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Article

Disappearing the asylum: Modernizing psychiatry and generating manpower in India

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Abstract
In recent years, the Movement for Global Mental Health (MGMH) and the World Health Organization have worked closely with governments across the global South to redress major treatment gaps to improve access to mental health services. In India, recent reforms include transforming public psychiatric institutions from sites of treatment to research and training institutes, known as "Centres of Excellence," to combat acute manpower shortages and modernize psychiatry. Drawing on ethnographic fieldwork at a public psychiatric hospital in Srinagar, Kashmir, one of the institutions selected to be a future "Centre of Excellence," this article focuses on how these reforms have affected psychiatric institutions themselves. Efforts at modernizing and increasing access to mental health care—that is, emphasizing shortened stays, increasing outpatient treatment, and providing care in the "community"—depend on quarantining stigmatized, chronically ill, long-term patients who reside in custodial conditions with fewer resources and limited attention from providers. Psychiatrists have a radically different vision for redressing manpower shortages than the MGMH and Indian state, revealing contradictions in the reform process. This paper demonstrates how modernizing mental health care splits mental institutions spatially, ontologically, temporally, and epistemologically, so that the process of modernizing the institution is neither seamless nor complete.

Keywords
Kashmir, mental health reform, psychiatric expertise, South Asia, the asylum

Spurred by the mass publicization of a tragedy, in recent years there have been growing—and increasingly urgent—calls for mental health reform in India. On August 6, 2001, at least 25 residents of a private mental asylum perished in a fire

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in the southern state of Tamil Nadu.[1] The residents were living near the Erwadi *dargah*, a local shrine where they had been receiving religious healing for mental illness and psychological distress. Images from the fire, published in newspapers and magazines with national circulation, showed charred bodies chained to beds or poles. The incident, known as the Erwadi tragedy, sparked outrage and galvanized the Supreme Court to lead a *suo motu* intervention against local healing shrines across the country, order the closure of all unlicensed mental asylums, and for teams of human rights experts to inspect and report on the state of psychiatric hospitals across the country (Murthy & Sekar, 2008). Those in support of reform argued that the Erwadi tragedy could have been prevented if there had been a local, biomedical, mental health care system in place (Sébastia, 2007, p. 74).

Such calls to action resonate with policy shifts already underway in India's public mental health system, including India's recent ratification of the Convention on the Rights of Persons with Disabilities in 2007, the implementation of a National Mental Health Policy (2014), as well as the growing influence of transnational advocacy efforts, including by the World Health Organization (WHO) and Movement for Global Mental Health (MGMH). Although the MGMH is not the only proponent of reform, this paper focuses on the specific effects of reform on mental hospitals, whose transformation has been central to both MGMH and Indian national public health goals. Founded in 2008, the MGMH is a transnational consortium that "aim[s] to improve services for people with mental disorders in low and middle-income countries" (MGMH, n.d.) by scaling up access to psychiatric treatment, particularly medication (Mills, 2014). As MGMH advocates argue, the vast majority of affected people and their families in developing countries do not have their mental health condition recognized and do not receive "evidence-based" care (Patel & Thornicroft, 2009) .[2] This resource gap is supported by stark statistics, such as the fact that there are only 4,000 psychiatrists and 30,000 in-patient beds for India's population of 1.2 billion people. MGMH and reform advocates argue that patients and their kin are also unable and unwilling to travel great distances to "colonial-era mental hospitals," which are unappealing due to their association with custodial care and human rights abuses (Patel, 2013).

In recent years, in consultation with MGMH advocates, the Ministry of Health and Family Welfare has responded to this crisis in mental health services with a "radical new vision for mental health in India" (Patel & Copeland, 2011, p. 407). Reform efforts include a new District Mental Health Programme (DMHP), a national policy on mental health (the first), and new legislation for mental health care. While calling for the abolition of unlicensed "private" mental health asylums, the reforms also aim to expand and transform public, biomedical mental health services across India. Unlike deinstitutionalization in the global North, reform advocates argue that, "what India needs is not less inpatient beds, but many more than we currently have, and that these should be located in community-based supported homes, general hospitals, or small mental health specialist centres, rather than in mental hospitals" (Patel, 2013). In this sense, the vision for reform

rests on increasing outpatient treatment and access to pharmacological treatment, while minimizing hospital stays. Meanwhile, asylums or mental hospitals are to be transformed from sites of treatment to research and training centers, in order to mitigate acute manpower shortages (Patel, 2007).

These reforms raise several questions that ethnographers are well positioned to answer. As Sarin and Jain (2013, p. 80) have argued, in order to answer basic questions about the effects of ongoing mental health reforms, we need to "move away from the published literature to the stories on the ground." This article takes one step in this direction by asking: how does an ethnographic view from a specific place (Kashmir),[3] help shed light on the modernization of public mental health institutions across India? How has the "mental hospital" or asylum been reimagined during these reform efforts? Finally, how do experts propose bridging acute manpower shortages, and what might be at stake in skilling "up" or "down"? In addressing these questions, I highlight some ambivalences, unintended effects, and internal barriers to modernizing psychiatric institutions and expanding access to biomedical mental health services in India.

Social scientists have critiqued the assumptions and practices of recent public health reforms, which many read as a sign of the neoliberalization of the public health sector (Campbell & Burgess, 2012; Das & Rao, 2012; Fernando, 2012; Finn & Sarangi, 2008; Jain & Jadhav, 2009; Mills, 2014; Summerfield, 2012). Scholars have also argued that post-Erwadi medico-legal events led to the exclusive targeting of healing institutions in the "private" sector—that is, those practicing indigenous, religious, or "folk" healing—as sites of human rights violations, while exonerating the biomedical, public mental health system (Basu, 2009; Davar & Lohokare, 2009; Quack, 2012; Sébastia, 2007). Others have questioned extending a predominantly biomedical rendering of mental health to communities. Jain and Jadhav (2009), for example, argue that notions of "care" in community-based care are often reduced to the prescription of pharmaceuticals. Scholars have also deconstructed the MGMH's rhetoric of "community involvement," by arguing that, "communities remain narrowly defined as patients and their families, and lay health workers… [who] are viewed largely as handmaidens of biomedical expertise" (Campbell & Burgess, 2012, p. 381). Summerfield and Fernando both argue that, despite gesturing to the "community," the MGMH's conceptualization of culture is "thin" (Fernando, 2012) and that, "to the global psychiatrist, the socio-culturally determined understandings that people bring to bear on their active appraisal of their predicament, and on their modes of distress and help-seeking, seem little more than epiphenomenal" (Summerfield, 2012, p. 524). By contrast, other perspectives emphasize that the effects of the District Mental Health Programme and attempts to integrate mental health within primary health are extremely variable from district to district; as such, Jain and Sarin write that, "we could tell the DMHP story as a heroic struggle against overwhelming odds or as a case of abject failure" (Sarin & Jain, 2013, p. 80).

Rather than gloss reform efforts from a macro perspective as either complete failures or resounding successes, this article examines one particular set of reforms

(modernizing hospitals) as it applies to one specific mental hospital, the Institute for Mental Health and Neurosciences in Kashmir. I argue that ongoing reform efforts contain different visions for generating psychiatric manpower in the face of acute shortages. This paper illuminates two key tensions in the Indian state and MGMH's goal of transforming hospitals from sites of care to research and training centers.[4] First, I focus on how the move to make mental health care more scientific, "evidence-based," and accessible—that is, more modern—has resulted in processes of further quarantining the chronically ill who reside in asylums. Efforts at modernizing psychiatry thus have a spatial dimension—in the form of closed wards for the chronically ill—but also temporal ("they belong to the past") and epistemological ("we don't do that anymore") dimensions, which are intended to distance custodial spaces, forms of care, and particular subjects from a refashioned, modernized psychiatry. As such, modernizing mental health care effectively means splitting mental institutions spatially, ontologically, temporally, and epistemologically, meaning that the process of modernizing the institution is neither seamless nor complete.

Second, there are two distinct strategies for addressing manpower shortages within the National Mental Health Programme (NMHP), which are profoundly in tension with each other, if not contradictory. The NMHP makes provisions for both increasing specialized psychiatric manpower—by turning psychiatric hospitals into research and training "Centres of Excellence"—while also advocating for extending mental health care through the existing primary healthcare system, in other words, by training non-specialized medical workers to diagnose and treat mental disorders at the Primary Health Centre (PHC) or district level. In this paper, I show how psychiatrists were ambivalent towards this second approach, or what I call the democratization of psychiatric expertise, and preferred building on the existing vertical model of expertise by training more *specialized* personnel, rather than distributing care from the ground up, which is what the WHO, MGMH, and Indian state bureaucrats have advocated.[5] These two, interrelated arguments reveal certain blind spots in current mental health reforms and legislation and gaps between the goals and actual implementation of these processes.

To make these arguments, I draw on six months of ethnographic fieldwork conducted between 2009 and 2011 at the Government Psychiatric Diseases hospital (now the Institute of Mental Health and Neuro Sciences)—the only stand-alone public psychiatric facility in the north Indian states of Jammu and Kashmir. I observed hundreds of clinical visits between doctors, kin, and patients in the Outpatient Department of the psychiatric hospital, conducted structured and unstructured interviews with patients, doctors, kin, and hospital staff, and spent extended periods of time in the closed, female ward, where long-term patients were institutionalized for months or in some cases, years.[6] In particular, the time I spent in the closed wards was invaluable for understanding how mental health reforms were experienced by individuals with severe mental illnesses. To protect the identities of my informants, I use pseudonyms throughout this article.

From asylum to "mental hospital"

Asylums were first introduced to British India in the late 18th century to treat Europeans and Indian elites (Ernst, 1987). While British India did not have a period of institutionalization comparable to what Foucault described as "the great confinement of the insane" in Europe, colonial asylum policies dovetailed with broader arguments for bringing civilized, humanitarian, and scientific treatment to the subcontinent (Ernst, 1987, p. 171). As Ernst argues, the operation of psychiatry as a tool of social control in British India was, however, restricted, given that institutional practices within the British Empire varied significantly. In the postcolonial period as well, psychiatry has remained marginal to biomedicine, which has itself occupied a somewhat marginal position in India's pluralistic health system. According to Michael Nunley, the belated promotion of psychiatry from the 1970s on was not because of "any groundswell of demand for psychiatric services at the level of rural communities," but was because policy makers and physicians argued that "psychiatric services [were] an integral part of modern, cosmopolitan allopathic medicine" (1992, p. 91). However, mental health care did not even figure in the national five-year plans until 1997, when a meager 270 million rupees (approximately US$5 million) were allocated—but not spent—for piloting the District Mental Health Programme in 25 districts (Goel, 2011, p. 95).

Under its "restrategized" National Mental Health Programme launched in 2002, the Indian government initiated national programs that aim to transform "large, unmaintainable mental hospitals" by streamlining, downsizing and rationalizing them (Goel, Agarwal, Ichhpujani & Shrivastava, 2003, p. 22), while simultaneously promoting psychiatry in general hospitals and community health centers. As Renu Addlakha argues, even before the formal launch of the NMHP, the locus of psychiatric treatment had shifted from the mental to the general hospital as part of liberalization reforms (Addlakha, 2008, p. 2) . The government also committed significantly greater resources to mental health beginning in 2002. Whereas the 9th Five Year Plan (1997–2002) budget for the NMHP had been 280 crore[7] rupees (USD $41 million), in the 10th Five Year Plan (2002–2007), the budget was increased to 1900 crore rupees (USD $284 million) (Goel, Agarwal, Icchpujani, & Shrivastava, 2004). The restrategized NMHP sought to address the large treatment gap between mental health care in the developed and developing world, but to do so in a cost-effective way. In fact, despite increases to the budget for mental health care, according to the World Health Organization, India's public spending on healthcare as a percentage of GDP fell from 4.3% in 2000 to 1% in 2014 (Kalra, 2015). Some scholars see the turn to outpatient care, the marketization of public services, and the use of technocratic expertise as connected to neoliberal priorities of reducing public health spending. According to them, neoliberal policies have gutted the state healthcare system, led to the massive growth of unregulated and profit-making hospitals, and have contributed to a "modern" system of medicine that severely disenfranchises the poor (Banerji, 2004; Gupta & Sharma, 2006; Kamat, 2004). However, the mental health sector is unique within the public

health system because calls for increasing access to mental health services in local communities have been accompanied by calls for modernizing, reforming, and in some cases, expanding public mental institutions in India (Goel, 2011). Since the Supreme Court writ petition in 2001, new hospitals have been initiated in the states of Haryana, Tripura, Himachal Pradesh, and Bihar; thus, unlike in the global North, there has been no systematic closing of mental hospitals under the new neoliberal model (Murthy & Sekar, 2008, p. 103). Instead, these reforms repurposed the institutions. This recycling was justified through an economic calculus: because of resource scarcity, mental health programs in low and middle-income countries like India needed to ''piggy back'' (Patel, 2007, p. 81) on existing institutions and programs, rather than build new ones from scratch.

While some scholars argue that biomedical mental health institutions were unfairly exonerated by post-Erwadi reforms, I argue that biomedical, public health institutions have also come under increased scrutiny post-Erwadi. However, rather than calls for their closure, there have been concerted efforts to reform these institutional spaces—efforts, which are by no means new. Asylums have been the targets of human rights and humanitarian critiques in South Asia since the colonial period. In 1946, for example, after a survey of public mental hospitals, the Bhore Committee recommended modernizing hospitals, consolidating psychiatric hospitals with medical colleges, and establishing ''proper mental health'' (Nizamie & Goyal, 2010). These aims were echoed, decades later, in the National Mental Health Programme. However, until 1990, when a series of Public Interest Litigations (PILs) were filed in the Supreme Court, reforms to mental institutions occurred on an erratic basis. In these instances, legal concerns over rights violations, rather than efforts from within mainstream psychiatry, were responsible for changes within particular hospitals in the 1990s (Dhanda, 2000).

In this history, the National Human Rights Commission (NHRC) report of 1999 represents a significant watershed moment. The study described two types of mental hospitals in India. The first, ''does not deserve to be called 'hospitals' or mental health centres... but are 'dumping grounds' for families to abandon their mentally ill member.'' According to the report, the second ''type'' of hospital provides ''basic living amenities... and... adequate food and shelter [but] very little effort is made to preserve or enhance their daily living skills'' (Sharma, 2008, p. 270). The report also observed wide-ranging human rights violations in psychiatric institutions. Patients were found to be naked or in dirty clothes, living in unhygienic conditions, and in some places, female patients were found to be without underwear. These troubling findings led members of the NHRC team to argue that many state mental hospitals in the country were in violation of Article 21 of the Constitution, which guarantees the right to live with dignity and the right to health (NHRC, 1999).

Ongoing concerns about the conditions of hospitals led mental health experts from the National Institute of Mental Health and Neuro Sciences (NIMHANS) to recommended specific changes to the structure and function of treatment facilities

in public hospitals, such as strengthening general hospital psychiatry units, promoting community-based mental health services, and monitoring rights infringements (Kapur, 2004) . As stated in the Mental Health Care Bill (2013),

> [L]ong term care in a mental health establishment for treatment of mental illness shall be used only in exceptional circumstances, for as short a duration as possible, and only as a last resort when appropriate community based treatment has been tried and shown to have failed. (Chapter V, Section 18)

The MGMH shares similar concerns about the custodial model of care in mental hospitals and argues for a diminished role for the hospital as a site of care in favor of ''locally available, affordable interventions in community and primary care settings'' (Patel, 2007, p. 82). Patel, for example, argues that while ''care is often compromised by poor standards'' in large psychiatric hospitals, community-care programs ''improve the odds that patients who have been discharged are able to recover fully and remain in good health'' (Patel, 2007, p. 91).

The reform of mental hospitals in India is thus justified by longstanding human rights and humanitarian concerns around asylum care, as well as the urgent need to generate psychiatric manpower. According to proponents of reform, ''acute shortage of manpower resources'' is not just a problem for the functioning and delivery of mental health services, but they also impede the implementation of legal measures, such as the Mental Health Act (MHA) (Math & Nagaraja, 2008, p. 52). Similarly, in the 2008 review of government psychiatric hospitals described above, despite improvements in a number of areas including hospital infrastructure, availability of emergency services, and patient diets, the authors describe how, while ''there has been [an] overall increase in sanctioned posts across all hospitals... the vacancies are striking and are a cause for serious concern'' (Murthy & Sekar, 2008, p. 123). Strikingly, in every category of mental health professionals—psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses— and in all hospitals surveyed, there were more vacancies than posts occupied. 44% of all state psychiatric hospitals had no clinical psychologist (Murthy & Sekar, 2008, p. 123). Ironically, despite a District Mental Health Programme being in place, there were not nearly enough professionals to implement it.

These manpower crises are redressed in the 11th Five Year Plan, by developing 11 mental hospitals into regional ''Centres of Excellence'' with a one-time grant of Rs. 30 crore for ''infrastructural development'' and starting or strengthening post-graduate programs in mental health (Math & Nagaraja, 2008) . The expected outcome of the Manpower Development Scheme under the NMHP is the graduation of 104 psychiatrists, 416 clinical psychologists, 416 psychiatric social workers, and 820 psychiatric nurses annually once these institutes are established (Sinha & Kaur, 2011, p. 261). The effects of these reforms were that human rights concerns were eclipsed by efforts to transform hospitals into ''Centres of Excellence.''

Making a "Centre of Excellence"

As one of 36 public mental hospitals under Indian jurisdiction, the Psychiatric Diseases hospital in Srinagar, Kashmir, has been a site of major policy and legal interventions in the post-Erwadi period, including the NMHP and the Manpower Development Scheme. Recently renamed the Institute for Mental Health and Neurosciences, Kashmir, to mark its new "Centre of Excellence" status, the hospital is located near Srinagar's famed *Badami bagh* or Almond Gardens in the Old City. The use of the term "Institute" and the specific material changes undertaken at the hospital exemplify efforts to position mental health as a research science capable of generating evidence-based knowledge, and psychiatrists as scientists, experts, and professionals worthy of this new practice.

As with other mental hospitals in India, the Psychiatric Diseases hospital has had multiple lives: it was constructed as an asylum for mentally ill prisoners in 1957, but the building was destroyed in a fire in the 1970s, rebuilt, and destroyed again in a fire in March 1996. From 1989–2002, decades of frustration with Indian rule culminated in an armed struggle for independence (*azadi*) against the Indian state. The Indian state responded to the "insurgency"—which it viewed as a Pakistani-sponsored movement rather than a legitimate struggle for political self-determination—with brutal and extrajudicial legal and military force. Despite the declaration of a ceasefire in 2002, Kashmir continues to be a highly militarized, securitized, and surveilled region. Over 60,000 Kashmiris have lost their lives in the conflict, more than 10,000 persons have disappeared, and thousands, particularly Kashmiri Hindus (Pandits), are displaced (Kaul, 2011). In 2003, Médecins sans Frontières (MSF, or Doctors without Borders) assisted with rebuilding the hospital, and thousands of patients suffering from traumatic stress related to the ongoing conflict began pouring in. The numbers of patient visitors to the mental hospital has skyrocketed from approximately 1,000 patients every year in 1988 to over 100,000 a year in 2008 (Matloff & Nickelsberg, 2009).[8] Mental health experts who visited the hospital in 2008 as part of the National Survey of Mental Resources noted the urgent need for mental health services in the state for victims of "terrorism," though they failed to mention the role of state violence in perpetuating widespread psychological distress (cf. Murthy & Sekar, 2008).

Since 2009, the hospital has undergone another round of transformation. The Psychiatric Diseases hospital in Srinagar was one of only 11 public psychiatric hospitals nationally to become a "Centre of Excellence," a training and research institute to produce psychiatrists, psychologists, social workers, and psychiatric nurses, after a rigorous application process through the Ministry of Health and Family Welfare. The aim is to transition away from the hospital as a site of treatment to a space where psychiatric and psychosocial manpower can be generated in order to address "chronic shortages" and "the uneven distribution of these scarce resources across geographical regions and rural/urban settings" (Goel et al., 2004, p. 13).[9] By using hospitals to generate "quality manpower in mental health" and by providing funding for projects including an academic block, library, hostel,

lab, and other works within the hospital grounds, the NMHP hopes to create an incentive for existing faculty to stay, while also expanding posts for psychiatric social workers and psychiatric nurses, which do not exist in many hospitals (Sinha & Kaur, 2011). These transformations are not only about increasing manpower, but are also attempts to remake psychiatric expertise as a modern science by relying on new modes of treatment, while distancing the institution from ''outdated'' subjects and practices of custodial care.

These priorities were evident in the material transformations taking place on the ground. At the hospital in Srinagar, I noticed the ''Centre of Excellence'' funds were not directed towards improving patient care in any substantive way, but rather, were directed towards improving the look and prestige of the hospital. NMHP funds were used to beautify the hospital grounds, manicure and landscape the hospital lawn. During my fieldwork, the flooring in the hallway of the faculty block was redone and expensive walnut wood panels—a Kashmiri specialty—were installed. Psychiatrists' offices were repainted, and new desks and swivel chairs added. These changes caused one psychiatrist to joke that his chamber had been turned into a ''bureaucrat's office.'' The statement was ironic and demonstrates a certain contradiction within reform efforts. On the one hand, psychiatrists were advocating that the future of mental health care be in the community, not in institutions, and on the other hand, they were witnessing—or, in some cases, actively participating in—the bureaucratization and reinvigoration of mental hospitals.

The material transformations were not enacted evenly across the hospital. The closed wards where long-term patients resided did not undergo any upgrades, and it was not clear how they would gain from these developments. While the hospital's ''outsides'' continued to change—the faculty and library block were the most visible spaces—the ''insides,'' the closed wards and those who inhabited them, were increasingly out of view and neglected. While the rationale for modernization included a concern for human rights abuses within institutions, the emphasis on generating manpower overrode these concerns, with long-term patients seeing very little to no qualitative changes in their lives. Rather, the shift of psychiatry from treatment to research-based science depended on separating from, or leaving behind, the long-term, chronically ill.

The closed wards and the patients residing in them were increasingly out of sync with the image of a cosmopolitan, modern psychiatry embodied by the ''Centre of Excellence.'' While at one time the Psychiatric Diseases hospital, as all other mental institutions in the subcontinent, had consisted primarily of closed, long-term wards with a tiny Outpatient Department, now the structure and priorities of the hospital were reversed, with all the money, energy, and reform efforts directed towards outpatient care and to the training of more specialized personnel. In many ways, my own experience in the hospital embodied these shifts and selective foreclosures. At the beginning of my fieldwork, I was allowed to visit the closed female ward in the hospital. Located in an interior courtyard of the hospital, the area around the ward was noticeably quiet in contrast to the bustling atmosphere of the Outpatient

Department. After a few months of research, however, a senior psychiatrist told me without further explanation that the wards were "no longer open to researchers," and I was not permitted to visit patients there.

The time I spent in the closed wards gave me a sense of how they were increasingly separated from the future "Centre of Excellence" that hospital administrators envisioned. This was both a matter of differential space and differential bodies: patients and kin who could be treated on an outpatient basis were much more palatable within "modern" psychiatry than those unable to bear the burden of at-home care.[10] Whereas public spaces in the hospital were undergoing dramatic aesthetic and material transformations, to my knowledge, the closed wards did not benefit from the NMHP grant money. The closed wards were spaces of low visibility. The beds were arranged dormitory style and a strong smell of urine and disinfectant mingled together. For the women living in the closed wards (I did not visit the men's wards during my fieldwork), the days were punctuated by meals and medication, and in between, the wards were locked. On sunny days, sometimes the women were allowed to sit on the grass outside the ward for a few minutes before their midday meal. The contrast between the darkened, closed wards, located in the hospital's innards, and the brightly lit, "bureaucratized" outer space of the faculty block was a part of the increasingly disjointed structure of the hospital in an era of community care in India.

Despite once being the primary site of psychiatric practice and knowledge making, the closed wards remained sites of treatment, but were not incorporated into the research and training priorities of the "Centre of Excellence." While there were spirited interactions in the closed wards between female patients, between "wardens" and patients (this custodial language was still in place in the hospital), and occasionally between patients and visiting kin or MSF counselors, doctor–patient relations were generally rare. Many of the senior psychiatrists avoided visiting the closed wards altogether, letting the junior residents make occasional visits only when there was a medical emergency. The lack of attention became astonishingly clear to me when, while browsing some of the long-term patients' medical files, I noticed pages and pages of the notation, "CST" (Continue Same Treatment), followed by a physician's signature. In some cases, the "CST" notations went on for months. When I asked one of the residents who had signed the files about this, he blushed and said that he had not felt the need to go to the wards himself—and none of his supervisors expected that of him. The assumption in "continuing same treatment" was that patients in the wards were beyond well-being, so their treatment required no change. Their daily needs were taken care of by nurses who dispensed medicines. By contrast, the Family Ward (for short-term stays) and Outpatient Department were crowded with senior doctors, residents, interns, and kin, the latter staying in the hospital for the course of treatment. Medical anthropologists have shown how short-term wards are thick with kin and social life, rather than abandonment (Pinto, 2014), in contrast to the monotony of life in the long-term wards. It appeared that the psychiatrists distanced themselves from the chronically mentally ill and the spaces they inhabited, perhaps because

these individuals reminded them of a ''backward'' custodial model of psychiatry, which they wanted to locate in the past.

In their everyday practice, hospital psychiatrists expressed little hope that the long-term patients would show any improvement and were surprised when it did happen. During my fieldwork, Mumtaz, a highly articulate 19-year-old female patient who had been diagnosed with paranoid schizophrenia, made a complete recovery and was discharged from the hospital. When her family refused to collect her on the day she was discharged, Mumtaz filed and eventually won a case for legal emancipation. The doctors who were dealing with Mumtaz's case were surprised, but took her case to be a miracle rather than an example of what was possible for the long-term, chronically ill. Mumtaz's case illustrated how doctors viewed severely mentally ill patients as beyond hope or recovery.

Current legal reform efforts around public mental health institutions do not make any concrete accommodations for individuals like Mumtaz. Thus far, in debates around the Mental Health Care Bill (2013), the chronically ill and those residing in institutions emerge only through legal concerns around autonomy and choice. A heated debate between Davar and Patel, for example, centers on questions of informed consent, namely, the capacity of severely mentally ill persons to make voluntary decisions to receive healthcare interventions (Davar, 2012; Patel, 2013). While establishing a legal framework that balances the right to receive care and the right to choose is extremely important for chronically ill patients, this discussion brackets rather than resolves questions that Mumtaz's case makes manifest, such as the role of the family beyond the moment of consenting to treatment. Within the current legal framework and in debates around the Bill, questions about care are restricted to the moment of in-patient admission.[11] As Mumtaz's case clearly shows, however, the question of voluntary or involuntary admission is not the only kind of abuse that severely ill patients are subjected to, and at the moment, legal reforms do not address the problem of family/community structures or the social context of mental illness. For example, while Mumtaz's confinement may be read as a form of discipline, it is also a ''crisis of dependency'' (Pinto, 2011, p. 8), raising questions about who in these networks will care for Mumtaz and how, as a young, female subject, she is always constructed as a dependent. Further, the experiences of chronically ill patients in custodial conditions demonstrate the limits of Patel's assertion that those in need of care should willingly suspend their autonomy in favor of ''a responsive medical system'' (Patel, 2013). This argument assumes an equivalence between access and care and locates abandonment as a problem of the family, rather than considering how institutions might unintentionally perpetuate abandonment—regardless of whether or not a person chooses to be there.

Efforts to ''modernize'' institutions were also limited by stigma in the hospital; interestingly, this stigma was not just perpetuated by patients and kin, but by mental health professionals themselves. While I had access to the closed wards, I befriended two female ''wardens'' who were in charge of the female ward. One of them, a recent divorcee, was flirtatious and wore shockingly bright red lipstick,

which created a stark contrast with her black headscarf. I heard some of the male resident doctors joke that she was "suffering from mania" and "should be admitted to the ward as a patient." This was a reference to one of the long-term patients in the ward who had also been diagnosed as manic and would reportedly "roam around" her village and surrounding areas without the accompaniment of kin. It was not clear to me whether doctors thought that the warden had transmitted mania to the patient, or vice versa. Yet this casual discourse, along with the more formal, selective implementation of modernization efforts reinforced the idea that madness needed to be contained (Chua, 2012; Jenkins & Carpenter-Song, 2008; Pinto, 2011). Thus, in contrast to official state decrees that "prison-like gate enclosures must be removed" and "cells must be abolished" (NHRC, 1999), the everyday language of doctors suggested the persistence among psychiatrists and hospital staff of the idea that the severely ill were contagious and needed to be quarantined. Thus, while some patients were considered the appropriate subjects of modern, psychiatric care, others, particularly women who demonstrated an unregulated or dangerous sexuality, were not.

As anthropologists of South Asia have described, this sense of contagion and madness-by-association that both psychiatrists and patients experience may emerge from a particularly South Asian sense of self as permeable to the moral qualities of others (Daniel, 1984, p. 8).[12] That psychiatric residents espoused this idea was significant as, in arguments for mental health reform, patients, families, and communities—never experts themselves—are seen as the conduits for "backward" or stigmatizing attitudes around mental health (Jain & Jadhav, 2009). As the example above demonstrates, stigma was not only perpetuated by patients and their families, to be beaten out by progressive doctors, but rather, also marked the way doctors viewed their patients and determined which subjects were worthy of their care and attention. It was thus ironic that the very experts charged with conducting "anti stigma interventions" within current reforms were themselves the conduits of prejudice (Mehta & Thornicroft, 2014, p. 411). Despite conscious efforts and commitments to modernize hospitals, psychiatrists and other mental health experts were influenced by cultural discourses around the contagion of severe mental illness; thus, the logic of keeping the mad "away" was left intact in the course of reforms.

Focusing on the closed wards and the chronically ill who reside in public mental health institutions reveals the limits of thinking of care and abandonment as opposed concepts—as current mental health reforms (and Foucauldian critiques of institutions) do (cf. Pinto, 2014). Instead, the case of Mumtaz reveals the complex relationship between ideas of accessing treatment, care, abandonment, institutions, and the family. In arguing that mental health reforms effectively split the institution, I am not claiming that this is a straightforward enactment of Foucauldian biopolitics—of regulating and measuring some lives, while excluding others. Though the attempt is to forget about the chronically ill, they cannot be completely excluded from institutions; they are already a part of them. As Sarah Pinto, Jocelyn Chua, and other medical anthropologists working in South Asia

have argued, fields of medical power and authority in India and people's habitations of them are seldom complete or seamless (Chua, 2014; Pinto, 2014, p. 26). In the case of Mumtaz, for example, rather than moving from care to abandonment, we see how she is caught in between her own desire, her family, medical institutions, and the law. Thus, rather than read these reforms as only "enforcing visions of normative subjects" (Pinto, 2014, pp. 26–27), we see how such visions fall short because of particular internal tensions within modernization efforts and the practices of Indian psychiatry. For the chronically ill, being increasingly out of legislative and professional view means paradoxically having to incur the discursive and disciplinary power of the state health system in a direct way.[13]

The dilemmas of building manpower

Reforms aimed at "modernizing" hospitals in India were implemented selectively and reveal psychiatry and mental hospitals as shifting epistemological and ontological forms. Although the reforms were intended to address human rights and humanitarian concerns around asylums, these concerns were occluded by the desire to build specialized psychiatric manpower. In this section, I explore the desire to increase manpower in some detail, particularly because it reveals another internal tension within reform efforts, namely, how two competing, contradictory visions for the expansion of mental health expertise came into conflict. As I have shown, the NMHP and the psychiatrists whom I interviewed in Kashmir were both committed to increasing specialized psychiatric manpower by transforming and modernizing psychiatric hospitals into "Centres of Excellence." By contrast, the MGMH and WHO advocated for training non-specialized medical workers to diagnose and treat mental disorders at the Primary Health Centre (PHC) or district level, a process I term the democratization of expertise. These latter recommendations were incorporated into the National Mental Health Programme (NMHP) and the District Mental Health Programme (DMHP), yet as I argue, "Centres of Excellence" and democratizing expertise are radically different.

The DMHP mandates developing decentralized training programs for health personnel and providing essential psychiatric drugs (Isaac, 1988), to allow for the early detection and treatment of mental disorders at the PHC level, one of the recommendations of the landmark 2001 World Mental Health Report (WHO, 2001, p. 91). Under the DMHP, doctors with MBBS degrees (Bachelor in Medicine, Bachelor in Surgery) are trained in basic psychiatry over a three-month period. The psychiatrists I interviewed, however, questioned opening up prescription and diagnostic practices to non-psychiatric professionals. One psychiatrist argued that rather than being a form of democratization, as was intended, the DMHP trainings only exacerbated existing social inequalities, since those who were targeted for the program were doctors with Bachelors (MBBS) degrees, who were at the bottom of the medical hierarchy. Psychiatrists viewed doctors with MBBS degrees derogatorily as "village doctors," whereas those who aspired to advanced degrees in psychiatry were typically from the urban middle-class. As

one psychiatrist resident put it, ''An MBBS degree is like a high school degree. It means nothing.'' Psychiatrists also questioned the ability of non-specialists at the primary care level to correctly diagnose and treat mental disorders, which, they argued, were difficult to identify even for those with years of training. By contrast, MGMH advocates and public health officials argued that this was necessary for the delivery of community-based care.

In order to explain this difference, we need to better understand the motivations of different stakeholders in undertaking reforms. Psychiatrists supported efforts to remake psychiatry away from a custodial model of care towards a research and scientifically-based enterprise—after all, they were the ones who applied for the ''Centre of Excellence'' grant in the first place. For them, the ''Centre of Excellence'' grant was an opportunity to make mental health care—and themselves—more mainstream within India's pluralistic health system (Varma, 2012). Their aversion to democratizing expertise comes from the fact that psychiatrists and other mental health professionals remain on the margins of people's help-seeking behaviors (Basu, 2009; Nunley, 1996). During my fieldwork, almost every patient I interviewed said that they had visited one or numerous religious healers (*pirs*) before entering a psychiatrist's office, and many continued to visit *pirs* during their medical treatment, despite the advice of psychiatrists to the contrary. The paradoxical position that psychiatrists occupy—increasingly visible through national and transnational reform efforts but marginal in everyday practice—helps explain their reluctance towards the democratization model, which they read as a dilution of their own expertise. Instead, they preferred a vision of reform that entailed shoring up psychiatry as a modern discipline based on outpatient, pharmacological, and ''evidence-based'' treatment.

Conclusion

This article shows the need for a grounded, ethnographic approach to understanding the impact of ongoing reforms to India's mental health system. The case study of a mental hospital in Kashmir shows that forms of custodial care and chronically ill patients were glossed as belonging to the past and reform efforts were redirected towards making psychiatry a more scientific, modern, and attractive discipline.

However, plans to modernize and expand access to mental health care through these techniques are based on the assumption that *access* to biomedical services will smoothly translate into *care*. This assumption obscures the reality of chronically ill patients who reside in mental institutions, and who continue to be marginalized by reform efforts. For these patients, problems of access or issues of informed consent are only one concern among many; they also confront marginalization within institutions due to the persistence of stigma, receive a consistently low quality of care, and may not have a willing—or able—family or community support system to which to return, issues which the current reforms do not address. This begs the question: what do we do with those who are ineligible for community-based care?

What should care within institutions look like for those who may have to reside in them long term? At the moment, the rush to make mental health care more ''feasible, affordable and acceptable'' (Patel, 2007, p. 87) depends on the selective exclusion of the chronically ill, who continue to live in inhumane conditions inside custodial-like institutions, with even fewer resources than before. In this sense, the asylum is not an archaic figment of people's imagination or an example of continued ''stigma,'' but continues to be a shadowy part of the new ''Centre of Excellence.''

Rather than improving the quality of care for the chronically ill, reform efforts have been directed towards generating more manpower. However, the aim of skilling up ''peripheral health workers'' (WHO, 1975), espoused by the MGMH, WHO, and the DMHP, fails to take into account the impediments to this approach, including psychiatrists themselves. Given that psychiatrists occupy marginal positions within India's pluralistic health system, they reject what they view as the further dissolving of their precarious expertise. In this sense, the goal of ''skilling up''—that is, of increasing access to non-institutional care—is directly in tension with other parts of the NMHP, which advocate rejuvenating institutions.

The unevenness of modernization efforts became clear to me when, during the rapid transformations of the hospital into a ''Center of Excellence,'' a small tombstone appeared at the edge of the new Library block and landscaped lawn. When I asked the hospital's clinical psychologist about the grave, she said that a patient from the closed male ward had recently died and no one had claimed his body. The tombstone represented a trace of the asylum that persisted within the hospital grounds, despite the frenetic reform efforts underway. It was also a gnawing reminder of more graves to come, given that the closed wards were full of men and women who had been placed there for the foreseeable future. The grave marked the inability of the hospital to transition smoothly to a ''Centre of Excellence,'' while being unable—and unwilling—to contend with its history as an ''asylum.'' In these busy times for mental health reform across India, this article is a reminder that more care and attention is needed for those for whom community-based care may not be a viable option. Reforms of mental hospitals in India cannot be restricted to spaces where outpatient care occurs and they should not depend on simply moving severely ill patients to less visible custodial settings. Instead, we need to think seriously what it means to live in closed wards and work toward more habitable and humane alternatives.

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Notes

1. A number of news outlets cited that 28 inmates perished in the fire, while others place the number of casualties at 25. There is also discrepancy in the scholarly literature (cf. Bearak, 2001; Davar & Lohokare, 2009; Krishnakumar, 2001; Sébastia, 2007).
2. While I cannot fully elaborate on the consequences of the shift to ''evidence-based'' medicine within global mental health here, scholars have shown how this process elevates the clinical trial over other forms of evidence. Scholars writing about evidence-based medicine have argued that such efforts are crucial in professionalizing and legitimating medical practices, for example, through generating guidelines to ensure accountability and consistency between different practitioners (Timmermans & Berg, 2003).
3. I use Kashmir as a shorthand to refer to the geographical region of the Kashmir valley, currently under Indian administrative and military control. From 1988–2002, the Kashmir valley was embroiled in an armed struggle for *azadi* or independence from the Indian state. Since the Kashmir valley is under Indian administrative and military control, for the purposes of this paper, I understand the psychiatric hospital and the effects of mental health reforms as within the framework of Indian national, public health reforms. However, the majority of Kashmiris continue to support *azadi* and view Indian control as an illegal military occupation (Kak, 2011). As such, including Kashmir within the ambit of Indian national reforms is not a political endorsement of Kashmir's place within the Indian nation-state.
4. Although Goel (2011) argues that the modernization of the 36 mental hospitals was linked to ''innovative strategies for dealing with the problem of long-stay patients,'' I found no ethnographic evidence for this statement in the context of the hospital in Kashmir. Instead, I found the argument for modernization justified by the need to generate more psychiatric manpower to be much more salient.
5. In 1975, in order to respond to chronic shortages in trained manpower in the developing world, the Expert Committee on Mental Health of the WHO recommended an increased role for ''nonspecialized health workers. . .working in collaboration with, and supported by, more specialized personnel.'' As if anticipating reluctance on the part of psychiatrists, the recommendations noted: ''This will require changes in the roles and training of both general health workers and mental health professionals'' (WHO, 1975, p. 33).
6. This fieldwork was approved by Cornell University's Institutional Review Board (IRB).
7. A crore is equivalent to 10 million rupees.
8. As the site of a long-term conflict, mental health care in Kashmir has also been shaped by transnational humanitarian psychiatry. From 2001–2012, Médecins sans Frontières (MSF) provided counseling at the Psychiatric Diseases hospital. While the goals of

MGMH and humanitarian psychiatry are distinct, both support the turn to the community as a site of care and advocate increasing awareness and education efforts around mental health. However, humanitarian psychiatry responds to specific emergencies whereas the MGMH attempts to address structural inequalities.

9. According to a 2005 report on mental health conducted by the WHO, there are about 0.2 psychiatrists per 100,000 people in India, significantly lower than the global average of 4.15 psychiatrists for 100,000 people (Kapur, 2004).
10. Scholars writing about the US have also expressed concerns that community-based care does not adequately address the needs of the two million chronically mentally ill (Shadish, Lurigio, & Lewis, 1989, p. 1).
11. The Mental Health Care Bill proposes setting up a Mental Health Review Commission that will regulate admission and discharge, deal with violation of rights, and thus prohibit the pervasive culture of exploitation, neglect, and abuse of human rights. However, it is not clear how those who are chronically ill might access this Review Commission.
12. Anthropologists of South Asia have argued that in some communities, all things are perceived to be constituted of fluid substances, which are in perpetual flux and have the capacity to separate and mix with other substances (Marriott & Inden, 1977; Lamb, 2000). Thus it is possible or inevitable for persons to establish inter-substantial relationships with other people and the places they live. While this work has focused on Hindu communities, the idea of fluid or substantially interpenetrative selves is also foundational to Unani medicine (Zimmerman, 1978).
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