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## Pills that Swallow Policy: Clinical Ethnography of a Community Mental Health Program in Northern India

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**Abstract** India's National Mental Health Program (NMHP) was initiated in 1982 with the objective of promoting community participation and accessible mental health services. A key component involves central government calculation and funding for psychotropic medication. Based on clinical ethnography of a community psychiatry program in north India, this article traces the biosocial journey of psychotropic pills from the centre to the periphery. As the pill journeys from the Ministry of Health to the clinic, its symbolic meaning transforms from an emphasis on accessibility and participation to the administration of a discrete 'treatment.' Instead of embodying participation and access, the pill achieves the opposite: silencing community voices, re-enforcing existing barriers to care, and relying on pharmacological solutions for psychosocial problems. The symbolic inscription of NMHP policies on the pill fail because they are undercut by more powerful meanings generated from local cultural contexts. An understanding of this process is critical for the development of training and policy that can more effectively address local mental health concerns in rural India.

**Key words** clinical ethnography • community psychiatry • India • mental health policy • psychotropic medication,

## INTRODUCTION

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

In practice, community psychiatry in India relies heavily on the pharmacological treatment of psychiatric disorders, while community participation and psychosocial approaches remain unrealized policy principles. In this article we examine why this has come about and contend that psychotropic medication has become the essence and embodiment of India's community mental health policy. In this article, 'the pill' is used as a trope for understanding the actualization of mental health policy. Tracing the biosocial journey of the pill from policy makers in Delhi to patients in a village in the state of Uttar Pradesh State, we argue that community psychiatry has, in practice, become an administrative psychiatry focused on effective distribution of psychotropic medication. While it initially embodies ideas of accessibility and participation, the 'pill' eventually achieves the opposite: silencing community voices, re-enforcing existing barriers to care, and relying on pharmacological solutions to address psychosocial concerns.

This article is part of a research project examining the cultural relevance of community mental health in India. It includes a consideration of the relationship between policy, clinical services, and local communities. The issues highlighted here are not intended as generalizations about the state of services throughout the entire country. Rather we consider the specificities of implementing services at a particular field site in the broader context of mental health policies and the health bureaucracy. Nevertheless, some of the findings are emblematic of the problems affecting the delivery of community psychiatric services in rural India generally.<sup>1</sup>

Data is drawn from: (i) 18 months of clinical ethnographic fieldwork conducted by the first author at a government community mental health program and a village in Kanpur district, Uttar Pradesh State; (ii) interviews with Indian mental health professionals and policy makers; and (iii) analysis of relevant policy and research documents.<sup>2</sup> Kanpur was chosen as a field site for several reasons. When this research commenced, it was the only community psychiatry program operating in the state of Uttar Pradesh and one of the longest operating programs in northern India. This

fit well with the research objective of examining a functioning program. The first author's extensive cultural knowledge of the region over several years, and his personal and academic links with Kanpur, facilitated this work. The second author is also familiar with the social geography of the area, and has been educated there for over 10 years. Both authors are fluent in spoken and written Hindi, the local language spoken in North India. Additionally, the second author's medical psychiatric training, clinical teaching and research experience in mental health in India, complements and contextualizes the fieldwork observation and analysis.

The Kanpur program (known as the District Mental Health Program [DMHP]) was unique in some respects. Data from the Kanpur city outpatient clinic (from November 1998 to December 2003) indicated that 48% of patients were diagnosed with depression while 11% were diagnosed with psychosis.<sup>3</sup> This focus on the diagnosis of mood disorders suggested a deviation from national objectives, which explicitly focus on severe mental disorders. The other program for which some comparable data is publicly available,<sup>4</sup> in Thiruvanthapuram district, Kerala state, reports approximately 30% of patients with a diagnosis of schizophrenia between 1999 to 2004 (DMHP Thiruvananthapuram, 2004).<sup>5</sup> The clinical vignettes presented in this article reflect the Kanpur program's focus on common mental disorders. While many patients with severe mental disorders failed to access the clinic,<sup>6</sup> among those who did, the 'story of the pill' was quite similar to those diagnosed with common mental disorders.

The role of psychotropic medication emerged as a central theme of discussion during fieldwork among mental health policy makers, clinicians and the general public. In this article, we use the journey of 'the pill' as a metaphor for the processes through which central policies reach the periphery (Lakoff & Johnson, 1980). This device serves to illuminate the social, cultural and political processes that shape and actualize policy. The article will proceed by analyzing the role of the pill at successive stages in its journey from the centre to the periphery: from the bureaucrats in New Delhi to the village via the local rural clinic.

### THE 'POLICY' PILL

In 2002, the Government of India unveiled a 're-strategized' National Mental Health Program (NMHP). This shift in policy took place in the context of wider international developments including the publication of two influential reports and new evidence highlighting the global burden of mental disorders (Desjarlais, Eisenberg, Good, & Kleinman, 1996; World Health Organization, 2001). More specifically, the new policy followed from a recognition that efforts to implement the original 1982 NMHP had met with limited success (Agarwal, Ichhpujani, Shrivastava, &

Goel, 2004; Kapur, 2004; Weiss, Isaac, Parkar, Chowdhury, & Raguram, 2001). The 2002 policy initiatives departed rather significantly from the original NMHP, which had emphasized access to services and community participation with a focus on serious mental disorders (Government of India, 1982; WHO Expert Committee on Mental Health, 1975).<sup>7</sup> The new policy favored provision and distribution of psychotropic medication, and was supported by a steep budget increase of Indian Rupees 16.2 billion (\$345 million U.S.). A senior health bureaucrat, an architect of the new policy, explained:

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

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

I was only referring to pharmacological interventions because you see as far as the health care system is concerned it is only drugs and treatment, you see. [T]here's no question of psychotherapy and treatment of psychosocial . . . because if you get involved in that, those things, they may be scientifically correct but . . .

So I said you cannot have a cheaper public health intervention and the results are phenomenal . . . so this . . . somehow appealed to them . . .

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

The Bellary model [an earlier model for delivering mental health services at the district level] . . . is unevaluated. It has become a holy cow which no one dares question and there were major problems in that . . . there were major dysfunctional aspects . . . and because it became a holy cow so we could not question it, we adopted it lock, stock and barrel and this is responsible for many of the problems we are facing now.

We have [now] modified it without specifying or saying it in so many words because it's a holy cow you can't touch it. So what we have done is that we have put it aside because no one really knows what is the Bellary model so . . . we are on safe ground. So whatever we do we can say it conforms to that model.

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

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

Additionally, the policy of 2002 redefined the relationship between psychotropic medication and mental health policy. The 1982 policy had placed a singular emphasis on access to treatment, including community participation, integration of mental health with primary care, psychotropic medication, and psychosocial approaches. The new policy is deliberately ambiguous in this regard. While not explicitly rejecting key aspects of the old policy, it implicitly emphasizes medication. Moreover, it is unclear about the role community participation, integration of mental health with primary care and psychosocial interventions play within this new approach.<sup>8</sup>

The absence of published literature contesting or resisting this change from the 'old' 1982 policy to the 'new' 2002 policy is particularly striking. Consultations on the re-strategized NMHP ('new' policy) did take place '... with various stakeholders ...' (Agarwal et al., 2004), but there is no indication of who was involved in this process and what resulted from it. While there have been several critiques of generic mental health policy (Kapur, 2004; Mondal, 1995; Murthy, 2004; Nizamie & Desarkar, 2005), these have not been substantiated with empirical data.<sup>9</sup> A national evaluation of DMHPs was conducted in 2002 but is not available in the public domain (Basic Needs India, 2004). Two programs in the southern Indian States of Kerala and Tamil Nadu have websites detailing services and providing annual reports, but these do not constitute formal evaluations (Arunkumar & Vijayachandran, 2008; Government of Tamil Nadu, 2008). In short there has been a notable absence of professional and popular comment on the shift of emphasis in the re-strategized NMHP. Thus, in the absence of any articulated resistance or critique, the 'pill' became central to the new mental health policy, ready to be advanced through the bureaucratic structures of the state governments.

In India, implementation of health services is undertaken by state governments with the central government providing overall direction, technical assistance and some funding (Misra, Chatterjee, & Rao, 2003). In this case, the mental health policy's singular emphasis on psychotropic medication was reinforced by multiple layers of administrative structures at the state level in Uttar Pradesh. The District Mental Health Program in Kanpur was initially funded by the central government as a pilot project with the stipulation that it would be taken over by the state government after five years.<sup>10</sup> Responsibility for implementation was given by the state government to the head of the Department of Psychiatry in a government medical university,<sup>11</sup> who was designated the 'Nodal Officer.' The Department appointed a mental health team at Kanpur (110 km away) based in the local district hospital.

Within these administrative structures, there were divergent understandings of mental health priorities and varying levels of commitment to

the Program. In the State Ministry of Health, an Indian Administrative Services (IAS) officer responsible for mental health services stated that there was '... no state planning' for mental health and that it was 'just there' in policy though not really a priority. This officer also argued that the purpose of the DMHP was 'to provide counselling to those suffering from mental illness ... from the patient's perspective,' an interpretation which appears closely linked to the original NMHP ideals of community participation. This idealistic view, distanced from the everyday practice of mental health care, reflected the institutional position of the Indian Administrative Services at the apex of the country's civil service hierarchy. In contrast, within the local Department of Psychiatry there was frustration with the state government's commitment. A senior academic psychiatrist commented:

According to them [bureaucrats], this [mental health] is something which is not very significant, it's not one of their priorities ... It varies from official to official. You see, sometimes officials are very sympathetic, they're considerate, they promise you things and they also do things according to your wish. At other times, they may not be very supportive, they may not listen to you or they may do things so late that it's not keeping with your own timetable.

However, even within the Department, the priority given to the program often depended on the inclinations of the particular Nodal Officer. By the time of our fieldwork, the post had been held by several psychiatrists with varying levels of interest in the program. Additionally, the project site's geographical distance from the Department of Psychiatry resulted in a degree of isolation for the project team and their sense that they were not receiving due attention. All of these factors led to various problems, which hindered the program's implementation in Kanpur, including difficulties in releasing of salaries from the state government, intermittent supplies and the poor quality of psychotropic medication.

In a setting lacking clear administrative responsibilities and priorities, 'the pill' became an important bureaucratic tool for implementation, and was perceived as a 'common minimum' that would be acceptable for both bureaucrats and health professionals. 'Common Minimum' is a term used in Indian political coalitions to refer to the most basic acceptable agenda for a government (Jha, 2004; Pai, 1996; Pant, 2004) It is an 'implementable' program that balances the needs of a range of stakeholders. In this sense, the 'pill' is a common minimum, a known entity, and good fit within the dominant biomedical structure and practice. Such bureaucratic structures and justification serve to reify the 'pill' as central to the delivery of care at the rural clinic.

## COMPLIANCE WITH MEDICATION: THE PILL AS A BOUNDARY MARKER

In the rural clinic, the pill interfaces with local culture where its acceptability is challenged by the power of local social moral worlds. Faced with the intractable problems of their patients, clinicians running such rural clinics often retreat into a monologue on compliance with medication. As a result, the pill ends up standing in for the entire mental health policy, as well as accentuating the gap between the centre and the periphery and creating new boundaries between professionals and patients.

The following two ethnographic vignettes illustrate the challenges at the rural clinic:

### *Lata*

I first met Lata, a 45-year-old woman, while driving out of the local mental health clinic with the team. Just as we were crossing the railway track to enter the highway someone came running after the jeep. The driver stopped the jeep. Lata smiled at the psychiatrist and explained that she was late. Looking at her percha (prescription slip) he asked her when she had last been to the clinic and whether she was taking her medicines. He admonished her for not coming to the clinic and pretending to be angry, said that next time he wouldn't dispense medication if she didn't attend regularly. It was several months later when I met Lata in the village and got to know her and her family that I learned she suffered from 'headaches.' Her problem had started when she had been hit on the head with a piece of wood during a fire. Over the one year that I interacted with her, she visited the clinic every few months. Each time she would go, the doctor would reproach her for not coming more regularly. One of her main concerns was whether she would be able to receive free medication. Often she would ask me to intercede on her behalf to obtain medication. I understood that her irregular attendance at the clinic related primarily to her inability to negotiate a visit to the doctor within the constrained economics of the family. I noted that she was more likely to visit the clinic when her husband accompanied. Lata also told me that she would 'forget' about the clinic day as she would get involved in some pressing agricultural tasks. She would attribute this 'forgetting' to being a 'dehatin' (a pejorative way of referring to a villager).

### *The Team's Journey into the Village*

The mental health team's jeep, seating the psychiatrist, the social worker, the psychologist and an assistant and driven by the team driver, leaves Kanpur city for a rural health centre at around 8 am. A box of medicines, patient case records, and a case register are carefully stored in the jeep. After a two to two and a half hour journey, along a dusty highway, at times over dirt roads, and riddled with long traffic jams, punctured tires and engine problems, the team reaches the health centre located at the edge of the

nearest town. As the jeep enters the compound, one is struck by the fact that the place appears deserted. A single doctor sits on the lawn at the head of a table, a few patients mill around . . . The Health Centre is a typical two-story pinkish-colored government building. The scenario changes as we proceed towards the outpatient entrance. Several motorcycles and bikes are parked, 10–15 people are sitting outside on the low concrete boundary, a few people are milling inside the building and on the steps. There is an air of anticipation and people chat in small groups. As the jeep turns in and parks, some stand around it and greet the doctor. A local relative of the doctor greets him and they exchange a few words. The doctor greets a young male patient by patting him on the shoulder; he smiles and is clearly pleased. Others move inside, anxious to register and obtain a 'number' to secure their place in the queue. If it is a summer day, the team moves into one of the offices on the ground floor. In the winter, they sit outside in the sun. Often enough chairs are not available and patients have to stand or sit on small stools. The psychiatrist sits at the desk while the social worker and psychologist are set up in separate positions; one of them volunteers the task of filling in-patient registers while the other conducts interviews with newly registered patients. The assistant brings in the box of medicines, begins collecting the patients' *perchas* (prescription slips) and placing them before the doctor. Usually the electricity supply is not functioning. The team and patients sweat it out. Patients and family members begin crowding the entrance to the consulting room, and the assistant and the driver carry out 'crowd control.' After several hours of work, the team packs up and leaves. Everyone is silent on the drive back. Exhausted and hungry, they return to Kanpur city by mid-afternoon.

Both of these vignettes are social dramas that highlight the incongruences and commonalities between the clinic's structure and the patients' everyday lives. For example, patients and clinicians appear to operate along different social calendars: the clinic staff rely upon linear clock time, while most villagers prioritize their more immediate needs in the harsh and rapidly changing reality of rural life. Moreover, although the pill appeals to both staff and patients there are important differences in how each group conceptualizes '*illaaj*' (treatment). While the limited level of interaction possible at the clinic precludes clinicians from exploring patients' ideas about treatment, the disjuncture in interpretations of the pill is largely shaped by the different social realities of urban mental health professionals and rural people.

The social divide commences with the professionals' 'journey' to the village. Typically these visits are referred by mental health professionals as 'going to the community,' a phrase that illustrates a particular and rather peculiar conceptualization of community. For the visiting urban professionals, rural health centers provide both a physical space and a conceptual framework for accessing the otherwise inaccessible village.

Additionally, because they encounter 'community' through the lens of 'cases,' visiting professionals tend to view the village as a site of disease and pathology. It is within such an epidemiological and geographical understanding of community that the pill as medicine assumes significance in the clinic and becomes the primary clinical intervention. (The clinical and cultural consequences of this are discussed in the following section.) Likewise, villagers do not view the health centre as part of the community. Despite being called a 'Community Health Centre,' it is geographically located at the edge of the area it serves. Within the popular imagination it exists outside or on the edge of the community: a place that is inaccessible to most rural people (Jain & Jadhav, 2008).

During fieldwork at DMHP clinics in Kanpur, the first author was frustrated by his inability to gain insight into the lives and experiences of patients and their families. Such difficulties with rapport illustrate how the dominance of 'the pill,' both symbolically and in everyday discourse in the clinic, leads to an effective muting of the voices of patients and families. Indeed, inside the clinic, medication is central to the interaction between the 'team' and the 'community.' The clinic itself resembles a noisy grocery shop where medications become the most sought-after commodity. Indeed, patient attendance often dropped when free medications were not available.

During the clinical encounter, staff members place an emphasis on *lakshan* or symptoms. New referrals to the clinic have their history initially elicited by a psychiatric social worker or a psychologist. These written accounts of patient history largely focus on the *lakshan* of the patient and omit the social context of the patient's lives. An excerpt adapted from field notes illustrates two clinical interactions:

#### Case 1

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

#### Case 2

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

Holding her head the patient responded: '*Sar dard*' (Head-ache). She then went on to provide a physical description of her problems, speaking about having vomited and describing pain in her eyes. In her narrative she

continued to emphasize her headaches saying: '*Saar ka jadha dikath hai*' (My head ache is the main problem). She also said she experienced *uljahn* (loosely and incorrectly translated by clinicians into English as restlessness or anxiety).

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

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

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

The completed English-language forms are then forwarded to the psychiatrist, who asks the patients and family some further questions, before filling out a prescription. Such interviews are thus meant to elicit a decontextualized and discrete list of symptoms in order for the doctor to make a diagnosis. The social worker explained that her role was to take down details about the patient's complaint in order to save time for the doctor. She was unaware that her history taking framed local categories of suffering in English and in the language of biomedicine, or that such patient 'symptoms' were, in effect, a co-constructed activity.

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

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

The power that the pill held for many patients became particularly apparent when patients happened to arrive at the clinic just as the team was leaving; they would rush towards the doctor's jeep and implore him to write a prescription. Once such incident is recorded in the ethnographer's field notes:

As we were leaving and had sat in the car, tea was served to us. Then a patient appeared at the car window – an old woman with her son. The male mental health professional admonished them for being late, becoming a bit angry and telling them that the team had come on time and therefore had to leave on time. Later when it turned out this woman had not been back to the clinic in a long time, he again got angry telling her that they wasted fuel to come here; and that they couldn't visit the clinic each month.

The woman had been suffering from some anxiety and lack of sleep. I asked her if she came from far . . . it didn't seem that far. The professional then said to me that these people take their medications for a few days then get better and stop. He then asked her a few questions and renewed the prescription. Apparently she still had some of these medications at home. He advised her to check the expiry date – it didn't look like she understood, he then told her to get some literate person to ensure that the tablets were still good. The prescription was written in English.

As we were departing, she said something about one of the medications being '*garam*' (hot). The professional told her that it isn't *garam*. [This however appeared to be the reason for her reluctance to come back.]

Along with the previous examples, this vignette underscores the centrality of the pill in patient–professional interaction. Indeed, almost all clinic dialogues centered on compliance to medication regimens. These dialogues about compliance were generally scripted in four sequential elements: (1) a general statement by the professional about the importance of regular medication; (2) a defence by the patient and family member that they will follow the instructions. Alternatively an admission, often with an excuse, for having stopped the medication; (3) a more emotionally charged rejoinder by the professional restating the first script, and reinforced by a sub-script: the patient will not get better if the medication is stopped; (4) this is followed up by a statement from someone else on the team, such as the jeep driver, reaffirming the professionals decree (such as 'don't be your own doctor').

In these uneven dialogues,<sup>12</sup> the pill also serves as a boundary marker that distinguishes professional identities of various team members. This boundary separates those who can or cannot prescribe. A mental health professional, who did not have the license to prescribe, said 'my job satisfaction would improve if I could prescribe,' a desire shaped by the overwhelmingly biomedical focus of the clinic. Moreover, the distinct professional identities of social workers and clinical psychologists were rarely acknowledged by patients, who regarded these staff members as 'assistant doctors' and a part of the physician's entourage.

The pill also emphasizes the boundary between patients and professionals – a set of multiple distinctions: urban versus rural, educated versus uneducated, and responsible versus irresponsible. Thus patients who do not visit the clinic or are non-compliant with medication were viewed as ‘irresponsible’ (rural, uneducated) as opposed to the ‘responsible’ (urban, educated) professional. In this scenario, rejection of ‘the pill’ by patients is tantamount to a rejection of the mental health professional, including her expert tools and remedies. Conversely, clinicians view patients’ non-compliance as antithetical to progress and advancement, construing patients as backward, uneducated, and irresponsible.

This divide between professionals and communities is related both to the nature of professional mental health training and to the use of language in the clinic. The knowledge base of mental health and training priorities are largely determined in Euro-American contexts, while local training is often a watered-down version of western psychiatry, which lacks grounding in local social and cultural concerns. Specifically, the clinicians have not been trained to develop self-awareness or to reflect on how their own social background and professional theories shape their understanding of suffering (Jadhav, 1996). Professional education thus does not equip clinicians with an ability to integrate an understanding of local context into their work. This is reflected in the use of language in the clinic; both the concrete use of the English language and the experience-distant professional language used to record and formulate distress. For example, in the case record and in clinical exchanges, suffering is described in biomedical terms that alienate the mental health professional from the experiences of patients. Clinicians appear reluctant to interpret suffering through the categories and idioms used by patients and their families. Consequently, when well-intentioned interventions are rejected by patients, clinicians project their frustration onto patients, attributing non-compliance to the villagers’ ignorance.

When asked about the main obstacles for community psychiatric services, many professionals referred to a lack of public support. However, fieldwork data suggest the opposite interpretation: villagers were aware of services and assisted others through informal mechanisms, such as providing advice about specific doctors, and accompanying friends and relatives to attend a clinic. From the perspective of community members, it was the clinic that did not comply with their needs, for example, local understandings about the nature, location and timing of services. The final section will examine some aspects of villager’s views of government mental health services and their power to render them ineffective.

## 'SARKARI DAVAI' (GOVERNMENT MEDICINE): COMMUNITY REACTIONS TO GOVERNMENT SERVICES

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

In visits to the DMHP clinic, one of the specific idioms used by patients to refer to their problems was *uljhan*. If a patient expressed this pattern of distress, the staff member eliciting the case history would enter the term *uljhan* in the symptoms section of the case record. In most cases the structure of the clinic did not allow for the time needed to probe the nature and causes of the *uljhan*. The clinic staff interpreted this local idiom either as an anxiety or a depressive disorder so as to ensure a goodness of fit with ICD-10 diagnostic categories, and prescribed the appropriate anti-depressant medication. While this section will briefly summarize the popular and professional understandings of *uljhan* among subjects from the present study site, a separate article will detail the ethno-semantics of *uljhan*.

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

The second form of *uljhan* deals with everyday concerns and worries about socio-economic matters, especially money. In this context, *uljhan* refers to unfulfilled economic and social ambitions and desires, and the *uljhan* is resolved when these ambitions are fulfilled. In a general sense, it also serves as a category used to mark economic and social distinctions. Thus, 'dominant' castes would claim greater *uljhan* than lower castes because they had greater responsibilities. Conversely, Dalits (formerly the 'untouchable caste') would say that 'dominant' caste groups did not experience *uljhan* because they were well off. Similarly, informants

revealed that *all* rural people have *uljhan* in contrast to their urban counterparts. Generally, it was noted that people had less such desires and needs in previous times, and that the current cash-crop environment had increased desires leading to *parivaric tension* (family tensions), which was linked to *uljhan*.

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

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

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

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

He had seen many private doctors to get medication for his 'cold' – but having experienced no improvement, he went to see this psychiatrist. The medication, he said, made him feel 15 years younger. Over the year, he reported feeling better. Most of the time it appeared he did not attend the clinic. In April 2005, he was still taking the medication but only once a week. The doctor had reduced the 'power' but he had figured out on his own that skipping a dosage didn't cause problems and concluded he only needed it once a week.

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

Raj's experiences with the psychiatric services were reflective of a wider experience amongst those that presented at the clinic with a 'common

mental disorder.' The clinic addressed his specific manifestations of *uljhan* – the symptoms they chose to hear – by editing his local idiom into a category analogous to a biomedical construct of anxiety and depression, stripped of its cultural meanings, and translated from Hindi into English. Raj reduced his medication once the basic symptoms had left him, but his *uljhan* persisted because of continuing social concerns that embodied his presenting idiom. Thus the healing power of the 'pill' – including the clinic and mental health policy in the village – is limited by its inability to engage with existential problems on the ground.

The relative power of different medication was implicitly recognized by villagers who distinguished between 'strong' and 'weak' tablets. Medication dispensed from government health centers was generally categorized as 'weak,' while that from 'private' doctors was seen as 'strong' or 'good.' These attributions of potency had some basis in reality, as the 'private' doctors, many of whom did not have professional qualifications, would often prescribe allopathic medication incorrectly. Also, general (not psychotropic) medications from government health centers were often diverted to the private sector, leaving only a limited range of medications at these centers. Thus, the 'weak' categorization of government medication reflected the 'weak' nature of government services. While there is no evidence that villagers viewed psychotropic medications as 'weak,' we contend that these 'pills' are rendered 'weak' in a cultural sense by the villagers precisely because the clinic is unable to address their social and cultural problems. The result is that patients do not comply with treatment. Metaphorically, the nation's rather patronizing community mental health policy fails because it has been swallowed by the pills.

## DISCUSSION

This article raises several sets of questions about the content and operationalization of mental health programs. First, are the issues around compliance and the dominance of biomedicine, generalizable to most psychiatric settings globally? What are the specificities of the north Indian setting? Although compliance is an issue, which any clinical medicine must address, the culture of community psychiatry in northern India has been shaped by its local political economy. Research literature on state-society relations in northern India has demonstrated how a range of social groups utilize the state to advance their economic and political interests (Harriss, 2006). This literature suggests a dynamic relationship between the state and the population, rather than the state as a top-down deliverer of goods and services. The implication is that whatever the state offers is drawn-upon by social and caste groups in order to leverage access to jobs, services and other benefits to serve particular interests.

Community psychiatry operates in this setting as yet another government service that can be manipulated to serve individual and group interests. Thus, according to one argument, patient non-compliance may not be due to negligence or illiteracy as suggested by health professionals, but may be predicated upon a local cultural logic that facilitates engagement with a range of governmental public services. In this consumerist approach, people make explicit choices about health care that are contingent upon maximizing benefits (Harford, 2008). Of course, such an explanation may obscure varying levels of socio-economic power: such an explicit choice of 'non-compliance' can only be made by consumers who have access to alternative providers. Some people may not have such choices, and simply do not reach the clinic.

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

Development policy researchers argue that development practice is motivated not by good policy but rather is the product of organizational cultures and multilayered relationships. Consequently, development workers strive to maintain coherent representations of policy as it is in their interests to do so (Mosse, 2004). As a policy, the National Mental Health Program reflects the recommendations of global public health organizations: the strategy of integrating mental health into primary care has long been promoted by the World Health Organization (WHO) as the best means of extending mental health services in low-income countries (despite the fact that evaluations of existing programs have been limited).<sup>13</sup>

A plausible explanation for the practical failure of the NMHP lies in the disjuncture between the articulation of policy objectives and the implementation of concrete programs. Indeed, an historical analysis of the failures of public health in India suggests a mismatch between the multiple ambitions of planners and the realities of poor infrastructure and resource constraints. This mismatch resulted in an overall reliance on programs targeting specific diseases ('vertical' programs) and technologically oriented interventions, largely supported by foreign aid (Amrith, 2007).

Taken together, these interpretations of public health and development policy, suggest that the transformation of a complex strategy into a narrow intervention results partly from the power of the 'pill' to balance multiple institutional functions and interests. Despite poor outcomes and limited evidence, mental health professionals and bureaucrats maintain rhetorical

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

Psychiatric professionals in northern India operate in a national and international professional environment dominated by biological approaches to psychiatry. An ethnographic study at two psychiatric hospitals in North India found that psychiatrists rely predominantly on multiple prescriptions and ECT (Nunley, 1996). The author suggests that this is due to an 'epidemic' view of psychiatric disorders among psychiatrists and the need to legitimate psychiatry both for the public and for their medical colleagues. This argument is bolstered by the circular relationship between pharmaceutical interests and biomedical approaches in psychiatry. A pharmaceutical representative in Kanpur explained how his company funded the majority of private psychiatrists in the area and their families to attend an international psychiatric meeting in 2005, in return for the psychiatrists' promise to prescribe a certain amount of their products. This dominance of pharmacology stands in counterpoint to the NMHP and WHO's largely unproven strategies of decentralization, integration and community participation. The picture is further complicated by the poor state of primary health care services (Bajpai & Goyal, 2004).

In such a scenario, reliance on the 'pill' becomes easily understood as the only 'effective' and 'proven' alternative.<sup>14</sup> Thus, the implementation of a biologically-oriented psychiatry appeals to health professionals as a way to both achieve desired professional outcomes (e.g., satisfied patients, income, and credibility among peers) and cement linkages with the dominant discourses and institutions of international psychiatry. This solution also allows health policy planners in New Delhi to claim their own official 'compliance' and 'adherence' with international public health strategies. In short, this process of replication and mirroring along a chain that links Geneva, New Delhi and the Kanpur clinic is a cultural dynamic that directly affects the rural patient population.

It appears that the 'pill' also acts as a 'cover' for various interests. In the realm of policy, it represents progress and reform and has the ability to garner new funding. Conversely in the clinic it evokes a deeply entrenched biomedical rationale, a way of sidestepping more fundamental issues related to development and social family dynamics.<sup>15</sup> In other words, it provides a 'cover,' legitimated by popular demand, that allows mental health professionals to avoid addressing issues for which they have neither adequate training nor resources. The recourse to psychotropic medication is therefore less a creative response to resource constraints than a reflection of the constrained choices faced by mental health workers in rural India.

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

Indeed, the 'pill' holds both symbolic and curative power in popular Indian conceptions of illness. Thus, while the health center as a state institution may not command respect, we suggest that the underlying technology of the 'pill' is popular in many quarters. Indeed, both biomedical and community mental health care flourish in the private (registered and unregistered) sectors of Kanpur district. Lacking the cultural and social capital to effectively engage with the health services, patients resort to placing medication at the core of their interaction with mental health professionals. Just as 'non-compliance' with treatment may be an adaptive strategy to dealing with state services, so may patient acceptance of the pill be seen as a 'rational' choice within constrained circumstances.

Finally, what are the practical implications of our findings for mental health services in northern India? We have already questioned the relevance of 'technical fixes' as outcomes of well-meaning policies, and it is clear that a great deal of rethinking is necessary before adopting any alternative policies or models. Indeed our findings caution against the idea that any magical quick fix can be offered. Our data suggest that the stalemate currently characterizing mental health care provision in rural northern India may be ameliorated through the promotion of a better understanding of local communities by health professionals, the appropriate training of professionals, and the encouragement of multiple models for mental health services.

While the current silencing of community voices and concerns within mental health programs cannot be addressed without a shift away from the monologues of compliance towards dialogues addressing broader issues, there are structural factors that impede such discussions. Among these is the training of mental health professionals in India, which as we have described often alienates professionals from the everyday realities of their patients. Overcoming these difficulties requires a fundamental

reconfiguration of health education and clinical training in graduate and postgraduate schools. In brief, this includes providing mental health professionals with: (i) awareness of how their own sociocultural background shapes their professional training, identity, and interactions; (ii) recognition that significant aspects of current psychiatric theory and policy are culturally alien in India (Jadhav, 2004); (iii) knowledge and relevance of a culturally embodied health and illness paradigm (Scheper-Hughes & Lock, 1987); and, (iv) skills to negotiate such cultural differences, beginning with locally valid clinical practice that could then be embodied into policy (Jadhav, Littlewood, & Raguram, 1999).

This may not necessarily be an impossible task. Over the past three decades, the new cross-cultural psychiatry (Kleinman, 1977, 1980, 1987; Littlewood, 1980, 1990) has consistently critiqued the theory and practice of western psychiatry and offered a range of alternative paradigms (Bibeau, 1997; Chakraborty, 1990; Chowdhury, Chowdhury, & Chakraborty, 1999; Jadhav, 2000, 2005; Kirmayer, 1989, 2006). Such changes in the training of professionals and effective dialogue with communities could create enabling conditions for the flourishing of multiple models of mental health care. There have already been several pioneering initiatives in India that highlight development of services in response to challenges that are particular to each setting.<sup>16</sup>

## CONCLUSION

By detailing how powerful meanings generated from local social-cultural contexts can thwart and render impotent well intentioned efforts of health professionals, this article helps illustrate the dynamics underpinning the failure of India's current National Mental Health Program. At times the social lives of medication appear to work against their own pharmacological properties. We suggest that our observations are critical to the future development of effective policies and services to address mental health problems in rural India. Specifically, they point to the necessity for: (i) a culturally-informed understanding of communities by mental health professionals and health planners; (ii) the training of mental health professionals so as to enable a more equal and effective dialogue with patients and families; and (iii) a social and political space that would facilitate and encourage the development of multiple models of mental health care.

In closing, we propose that this paper be read as an invitation to further research on several critical issues that we have not been able to address within the scope of this research. Some of the topics that demand further enquiry include a study of the (i) rapidly shifting indigenous folk models of mental health and illness; (ii) reinvention and commodification of

traditional healing systems and their remedies; (iii) impact of globalization on existing social boundaries between the centre and periphery; and, (iv) generation of newly marginalized groups and attendant mental distress within urban metropolitan spaces. An enquiry that extends into such spheres demands a multidisciplinary approach that itself has so far received scant attention. This is only possible if the currently inflexible boundaries between biomedicine and social sciences can be made porous.

These concerns will also help to further interrogate how India's official 'mental healthcare system inherently marginalizes the very people it is meant to serve through its myopic methods' (Gaitonde, 2008).

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### NOTES

1. Although this article critiques existing policy and services, this in no way belies the dedication and sincerity of those involved in conceptualizing, operationalizing and delivering mental health services in India. Here, the ethnographer's position is unique in allowing the luxury of a critique that is written in a western academic space. This contrasts with the day-to-day struggles of those placed in a position to implement services in rural India under complex and challenging circumstances. The authors consider both positions useful.
2. Approximately 25% of fieldwork time was spent with the local community psychiatry team, 65% living in a village where the team provided services and 10% interviewing professionals and policy makers. Research with the team involved participant observation at clinics, training sessions and social activities and formal and informal interviews. There were three aspects to the fieldwork in the village. One, involvement and observation of the daily activities of village life (including agricultural activity, festivals, funerals, trading,

healing rituals and marriages). Two, interactions and informal interviews with a range of informants. These included healers, local doctors, village council members, storekeepers, politicians, and people with health problems. Third, observations and interactions at specific sites in and around the village. These included a local *Dargah* (Islamic shrine and healing centre), the local government health centers and the homes of patients of the community psychiatry program. Interviews with professionals and policy makers involved informants within state and central government, non-governmental organizations and mental health professionals at several sites.

3. In the seven rural health centres covered by the program, 155 patients were seen in the period August, 1999 to December 2003. The diagnostic breakdown of the patients was as follows: Depression – 67.4%; Psychosis – 10.3%; Substance abuse – 1.2%; Epilepsy – 10%; Mental retardation – 2.7%; other – 8.3%.
4. The Kanpur and Thuruvananthapuram data are not directly comparable as different diagnostic categories have been used.
5. A DMHP in Madurai, Tamil Nadu reports some data on patient diagnostic breakdown (<http://www.cbhi-hsprod.nic.in/files/PROD78/DMHP-Madurai.ppt>). However the time frame of the data is not clear. It would appear the program received 1020 patients. Out of these 137 (13.4%) received a diagnosis of ‘acute psychosis,’ 290 (28.4%) a diagnosis of ‘anxiety disorder’ and 130 (12.7%) a diagnosis of ‘mood disorder.’ Similarly, some data is reported for a DMHP in Trichy, Tamil Nadu State (<http://www.tnhealth.org/dmhp.htm>) but the time frame is not clear though it appears to refer to 2000–2001. The data indicates a total of 715 new patients of which 14.7% were given a diagnosis of schizophrenia and 22% a diagnosis of depression.
6. The reasons for this relate to a fatigue among caregivers, previous experience with poor treatment outcomes, internal family and community dynamics (including stigma, issues about inheritance, and gender), and explanatory models that diverge from biomedicine. These issues will be detailed in a separate article.
7. The National Mental Health Program has its official origins in a seminal World Health Organization 1975 report on mental health services in developing countries (WHO Expert Committee on Mental Health, 1975). The report strongly argued for training primary health care staff to identify, treat and follow-up persons with mental illness in the community. This report also advocated community participation, decentralization, and integration of mental health knowledge in social development activities. Following two widely reported experiments in India, this approach became part of official government policy in the early 1980s (Government of India, 1982). In subsequent years, the National Mental Health Program was further operationalized through a DMHP.
8. In an interesting about turn, it was recently reported that the Indian government is ‘re-vamping’ its National Mental Health Program to focus on training of MBBS doctors to deal with mental health problems. This would

appear to be a return to earlier policies and is in part a response to increasing suicide rates. The Minister of Health stated: 'I do confess that the national mental health programme of my ministry is not performing well. I am worried and we are in the process of reviewing the programme.' (India Abroad News Service, 2007; Sinha, 2007)

9. A brief study of a DMHP in Delhi (Kumar, 2005) is a singular exception.
10. After five years, the state government refused to take over funding following which Central funding was renewed.
11. Chhatrapati Shahuji Maharaj Medical University, Lucknow (Capital of Uttar Pradesh State), formerly known as King George Medical College, Lucknow.
12. The scenario takes on the flavour of a judicial court in which the onus is on patients ('accused') to prove themselves 'not guilty' of an alleged offence.
13. A WHO evaluation of this strategy suggests that, '... in the absence of adequate data on the effectiveness of specific intervention for specific conditions, the success of existing primary care mental health programmes is difficult to assess.' (Cohen, 2001, p. 30). The author concludes however that given resource constraints, '... integration is the only realistic option.' (p.30). Similarly, a recent review of community mental health services in low and middle-income countries suggests that there are several gaps in existing evaluations. These include limited evaluations of (i) cost-effectiveness, (ii) programs in rural areas, and (3) outcomes in bipolar disorders and panic disorders (Wiley-Exley, 2007).
14. The clinical efficacy of psychotropic medication versus psychotherapy and other non-medication based interventions such as yoga have been considered in the literature with somewhat inconclusive results. A recent clinical trial in Goa, India compared the efficacy of psychotropic medication with psychotherapy (Patel et al., 2003). It found no significant differences after 12-month follow-up. A systematic review of five studies sought to compare the efficacy of yoga in depression (Pilkington, Kirkwood, Rampes, & Richardson, 2005). The authors of the review conclude that yoga has potential benefit but requires further investigation on the aspects of yoga that are most effective and for which levels of severity of depression.
15. We are grateful to an anonymous reviewer for suggesting these two points.
16. Although we do not intend an exhaustive review of these programs, some innovations merit attention. For example: (i) The Banyan, a charismatic non-governmental organization, developed at Chennai in response to the plight of homeless mentally ill women (<http://thebanyan.org/>); (ii) Eco-Psychiatry, a theoretical and service framework that addresses the mental health consequences of local ecological problems in the Sunderban region of West Bengal (Chowdhury et al., 1999); (iii) Asha Gram Mental Health Program, which focuses on a community based rehabilitation model for mental illness in a remote tribal region of Madhya Pradesh (Chatterjee, Chatterjee, & Jain, 2003); (iv) The Psychiatric Centre in Miraj, Maharashtra that utilized over two decades of group meetings with patients and families, leading to the development of a text book predicated on local suffering; and in a manner that is accessible for both carers, patients and professionals (Rukadikar &

Rukadikar, 2007). Such texts offer potential blueprints for development of services that might more effectively address local concerns and inform policy; (v) Bapu Trust in Pune, Maharashtra, that addresses gender and mental health concerns through advocacy, service development and research (<http://www.camhindia.org>).

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