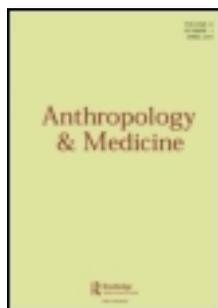


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### Ignorance and utilization: mental health care outside the purview of the Indian state

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## **Ignorance and utilization: mental health care outside the purview of the Indian state**

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The paper discusses different positions by psychiatrists and anthropologists taken towards 'folk' mental health care and summarizes what has been said in favour of the folk sector. Further, examples indicating a changing relationship between the Indian state and the folk sector are outlined, including the impacts of the fire tragedy at the dargah of Erwadi in 2001. On this basis it is argued that a prevailing ignorance of the folk sector has provided it with some autonomy, while at the same time, recent attempts at collaboration tend to utilize folk practitioners rather than valuing their positive elements in their own right.

**Keywords:** beliefs; mental health in low income nations; name of country/region of field work; medical anthropology; psychiatry

### **Introduction**

Anthropological studies of mental health in India often differentiate between three realms of treatment: 'folk' therapies (faith, local, symbolic, ritual or religious healing practices), the learned or codified traditions (Ayurveda, Unani, and Siddha), and bio-medicine (allopathy, modern, English or Western medicine; Fabrega 2009, 662–3; Halliburton 2009, 42 and 118; see Sébastia 2009a, 8–20). The borders between these realms are fuzzy given that there are practitioners who combine and fuse different therapeutic approaches (see Connor and Samuel 2001). Further, many scholars emphasize that such differentiations are of little relevance to the people who look for relief from their problems. Finally, besides the important but difficult question concerning the different therapeutic powers of these three heterogeneous realms, there are asymmetries as well as prejudgements with respect to their epistemological foundation (religion vs. science), their degree of medical competence in combination with social, cultural and economic capital (folk vs. professional), their applicability (local vs. universal), their primary means of efficacy (faith, ritual and symbols vs. materia medica), their stage in history (traditional vs. modern) and their colonial legacy (East vs. West).

This paper suggests shifting the focus towards the institutional and legal context of the various ways people deal with mental health problems (in India). The aim is to emphasize and discuss the differences, hierarchies and relationships between (1) practices recognized, supported and controlled by the Indian state (such as hospitals, clinics, private practices and universities) compared with (2) the ways of

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dealing with mental health problems outside the purview of state, i.e. practices for which (so far) no specific laws, educational system, financial support or forms of state control exist (the extremely important role of mental health care within families is not discussed here). Against the labelling of medical traditions such as Ayurveda as 'complementary' and 'alternative' to the official (bio)medical system, as in many Western societies, the respective fault-lines are drawn differently in India, especially after the establishment of the department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) in the Ministry of Health & Family Welfare in March, 1995. The group outside the purview of the Indian state is labelled here – for a lack of better alternative – the folk sector. 'Folk' is used as an umbrella term for a set of quite heterogeneous practices. The places where they are applied are often referred to in the literature as Traditional Healing Centres (THCs), a term that includes private homes as well as public treatment centres of healers, astrologers, tantriks, and oracles; or those vaidyas, hakims and gurus treating in their communities without official recognition from the Indian state; or religious specialists practicing at Hindu temples, Muslim dargahs, and Christian churches. Countless THCs are regional, while others are national centres. Amongst the most famous are the Hindu temple 'Balaji' in Rajasthan (see Dwyer 2003; Kakar 1982/2006, 54–88; Pakaslahti 1998, 2005, 2009), the Muslim Mira Datar Dargah in Gujarat (see Basu 2009 and Pfeleiderer 2006), and the Catholic shrine of Puliampatti in Tamil Nadu (see Sébastia 2007, 2009b).

It is important to add that the concept of 'mental health' is not regularly applied in the folk sector. To give but one example, William Sax describes how people approach oracles and gurus, often as a result of tension and strife within the family, which lead to severe physical and psychological problems (see Sax 2009, 136). Sax highlights that although the central concerns of the oracles and gurus are to diagnose and remove the causes of such problems, illness and healing are not the exclusive focus of the cult. The oracles also deal with financial problems, runaway children, runs of bad luck, family problems, and so forth (see Sax 2009, 54). As it would be wrong to reduce all the practices within the folk sector to mental health care, this paper argues that it is equally problematic to ignore their important contributions to mental health care in India (e.g. Halliburton 2004, 2009, 98; Pakaslahti 2008, 159; Raguram et al. 2002; Sax 2009, 135–64).

The main argument of this paper is based on a review of the literature, primarily from (cultural) psychiatry and (medical) anthropology as well as on empirical research by the author.<sup>1</sup> The paper begins with a brief overview of mental health care in India and argues that the quantitative as well as qualitative importance of the folk sector is often ignored by studies and descriptions of mental health care in India. In the second half of the paper, the significance of the Erwadi fire tragedy is outlined as exemplary of the growing interest among representatives of the Indian state mental health professionals, the media and the general public discourse on the folk sector. The final section of the paper focuses on interrelations between various approaches taken towards the role of folk therapies. These can be labelled ignorance, abolition, utilization and collaboration. The first aim is to show that the prevailing form of ignorance exhibited by authorities of the Indian state brought with it a degree of autonomy for folk practitioners from certain legal and other control mechanisms of the state (with all their positive and negative implications). The second aim is to outline why some of the current approaches towards collaboration

are actually forms of utilization and are likely to result in the abolition of some of the positive elements specific to the folk sector.

### **Ignorance of the folk sector**

Mental health care in general has not been a major focus of the Indian Ministry of Health thus far. The mental health care sector under the control of the Indian state has been criticized from various sides over the last few centuries.<sup>2</sup> The main facts and figures about the number of psychiatrists, hospitals, beds, etc. in India as opposed to other countries in the world are available in the *Mental Health Atlas 2005* of the WHO. Yet, it is important to note that all the facts and figures listed in such overviews take only some aspects of mental health care in India (and in other countries for that matter)<sup>3</sup> into account.

Most of the publications on mental health care in India give the impression that if there are no hospitals, psychiatrists or NGOs, people with mental health problems have nowhere to go. Murthy – to give but one example – mentions ‘the great variety of community care alternatives’ but refers only to ‘day care centres, half-way homes, long-stay homes, suicide prevention and school mental health programmes’ in his discussion (Murthy 2004a, 64). He does not discuss or even refer to the realm outside the purview of the Indian state and its mental health professionals (cf. Murthy 2008, 80), which, nonetheless, makes a major contribution to community-based resources for the people.

This ignorance is striking given that there are a few exceptional studies that highlight the significance of the therapeutic alternatives to the mainstream medical system. The Indian psychiatrist Neki estimated in 1973 that around 80% of the Indian population approaches folk practitioners and THCs for treatment of mental health problems (see Pakaslahti 1998, 129). This figure has been subsequently confirmed by various other studies (see Campion & Bhugra 1997, 215; De Sousa and De Sousa 1984a, 6; and Shah 1984, 737). The Finnish psychiatrist Pakaslahti (1998, 129) writes:

Most developing countries have a network of non-Western traditional health practitioners operating outside the modern official health care system, often unknown to health professionals. In fact, such local healing systems provide the vast majority of care and support for those who suffer from mental health and substance dependence problems.

Finally, the psychiatrist Kapur (2004, 92) concludes his study of three communities in the Kanara district of Karnataka with the observation that ‘the abundant community-based resources of the traditional mould, which still continue to flourish and which have been regarded as ineffective or indeed harmful without sufficient exploration and systematic examination, are being ignored’.

### **Different evaluations of the folk sector**

Besides the need for a greater awareness of the quantitative relevance of the folk mental health care sector, there is further the question how the quality of its therapeutic methods is to be evaluated. A review of the books of Indian psychiatrists as well as their publications in the major national and international journals reveals that those few studies that assess the folk sector in India can be separated into

three groups. The first group implicitly or explicitly aims at the abolishment of folk therapies. One example for this position is given by the psychiatrist Shah, who writes that folk practices are prevalent on account of 'illiteracy' and 'blind faith' (see also Hakim 1969/2008, 117; Shah 1984, 748; and Sharma 2008, 83).

Most such statements follow along the lines of the asymmetrical oppositions outlined above (modernity vs. tradition, local vs. universal, etc), where the diverse and heterogeneous realm of the folk sector is generally associated with superstition, illiteracy and blind faith and thereby implicitly characterized not only as ineffective and invalid, but often also as harmful.

A second group of scholars may be critical or even hostile to such practices, but at the same time, acknowledges the advantages of using the folk healers as means to the end of spreading psychiatry. For example, De Sousa and De Sousa oppose 'education and rationality' to 'religion and irrationality', and see the latter as contributing 'directly to the causation of psychiatric disorders as seen in hysterical disorders characterized by the "Devi Syndrome" or "Possession Syndrome"' (De Sousa and De Sousa 1984a, 3). On the other hand they note – referring positively to the position of Kapur – that psychiatrists could also 'utilize traditional healers to bring patients for treatment' (De Sousa and De Sousa 1984b, 16).

However, the way in which Kapur aims at utilizing folk therapies is shaped by a deep respect for their knowledge and practices. To the lines quoted by De Sousa and De Sousa, Kapur adds that psychiatrists 'must learn to work *with* traditional healers, and make no effort to shake the beliefs of the public but rather utilize these beliefs *to bring home new knowledge* (De Sousa and De Sousa 1984b, 16, emphasis added). Accordingly, one could take Kapur's position as characteristic for the third group of scholars who aim at collaboration rather than utilization.

The classification of scholars into one of these three groups is not always clear and varies according to what kinds of practices are subsumed under the umbrella term 'folk'. There are, for example, a couple of Indian psychiatrists who studied THC's and engaged with the folk sector, especially between 1960 and 1985, such as Neki (1973a, 1973b, 1974, 1975); Meha (1984); Satija and Nathawat (1984); Satija et al. (1982); Sethi (1977); Trivedi (1979a; 1979b); as well as Wig and Akhtar (1974). Although these psychiatrists are generally quite open towards the folk sector, Sébastia argues that their attempts might not correspond to the needs of patients who frequent THC's (2009a, 7; 2009c). Further, their general position still differs from the position taken by psychiatrists such as Kapur. Sébastia states that in the work of these psychiatrists, 'folk healers' therapies are quite often deemed irrational and non-scientific' while Kapur recognized 'that the priests, the sorcerer, and the exorcist can be very effective in helping patients with particular kinds of disorder' (Sébastien 2009a, 12).<sup>4</sup>

The lifelong interest and openness of Kapur towards the folk sector is somewhat exceptional in this respect. He pointed out more than three decades ago the importance of taking folk therapies seriously in the context of mental health care plans and policy making. He considers it unfortunate that mental health care plans are being put forward without sufficient knowledge of the existing patterns of mental health care in Indian villages. At the same time, he argues that '[s]ocial anthropologists never tire in warning health officials that welfare schemes cannot be thrust down the throats of people willy nilly' (see also Champion and Bhugra 1997 and Fabrega 2009, 166–7; Kapur 1975, 287). This raises the question of how

other scholars such as social anthropologists evaluate the quality of folk therapies in India.

### **Positive aspects of the folk sector**

Besides the work of Kapur there are many more studies of the folk sector that are positive or at least sympathetic to the therapeutic offers made there. Many of these were written by (medical) anthropologists. This greater quantity might be due to the fact that such practices are a classical anthropological field of study and often require ethnographic fieldwork.<sup>5</sup> The difference in assessment might be to some degree related to disciplinary differences between the social and medical sciences (see, for India, Fabrega 2009, 166 and 612) but are surely also shaped to a considerable degree by the private ideological convictions of the respective scholars. The aim here, however, is not to oppose scientific traditions. The aim is rather to highlight the positive characteristics attributed to folk therapies in empirical studies on two grounds. First, the intention is to counter the largely negative portrayal of such practices as merely backward, harmful and superstitious. Secondly, the following list indicates the nature of positive elements that can be lost if the folk sector is not valued in its own right but abolished, or merely utilized as an outreach programme for the psychiatric system. A very important note of caution is crucial here. The following list only focuses on the various arguments that have been presented in favour of the folk sector. This, of course, does not mean that a similar list with negative aspects cannot also be made.

As stated in the literature, folk therapies can be (a) easily accessible and usually (b) affordable (two factors that already rule out often psychological alternatives, even if preferred). In addition, the fact that (c) patients, healers, and the wider community share the same cultural values is very often emphasized in the literature. Framing peoples' distress within a shared 'language' makes it recognizable to the sufferers and facilitates their gaining personal control over the situation. These factors are presented as central to the process of healing in the folk sector. Further, there is the often-repeated claim that (d) patients are never alone but that family and community, and if necessary the ancestors, are included in the healing process.<sup>6</sup> It is not only the physical and psychological, but (e) also the social and spiritual aspects of life that are considered by the patients to be in need of 'healing'. The social aspect is further emphasized by the claim that (f) patients and their families are helped to rebuild social bonds and are protected against discriminatory attitudes and rejection, and (g) sufferers are re-integrated into the community after successful treatment. As a further positive factor, (h) the lack of stigma, guilt or shame is listed. (People are not labelled as 'ill' especially if the problem is not seen as within and caused by the person, but coming from outside). It is also said that healing sites (usually temples and dargahs) are often visited (i) based on voluntarism and choice, which is connected to the open spaces and non-threatening environment of such locations. In general the 'space' and 'architecture' of THC's is said to (j) have a supportive character and a positive atmosphere – normally associated with its proximity to nature and the associated religious and spiritual implications. They are also therefore described as (k) aesthetically attractive, featuring music, smells, tactile and kinesthetic experiences, and visually engaging settings. The religious and spiritual aspects are also central to the people who heal or facilitate healing by performance of

religious rituals. The ‘presence of the divine’ often implies that (l) nothing is seen as incurable and nobody is turned away. In fact, all this in combination with rumours and legends about miraculous curing leads to (m) a very strong degree of hope and faith on the side of the patients and care takers.

Obviously this is a condensed and abbreviated conglomeration of arguments found in the literature.<sup>7</sup> The folk sector is diverse and heterogeneous and therefore not all the characteristics listed here are necessarily found in each THC! Further, the respective folk practices and places can have many negative characteristics as well (such as the lack of privacy, violence, the reproduction of local hierarchies, inappropriate treatment, delay of other treatment, and many more).

One characteristic of particular importance is that in the realm of folk therapies, the sufferers, healers and the wider community usually share the same way of life, the same worldview. When a healer diagnoses a person’s suffering in cultural or religious terms that are familiar to him or her, then this diagnosis is socially meaningful to everyone concerned. As Leslie (1992, 205) said of Ayurveda: ‘a way of life is at stake in their interpretation of illnesses, and not just a set of medical practices’. Above it was argued that only a few representatives of the Indian psychiatric system have acknowledged such positive aspects of folk therapies. A similar point is made by Sébastia when she elaborates upon her distinction between ‘codified’ and ‘folk’ therapies (Sébastien 2009, 7). In the following, the paper engages with the factors that led to the increased engagement of the Indian state and its mental health professionals in the folk sector in recent years.

### **Erwadi and after**

The Erwadi dargah is located in Ramanathapuram district in Tamil Nadu. According to the dargah committee manager, about 1000 pilgrims, belonging to different religious groups, visited the dargah every day until the early 1990s. Since then the flow of cure-seekers increased, and ‘private nursing homes’ or ‘asylums’ for people with mental health problems were built outside the dargah to take care of them.<sup>8</sup> On August 6, 2001 a fire broke out in these asylums and between 25 to 30 people (the figures vary in the literature) died because most of them were chained and could not escape.<sup>9</sup>

In the Indian history of mental health care, the Erwadi tragedy is a landmark event for two reasons. First, the representatives of the state connected to mental health care were, for the first time, forced to deal with the folk sector. Secondly, human rights activism began to gain momentum in the field of mental health care. Both factors led to policy debates on human rights regarding the mental health care sector under the purview of the Indian state as well as the folk sector. On the side of the state, the most prominent reaction was a *suo moto* action taken by the Supreme Court against all the state governments of India for the non-implementation of the Mental Health Act (*Writ Petition Civil No. 334 of 2001*). Following on from this, the closure of all unlicensed mental asylums in the country was ordered. The Supreme Court further ruled that there should be at least one mental hospital per state and that their services should be improved. A Human Rights Commission came up with 19 recommendations including penal action against mental homes operating without a licence, which includes practically all THCs.<sup>10</sup>

A decade after the tragedy, most of these recommendations had not been implemented. Yet, the fact that more action was announced in the wake of the Erwadi incident than finally undertaken should not lead to an under-estimation of the changes initiated by the recognition of the tragedy. The consequences resulting from the involvement of the media, as well as legal and political actions, did have repercussions on the folk sector.

Kevin Cremin visited Erwadi in 2007 and reported that the dargah was still used as a site of pilgrimage, as well as an asylum for people with mental health problems. He was told, 'no one is ever turned away' and that – describing the situation before the fire – 'at night some 1,000 people gather to take part in the ceremonies and/or to become healed' (Cremin 2007, 11; see also Padmavati, Thara, and Corin 2005). On the other hand, Cremin reported that, administrators stated that there were no longer any makeshift shelters or asylums in the town. They further explained to him that rich people stay in nearby guesthouses and that the poor people tend to stay on the grounds of the dargah (see Cremin 2007, 11).

Visits to THCs by the author confirmed that trustees and other officials at such places were aware of the insecure legal situation and the public critique, and many THCs reacted accordingly. The same results were gathered by a group of researchers from Bapu Trust, Pune (D. Dandekar, B. Davar, and M. Lohokare), who conducted a study of 22 THCs in Maharashtra (see Davar and Lohokare 2009; Sébastia 2009b, 190). Some THCs were closed by the state governments for not having the necessary authorization, some THCs came up with sign-boards to distance themselves from practices associated with folk therapies, so as to be on the safe side should they be accused of offering unlicensed mental health care. In reaction to direct legal threats, some have forbidden the chaining or restraining of people within their premises, while others have stopped offering most of their therapeutic practices, or have stopped providing shelter for health-seekers altogether.

A further influential factor is that the wider media became interested in the folk sector in the wake of the Erwadi tragedy; the first reports on the situation of mental health care with a special focus on the situation in THCs were produced (Basu 2009; see Sharma 2003). Such media activities were supported by some people working in the field of human rights and mental health, while others were critical about the consequences of such practices. The general concern among mental health activists was that such public 'exposures' by the press failed to discuss the positive aspects of folk therapies. To give but one example: as a result of negative press coverage by NDTV (on 6 August 2007), the authorities of the Langar Houz Dargah have stopped providing night shelter for help-seekers who come to the dargah. Such criminalization of the whole sector does not provide alternatives to the people suffering from mental health problems. It often results in the abolition of such practices or forces them to 'go underground', thereby reducing the social control that is a natural outcome of their being embedded within local communities.

### **Engagement with the folk sector**

The fire at Erwadi was only one element that shaped the changes in the relationship between the Indian state, its mental health professionals and the mental health care sector so far not under the state's purview. Besides the Erwadi tragedy, factors such as the increasing importance given to mental health care by international health

organizations contributed to recent mental health policy shifts within India (Saxena and Tharyan 2003). In a further sign of changing policies the 'Convention on the Rights of Persons with Disabilities' was signed and ratified by India in 2007.<sup>11</sup> Given that the Supreme Court asked states to take action with respect to folk therapies, Karnataka and Gujarat developed their own approaches. Various states have debated specific laws to regulate the folk sector. In Tamil Nadu, the implementation of an 'anti-quackery act' is publicly demanded (see *The Hindu*, 13 June 2010) while in Maharashtra a similar 'anti-superstition bill' was passed by the *Vidhan Sabha* (Legislative Assembly) in 2005.<sup>12</sup> Finally, the government of India increased its overall budget allocated for mental health care.

The question remains, however, whether and in what ways the respective bodies will take into account the full extent of the existing mental health care infrastructure in India, by including the folk sector into their plans and by elaborating upon their strengths and weaknesses. In taking this part of the mental health care sector into consideration, one would not only follow Carstairs' and Kapur's findings from 1976 (Carstairs and Kapur 1976), but also suggestions made by the WHO 20 years later (Desjarlais et al. 1996, 51). This would be a step towards a more 'community-based' approach that has been talked about for decades but never fully implemented.<sup>13</sup> As ignorance of the various forms of folk therapy continues to decrease in importance as a valid position, the question remains as to what role is to be ascribed towards these practices within the Indian mental health care sector.

### **From ignorance to utilization**

Most national plans and policy programmes highlight the spreading 'awareness' of mental health as one of their central goals (see Saxena and Tharyan 2003, 122; Sharma 2008, 83). Above, it was indicated, however, that these plans and programmes often themselves lack an awareness of the ways in which many people actually deal with their mental health problems. The few scholars who have, for several decades, reported on their experiences and perspectives and the therapeutic practices in the folk sector highlight that people have their own mental health awareness. Kapur reports that in his study a 'very high proportion' of the respondents had consulted one healer or the other for psychiatric symptoms demonstrating a 'very realistic assessment of the patient's own condition'. Kapur therefore concludes that educating or spread of awareness 'may not be necessary' (Kapur 1975, 291).

While the folk sector experienced a degree of autonomy (with all its positive and negative implications) due to this lack of awareness, it has also been argued above that the developments after the Erwadi tragedy indicate changes in this respect. The most important aspect is that the folk sector poses a major problem to the authorities when it comes to questions of control and assurance of minimum standards and human rights. Since such practices 'are not within the purview of the [mental health] law, access to them is in no way limited by legislation' (Dhanda 2000, 56). In addition to the actions pursued by the Supreme Court, the most drastic attempt to regulate the sector was the 'anti-superstition bill' of Maharashtra with the aim to abolish the whole folk sector.

Yet, there are also other approaches towards folk therapies in the realm of mental health care that stress the goals of collaboration and integration

(see Fabrega 2009, 570–1). A major point for the positive evaluations of the practices in the folk sector is that practitioners, patients and the wider community share the same cultural values and speak the same ‘language’. It was pointed out above that when it comes to the interpretation of mental health problems, a way of life, and not just a set of medical practices, is at stake. This way of life is often very different from that of those who develop mental health care plans (see Mahal 2008 [1975], 142–3). This difference is crucially connected to the fact that, so far, the dominant paradigm of scientific and modern mental health care has largely been blind to the role of other forms of mental health care. Furthermore, for similar reasons there is the threat that attempts for collaboration may also devalue the intrinsic positive aspects of the folk sector.

Only further studies of concrete attempts of collaboration and integration will reveal whether this is possible on equal terms, given the pervasiveness of the asymmetries and prejudices underlying the opposition between folk, religious, and local practices on the one hand, and professional, scientific and universal practices on the other. Based on the list of positive elements found in the folk sector, the following questions must be raised: which of these elements are compatible with psychiatry as practiced (in India) today? To what extent are the ways of life in which the folk therapies are embedded at all compatible with the psychiatric system? To what degree are collaboration and an integration of all the existing, heterogeneous approaches possible? Or, to what degree will current developments force scholars to reiterate Fabrega’s assessment of the past, i.e. that Western psychiatry did ‘colonize India’s indigenous psychiatry’ (Fabrega 2009, 565)?

Some dilemmas that can result from attempts to incorporate the folk sector into the official medical sector have been highlighted by Asuni (1979). The statement by Sivachidambaram and his colleagues at the Institute of Mental Health, Chennai, explicates the problem central for the argument of this paper:

There is a basic conflict between the magico-religious system and ours. We are willing to accept their system, but they direct the patients not to come to us. It should not be difficult for them to ask the patients to come to us for treatment in the morning and return to pray in the evening. (Quoted in Sébastia 2009a, 7)

Such positions, according to Sébastia, reflect the objective of psychiatrists to invite folk healers ‘to collaborate, that is to say, to refer the patients with mental disorders to psychiatry’ (Sébastien 2009b, 7–8). This is a very one-sided form of collaboration given that it primarily means that the folk sector refers to psychiatry. Another example of such a one-sided form of ‘collaboration’ is the *dava aur dua* (‘medicine and prayer’) programme. This project is part of a larger study on ‘Community-based Interventions and Role of Traditional Health Practitioners’ as described in *Mental Health Care Pilots in Gujarat* (Bhat et al. 2007). It is primarily run by the NGO ‘Altruist’ in cooperation with the Sufi shrine of Mira Datar in North Gujarat.<sup>14</sup> The whole programme has been researched by the anthropologist Helene Basu who documented its first years in an ethnographic film as well as in writing (Basu 2009). The aim of the *dava aur dua* project is to train people in the folk sector ‘to identify mental health problems, provide counseling and refer appropriate cases to the closest mental health facility’ (Bhat et al. 2007, 211). Such statements disguise the underlying perspective on the folk sector: folk practitioners do not count as a ‘mental health facility’. It would be more appropriate to speak of such cases as ‘utilization’ rather than ‘collaboration’.

The question is whether such an approach results in a transformation of the folk sector, along with its practitioners, into subordinate versions of the institutionalized mental health care system. Other attempts to ‘integrate’ psychiatry into the religious sphere have been proposed for places like Erwadi (see Sébastia 2009b, 205), but it remains to be seen which direction these will take.

The future role of the folk sector within Indian mental health care is unwritten. The main challenge will be to find an answer to the question of how to recognize and value folk therapies in their own right, without ignoring malpractices and exploitation. After all, there are many good reasons why so many people suffering from mental health problems seek help from people and places that are so far not recognized, supported and controlled by the Indian state.

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Conflict of interest: none.

### Notes

1. The author conducted ethnographic research in the psychiatric wing of a private hospital in North India for ten months in 2010 and at Balaji healing temple in Mehendipur, Rajasthan together with the anthropologist William Sax and the psychologist Jan Weinhold (see Sax and Weinhold 2010). He further visited several THCs in western Maharashtra and Gujarat in 2007.
2. For critical discussions see the 1999 report *Quality Assurance in Mental Health* by the National Human Rights Commission (NHRC), and Dhanda (2000, 48–50); Agrawal et al. (2004, 114–16); Channabasavanna and Murthy (2004, 111–12).
3. For the same observation with respect to ‘low-income countries’ see Pakaslahti (2009, 149–50) and Warren et al. (1982).
4. In this context one should also highlight the work of M.V. Govindaswamy, S. Kakar, and A. Chakraborty.
5. This argument should not be understood as a criticism of psychiatrists in India who are usually neither trained, nor do they have the time or resources to explore such practices. Further, the colonial background against which Indian psychiatry emerged must be kept in mind (see Fabrega 2009, 549–671).
6. This aspect might also be good for the wider community since it happens ‘in the open, in front of everybody, posing a moral question to the community all the time’ (Davar 2006, 12).
7. See, for example, Opler (1958); Skultans (1987); Vitebsky (1993); Campion and Bhugra (1997); Pakaslahti (1998, 2005); Carrin-Bouez (1999); Dwyer (2003); and Greenough (2003); Halliburton (2004, 2009); Sax (2009); Davar (2006); Pfleiderer (2006); Sébastia (2009a, 2009b).

8. See the articles 'Deliverance in Erwadi' and 'Escape from Erwadi' in *Frontline* 18 (17, 18) 2001 (Krishnakumar 2001a, 2001b); Padmavati, Thara, and Corin (2005); and Sébastia (2007, 2009a, 3).
9. At many such places, care-givers who are not able to constantly monitor people who could pose a threat to themselves or others often have no choice but to restrain them while they are away.
10. See the article 'Prevent recurrence of Erwadi-type incidents: SC' in *The Hindu* (18 April 2002).
11. This Convention imposed new obligations on governmental and non-governmental actors to ensure that the rights of disabled are fulfilled. It recognizes the rights of disabled people to participate in their community (Article 19) as well as to equal participation in public, political (Article 29) and cultural life (Article 30).
12. The 'anti-superstition bill' is officially entitled 'The Maharashtra Eradication of Black Magic, Evil and Aghori Practices Bill, 2005'. Its implementation through the *Vidhan Parishad* (Legislative Council) of Maharashtra has yet to take place.
13. The newest 'National Health Policy' of 2002 repeats a claim concerning the necessity of decentralized mental health services that is several decades old. See Murthy (2004b, 75). See also Dhanda (2000, 54); Kapur (2004); Jain and Jadhav (2008).
14. This NGO is the implementing agency and works together with the Gujarat Foundation for Mental Health and Applied Sciences as well as the Hospital for Mental Health, Ahmadabad.

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