**Narratives of Coercion: Law as a social determinant of clinical interactions in mental hospitals**

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**I**

The purpose of this paper is to show the impact of a custodial/penal law on client-provider interactions in the mental health sector. Law is the macro environment within which the mental health system works. Mental hospitals, an over-determined mode of service provision in the country, have been instituted and regulated by the Mental Health Act, 1987. The Act is a peculiarity of the health sector. Unlike health care patients, who are distal from the universe of law and courts, psychiatric patients become medico-legal subjects the moment a psychiatric diagnosis is received. The MHA provides liberally for involuntary commitment into a mental hospital; the legal format and process of commitment is more like an arrest, and less like a critical health admission. The police have a role to play in mental hospital commitments, which is another peculiarity. The implications of having a penal law in a health sector has been critically examined (most notably by Dhanda, 2000). Through the punitive legal devices enshrined in the Act, psychiatric patients become high risk for state coercion, particularly involuntary incarceration and treatment[1].

Custodialisation of people living with a mental illness is more than just law. It is an outlook and an attitude created in community care giving by the extant medico legal environment. A study (Cremin, 2007) situating the place of law in non-institutional or private settings (General Hospital Psychiatric Units and Rehabilitation Centers, for example) showed that this environment is a great barrier to developing voluntary community mental health services. The MHA has influenced not only hospital administration but also the working contexts of care giving staff working therein. A picture of the dangerous and incapable mentally ill patient who has to be managed by force is perpetrated by the MHA, which the staff are expected to maintain. The law sets up expectations from care giving staff contrary to their own professional skills and ethics.

In India, the reform of the mental hospitals has always been seen as a legal matter settled by the higher courts (Dhanda, 2000), the human rights commission (NHRC, 1999) or as public administrative measures by the Mental Health Authorities, the police and prison commissionerates, and other public machinery. Mental hospitals have not been mainstreamed in social science research, public health, and management literature, barring a few exceptions (Mission Report, 2003).

The role of law in confounding the micro-environment of mental health service provision, and the client-provider relationship, has not been studied. Goffman's classic, *Asylums* (1961) stands as evergreen evidence to show that the normative institutional framework controls therapeutics. Addlakha (2001) wrote about the flow of gender stereotypes within clinical decision making in a general hospital psychiatric inpatient setting without touching upon the influence of law. The social

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[1] For two testimonials of the experience of being forcibly committed into a mental hospital in India, see Noah (2010) and Saroj Acharya (2007). For international user stories, see WNUSP / Bapu Trust (2005).

repercussions of law within mental hospitals, and other non-institutional settings, need to be studied because this determines the quality of care. This paper establishes that law is a social determinant of clinical interactions in mental health care. It provides the ambiance within which the staff defines their own roles and responsibilities. The law also sets up expectations from care providers contrary to their own professional ethics. It influences service providers' consciousness and attitudes about persons labeled mentally ill.

I am describing here a social experience of the MHA, showing how it affects client-provider relationships in mental hospitals. In this paper, a systems approach is taken: the mental hospital is comprised of a web of human relationships and the care provided is a net result of the information transaction within human interactions, the law being the primary source and channel of information. The overwhelming presence of a custodial law in mental health sets up a web of therapeutic relationships and communications within services where the inter-actional intent (seen as "duty") is one primarily of taking custody and maintaining control. The impact of this role upon care giving staff is also described.

Narratives of client provider interactions widely prevalent within the mental hospital system are provided as illustrative, one, on "the good patient", another on the "violent" patient, and a third on "Escape-Death-Suicide" (EDS), a syndrome typically found in most custodial institutions.

As a caveat, I add that meanings implied herein and practices described may be interpreted from a universal human rights perspective. However, this is not the intent of the paper, which tries to keep close to description of micro-level interactions.

## II

The paper is based on an exploratory study conducted within four kinds of custodial institutions in the state of Gujarat: Mental Hospitals, Beggars' Homes, Central Jails, and the state home for women, totaling 101 in-depth interviews. All custodial institutions were studied because of the chaotic legal maze created by multiple penal laws and the consequent transfers of mentally ill people across institutions, a process termed 'trans-institutionalisation'. The data presented here is only of the three mental hospitals in Gujarat, including 32 interviews, conducted between the years, 2007-2009.

|    | Institution                  | Total no. of Interviews |
|----|------------------------------|-------------------------|
| 1. | Mental Hospital, Ahmedabad   | 17                      |
| 2. | Mental Hospital, Baroda      | 11                      |
| 3. | Mental Hospital, Jamnagar    | 04                      |

The staff interviewed in Mental Hospitals included superintendents/officers-in-charge, psychiatrists, medical officers, administrative staff, staff nurses, social workers, clinical psychologists, occupational therapists, attendants/*aayaas*, and senior cooks. At the senior level (up to class II), we interviewed *all* staff; at the level of nurses and attendants we interviewed 2 to 3 men

and women who volunteered to participate. Our open interview topics included: procedures for commitment and discharge; illness determination; processing of gender; communication flows between patient and staff; providing in-house facilities to patients; quality of relationships between patients, families and staff; the mental health needs of staff; themes about violence and control; response to hierarchy; and how they perceived human rights issues.

Permissions were obtained from the Government of Gujarat Health Department, the State Mental Health Authority and the superintendents, and consent obtained from respondents. As recording devices were not permitted within the institutions, two people engaged with each interview, one conducting the interview, and the other recording. The interviews were conducted in English, Hindi, or Gujarati. The interviews were transcribed and translated into English with standard codes for translations. The duration of each interview ranged from 30 minutes to 2 hours, conducted in one or more sessions. The analysis of data was done on NUD*IST (Version 4) software. A coding tree was finalised, standard coding procedures formed, data sheets coded, cross verified between researchers, and entered in the software. Analysis questions were compiled, content picked out and sorted. Cleaning was done manually using Word.

**III**

Unlike a general hospital, any admission to a mental hospital is a matter of legal custody[2] and a constitutional matter. Voluntary admission, provided for in the Mental health Act (S 15) has the highest chances of being consensual, but is used sparingly and only for depressed patients in Gujarat[3]. All other admissions involve ascriptions of 'safety' provisions or medical certification and are explicitly involuntary. In Gujarat, 'Under Special Circumstances' admission (S 19), interpreted locally as voluntary admission, is most commonly used. In this admission,

"If the family members want to admit the patient and if the psychiatrist also feels that the admission is necessary, then the patient is admitted". (Superintendent)

"In Section 19, relatives bring them here. Most admissions are done under this section". (Social Worker)

Under this section, only social agents (doctors, hospital authorities, and family) are involved in making a decision about commitment. Patient consent is not necessary. Cremin (2007) noted that

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[2] International benchmarks mandate that admission should take place only for therapeutic reasons and not for management purposes. The benchmarks talk about competence required in making assessments, particularly risk assessments. As "danger to self" and "danger to others", as well as competence to consent are measured criteria in admissions, measuring instruments and competence to do these measurements is required. There must also be the discernment that appropriate care in other least restrictive environments is not available. Standards of expertise have to be set for admissions. The duration of admission should be specified. The decision taken must be prompt and also duly documented.

[3] It is not clear why non-depressed, psychotic patients are not admitted voluntarily, as the law does not specify this.

in many instances, the admission form does not have space allocation for the patients' signatures. These admissions go without legal scrutiny as legal authorities are not involved. 'Safety of self and others', the determination of which is central to admission, has not been defined in law.

A question arises then, regarding why safety of self and others is an important *mental health* indicator, failing which someone needs to be incarcerated. Narrations from staff indicate that violence perceived by the care giver or by the service provider is an all important admission criterion for commitment.

"The admission criterion is whether the patient is harmful to society or home". (Medical Officer)

"Those who are violent, harms others, or the neighbors complain of violence … are also admitted". (Nurse)

"Mental illness, excitement, violent, destructive, depression and suicidal patients are admitted". (Mental Health Worker)

"Also if the patient is dangerous to self or others, is not compliant, then we admit him/her". (Superintendent)

In response to a question about patient refusal to hospital admission, a social worker says,

"If he doesn't want to get admitted we explain to him. If he does not understand, we admit him under Section 19 (of the MHA). Sometimes, patients are too excited. So in the OPD, we give them an injection (Serenace) so that he/she feels sleepy and becomes calm and quiet. Then we admit him/her".

Reception order (court certified) patients are discharged through the court. If a voluntary patient gives a written application to the superintendent, then the patient has to be given discharge within 24 hours, as per the MHA. But in conjunction with other provisos, recovery is assessed for every voluntary discharge by a medical board. Every patient is subject to observational monitoring, and so, a voluntary discharge request may be nullified by staff observations indicating non-recovery. This is not a requirement of law, but of practice. The voluntary discharge provision is not legally linked to recovery.

"If the patient is cured, we give the patient discharge. Meaning, that if the mental illness is not severe, the patient can do personal things, the patient can communicate well, can do some work, then the discharge is given". (Superintendent)

From such patients, a written resolve is expected that they will be compliant to treatment and will seek help once again.

"(I)f he writes that he thinks he has recovered and if he thinks he will come back, then we give discharge." (Psychiatrist)

Voluntary patients can and do become involuntary patients.

"If the voluntary cannot be sent, then we do not send, we certify him" (Medical Officer).

Compliance from the patient to the given treatment and to assigned routines is an important discharge condition.

"If the patient communicates well, complies with medicines, has insight regarding the illness, then we discharge the patient" (Superintendent).

"We also assign them some work in the hospital. Then the patient's behaviour is observed and noted. What was the task assigned to the patient, how the patient did it? Does the patient comply or not? All this is recorded." (Superintendent)

"For discharge we see whether sleep is good, diet, clothes, non-suicidal, stable mind etc."

Discharge is done, according to staff reports,

"When they become good or when they recover". (Female Aayaa)

"If the patient starts doing some work, or his behavior improves we come to know that he is recovering". (Nurse)

"The patient who listens to us, who does work without fighting with others, behaves well, sleeps in the night, and changes the clothes daily, takes daily bath". (Male Aayaa)

"When the treatment works and the patient gets better; can do his own work, can brush, eat, change clothes, bathe, and talk, then he can be discharged". (Nurse)

"The patient who gives good answer, understands all the things, lives peacefully, takes regular treatment, behaves with us in good manner, takes daily bath, changes clothes every day, can take care of personal things, these kind of patients are given discharge".  (Nurse)

"The doctor asks nurse about the patient such as whether the patient becomes violent (*tofaan kare*), works or not, what does he do, mumbles less (*badbadat kam ho gaya*). If we have noticed some improvement in a patient then we tell the psychiatrist." (Nurse)

Patients are discharged if and when relatives claim them.  If unclaimed, patients risk being certified through the court indefinitely. This, incidentally, poses a constitutional challenge to institutional authorities, as the reason for hospitalization is no longer the need for treatment.

## IV

To demonstrate how barriers set up by law within mental hospitals influence client provider relationships, I present some 'stories' about patients constructed by the staff. These stories help to sustain their roles and responsibilities, and their sense of executing their job and fulfilling their 'duty'. Since the law is built upon the function of taking custody, these stories help the staff in relating to each other and relating to the clients without giving up their basic sense of dignity, self worth, and usefulness within the mental hospital system. The staff members present themselves as having a strong social service identity, while engaging in behaviours quite incongruent with that identity.

### 'The Good patient'

The law allows admissions on the basis of the 'health and safety' of patients without further defining these, as described above. Often, applying rules of this clause within services, clinical decisions are made on the basis of subjective categories, such as prejudices about the mentally ill and gendered perceptions about 'good' and 'bad' (Addlakha, 2001; Ranade, 2002). Responses given by staff to questions of diagnosis and treatment topics were in terms of 'good' patients (*jo acche hein*), to such an extent that this was developed as a separate code for analysis[4]. Meanings of "*acche*" patients involve judgments about personal conduct, morality and behaviour, rather than terms of a psychological or diagnostic language.

"Good patients are those who can speak properly and can work."(Senior Nurse)

"Meaning patients who can take care of their personal hygiene, whose behaviour with other patients and staff members is good. (Social Worker)

Compliance to medical treatments is an important indicator of a patient's goodness.

"Once the medication is given, they think that the patient is good now." (Superintendent)

Imbuing health conditions and categories with moral colour is undoubtedly a practice with respect to all health problems, but absent bio-physiological parameters of diagnosis and cure, heighten the risk in mental health. Contained within the meaning is also the patient who is compliant and easy to manage.

"The patient who doesn't fight with others, who is sixty and above, improved. Then there are chronic patients who are quiet. Symptoms are there but they stay quiet". (Social Worker)

"Good patients are those who understand and are not violent". (Nurse)

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[4] We also included a direct question on their definition of a "good" patient.

The staff, particularly those in class III and IV develop relationships with 'good' patients and achieve their sense of group and community, and their satisfaction about success, from them. Patients who do not 'manage' the staff well and express themselves or complain are considered as bad patients.

"The patient who speaks abusive words and who consider us a bad man are the bad patients". (Male Aayaa)

"The patient who behaves nicely with me and is educated, that patient is good" (Male Aayaa).

Good patients receive benefits, including basic needs of clothes, grooming, and hygiene (soap, oil, toothpaste, comb, sanitary cloth), mobility, privacy (locker facility), recreation, and rehabilitation. Good patients and others are segregated from each other.

"If the patient is good then with the psychiatrist's permission they can wear their own clothes if they want". (Senior Nurse)

"There is a library on the first floor…. The good patients are taken there". (Nurse)

"Good patients are allowed to keep combs, etc. with them. (Nurse)

"Good patients keep their brush, soap bag, etc. in the locker". (Female Aayaa)

"We get the soap and then give it to the patient. Good patients take very good care of soap and keep it safely." (Sweeper)

"Only good patients are given lockers. Ten twelve good patients are kept in one room and they have a locker". (Nurse)

"Good women bathe on their own; they have to be told though." (Sweeper)

"Good patients wear underwear. They put pads during menstruation. Others don't wear pads. We change their clothes and wash the clothes. We keep them in one room". (Psychiatric Social Worker)

Further, good patients meet their family and engage in social interactions.

"Good patients are taken to the waiting room in Out Patient. The patients are dressed in a saree and then taken there. Some relatives come to meet the patients". (Female Aayaa)

"Good patients … are sent to the Occupational Therapy to make candles, embroidery etc." (Nurse)

The staff builds relationships and collaborates with good patients in the general upkeep of the hospital. Good patients contribute to the workings of the hospital, including giving medications to fellow patients, grooming, food and dining, general cleaning, and maintenance activities.

"Attendant changes (clothes of patients) with the help of good patients". (Senior Nurse)

"We get the ward swept and mopped by the patients. Those who are good patients and want to do it, we get it done from them. They also wash their own dishes and make the beds". (Female Aayaa)

"The food is served by attendants and cooks. Some good patients also help them to serve food." (Social Worker)

"Good patients cut the vegetable and wash the rice in the kitchen with the cook." (Male Aayaa)

"We ask the good patients to help us in bathing the other patients." (Sweeper)

**'The Violent patient'**

Within the mental health system, staff members are expected to manage behavioural attributes. That violence is an essential attribute of mental illness is an overwhelming paradigm within the mental hospital, unlike other public health care systems. Narrations of violence often include attributions of the unexplained or the irrational ("for no reason", "we don't know why", etc). Instances of violence are reported in vivid detail, and remains in common institutional memory.

"One patient hits the staff many times. She has bitten others and hurt others with plates". (Female Aayaa)

"During my service, two times I have been bitten". (Male Aayaa)

From scattered instances of violence, staff members universalise attributes to the community of the mentally ill:

"They fight in the night". (Male Aayaa)

"Love is more between them than us". (Male Aayaa)

"They are very dangerous. They have power. They are very strong. We have to hold them tight." (Male Aayaa)

"There was one superintendent here. He became mad. I am not joking. There were five to six attendants and two sweepers. They also became mad while working here. It is a dangerous place to work." (Male Aayaa)

"They all are dangerous patients in the hospital. They can attack on you anytime. I have seen many dangerous patients. At one moment they are talking with you, and the other moment they would attack you". (Male Aayaa)

It is an explicit role definition of staff to manage the violence, a task seen sometimes as 'heroic social work'. Perceived or actual violence by patients leads to "reverse violence" (i.e., violence by staff on patients), physical restraint, chemical restraint ('injection'), threats of solitary confinement or electro convulsive therapy, or worse, the certification of being 'unfit for discharge'. Expecting violence, attendants go into wards in teams, prepared for counter attacks. Workers 'experienced' in this function are more useful. The job of managing this issue is left larger to Class IV staff.

"I do not have to go into ward. Our attendants are there. They are also working in the hospital for a long time. So they handle the situation".    (Resident Medical Officer)

"We don't go alone. Two three people go together into the room. If he becomes violent then we can control him, hold him". (Male Aayaa)

"When a patient attacks us, we persuade him. At that time, two other people cover the patient from behind with a blanket. Then we hold the patient and the sister or brother gives an injection to the patient." (Male Aayaa)

Actual or perceived violence provides the impulse to start treatment:

"Excited patients are kept separately. We keep them locked up in the barred room." (Female Aayaa)

"If they fight we have to separate them and explain to them. Sometimes we have to show them the stick." (Male Aayaa)

"We were counting the patients. At that time one patient suddenly attacked me. We had to keep that patient in a separate room." (Male Aayaa)

"When they come, if they are very violent we give them injections. Medicines nowadays are very good." (Medical Officer)

Treatments are continued until the patient is observed to become 'good'. It is considered a duty of the patient to tolerate everything. Forced medicines and visits to the isolation room are considered as a part of the treatment which they have to deliver under critical circumstances.

"If he speaks abusive words, we have to listen to it. We give medicines and keep them in isolation". (Psychiatric Social Worker)

"The patient calms down after giving an injection. If the patient does not then it is given every hour. The patient is held by the attendant and then injection is given". (Senior Nurse)

"We keep him in the confinement room till he becomes calm and quiet. We ask him, will you bite other patients now? If he says, No, we will take him out." (Male Aayaa)

"We keep them closed for two-three days, or unless they become quiet. If they do not eat, we have to feed them food". (Male Aayaa)

Despite the stretching of their administrative functions as Social Workers or Attendants in the case of managing 'bad patients', and the use of control rather than co-operative methods, the staff are clear that their intent is to provide care.

"They are like a child. If the child is doing tantrums, we do beat the child. We have to take stick to organize them in a row (during roll call); otherwise they don't listen. There should be some fear in their mind". (Male Aayaa)

At the time of conducting this study, the staff has not received any training in the changed political situation of universal human rights. NHRC interventions and other reform methods are experienced with resistance and as interference in their routine custodial mandates.

"We have to keep excited patients in lock and key. But human rights commission ordered not to keep the patients locked. So we cannot keep them in restraint. If the superintendent comes for a round and sees that a patient is locked, then he scolds us". (Male Aayaa)

"We cannot beat them. We don't do anything. If they beat us, the superintendent will say that is our duty". (Male Aayaa)

"Two-three years back, it was good. The superintendent was good. What he would say, if a woman is mad, insert a long stick in her vagina, then she will automatically behave like a normal person." (Male Aayaa)

Institutionalised patients' stories of violence do not exist, except for scattered personal experiences and self expression through poetry, song, and art (Arya, 2007; WNUSP/Bapu Trust, 2005), suggesting that violence within the mental health system is structural and inter-actional. What the staff members see as a duty, the patients see as a violation. The mental health system endorses the duty to manage a violent patient by providing compensations.

"We have to speak with them loudly, we have to give them verbal warnings. We cannot beat the patients. The patients can beat us. We get maintenance allowance of __ rupees per month (*for taking the beatings)*". (Male Aayaa)

"I was also beaten. We get allowance of Rs. __ for being beaten by the patients i.e., Mental Allowance". (Nurse)

"We get 50 rupees allowance to get beaten up. We cannot slap them." (Male Aayaa)

**'Escape-Death-Suicide'**

The staff has a duty to prevent escape, and death by suicide (E-D-S) of patients. Stories of E-D-S are recalled in detail and serve as points of administrative censure and rule consolidation. Being alert and vigilant is a requisite competency for the staff. The staff counts patients two or three times every day, because:

"They try to run away, we have to keep watch on them". (Male Aayaa)

"I have to tell nurse if any patient runs away from the hospital. Yes, patients run away from hospital by jumping the wall". (Male Aayaa)

"It has happened that patients run away during the prayer. When they get opportunity they run away from the back side. So we also run behind them to catch". (Male Aayaa)

Involuntary commitment procedures in the MHA places complete responsibility of patient actions on the institution. Therefore, prevention of E-D-S is a vital function of the institution, which are duly passed on to lower cadre staff. Staff members who have to maintain a high level of vigilance under special circumstances (for example, when construction is going on) are seen as doing a 'tough job'. The institutional authorities also see the staff handling suicidal patients as requiring training. Restraint, (the serious limitation of personal liberty), and forced treatment, other than changes in the physical parameters of life within the hospital, is seen as preventive. Care, within this system, is designed in the architecture, the wards and cells, and in the mechanics of restraint. This watch keeping duty of the staff gives a sense of heroism in their line of duty.

"In the night-time, they have to be very careful, so that no one can go outside or get an opportunity to run. These attendants have to keep watch on each and every patient, which I think is a tough job". (Male Aayaa)

"In the old building patients were used to escaping with the help of water pipe. But now they are transferred in the new building. So there is no chance to escape". (Male Aayaa)

Deaths may be natural or unnatural, the latter referring to suicide related events. Death of patients by suicide or attempts to commit suicide by patients results in 'special duties' for the care giving staff, including relieving the patient of their personal belongings, vigilance, ECT, medication, and lock up.

"If they say that 'I will die, hang myself' then we take away clothes, bedsheets etc. Then treatment is given by the doctor. We personally give them food and water. (Female Aayaa)

"We have to do special duty. If the patient dies in the hospital, then the attendant who is on duty is responsible for it. How can they hold us responsible for it? Once one patient told that *mataji* (goddess) came in his body and he killed other patients. He (patient) killed other patients in madness". (Male Aayaa)

"We keep a doorkeeper when we suspect suicide. In the old wards we did not provide fan, switches, blade, bidis, cigarettes etc. We take due care. 3 months earlier a patient had burned himself because of *bidis*. We give counselling where we give them better options to control temporary impulse. We keep a watch the whole day. We keep record of patients violence, but we do not make a police case. To reduce violence we give espinol injection". (Medical Officer)

"Patients themselves tell us that they will commit suicide. So we keep the patient away from rope, knife and cloths like *Dupatta* (scarves). Once one patient committed suicide with the pajama lace. So if the patient tells us something like that, we locked up the patient for sometime". (Nurse)

"In the old building, there was one underground water tank, so we used to take care that the patient shouldn't go there and attempt suicide. We are also careful with the dupattas, so that the patient shouldn't attempt suicide". (Medical Psychiatric Social Worker)

When the law prescribes involuntary commitments, execution of the law takes on incredibly dehumanizing dimensions, as described above. Not only patients, but also the care providers are diminished in their role and function, and their professional dignity. However, the ethical dilemmas for social workers are not fore-grounded, and they have invented a heroic self to deal with those unconscious conflicts.

**V**

At the time of conducting the study, the staff reported that very little training was attended by them in 10 years or more. A training culture, wherein the staff is given regular, up to date training in line with their needs and job description, does not seem to exist. Leave sanctions are not obtained, and further, salaries are deducted if the staff goes on training. The acute shortage of mental health personnel in the public sector in Gujarat, as elsewhere in the country (Goel, et. al., 2006), puts severe strain on people going on training programs. Most of the mental health and psychiatric social workers reported that they are interested in new trainings, particularly in the area of rehabilitation and counseling, psychotherapy, group therapy, and managing patients in day-to-day life, and human rights of the patients. The psychiatrists reported that they would like to know more about rehabilitation of the mentally ill patients, government policies, law and mental health, and community mental health, as these areas are not covered in their degree course syllabus.

"I would like to attend training programmes on rehabilitation, regular continuation of rehabilitation programmes, some newer strategies in treatment, some newer approaches. I would like to know about Government policies. You know what happens - everything is decided at the top level. The Government decides something at top level and we are working with patients at grass root level. So

we don't get to know what is happening. We should be informed about it but we are not informed."(Psychiatrist)

Some of the psychiatrists reported that there are barriers in attending a training programme in a government institution, like financial problems, keeping follow-ups, and getting permission from the health department. Clinical Psychologists feel de-skilled in the mental hospital system and express that they need training in various therapies so that they can practice them in the hospital setting. In the case of the lower cadre staff, the training content, when delivered, was mostly about handling patients in crisis situations, managing violence, and behaving well with the patients.

The lack of training results in a feeling of threat, fear, and a high degree of insecurity, particularly amongst the lower cadre staff:

"They are very dangerous. … We are not safe here. You don't know when they will attack you. They are mad people. They all are dangerous patients in the hospital. They can attack you anytime. It is really difficult to handle them. You don't, I have seen many dangerous patients. At one moment they are talking with you, and the other moment they would attack you." (Male Aayaa)

 "We fear to work here, because there are patients who can kill us." (Male Aayaa)

"Nobody feels any security here. The patients are allowed to move freely in the hospital premises outside the ward. (He pointed to a patient) this patient can beat you at any time. So we don't feel secure. There are not enough attendants to control them." (Social Worker)

The top management does recognize that staff stress exists.

"Most of the staff members are under stress". (Superintendent)

"I feel that there are some staff members who have some mental health problems, these are not severe problems, but they need some help, some counseling". (Psychiatrist)

"Sometimes I don't feel like talking to somebody; feel like sleeping peacefully. At home I don't feel like talking to my children".  (Nurse)

"Yes, I do experience stress". (Psychiatrist)

"I have headaches. I feel mental stress (*mansik tanaav*). Sometimes because of the stress I quarrel at home, get angry with the patients, make mistakes in my work, and get angry on the staff or the in charge". (Nurse)

"That (We feel stress) is every day. I am working here since the last twenty years. There are two or three attendants who themselves became patients. One cook was there. He also became mentally ill.

One attendant was admitted here. He used to remove his clothes. He was kept in the hospital for 15 days. Thank God! I am well." (Social Worker)

"I became mad because of staying with them (patients), now I do not go inside the ward". (Male Aayaa)

The emphasis placed by the management on "managing violence" and EDS, without providing knowledge protection or safety, has placed the lower level staff in an extremely fragile state of mind. The attendants working with the patients perceive their whole day as stressful.

"As of now we have been told that if any of the patients becomes violent then immediately he has to be given an injection. But that doesn't solve our problem. We cannot give injections to all the patients." (Nurse)

"We have to always keep watch on them otherwise they fight with each other."(Male attendant)

"When a patient becomes excited, we are under stress." (Male attendant)

"There should be a grill on the door. We feel insecure. Some patients come in front of us and get naked". (Nurse)

The psychiatrists reported that dealing with patients who have suicidal thoughts as stressful. They also reported that if the patient is not responding to the treatment, then they experience stress. The nurses who participated in study reported that dealing with patients and patients' behaviour was stressful. When asked whether the participants enjoyed working in the hospital, most of the lower cadre staff reported that they did not have any choice in the matter. They are government servants and they have to perform their duty. There was no question of liking or disliking anything. In India, government jobs are coveted because of the stability and security they offer.

**VI**

In conclusion, the paper has tried to provide arguments for a change of law (the MHA) from involuntarism to voluntarism in the mental health sector. I have tried to show:

(1) It is not enough to change the law or bring about reform through public litigations, etc. The web of relationships within the mental hospital system has to be addressed through structured thinking and training activities. As vulnerable as the clients of the system are the lower cadre staff, particularly the nurses and attendants, who struggle to maintain their own self respect and mental well being within a medico-legal system which expects them to function primarily as tormentors.

(2) That a system based on coercion is pernicious definitely for the clients, robbing them of their very "clienthood", but equally so for the others who are anchored in supposedly therapeutic relationships with the client.

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