

## ‘PULLEPADY INCIDENT’: LESSONS IN STRENGTHENING OF PUBLIC MENTAL-HEALTH SYSTEM IN KERALA

GS Ramkumar

Assistant Professor, Dept. of Psychiatry, Government Medical College Idukki, Idukki District.

*Correspondence:* Dept. of Psychiatry, Government Medical College Idukki, Idukki District. E-mail: ram3481@gmail.com

### ABSTRACT

This report inspects a murder that happened at Pullepady, in Kochi city of Kerala, in which the accused was a person on psychiatric treatment. Based on details in newspaper reports, it discusses certain lessons and implications for strengthening the public mental health system in the state. The incident helps to discuss issues like access to custodial care at district level, need for and provisioning of after-care services and mechanisms to support family caregivers. There is an urgent need for all stakeholders to come together and chalk out an action plan for the state to strengthen the system to address the lacunae noted.

**Keywords:** public mental health system, mental health policy, custodial care, family caregiver, community care.

### INTRODUCTION

The public mental health system (publicly funded facilities) is facing administrative and political neglect because of low priority allocated to it in health policy and plan. Social stigma that is prevalent among the general public about the mentally-ill also prevents patient-led or caregiver-led lobbying to improve the status quo. In these circumstances, untoward incidents in relation to mental illness exert a strong influence to reform the system, and this happens by way of bringing abrupt and intense public attention onto the system. Examples of such incidents include the Erwady tragedy<sup>1</sup> and the more recent court direction in Kerala for designing a dress code to prevent indignity of suicidal patients undergoing treatment in seclusion in government mental hospitals.<sup>2</sup>

The ‘Pullepady Incident’ is a recent incident that occurred in Kerala, which received much media attention though it was of a minor magnitude

involving just a single individual with mental illness. It can teach us some lessons regarding the strengthening of Kerala’s public mental health system.

### DETAILS OF THE INCIDENT

The incident happened in a place called Pullepady in the mainland portion of the city of Kochi, the largest metropolitan region of Kerala. At 7.00 AM on 26th April 2016, a 10-year-old boy was stabbed repeatedly to death on roadside by a man who was later identified as his neighbor. The aggressor was caught by the public on being alerted by a witness, and was handed over to the police. The incident received high media attention in newspapers, and the details about the incident described in this report are collated from them.

The accused, 40 years old and unmarried, reportedly suffered from drug dependence and mental illness. He lived with his mother, his only caretaker. A news report (Times of India, April 27,

Please cite this article as: Ramkumar, GS. ‘Pullepady incident’: Lessons in strengthening of public mental-health system in Kerala. Kerala Journal of Psychiatry 2016; 29(1):58-62.

2016) speculates that the accused had a grudge against the boy's father, and that it could have been a motivation for the aggression against the boy. The boy's house had been a solace for the mother of the accused whenever he had been violent to her; and the boy's father, an auto rickshaw driver, had also helped her in the past to get him admitted to a mental hospital.

The news titles on the next day (April 27, 2016) read as follows – “*Boy stabbed to death by neighbour*” (The Hindu); “*10-year-old boy killed in road by drug addict neighbor*” (Malayala Manorama<sup>a</sup>); “*10 year old boy stabbed to death by mentally ill drug addict*” (Mangalam<sup>b</sup>); and “*Smarting over insult, man stabs neighbour's kid 17 times*” (The Times of India).

An excerpt from The Hindu says:

*“The police, meanwhile, maintained that A\*\*\*\*\* had been mentally unstable and added that the exact reason for the attack was yet to be ascertained. ‘On a complaint from A\*\*\*\*\*’s mother, about his becoming violent towards her, we had earlier admitted him to a mental hospital at Thrissur. He was released only a week back,’ said M.P. Dinesh, Commissioner of Police, Kochi city.*

*However, local people claimed that the accused was addicted to liquor and drugs”.*

The Times of India (“What prompted the child's murder remains a mystery”; April 28, 2016) adds...

*“Before admitted at Thrissur health centre for the last time, A\*\*\*\*\* had reportedly been treated for mental disorder at five different psychiatric institutions across the state for the last 10 years.”*

## LESSONS FROM THE INCIDENT

1. Need to provide custodial-care services for mental illness and substance-use treatment in every district:

Even though Pullepady is in the district of Ernakulam, the patient had sought treatment in psychiatric institutions (both government and private) in places located as far as the districts of Thiruvananthapuram, Thrissur and Idukki. His last admission, through an order of the district magistrate of Ernakulam, was to the Government Mental Health Center at the adjoining district of Thrissur, as facilities for custodial admissions such as high security wards are not available in Ernakulam district. Currently, such facilities are available only in the three government mental health centers (mental hospitals) of Thiruvananthapuram, Thrissur and Kozhikode which are located in the south, central and north of the state respectively. Similar services for custodial care for mentally ill patients have to evolve at all district headquarters to ensure self-sufficiency for psychiatric treatment facilities at district level. Small mental health units can be started attached to district jails, to keep mentally ill offenders who will need psychiatric evaluation and treatment. The Kerala High court had also sought to explore the feasibility of setting up rehabilitation centers in prisons for mentally ill prisoners.<sup>2</sup>

2. If families do not have the capacity to shoulder the burden of care after successful inpatient (custodial) care, the system needs to start thinking about alternatives that can be provided:

Though family-support is a great boon which absorbs most of the responsibilities of after-care of a patient following a hospital discharge, in recent times we recognize that care of mentally ill can be demanding and burdensome, especially for small families.<sup>3</sup> In a prospective study in rural Karnataka, 184 schizophrenia patients were followed up after active case finding, initiation of treatment and ensuring follow-up services in nearby primary health care centers. The study found that even in such conditions equipped to supplement the caregiving role, about 15.8% of patients dropped out

<sup>a</sup> “പത്തുവയസ്സുകാരനെ ലഹരിക്ക് അടിമയായ അയൽവാസി റോഡിൽ കൊലപ്പെടുത്തി”

<sup>b</sup> “പത്തുവയസ്സുകാരനെ മയക്കുമരുന്നിന് അടിമയായ മാനസികരോഗി കുത്തിക്കൊന്നു”

of treatment.<sup>4</sup> The reasons reported were unsatisfactory improvement with previous treatment attempts, poor bond between the patients and the families, ongoing active symptoms in the patient precluding any family involvement, and so on. The authors suggest providing both medical and social care and exploring legal provisions to treat patients who lack insight into their illness.

In the Pullepady incident too, the family caregiver role was performed by the elderly mother alone. The patient's last inpatient care was sought through legal measures, and the caregiver was left to her own means to navigate the legal system to obtain it. As he became a "menace" at home, the mother approached the police and the court and obtained a legal order for admitting him involuntarily ('Shunned by everybody; he took a child's life in the end': Mathrubhoomi news report 27th April, 2016).<sup>c</sup>

*In the end, as the menace at home became intolerable, a complaint was lodged with the City Police Commissioner.*<sup>d</sup>

There was tension at time of discharge also, as is mentioned in the same news report.

*"After one month, the hospital authorities informed that he should be taken back home. If nobody comes he will be let out based on self-surety. So he was brought home. After coming home, A\*\*\*\*\* completely stopped taking medicines,' said T\*\*\*\*\* [mother]."*<sup>e</sup>

The accused appears to suffer from 'dual diagnosis' — substance misuse along with severe mental illness — which makes him vulnerable for various consequences including treatment non-adherence and aggression. This comorbidity brings additional burden on families and those providing services to

them and therefore the need to prioritize services for them is being recognized at a global level.<sup>5</sup>

This incident not only illustrates a diminishing capacity among small family units to shoulder the burden of care of cases with overwhelming /complex needs, but also a lack of preparedness of the formal care system to be responsive to the needs of such cases as it is attuned more to the care of patients with good family support. Though most research papers from the past addressing the issue of caregiving looked at the burden and hardships involved, the attention has now shifted to looking for programs that will support family caregiving with skills, guidance and supervision.<sup>3</sup> The mother in this case also reports that, soon after the discharge, the patient had stopped his medications. We have currently no formal system in place to inquire about drug adherence after a patient has been discharged. Methods like active-follow up through telephone calls, letters or home visits to enquire about patients who don't turn up for scheduled outpatient follow-up visits, field based techniques like assertive community treatment, case management, outpatient commitment (community treatment orders), out-reach and in-reach models for seamless engagement between inpatient, outpatient and community based services will have to be explored in the state to compliment the increasingly fragile family-based caregiving. The District Mental Health Program (DMHP), the operational arm of the National Mental Health Program (NMHP), in its 12<sup>th</sup> five-year plan proposals (mental health national policy group document dated 29<sup>th</sup> June, 2012) do observe that the DMHP is not providing any sort of 'continuing of care in the community' — it focuses mainly on case detection and treatment. This could be indirectly contributing to (i) extended stay of patients treated

<sup>c</sup> "എല്ലാവരും അകറ്റി; ഒടുവിൽ കുട്ടിയുടെ ജീവനെടുത്തു"

<sup>d</sup> "ഏറ്റവുമൊടുവിൽ വീട്ടിലെ ഉപദ്രവം സഹിക്കാതെ വന്നപ്പോൾ സിറ്റി പോലീസ് കമ്മീഷണറെക്കണ്ട് പരാതിപറഞ്ഞു."

<sup>e</sup> "....ഒരു മാസം കഴിഞ്ഞപ്പോൾ കുട്ടിക്കൊണ്ടുപോകണമെന്ന് ആശുപത്രി അധികൃതർ അറിയിച്ചു. ആരും വന്നില്ലെങ്കിൽ സ്വന്തം ജാമ്യത്തിൽ വിട്ടയക്കുമെന്ന് പറഞ്ഞു. ഇതേത്തുടർന്ന്... കൊണ്ട് വന്നു. വീട്ടിൽവന്ന ശേഷം മരുന്നുകഴിക്കുന്നത് [രോഗി] പൂർണ്ണമായും നിർത്തിയതായി \*\*\*\*\* [അമ്മ ] പറഞ്ഞു."

in mental hospitals, as they could not be discharged due to lack of support in community, and to (ii) illness relapse and becoming lost-to-follow-up after discharge. The proposals seek to address these issues at district level with a three-component approach, namely 'Home/Family based continuing care, Day Care centers, and Residential Continuing Care'. Kerala has been able to start 'day care' centers in its districts during the plan period via a program named 'Comprehensive Mental Health Program'.<sup>6</sup> However, the other components are yet to be implemented.

### 3. Need for provisions for continued care that is tailored to the needs of individual patients at the time for discharge:

Discharge planning in our system is predicated on the availability of a secure support from the family which shall take the patient home, supervise drug administration and bring the patient for regular follow-up. However, increasing family isolation as part of social recession<sup>5</sup> and decreasing family size as part of changing demographics and urbanization has resulted in shrinking family resources to take up the caregiving role. Mental hospitals in the state often report that they face difficulties in discharging many patients who lack enough family support or face rejection by families. In the incident case, the patient, who was admitted involuntarily due to violent behavior at home, was also discharged under care of the family after his hospital stay — the default option for discharge from inpatient care. The need has risen, as envisaged in the 12<sup>th</sup> plan proposals of DMHP, to set up facilities for continued support after discharge, like 'short stay residential continuing care' (half-way homes) and 'long stay residential continuing care' (rehabilitation homes). Supported housing models could also be explored for patients who do not have houses or primary caretakers. In order to materialize these needs, a lot of intersectoral dialogue and collaborative work need to happen between the various stakeholders, the important participants being the health-care and social-care departments of the Government, the DMHP, the NGOs, the

private sector and mental health professional bodies like the Indian Psychiatric Society.

## SUMMARY

The 'Pullepady incident' gives an opportunity to think about the lacunae in current delivery of mental health services in Kerala. Equitable distribution of facilities for secure admission should be available at every district level. Default options on which current service orientation is predicated — like the approach of discharge and after-care under family caregivers and the undifferentiated care methods directed alike across all case situations — have become suboptimal in catering to the diverse needs of patients and families in current changing scenario. Family caregivers need more support to partake in the caregiving which they are already providing.

In situations where family caregiving is felt as sub-optimal, the system has to step in to fill the gap. The incident is a pointer to think anew about a 'Kerala model of mental health care' which should inculcate principles of care matching needs of individual cases and providing families more support in caregiving role.<sup>7</sup>

## WAY FORWARD

Unfortunately, many of the specifics of policy implementation in Kerala has not materialized because the Health and Family Welfare Department has not formulated an action plan to implement the objectives of the State Mental Health Policy (2000) even after 13 years, as remarked in the report (79<sup>th</sup>) of the legislative assembly committee on public accounts (2014-2016) presented on 16<sup>th</sup> December 2014. The legislative committee has directed the ministry to formulate the plan as early as possible. Thus, an opportunity to envision changes in service orientation and reform is arising through such plan formulation. The report (6<sup>th</sup>) of the Estimates Committee (2011-2014) of the legislative assembly had also recommended that a yearly audit mechanism which includes "feedback, incident monitoring and random case review" should be put in place to monitor the system. It is hoped that this

report on the Pullepady incident will contribute in that direction.

## REFERENCES

1. Antony JT. Let us learn the right lessons from Erwadi. *Indian J Psychiatry* 2002; 44:186-92.
2. Mental hospitals told to frame dress code for secluded patients. *The New Indian Express* [Internet]; [cited 2016 June 04] Available from: <http://www.newindianexpress.com/cities/kochi/Mental-Hospitals-Told-to-Frame-Dress-Code-for-Secluded-Patients/2016/04/06/article3365162.ece>.
3. Murthy RS. Caregiving and caregivers: Challenges and opportunities in India. *Indian J Soc Psychiatry* 2016; 32:10-8.
4. Kumar CN, Thirthalli J, Suresha KK, Venkatesh BK, Kishorekumar KV, Arunachala U et al. Reasons for schizophrenia patients remaining out of treatment: Results

from a prospective study in a rural south indian community. *Indian J Psychol Med* 2016; 38:101-4.

5. Hunt GE, Siegfried N, Morley K, Sitharthan T, Cleary M. Psychosocial interventions for people with both severe mental illness and substance misuse. In: Hunt GE, editor. *Cochrane Database of Systematic Reviews*. Chichester, UK: John Wiley & Sons, Ltd.; 2013.
6. Chandran R. Pakalveedu- The Kollam Experience. *Kerala Journal of Psychiatry* 2016; 28:189-94.
7. Therayil MK. Mental Health Care: Can We Create a New Kerala Model? *Kerala Journal of Psychiatry* 2015; 28:100-8.

Source of support: None

Conflict of interest: None declared

.....  
First submitted: 15<sup>th</sup> June 2016

Published online: 17<sup>th</sup> August 2016