” the intentions of its pioneering leaders. These intentions include developing a psychology that can contribute to the overall good of the society. Valuable knowledge and services provided so far will have to continue.

Some urgent issues to be underlined are:

- Developing a new agenda for furthering and strengthening this field. The need of the hour is determination and cohesiveness among scholars, practitioners, trainers, and employers to achieve the common goal of broadening the field of action by becoming a significant part of public health. Two specific reasons for this are:
  
  (i) There has been a proliferation of specialties within clinical psychology. Consequently, this has distracted the professionals from unifying themes that bind them together as clinical psychologists even though there might have been an increase in knowledge.

  (ii) Developing a new agenda relates to surviving in a competitive market. Why clinical psychology is unique among the health professions must be enunciated. The uniqueness is the science-practice intersection that ties what we do to add to knowledge from the study of
behavior. The present status is that different frameworks coexist, sometimes “peacefully”, sometimes in intense “rivalry”. Though co-existence of a spectrum of theories and approaches enriches the learning experience for students and practitioners, a collective effort should be made by the professionals, from the applied and research areas, to support dissemination of empirically validated treatment procedures and to enhance linkages between research and practice.

- Initiation of interaction to develop a working relationship between the academic and service settings and to strengthen the base in teaching, research and service activities, as is being emphasized repeatedly (Prabhu 1975; 2001b).
- Completion of registration by the qualified clinical psychologists so that their practice in the profession could be regulated effectively. A notification to various governmental/non-governmental agencies and prospective employers, regarding the requirement of compulsory registration under the regulatory body will be effective in this direction. Fresh recruitments, at both State and Central levels, should be restricted to the registered clinical psychologists.
- Furnishing the necessary information about content of the course, examination pattern, requisites for obtaining qualification, etc., as required by the statute and complete the inspection and follow the approved norms and guidelines.
- To work towards developing the required manpower to meet the current and future needs. The Bridge program, already developed by RCI, may be marketed aggressively and the present infrastructure available in the academic institutes must be utilized optimally to generate the required number of qualified professionals.
- To open independent departments of Clinical Psychology in all mental institutes, mental health centers and in medical colleges, so that these departments can meet the growing demands in the service sector and can mobilize/build-up the required infrastructure, in the years to come, to start short- and long-term training programs in clinical psychology.
- To include an appropriate teaching and training module in behavioral sciences and rehabilitation sciences at the undergraduate level to sensitize the future young doctors in the psychological dimensions of medical diseases and rehabilitation processes.
- To conduct and support Continuing Rehabilitation Education (CRE) programs for updating the knowledge for the clinical psychologists already in the field. Also to design and offer short courses in various specialty areas like HIV/AIDS, Pain Management, Palliative Care and issues related to death and dying, rehabilitation of those with head injury, etc.
• Continuous training and upgrading of their knowledge and skills by the Clinical Psychologists to avoid stagnation. There is a training need for acquiring new competencies to cater to specialized patient-population and to deal with the daily heterogeneous demands made on the clinical psychologists. This implies continuous evaluation of the clinical psychologists’ actions, services and domains where they work.

• Training schedules to focus on the methods of interviewing and contact with the individuals and families, listening skills in dealing with clients, assessing their needs, counseling and identification of high risk families and clients. Community organization and mobilization of resources are other areas to be taken note of.

• To introduce Conditional Registration—All candidates must obtain RCI registration (conditional) as soon as they commence their training at a recognized center. Regularization may be done depending on the successful completion of the course.

• Setting up a board/committee to issue Statement of Equivalence (SoE) to overseas graduates (M.A./M.Sc. in Psychology) intending to continue their higher studies and pursue a clinical psychology career in India.

• Conforming to the Code of Ethics established by the regulatory body. Information booklets containing information on the discipline, activities of the professionals along with the information where to lodge the grievances should be made available at all service centers. Public Grievance Cells are to be set up to investigate the clients’ discontent by the regulatory body.

There is definitely much to be done. But, given how much has been achieved in these last few years, one cannot but be optimistic.

Experts who contributed to the section on Mental Illness
Dr. K.B. Kumar (Editor)
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**Resource List**

(The author has drawn freely from the following publications and expresses his indebtedness to their authors and publishers.)


Vikram P. Sangath Society for Child Development and Family Guidance, Goa, for information see: http://www.goacom.com/community/sangath