It is indeed difficult to locate and evaluate clinical research endeavors related to measurement of change in “Growth Oriented” efforts, as they often lead to “Disasters” in community health programmes. Nevertheless, developmental outcomes in impaired pediatric or adult, rural and urban populations that are affected from cognitive and emotional sequels of acquired mental disorders, need to be enquired into.

The onerous and vexing methodological issues concerning the measurement and analysis of change or ‘inertia’, persists in the vistas of morbidity and mortality. Perhaps, some of the problems of measuring either change or inertia are mere artifacts and inappropriate conceptualizations, as they have emphasized average shift in perspective orientations and outcomes, over individual—micro level changes. Glaring instances of emphasis on the disasters in mental health care institutions and traumatic closed head injuries due to roadside accidents are cases that fall in this realm.

Change Contaminants

Changes or lack of it due to inertia are discernable both in the quantitative and qualitative levels of data. Qualitative changes in the...
behaviour are evidenced through changes in the factor structure of measuring instruments. Thus, constructs or notions of mental health care change qualitatively with development or the lack of it. Structural changes in the community strata based on ‘stigma-reduction’ are related to intra-individual changes based on multivariate perspectives.

**Methodological Perspectives on Change**

Traditional methods for measurement and analysis of Change, have only considered it as an incremental phenomenon and not as a decremental phenomenon. Use of $D_1$ $D_2$ indicates only a differential increase in levels of change in a time series situation where, Differential = (Difference in psychopathological manifestations over time spans) indicating difference scores $(n)$ have been used as a “metric unit” of change. Enigmatic methodological issues, *i.e.*, the unreliability of difference score $(n)$ owing to lack of consistency in change patterns- leads to an inverse relationship between $n$ and homogeneity or reliability.

However, the crucial issue pertains to the nature of change that occur in spurts sporadically and is intrinsically inconsistent, hence, it lacks reliability in it’s measurement. How can then $n$ scores be used as correlates of change. A number of alternatives to overcome these critical problems of measurement of change or inertia, has been to include Messick’s “Base- free measures of change”, representing residualized changed scores and regression based measures of $n$ (true change or inertia).

Willett (1988) has stated that conceptualization of change can remove the methodological impasse or flaws in difference scores, *i.e.*, $n$ scores. Willett *et al.*, goes on to say that “Between the idea of measuring change and the reality of it’s empirical measurement has fallen a shadow of an unnatural, or atleast unhelpful, conceptualization.” Analysis of change or inertia in mental health care and for that matter health care in general, should be based on dialectics of change proneness using “Base- free measure of change”, as espoused by Messick, (1981). So, change in the health care
programmes in general and specifically for mental health care programme must be based on a bilaterally-oriented interaction of awareness and availability of such services in a timely manner.

**Societal and Cultural Scenario of Indian Mental Institutions**

Prevailing misconceptions, and indigenous health care practices tend to be preferred over modern scientific methods of treatment. This is due to easy accessibility and acceptance of belief structures, and traditional trends resting on social support systems. Hence, all programmes of health care have to encounter a resistance from belief systems and dogmas that have to be overcomed so as to usher an awareness towards modern health care practices.

The authors conducted an attitudinal survey of preference for adaptation of modern health care practices (reported in the ‘The Reference Journal of Social issues’ 1991) in rural and urban Primary Health Centres (PHC) based on approximately 400 PHCs in Rajasthan. It was reported, either the Health Care Centres were dysfunctional or if they function at all in the absence of inertia then, there exists a negative attitude structure of not availing the health care facilities. Initially, there is an avoidance reaction in availing/attending the health care facilities. Among 69% of population covered by the PHCs.

The dyad of health care including individualized care preferences interacts with the attitudinal predisposition with the institutional health care centres. Thus, there is an interaction of attitude towards health care facilities provided to the patients which, interacts with their family orientations and their impression-formation of causes of illness or the disease-oriented process.

Patients as well as their family’s misconceptions of mental health care and lack of awareness of the taxonomical classifications of disease entities add fuel to the fire of neglect and nescience. As a result, indigenous health practices are surreptitiously adopted within closed doors and are confined to the home fences only. Most of the indigenous based unscientific methods of treatment are adopted only because they find it “stigma – reductive”.

In several parts of India including Rajasthan, there are well established centres in temples of certain deities like Lord Hanumana,
where the patient is quietly taken in the guise of worship and adoration, even today in the 21st Century for practicing exorcistic techniques and are justified with modern labels of aversion therapy. The entire spectrum of neurotic and psychotic mimicking states are exposed to these inhumane treatments. Pseudo – recovery is reported under social pressure to seek social support. By and large, such practices are prevalent amongst rural – based – residents, who systematically sustain a superstitious misconception. Such practices are also prevalent in other states of India like, Bihar and Madhya Pradesh.

Centralized i.e., centrally funded as well as State Health Care Resource based institutions for Mental Health Care – known as Mental Hospitals, offer a scenario of devastation and gross crassness as a part of institutionalized Health Care. The media i.e, newsprint and television often report glaring instances of so-called mental health institutions and the powerlessness from which they suffer. The ubiquitous free market with its promise of the modern and its emphasis on a brutal productivity ethics has reinforced traditional structures of exploitation. Chained to a tree for two years, ‘Asainar’ a mental patient has little hope of escaping his madness. Or the insanity that surrounds him at the Erwadi dargah (a religious worship place), in Tamil Nadu. Where hundreds of mentally ill like Asainar are left to rave, rant and rot. Some are shackled for days, others for decades. In August, 2007 a diabolical fire broke in Erwadi dargah and 27 mental patients were charred to death in one of Erwadi’s many hellish ‘mental homes’, the others are still fettered and already forgotten in India’s amnesic collective consciousness (Wadhwa, 2001).

Apart from these startling and revealing occurrences, institutional care is alarmingly impoverished owing to poor doctor – patient ratio. Admissions to such institutions are based on higher exponential values ($10^n$) and health care staff exist in unitary figures only. There are seven million patients in India with psychiatric disability, and twenty five million need psychiatric care. But the infelicity is that there are only thirty-six government run and a handful of private mental hospitals existing in India (Veeraraghavan, 2006).
Only three thousand five hundred mental health professionals are available, when we need a whooping number of four hundred thousand mental health Professionals. The Mental Health Act, 1987, of India stipulates that the government will care for the mentally ill, it lays down procedures for care by mental institutions and forbids chaining. But, just one look at the predicament of the mental patients suggests that the government has proved to be completely incompetent and crass about the whole mental health scenario (Veeraraghavan, 2006).

Proposal for Probable Change from Hopelessness to Hopefulness

Incremental or decremental differences across fixed time series between pathology predisposed and non-predisposed contrasting groups show a confounding effect of growth and recovery due to the intervention of health care programmes.

Trend analysis, could have been carried out but, it allows the investigation of time dependent changes in a pattern of symptomatology, and it hardly includes catastrophic or calamitous in the intervention scenario, as was suggested by Fletcher, J.M. et al. (1990)

Finally, our approach should be based on the study of attribute treatment interactions with access to the moderating effects of social support systems. If we need to revolutionize the mental heath scenario of India, first we have to educate the people about mental health. The two major factors hindering the amelioration of Indian Mental Health Institutions are, ignorance and empathy. The lay people dissociate the mentally challenged patients due to their lack of erudition about mental health, and a large number of doctors dealing with such patients are completely devoid of empathy, treating the patients with the belief that they are never going to redeem their mental integrity. Apart from the affective aspect on concrete levels India needs better medical facilities for the mentally – ill patients. There are mental hospitals no doubts, but these places are more of a prison, devoicing the patients of their human existence and reducing them to crippling animals. With no proper sanitation, lack of proper
medical care, and rooms that looks no better than a cage for two animals, accommodating twenty instead in a zoo.

We need to have certain amount of intervention from Medical Associations like World Health Organization, Indian Psychological Association, United Nations Organizations, etc. The need is to initiate a change, which people can follow. Once, such organizations start proper funding, not only monetarily but also in terms of more awareness, rest will follow suit. Nevertheless, there exists a state of partial hopelessness in India, which indicates that there is still some hope left. The day will definitely dawn when mental patients will be treated as any other patients with a treatable problem only if partially. We have to wait for that fortuitous day when the road to mental emancipation will open up. The question is, for how long?

REFERENCES


