

for registered nurses. Ottawa: The Association; 2002. Available: [cna-aiic.ca/CNA/documents/pdf/publications/PS71\\_Code\\_ethics\\_RN\\_June\\_2004\\_e.pdf](http://cna-aiic.ca/CNA/documents/pdf/publications/PS71_Code_ethics_RN_June_2004_e.pdf) (accessed 2007 May 11).

DOI:10.1503/cmaj.1070031

Editor's note: This letter writer's name and affiliation have been withheld at our request and with the letter writer's consent to protect the privacy of all concerned.

## Treatment of mental illness in India

I read with interest the article by Stephen Kisely and colleagues on inequitable access for mentally ill patients to some medically necessary procedures.<sup>1</sup> In India, the prevalence of major mental and behavioural disorders is estimated to be 65 per 1000 population, which translates to 70 million patients.<sup>2,3</sup>

India's ability to treat, care for and rehabilitate mentally ill patients leaves much to be desired. Mentally ill people are almost never taken seriously; they are treated with little or no dignity and are often locked away.<sup>4</sup> There is only 1

trained psychiatrist for every 100 000 people with a mental illness. Most (75%) mentally ill patients live in villages, where access even to basic health care is difficult. Half (53%) of the state-run psychiatric hospitals do not have a rehabilitation program.

The country's mental health budget does not exceed 1% of total health expenditures. The National Mental Health Programme was implemented to provide services to rural as well as urban populations, but 80% of people in rural areas cannot access its services. Health and labour policy-makers, insurance companies and the general public all discriminate between physical and mental health problems. Mentally ill patients are being systematically and continuously ignored and denied the social rights they deserve.

**Akashdeep Singh**  
Pulmonologist  
Christian Medical College and  
Hospital  
Ludhiana, India

## REFERENCES

1. Kisely S, Smith M, Lawrence D. Inequitable access for mentally ill patients to some medically necessary procedures. *CMAJ* 2007;176(6):779-84.
2. Ganguli HC. Epidemiological finding on prevalence of mental disorders in India. *Indian J Psychiatry* 2000;42:14-20.
3. Reddy MV, Chandrashekar CR. Prevalence of mental and behavioral disorders in India: a meta-analysis. *Indian J Psychiatry* 1998;40:149-57.
4. Kumar S. Indian mental-health care reviewed after death of asylum patients. *Lancet* 2001;358(9281):569.

DOI:10.1503/cmaj.1070045

## Correction

In a recent article,<sup>1</sup> the text referred to a lesion on the patient's right foot, whereas the images showed the patient's left foot. The lesion was indeed located on the patient's left foot, and we apologize for this error.

## REFERENCE

1. Low HL, Stephenson G. These boots weren't made for walking. *CMAJ* 2007;176(10):1415-6.

DOI:10.1503/cmaj.070720

**CMA PMI**

New  
content!

## Superior leadership programs for physicians

What do more than  
**3,000 effective  
physician leaders  
have in common?**

They have benefitted  
from the **CMA PMI.**

Approved for RCPC,  
CFPC, CCHSE credits

**PMI III – Negotiation and conflict /**

**PMI IV – Change management**

23–25 Sept. / 26–28 Sept. ....Halifax, NS

4–6 Nov. / 7–9 Nov. ....Vancouver, BC

**PMI V – Strategic thinking**

19–21 Oct. ....Toronto, Ont.

**In-house PMI also available: On-site courses for health leaders**

P

M

Celebrating 25 years of success!

I

For information: tel. 800 663-7336 or 613 731-8610 x2319;  
professional\_development@cma.ca; or visit [cma.ca](http://cma.ca)

ASSOCIATION  
MÉDICALE  
CANADIENNE  CANADIAN  
MEDICAL  
ASSOCIATION