Psychiatry in Kerala

KERALA PSYCHIATRY YESTERDAY AND TODAY: RECOLLECTIONS AND REFLECTIONS

-B*ased on a background paper presented in SIPSCON 2019 at Thrissur*

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ABSTRACT

During the 35th annual conference of Kerala State branch of Indian Psychiatric Society (SIPSCON 2019), conducted in Thrissur, a group activity was designed, titled 'Voices from the floor: group activity on contemporary psychiatric issues in Kerala'. In this academic program, the participants were given the centre stage. It was designed as a group activity where all the delegates were divided into small groups to provide their experiential account and reflection related to mental health care in Kerala. The topic of discussion and exploration in each group were chosen from either one of the broad perspectives of the clinician, academician or mental health activist.

This narrative is based on the introductory remarks made in the workshop, co-authored by all the authors and presented by the third author. From this activity, the outcome expected was to discover a treasure of information which could pave the way for further exploration and action plans. No consensus was aimed at. These could give insights which can help shape the future of Kerala mental health scenario.

Keywords: Kerala Psychiatry, SIPSCON 2019

BACKGROUND

"The only constant in life is change"- is an oft-cited quote by Heraclitus. But even change, changes in pace, intensity, direction and time. There are changes that we are aware and unaware; unaware because they are obscure, too slow or too familiar to be recognized.

Attempting to recollect the changes individually or in groups with a specific focus and in a guided manner is one way to enhance awareness. Being aware of the changes will help in modifying them to suit the practitioners or preparing practitioners to deal with them better. It is in this background that a program was designed in SIPSCON 2019,

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the 35th annual conference of Kerala State branch of Indian Psychiatric Society, titled 'Voices from the floor: group activity on contemporary psychiatric issues in Kerala'. In a typical workshop, a few experts train a large number of participants relying on textbooks, journals and research. In our program, the roles were reversed to give priority for participants, because the practitioners are hearing, seeing and feeling the agony of sufferers. It was designed as a group activity where all the delegates were divided into small groups to express their experiences, perceptions and interpretations related to mental health care with a motto, *from silences to voices- for the mental health of Kerala.*

This write up is based on the introductory remark made in the workshop, co-authored by all the three authors and presented by the third author. A few changes did happen, and a few remained unchanged in the past decades - from the broad perspectives of the clinician, academician and mental health activist. A few were listed and briefed as follows:

Changes from the perspective of Clinician

Mental Hospital

In earlier days, patients were taken to mental hospitals, only when they were violent, chronically ill, non-responding to treatment or when treatment became un-affordable. The same pattern is continuing. In mental hospitals, the progression of new patients to institutional syndrome described by Goffman seems to be less, though the influencing factors like the infrastructure of institutions, policy and rules regulating care, paternalism in clinician-patient relationships and patients' adaptive behaviour to care rarely changed.[1] Violence management beyond medication is still primitive; sometimes resorting to using overly coercive techniques.[2] The manpower of carers at different levels was reported as inadequate.[3] In hospital wards, the most trained doctors were the most distal to the patients (meeting patients only at the time of ward rounds when it happens) and the least trained warders were the most proximal (being with patients round the clock). Those practices are continuing. It is known that elsewhere in the world, advances have been made in non-pharmacological management, multidisciplinary team involvement and addressing human rights issues. How far these advancements have been percolated into the mental hospitals of Kerala are yet to be evaluated.

Earlier practices included keeping patients nude to prevent suicide. Care of patients, including managing violent patients, were done by partially recovered 'working patients. Personal cleanliness of inpatients used to start with an open-air bath in groups around a water tank, patients being partially or fully naked. Tobacco (beedi) was widely used for conforming patients to the 'ward norms', whether the patient is in excitement or withdrawal. Though these practices are now rarely observed, some of these continue in a few centres.

At different points of time, mental hospitals in Kerala were either administered by the Medical Education Department or the Health Services. There were times when the Institution head was non-psychiatrist or Medical officer with a basic degree from streams other than modern medicine. The relative efficiency during those different periods is not subjected to evaluation until this date.

Sri Chithra Thirunal Institute of Medical Sciences and Technology (SCTIMST), Regional Cancer Centre (RCC) and Institute of Mental Health & Neuro Sciences (IMHANS) were initiated in the same period for the treatment of Neurological & Cardiovascular diseases, cancer care and mental health respectively; though they started functioning at different times. Their present stature in their respective specialities for patient care, professional education and research remain glaringly different, with IMHANS lagging. This observation requires both examination and introspection.

General Hospitals

Starting at Ernakulam General Hospital in the early 1960s, general hospital psychiatry has since had a widespread impact in the state. Scarcity of trained manpower as well as Psychiatrists concealing specialist identity to avoid getting posted to mental hospitals was reported earlier.[4] Mental hospitals had General outpatient department (OP), and there were professionals practising both general practice and psychiatry. The present status of such practices needs to be explored.

Previously non-psychiatrists used to keep a distance from psychiatrist counterparts or pass on bits of their mental health knowledge to psychiatrists, presuming that practising psychiatrists are ignorant. Both are reportedly less prominent now.

Clinical Practice

Changes in clinical presentations of illnesses were observed during the past decades. In a typical mental hospital OP in the last century, up to 70% would be catatonic schizophrenia, 10-15 % paranoid and the remaining simple and hebephrenic. Over the decades the pattern has changed. Now it is the paranoid subtype that predominates, and the last two subcategories are totally unseen. Categorization of depression (to neurotic and endogenous) or anxiety (to Generalized Anxiety Disorder and Panic Disorder) used to be a common question for current postgraduate examinations when most of the senior psychiatrists were students. That clinical picture changed, and such watertight separation does not hold now. “Functional” cases with total unresponsiveness (hysteria) responding to spiritus ammonia was a common presentation to any hospital casualty. Indication of Spiritus Ammonia in ‘languor, faintness, and the slight nervous disorder incident to hysteria’, was a textbook description. Such clinical presentations and treatment methods are rare now. These changes in the pattern of clinical presentations are not understandable by the biological models of illnesses alone. Criteria based diagnosis and guideline-based treatments have increased. But care involving other mental health professionals (either concurrent or for continuity) is still infrequent.

A lot of changes happened *from the perspectives of Academician*

Earlier it was reported that nurses were more trained than doctors in Psychiatry. This continues to remain the same. This is because, during the MBBS course, the students get posted for two weeks in Psychiatry in the fifth semester for understanding Common Mental Diseases and Psychiatric Emergencies and receive 20 hours of lecture classes. They have 15 days compulsory and 15 days optional postings in Psychiatry for internship.[5] Whereas, a BSc Nursing student receives 60 hours training in psychology during the first

year, 60 hours training in sociology in 2nd year and 110 hours theory (80 by Nursing teacher and 30 by Psychiatrist) and 360 hours practical in 3rd year[6]for Psychiatry. Many UG students report Psychiatry postings are ineffective. In some centres, even now the UG classes and clinics are scarcely attended, inadequately supervised and skipped by teachers.

Quality of PG training appears to have improved. There are more formal programs, not limited to case presentations in OP. Thanks to the University regulations. There is an emphasis on dissertations. Psychiatry does attract more applicants. Currently, 15 Medical Colleges in Kerala run PG courses in Psychiatry with a total of 47 seats.[7] All the seats are filled up routinely. PG students' participation in continuing professional development (CPD) programs is more. Regular use of journals and textbooks were rare earlier and could still be so today. Synopses version of books is preferred more, and students are fond of short workshops, preferring capsule forms of information and skills transfer. However, most of the centres have no system for long term follow up of cases, running through the entire period of course. There are hardly any centres imparting training for teamwork while multidisciplinary care team is the pattern elsewhere.[8] Inspiration for research is also inadequate.

Academics once used to be the monopoly of teaching departments. It then spread to Government General Hospitals and later to private non-teaching centres. Now Mental Health centres and private hospitals are running PG courses (DipNB) in Psychiatry.

Perhaps orientation program on International Classification of Diseases (ICD) by Prof.NN.Wig in a mid-Kerala hospital during the late nineties initiated the interest in academics, especially for those in the non-Government sector. It was a curtain-raiser of many notable contributors to Psychiatry from Kerala. There is widespread readiness to participate, present and publish.

Research

Unlike in the past decades, more Psychiatry journals are available now, and most of them are published regularly. As a result, there are more published research papers and more journal editors among psychiatrists from Kerala. However, there is no data on the funded projects, collaborations, and research field/centre management to verify whether the increase in research is substantial and widespread. There is no data available on whether the research projects were locally generated or relevant.

Elsewhere Psychiatry branched into several sub-specialities. Sub-specialities for child, old age, community and addiction are presently noticeable in Kerala. Clinical neurophysiology, forensic psychiatry, hospice and palliative medicine, pain management, psychosomatic medicine, consultation-liaison psychiatry, sleep medicine, brain injury medicine, cross-cultural psychiatry, emergency psychiatry, learning disability, neurodevelopmental disorder, cognition diseases, biological psychiatry, global mental health, military psychiatry, sports psychiatry, administrative psychiatry, mental retardation psychiatry, public health psychiatry, psychiatric research, psychoanalysis are other sub-specialities existing,[9,10]of which some of them grew and became independent. But all

of them are rudimentary in Kerala, not attracting full-time practitioners or researchers. Lack of difference or novelty at point of delivery does not seem to generate demand by service users.

Continuing Professional Development (CPD) Programs

There seems to be increased participation in CPD programs. Programs are available regularly and frequently, near clinics/residence. More and more psychiatrists are taking active roles in sessions, though some of those registered would not participate with the excuse that the contents are either too heavy or too simple. This avoidance appears more and more in programs organized at higher levels, from local branch meeting to national conference.

There appears to be a shift in topics from bio-psycho-social to purely biological. A shift of focus to extravaganza from academics is experienced. Presence of Industry is more palpably felt at programmes. Companies choose to attend to a preferred few at the conference venue. There is also another view that the younger generation is more demanding and bargains with industry personnel. VIP status in the conferences has shifted from the secluded academician to the busy practitioner.

Changing the gender profile

Two or three decades ago, female psychiatrists were very few in Kerala. Now more women are joining the PG course in Psychiatry. This follows the general pattern among UG medical students, [11] though there is contradicting observation related to Post-graduation in general.[12] This shift in gender pattern is likely to bring in changes, which already might have started. Paternal to maternal shift in approach, increase in an affectionate approach in care delivery and more concern for distress would be a few. The rise in community acceptance also is noticeable. The psychiatrist, as a manager of the violent patient, is not a view held by many nowadays. The spread of child psychiatry is already happening. But Kerala Psychiatry has to go a long way for focusing on women mental health to develop gender sensitivity in understanding and caring.

From the perspectives of (mental) health activist/educator

Public approach to mental health has changed its focus from violent, mentally ill persons to individuals in distress. Relief for significant others has currently shifted to relief for the sufferer.

Public Health Education

In the field of public health education, mental health is showing its sustained presence. The canvas of health education has shifted from unnoticed small classrooms to a dominant presence in print and visual media. Previous write-ups by practitioners in 70s and 80s were about 'specific symptoms, illness, and how I treat'. Now the canvas is wider mental health issues in the society. There are Psychiatrists who are popular writers and presenters, among whom a few are frequently solicited. They are readily available at short notice.

Practice

There are more seekers but lesser crowds at care delivery points, thanks to an increase in the number of available practitioners. Psychiatrists are more acceptable now in society. Though professional rivalries among them are still present, they are less extreme.

The stigma is less overall. More clients are seeking help early from nearby Psychiatrists. There is more openness in care-seeking, especially for non-psychotic conditions.

Matters of concern

The broader social and legal aspects of mental health are still decided by personnel from outside the profession of Psychiatry. Acts and revisions originate from political leadership. POCSO, Nirbhaya, Mental Health Care Act, Rehabilitation schemes etc. are some of the examples in the recent past. Whether the profession follows or leads in those areas is a debatable question. How far the profession could effectively express its concern for dignity to the mentally ill and their rights is another matter.[13,14] Wandering lunatics, mentally ill in chains, substandard and unlicensed centres of care, ill-treatment to mentally ill, murder in asylums[2] all are still being reported. Lessons learned, and corrective actions taken are yet not reviewed by mental health professionals. Lynching crowds, honour killings, mentally ill on the roads, inhumane custodial centres, unmet training needs of care providers… all these are a reality even now. There are views that the professional avoids "seeing this" or are too busy or "sophisticated" to notice or pay heed to this.

Many other changes are happening around us slowly but firmly. There are diminishing borders of culture with the growing dominance of western culture. The pattern of family and roles within are in transition. Give and take between near relatives living in different countries is an emerging model of social support. Digital world enabled a new style of communication at 'no-touch but seeing distance' is increasingly becoming the norm. Sedentary lifestyle is spreading despite its negative consequences on physical health. Does the profession need to have concerns about these also?

Conclusion

No conclusions or deductions were attempted. Only a few anecdotal observations were presented to encourage participation from all delegates and guide the framework for discussion. From the delegates' workshop, the outcome expected was to unearth a '*large fund of rich information'* from all representatives, which will give rise to pointers for further exploration, auditing and possible action plans. All of them combined should assist in moulding the future of mental health in Kerala, by gaining insights from the past, learning about the evolution of psychiatry in Kerala, exploring the possibilities for future development and chalking out plans for the same.

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Conflicts of interest

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