Private hospitals in India are showing that the best treatment for mentally ill patients is to lend purpose to their lives.

CHENNAI, INDIA—Incense wafts around two dozen men standing in a circle stomping, clapping, and chanting to the rhythm of a drum. This ceremony for the Hindu god Krishna wouldn’t seem out of place in a temple, but this evening the venue is a rehab clinic, and the men are patients with schizophrenia.

Earlier, the men were hard at work here at the Schizophrenia Research Foundation (SCARF), making chalk sticks or fashioning sturdy shopping bags from old newspapers. The clinic sells the items, along with dolls and candles made by female patients, to local shops in Chennai, a sweltering city of 6 million on India’s southeast coast, and shares the proceeds with the patients. The buzz of activity makes SCARF feel more like a summer camp than a psychiatric ward. About 40 patients live at SCARF’s Chennai headquarters, and several dozen others spend their days here and return home at night.

Although the patients take antipsychotic drugs, it’s the healing power of social interventions that has given SCARF an international reputation as a leader in schizophrenia treatment. The clinic’s success at rehabilitating patients—many of whom recover enough to hold down a full-time job, marry, and otherwise lead fairly normal lives—offers a powerful lesson on the benefits of going beyond the standard biomedical approach. “If I become psychotic, I’d rather be in India than in Switzerland,” confesses Shekhar Saxena, director of mental health research at the World Health Organization (WHO) in Geneva.

Some Western psychiatrists argue that social activities such as those employed at SCARF and other Indian nongovernmental organizations (NGOs) are too often shunned in the pursuit of pharmacological solutions. “One of the great disgraces of American psychiatry is that we’re very, very invested in medicines,” says Paul Fink, a psychiatrist at Temple University in Philadelphia, Pennsylvania, and a former president of the American Psychiatric Association. Despite decades of research indicating that mentally ill patients respond best to a combination of drugs and social programs, Fink and others see few signs that U.S. psychiatric institutions are moving to integrate more social interventions into treatment regimens.

Family ties
Narendran, a handsome, animated man in his 30s, lives at SCARF’s home for men in Mamallapuram, about 50 kilometers down the coast from Chennai. Sitting at a table in the center’s cafeteria, Narendran, who like many Indians goes by a single name, explains how the activities at SCARF give him a sense of purpose. Captaining the center’s cricket team has brought out his competitive side, he says. During the day, Narendran tends the gardens at a nearby office complex. He’s proud to be able to spend part of his earnings on political biographies for a niece. At SCARF, finding a job is viewed as essential to a patient’s recovery; family members are advised to bribe employers—typically friends or relatives—if necessary.

SCARF’s philosophy taps into an emphasis on family and community long flagged as an explanation for evidence that schizophrenia patients fare better in developing countries than in wealthier countries. These findings are especially remarkable because most people with a severe mental illness in India, for example, receive little if any specialized care; extremely few are lucky enough to get into a program such as SCARF’s. The country has only 25,000 psychiatric hospital beds—a third of which are in a single state, Maharashtra—for 15 million people sick enough to need them, including about 3 million with schizophrenia.

Yet a long string of studies, beginning with WHO’s International Pilot Study of Schizophrenia, launched in 1967, have reported that patients in India and other developing countries are more likely to have long-term remission of symptoms and fewer relapses than patients in the developed world. Subsequent studies with refined methodologies have concluded the same, says Assen Jablensky, a psychiatric epidemiologist at Western Australia University in Perth who led one of the largest follow-ups, a 10-country project that wrapped up in the early 1990s. He chalks
up the difference to better social support in more traditional societies.

Indeed, out of necessity, about 99% of Indians with schizophrenia live with their families, says psychiatrist R. Thara, SCARF’s director. In developed countries, estimates range from 15% to 25%; most patients live alone or in a hospital or an assisted-living facility. In the United States, about 6% of people with schizophrenia are homeless, and a similar percentage are in prison. In one study in Chennai, three-quarters of patients got married and held jobs—considerably more than in Western countries, Thara and colleagues reported in the August 2004 issue of the *Canadian Journal of Psychiatry.* Thara involves the patients’ social network in their care. “We have a much more global view of the patient,” she says.

Other illnesses also appear to respond to this holistic strategy, says Prathap Tharyan, head of psychiatry at Christian Medical College (CMC) in Vellore, about 150 kilometers west of Chennai. Tharyan will only admit a patient on the condition that at least one family member stays in an on-campus apartment with the sick relative. CMC may be the first psychiatric hospital in the world to insist on this arrangement, Tharyan says. “It’s absolutely crucial to have the family involved.”

Like many Eastern psychiatrists, Tharyan shares the view of Western medicine that mental illness is a neurobiological problem. “I have no doubt that schizophrenia is caused by something that goes wrong in the brain,” he says. But Western medicine often overlooks how mental illness disrupts social networks, Tharyan says: “It affects the entire function of the family and the individual’s role in the family.”

**Drug culture**

That idea is more studied than practiced in the West, particularly in the United States. Researchers have identified at least half a dozen interventions—including work training and placement programs, education and support for families, and programs that teach social skills—that improve the lives of schizophrenia patients, says Wayne Fenton, director of adult translational research at the U.S. National Institute of Mental Health (NIMH) in Bethesda, Maryland.

The problem is that these findings don’t make it into the clinic. A 2001 study in *Schizophrenia Bulletin* found that although 61% of schizophrenia patients in the United States want to work, fewer than 20% find employment. A 1998 study funded by NIMH and the Agency for Health Care Policy and Research hints at the reason. It found that only one in four schizophrenia patients in the United States receive employment assistance. In addition, less than 10% of patients participate in community-based programs that help prevent relapses and hospitalization, and less than 10% of families receive education and support. Moreover, U.S. psychiatric facilities aren’t designed to reduce social isolation or facilitate reintegration into the outside world, says William Carpenter, director of the Maryland Psychiatric Research Center in Baltimore. “If you go into a hospital, you get pretty much cut off from other things.”

Ironically, part of the reason may lie in the importance attached to patients’ rights in Western countries, Carpenter and others say. Under the U.S. Health Insurance Portability and Accountability Act, privacy restrictions limit communication between clinicians and patients who don’t live at home often end up in giant state-run mental hospitals. “All that is done in a typical state hospital is to ask, ‘How are you doing? Are you still hearing voices?’ and give them medicine,” Thara says. She would like to see hundreds of organizations such as SCARF spread across the country.

It’s an idea worth considering, says the World Bank’s Benjamin Loevinsohn. He co-authored a review published in *The Lancet* last August that concluded that NGOs often provide higher quality service at lower cost than governments do, and he thinks this would apply to mental health NGOs, too.

On an annual budget of about $70,000, SCARF provides low-cost care for 140 in-patients and up to 100 outpatients a day. Most of the 25 permanent staff are psychiatric social workers. “SCARF has a truly innovative way of doing social interventions without highly trained people” such as psychiatrists, who are in short supply in India, says Vikram Patel, a psychiatrist at the London School of Hygiene and Tropical Medicine. It’s a lesson worth noting for rich and poor countries alike.

—GREG MILLER