Journal of the Asiatic Society of Mumbai
ISSN: 0972-0766 UGC Care Group 1 Journal

PSYCHIATRIC SOCIAL WORK IN INDIA: EVOLUTION AND CURRENT STATUS

Vrushali Gaikwad

Psychiatric Social Worker, Jagruti Psychiatric Rehabilitation Centre, Pune

Chetan Diwan

Assistant Professor of Social Work, Karve Institute of Social Service, Karvenagar, Pune

Mahesh Thakur

Professor of Social Work, Karve Institute of Social Service, Karvenagar, Pune

S Chaudhury

Professor & Head, Dept of Psychiatry, Dr D Y Patil Medical College, Hospital and Research Centre, Pune

INTRODUCTION

The first perspective to explain mental illnesses was demonic perspective. The belief that mental illness is similar to physical illness and they have natural causes emerged around Graeco-Roman area, leading to trying out of medical treatments for mental illness. In 19th Century there was increased scientific enquiry into the aetiology of mental illness within medical field, though people with mental disorders were treated like deviants and were isolated from society in large custodial institutions – lunatic asylums, later known as mental hospitals (WHO, 2001). The word 'insanity' was used to mean an inability to use the faculty of reason and institutionalization became an accepted norm to 'correct' the eccentric or irrational behaviour or if not 'correctable' then to protect the society from 'insane people' (Rosen, 1968).

In the second half of the 20th century with the advancement of psychopharmacology, development of new forms of psychosocial interventions, emergence of human rights movement and incorporation of mental component into the concept of health as defined by the newly established WHO, there was a major shift in the mental health care paradigm and psychiatric medicine as a field separate from general medicine or surgery developed at an increased pace (WHO, 2001).

History of Psychiatric Social Work:

As Psychiatry emerged as a biomedical model to explain and treat a mental disorder, the need for psychiatric social work was felt and acknowledged. Psychiatric social work or rather, case work in mental health setting gained attention and importance as an important field within social work after World War I, when the Red Cross and the army requested social workers to apply casework skills to treat solders for 'shell shock' (Pierson, 2011).

A child guidance programme and a clinic to address the issues related to behavioural and mental health concerns of children was started in 1927 in Great Britain, followed by a graduate course of training in psychiatric social work (Scoville, 1942). Commonwealth Fund, while agreeing to finance the establishment of child guidance clinics in Britain, brought attention to the need for social work training in a university training. Thus, in 1929, the London School of Economics started the first course to train social science graduates with some experience of social work as Psychiatric Social Workers (PSWs). At around the same time with the objectives of promotion of mental hygiene and according professional status to psychiatric social work, the Association of Psychiatric Social Work was inaugurated. In 1994, Edinburgh University started course for PSWs, followed by Manchester University (1946) and Liverpool University (1954) (Long, 2011). By 1939, there were around 200

psychiatric social workers in Great Britain mainly employed in mental hospitals and child guidance clinics.

Just before World War II, there was a redistribution of population from the targeted areas and many schools, child guidance clinics and psychiatric hospitals in these areas were either closed or converted into emergency medical services during the war. However, psychiatric services were not redistributed along with the population with the result that when there was a critical need for such services, they were not available (ibid). Before 1940s there was limited scope for psychiatric social workers due to economic pressures though it was accepted as a profession (Courtney,1992).

However, despite these efforts to train professional PSWs, there were quite a few, mainly in psychiatric and medical profession, who believed that causes and treatment of mental illness are located in the biological sciences and therefore, sociology and social work have negligible role in the field (Sargant & Slater, 1948; Mayer-Gross, Slater & Roth, 1954).

However, gradually there was a realization that 'physical therapies' and drugs have side effects – not only physical but also on the personality of the individual and his/her interpersonal relationships. There were cases of women patients whose family life collapsed after leucotomy operation to treat 'obsessional phobic symptoms'. In many cases, the husbands left the wives because they could stand "the smiling stranger" in their house. The leucotomy operation was seen to have led to inappropriate emotional response to situations. Such observations led to two things – first, there was an effort to find alternative medical treatment; for instance, in place of leucotomy operation, tranquilizer Largactil became preferred treatment alternative, and psychiatric social workers started working with the patients not only during their hospital stay, but also once they were discharged and resumed their life at their home and community. Psychiatric social workers started focusing on helping them to function socially outside of the hospital.

One of the pioneers to develop and practice 'psychiatric social treatment' was Margaret Ferard, who was employed that time at a psychiatric hospital and worked with clients who had paranoid schizophrenia. One of the major components of her intervention consisted of identifying professional skills among her clients and helping them to build on their capabilities and find an employment once they are 'cured' (Ferard, 1947). Other psychiatric social workers such as Heimler worked on the approach developed by Ferard. Eugene Heimler created a Social Function Test that measured levels of satisfaction in the fields of family relationships, friendships, work and hobbies, sexual satisfaction and financial security.

Gradually, there was a realization that physical and social treatment were complementary rather than antithetical. Both the approaches coexisted with clearly demarcated roles. Though these earlier efforts have been criticized for the creation of the image of chronic mental patient and maintenance of traditional hierarchies, they paved way to emergence of different perspective – a social one – to understand and work on mental health and mental illness.

Medical social work was coupled with psychiatric social work in social work education programmes. Later, as the importance of preventive and promotive mental health programmes became evident, social work education institutes started educational programmes in social work in the field of mental health which covered psychiatric social work (Banerjee, cited in Francis, 2014).

Practice of psychiatric social work:

Bertha Capen Reynolds (1951) highlighted the role of social workers in upholding the human rights of all those with whom they work, including persons with mental illness –

The real choice before us as social workers is whether we are to be passive or active… shall we be content to give with one hand and withhold with the other, to build up or tear down at the same time

the strength of a person's life? Or shall we be conscious of our won part in making a profession which will stand forthrightly for human wellbeing, including the right to be an active citizen?

There have been different perspectives that have guided social work practice in mental health. One of these perspectives is the strengths model (CSWE, 2011). Strengths based practice in the field of mental health gained wide acceptance because it shifted focus from problem to strengths of an individual. It systematically assesses strengths, identifies resources in the environment, perceives the positive potentials of relationships and strives to attain specified goals. It also acknowledges that individuals have the capacity to make meaningful choices and should have the right to make the choice (ibid).

Another practice model that has that is gaining a prominent place in the field of mental health is Recovery Oriented Mental Health Practice (SAMHSA, 2006). 'Recovery' in this practice model is defined as a process in which people are able to live, work, learn and participate fully in their communities (President's New Freedom Commission on Mental Health, 2003; cited in CSWE, 2011). This model acknowledges that the exact meaning of recovery will differ for different people. For individuals with disability, it would mean ability to live a fulfilling and productive life despite a disability. For some individuals, it will imply the reduction or complete remission of symptoms (ibid).

The practice of psychiatric social work is characterized by social work functions and roles to facilitate maximum possible mental wellbeing in human beings. Thus, both aspects of psychiatric social work – assessment and interventions – are psychosocial in nature (Sahu, 2019). The biological, physiological assessment and treatment is more within the purview of psychiatrists and clinical psychologists, though psychiatric social workers need to have basic information about both. The aspects that psychiatric social work is more focused on are behavioral, emotional, interpersonal, social and environmental in nature.

One another important practice models in the field of psychiatric mental health is partnership model. It encourages social workers to work in partnership with the clients or service users. The partnership aspect of the intervention model is practiced throughout the process. During intervention it means that social workers would discuss with the clients or service users as to what should be the focus of work and decide on mutually agreed upon desired outcomes of the intervention. Once the intervention goals and objectives are mutually agreed upon, the intervention would be characterized by social workers' and client's collective efforts to enhance client's capacities and help client resolve problems (CSWE, 2008)

Psychiatric Social Work Education and Training:

Psychiatric social work education programme, within social work education, aims to prepare a cadre of social work professional in the field of psychiatry and mental health, who would be equipped with the theoretical as well as a certain level of clinical practice knowledge (which primarily deals with problems of the mind and associated disorders) and skills to work with the team of mental health professionals to understand and intervene with the social and/or environmental factors responsible for the mental health issues of people (Talwar & Singh, 2012).

Psychiatric Social Work in India:

Indian census reports have been counting the numbers of people with mental illness since pre-independence era. These reports also included suggestions for mental health services such as increasing the number of asylums and reducing the sale of intoxicants to 'at-risk' populations. Though mention of the number of people with disability can be found in 1881 government report, it was discontinued from the census of 1951, soon after Independence, and then re-introduced later. The systematic neglect and invisibility of people with mental illness that time had resulted in much lower

numbers in census data than was the case. This absence of data had detrimental effect on planning for services for the people with mental illness.

The emergence of mental health care services in India happened alongside that in the UK, i.e. after the First World War, with more responsible positions in the medical institutes and hospitals held by the Indian doctors (Mills, 2006). Advances in psychiatry and increased application of psychoanalysis in cities like Calcutta and Lahore marked an important change in the treatment of mental illnesses (Ernst, 2013). Indian Medical Gazette carried and article by Colonel Owen Berkeley-Hill in 1923 in which he proposed mental hygience movement in India and highlighted the importance of psychiatric care in settings other than mental hospitals, such as jails and educational establishment. Thus, psychiatric care and treatment expanded its scope beyond medical profession and hospital settings.

Though the census of 1955 did not include people with disability, planning authorities had included mental health care and hygiene in the Five Year Plans in India after independence. The beginning of psychiatric social work training in India can be traced to the training course that was started under the leadership of Ms. Banerjee in Sir Dorabji Tata Graduate School of Social Work, Mumbai. All India Institute of Mental Health (AIIMH) was established in Bangalore in 1954 that offered training in psychiatry, psychology and psychiatric social work.

From the initial employment of a psychiatric social worker was employed in a Child Guidance Clinic, a lot new settings such as de-addiction centres, rehabilitation centres, hospitals and community centres have opened positions for a psychiatric social worker.

Despite these early recognition of non-medical fields in mental health care and services, however, the administrative and regulatory ambit of the health care system has not given much space to fields of psychiatric social work, public advocacy and health administration (Fairburn and Patel 2014; Gopikumar et. al. 2015).

Times are changing, however. The increased acknowledgement of these related professionals in the field of mental health is evident from the composition of task force that developed National Mental Health Policy (2014). This task force consisted of a psychiatric social work practitioner and representative of an NGO along with other professionals. National Mental Health Policy was prepared and released by the Union Minister for Health on 10 October 2014, titled ‘New Pathways, New Hope’.

Though the time and experiences have established the need of social work beyond doubt, there has always been a lack of clarity about its scientific and professional status. In India, in the absence of national level accreditation and licensing organization for social work, the struggle for professional social workers to establish their independent identity and credibility is even more challenging. This applies to all fields within social work, including psychiatric social work or social work in the field of mental health (Sahu, 2019).

The Mental Health Care Act, 2017 included psychiatric social worker as one of the mental health professionals to be recruited in psychiatric hospitals. As per the Mental Health Care Act 2017, psychiatric social worker means a person having a post-graduate degree in social work and a Master of Philosophy (M. Phil.) in Psychiatric Social Work obtained after completion of a full-time course of two years which includes supervised clinical training from any University recognized by the University Grants Commission established under the University Grants Commission Act, 1956.(MHCA 2017)

Importance of Psychiatric Social Work:

According to Maslow’s theory of hierarchy of needs (1943), there are different types of needs with differing perceived urgency of fulfilment, but linked to each other. Though the physiological needs

and security needs are basic to the survival of human beings, the quality of life is determined by affiliation and higher level of needs, ultimately leading to self-realization. How well a human being adapts to internal and external changes and challenges is one of the most important determining factor of his/her well-being – physical, psychological and social. Herein lies the importance of psychiatric social work.

World Health Organization's health report, titled 'The world health report 2001 - Mental Health: New Understanding, New Hope", outlined the needs of people with mental disorders in four domains: Medical, Community, Family and Rehabilitation. Within medical domain the needs of a person with mental health issues pertain to information about illness and treatment, early identification, medical care, psychological support and hospitalization. The social worker has a role to play in each of these, besides the actual medical care or treatment.

The community needs included avoidance of stigma and discrimination, full social participation and human rights. Professional training in social work and commitment to the social work values make social workers probably the most important professionals to work on these needs along with the person with mental health concerns and his/her family.

World Health Organization (2001) emphasized the need to work with family to enhance and support their care giving, help protect and build strong interpersonal relationships within family, develop family networks, provide crisis and financial support and respite care. Again, one can identify the many ways in which a social worker can work with the family on these needs.

The rehabilitation needs identified by World Health Organization (2001) encompassed the main social systems and structures that can be made accessible to a person with psychiatric disorder like social support, education, vocational support day care and spiritual needs. Social workers work with systems and structures to make them accessible to the vulnerable groups and those in need. Thus, psychiatric social worker has a tremendous role to play in the management of mental and behavioural disorders.

Literature Review in History of Psychiatric Social Work:

There have been studies conducted in the field of mental health and psychiatric social work on various aspects such as curriculum components and training needs, mental health programmes and management of psychiatric hospitals.

A cross-sectional survey of all accredited training programs in psychiatry, psychology and social work was conducted in United States (Weissman et. al., 2006). Training directors or their designates across 221 programs were included in the sample. The objective was to determine the amount of evidence based therapy (EBT) taught in accredited training programs in psychiatry, psychology and social work. It also aimed to find out type of this EBT training in terms of elective or required as well as in terms of didactic (coursework) and/or clinical supervision. The findings of the survey were that very few programs had a component of EBT. One programme that required coursework and clinical supervision in EBT was Psychiatry (28.1%). Among evidence based therapies, Cognitive behavioral therapy was the most frequently offered training courses a didactic in all 3 disciplines. Surprisingly the two disciplines with the largest number of students and emphasis on clinical training – clinical psychology and social work – were the ones where maximum number of programs (67.3% n professional clinical psychology and 61.7% in social work) did not require a didactic and clinical supervision in any EBT. Thus the research study concluded that there is a considerable gap between research evidence for psychotherapy and clinical training.

In India, much of earlier research was on the quality of care and conditions at psychiatric hospitals. It was as early as 1938, when the researchers had pointed out the pathetic conditions in the then psychiatric hospitals and had suggested recruitment of psychiatric social workers at the psychiatric hospitals. Mapother'r report of 1938 was based on the comparative study of the state of psychiatric

services in London and India. He found huge differences between the London mental health scenario and Indian mental health scenario. Where in London the psychiatric bed ratio was 1:200, it was 1:30000 in India. He found the state of mental hospitals in India 'bad' and suggested, among many other structural and procedural guidelines for improvement, recruitment of psychiatric social worker at the mental hospitals (Venkatasubramanian in Nagaraja & Murthy, 2008).

Such evaluative studies were undertaken in India post-independence, also. An evaluative study of 37 Government run mental hospitals in India was conducted by NIMHANS by request of NHRC in 1997. In terms of staffing and personnel the study findings showed that very few hospitals recruited mental health professionals other than medical. In thirty percent of the hospitals covered in the study, there was not even a post of psychiatric social worker and 24% of the hospitals had only one post of a social worker. Probably the major finding of the study – policy makers, professionals and users were not aware of human rights and related issues and the mental health care at these hospitals was custodial than therapeutic – reflect also the outcome of the absence of other mental professionals such as psychiatric social worker at the hospitals (Rao, in Nagaraja & Murthy, 2008).

Sadly, the picture remained the same even after more than 10 years. In another similar study carried out by NIMHANS in 2008, again on the request of NHRC to study the then status of government run psychiatric institutions (36 hospitals as one hospital – the Mental Hospital at Mankundu in West Bengal was closed down after its rating as 'very poor' in earlier study; hospitals which were started recently were studied separately), 50% of the hospitals had no psychiatric social worker. There was one psychiatric social worker in 31% hospitals, two social workers in 2 hospitals. Only 5 hospitals out of 36 had 3 or more psychiatric social workers. Though the sanctioned posts have increased over years, vacancies in the hopitals for the post of psychiatric social worker were not filled fully (Murthy & Sekar, 2008).

One of the major findings of the study was that wherever active inputs of psychiatric social workers were available in the hospitals, the number of long-stay patients were significantly less (more than half) as the efforts of social workers and involvement of an NGO ensured continued rehabilitative efforts within the family and community and social support (ibid).

Studies that are conducted in hospital settings have a different focus than those conducted in the community settings. With more community-based mental health programmes being initiated by government and non-government agencies, these studies looked at the learnings for psychiatric social workers at the field –rural as well as urban.

Jain S. and Jadhav S. (2008) have narrated the observations and evaluative analysis done in 2004, of a rural community based mental health programme in Kanpur district, Uttar Pradesh, India. The study also used secondary data that consisted of published papers, conference proceedings, official policy papers and articles in popular media. It pointed out the challenges faced to make community mental health programme effective at the grounds level, especially in rural India. Bureacractic set up, vast difference between experiences of the psychiatric professionals and local rural communities leading to cultural asymmetry were the main barriers to the expected outcomes of the mental health programmes in rural India.

The researchers opined that there is resistance to try out alternative approaches for community mental health. The continued practice has been to integrate mental health with existing primary care services despite of the evidence for its limitations. The study also found that the coverage of community mental health programme is very much limited. For instance, at the time of study, the programme was functional only in 100 districts out of 593 districts.

The clinical model adopted in the programme by the professionals also meant that the psychiatric professionals conceptualized community only in terms of the interactions they had with 'patients' or 'cases' at the community centre. Thus, lenses used while working with people were problem focused, wherein the problems were located within individuals, which needed to be corrected. There was no attempt to understand the rural culture.

The study found that people continued going to the local religious places and gurus for the 'treatment' of mental illness despite the fact that the medical centre was located in the community, because they felt places of worship provided them spiritual strength, healing space where they would find both – acceptance and support and lastly and most importantly, friendship of others. This highlighted the cultural distance between clinic staff and the local villagers.

The study highlighted the need for culturally sensitive psychiatric theory and clinical services so that the field of mental health in India will not only offer viable effective practice models but also generate culturally valid theory. Psychiatric social work can play an important role in sensitizing the medical and clinical practitioners as well as bridging the divide between the psychiatric professionals involved in clinical practice and people in rural India.

The importance of culturally sensitive social work practice was also highlighted in a study of a community mental health programme conducted in an urban setting. A qualitative study of a community mental health initiative (Davar, 2012) highlighted the unique ways in which Indian culture and urban community culture interact with the community needs, including mental health needs. Participatory research methods were used to identify the core and unique features of local community support groups with respect to mental health and illness and to capture the experience of mental health and disability in these various support spaces, ethnographies of what is transacted in such spaces and the methods and the views of altruists in the community. The study also explored the gendered aspects of mental health and mental health care services as in a patriarchal society in India, the health status – mental and physical - as well as access to health services is influenced by gender discrimination. Lived realities of women related to mental health are also different than their male counterparts.

The findings of the study highlighted the gap in the 'exported' western models of mental health and Indian scenario at the community level. This community mental health programme was started in two communities or bastis in Pune – Lohiyanagar and Kashewadi. These communities were located in an urban area surrounded by busy market areas like Ravivar Peth and Mandai area in Shukravar Peth. The total population was 50000. The community mental health programme was a multi-layered with peer supporters available all the time in the community, fieldworkers who provided support counselling and other supportive services, counsellor, clinical psychologist, arts-bsed therapist, project leaders. It collaborated with the psychiatrists and doctors from the public health system (ibid).

The qualitative enquiry into this programme concluded that in Indian context, community mental health programmes that identify people within community as resources not only to provide support to the person with mental illness and his/her family but also play an important role in the therapeutic process itself need to be studied further as they can prevent further deterioration of mental illness and promotion of mental health at the community level.

The researchers opined that more such field level studies are needed to understand and integrate these learnings in training as well as practice so that mental health initiatives become successful at the community level in India. Addressing the need to develop psychosocial content to train workers at the field so that they are capable to address a variety of mental health needs is a challenge that needs to be undertaken by training institutes, especially social work education institutes (ibid).

There is an ongoing research on the literature on social work education and training specifically in mental health. A research team consisting of Kourgiantakis, Sewell, McNeil and others

(Kourgiantakis, 2019) have undertaken a study using secondary data related to social work education and training in the areas of mental health, addictions and suicide. A scoping review has been undertaken to examine literature on social work education and training in mental health, addictions and suicide. Using a scoping review framework developed by Arksey and O'Malley, seven academic databases would be searched: PsycInfo, Sociological Abstracts, CINAHL Plus, Social Sciences Abstracts, Education Source, ERIC and Social Work Abstracts. The review will look at variables such as educational or clinical setting, social work in mental health, addiction and /or suicide, undergraduate/graduate social work students or social workers, teaching and training methods and recommend needed future research and education initiatives in social work in this field. The study is proposed in acknowledgement of the lacunae in social work knowledge and skills in assessing mental health, addictions and suicide risk and the scope of social work education programme to address these lacunae.

As seen from the literature review, psychiatric social work practice has been multidisciplinary in nature from its very beginning. Psychiatric social work has always worked with other professionals to ensure the concept of mental health care involves not only the medical care but also social support, facilitation of independent living and protection of human rights. Such an approach to mental health necessitates holistic worldview. As Okasha and Chandra (2009, cited in Davar, 2012) said, in today's times, the way psychiatric illness is viewed has changed and become much more complex –

"The view is kaleidoscopic in that it is widened both physically and psychologically – where the disorder is viewed in a much larger context, and the multiple mirrors reflect images on each other. These images are those of the concepts of feminity and masculinity, of cultural and social realities, of violence and safety, of social networks and isolation, and of motherhood and the nurturing roles of women."

Psychiatric social work – education as well as practice – has taken cognizance of these complex interactions between personal and social factors, but there are many challenges and barriers when it comes to addressing them in the best possible way in the field. A study that would look at the emergence of psychiatric social work education and practice in India, different perspectives towards mental health and role of psychiatric social workers, as well as social work education in this field and different practice models, would contribute to the existing indigenous knowledge and literature on this subject.

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