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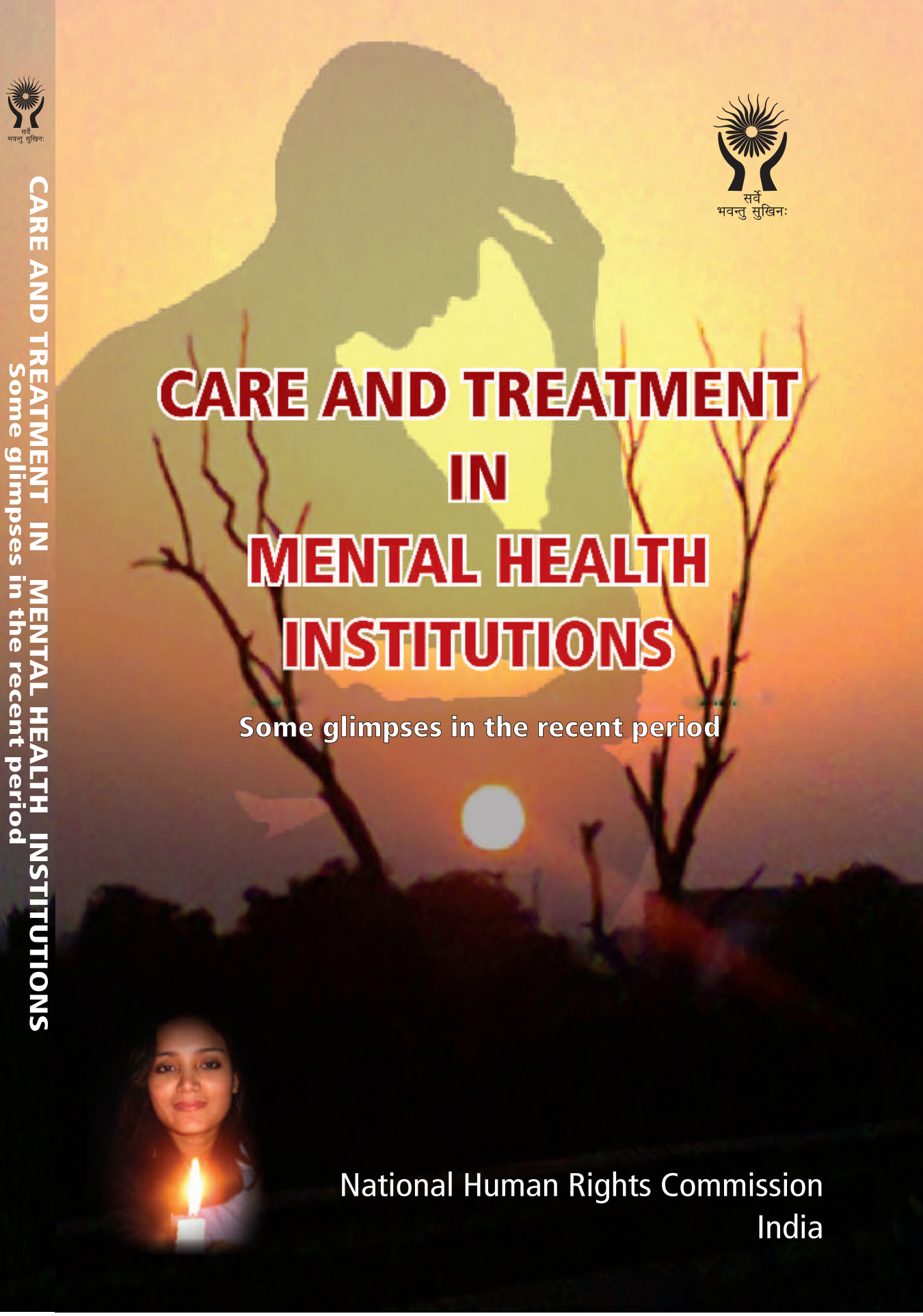
CARE AND TREATMENT IN MENTAL HEALTH INSTITUTIONS
Some glimpses in the recent period



CARE AND TREATMENT IN MENTAL HEALTH INSTITUTIONS

Some glimpses in the recent period

National Human Rights Commission
India

Care and Treatment in Mental Health Institutions– Some Glimpses in the Recent Period

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Some Glimpses in the Recent Period

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CHAIRPERSON NHRC

Foreword

The World Health Organization in 2002 elucidated that health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In other words, it is a condition in which the person can realize his or her own potential, cope with the normal stresses of life, work productively and fruitfully, and is able to contribute to his or her community. Health is thus a vital resource for a nation's development, and its absence represents a great burden to the economic, political and social functioning of any nation.

The International Covenant on Economic, Social and Cultural Rights that was adopted by the United Nations General Assembly on 16 December cially interpreted by the Supreme Court to expand the meaning and scope of the right to life to include the right to health. It is, therefore, necessary that the mentally ill persons are ensured a life of dignity in the spirit of Supreme Court interpretation of the Constitution. Hence, they should not be discriminated or for that matter stigmatized or ostracized and there is a need to provide them with good quality care and treatment. They are required to be fully integrated into the mainstream of society.

As part of the mandate given by the Supreme Court in 1997, the National Human Rights Commission (NHRC) has been monitoring the functioning of three mental health hospitals at Agra, Gwalior and Ranchi. However, with the passage of time it has taken the responsibility of monitoring all the mental hospitals in the country. In this context, the Chairpersons, Members, Special Rapporteurs and officers of the NHRC have been visiting mental hospitals all over the country to know their functioning as well as find out the conditions of mentally ill patients admitted therein for treatment. In 1997-1998, it also undertook a research project on mental health with NIMHANS on "Quality Assurance in Mental Health". In 2008-2009, the Commission brought out the latest status report on mental health entitled "Mental Health Care and Human Rights".

Though the situation with regard to mental health services in India has improved considerably, with the efforts of NHRC, a lot still needs to be done to protect

mentally ill persons. For instance, there is an ardent need to educate and change public attitude towards mental illness and in advocating for the rights of people with mental disorders. In addition, there is need to train more mental health professionals, who are in dearth in this country in order to ensure that mentally ill persons have access to good quality mental health services at each level of the health care system. The Government should also put in place a disability legislation, which does not ignore the rights of people with mental disorders since they are more vulnerably placed in the society. Such legislation should empower them to make choices about their lives, provide them legal protection and ensure their full participation in the community in consonance with the UN Convention on the Rights of Persons with Disability.

This publication is a compilation of visit reports undertaken by the Special Rapporteur of the Commission to mental health care institutions from 2009 to 2011. The compilation will indeed give us an opportunity to assess the improvements that have taken place in the field of mental health care and treatment in India during these recent years.

I am sure this publication will be of immense use to government officers and functionaries of health ministry/departments, mental health professionals, academic and technical institutions, non-governmental and civil society organizations and other stakeholders.

(K.G. Balakrishnan)

Preface

The National Human Rights Commission (NHRC) has taken up several initiatives to improve institutional mental health care. While the Supreme Court mandated to ensure improvement in Government mental health institutions at Agra, Gwalior and Ranchi; the Commission broadened the same on its own to other similar Government institutions across the country. Several visits were undertaken by the Commission and its representatives to mental hospitals in the country to assess the conditions prevalent in them for the mentally ill. It has done so in all areas of institutional care for mentally ill, which include proper physical infrastructure, outpatient departments, human resources and other associated services like food, water and sanitation. Mental illness entails a possibility where grave human rights violations of people affected can occur leading to denial of basic human dignity. These basic facilities can ensure the protection of their dignity. Sensitivity of family members, doctors and other caregivers can further enhance their well being.

The improvements in mental health care in many of these institutions across the country can be attributed to a large extent to the initiatives of the National Human Rights Commission. Today, there is need to supplement this improved institutional care with involvement of community. This alone will result in the protection of all rights of the mentally ill persons in accordance with the provisions of UN Conventions on the Rights of Persons with Disability.

This is a compilation of reports prepared by Dr. L.D. Mishra on the basis of his inspection visits to 13 mental health institutions across the country while serving as Special Rapporteur to the Commission. Important issues relating to mental health care have been discussed in defferent chapters of the compilation. It was the inspiration of Hon'ble Chairperson, Justice Shri K.G. Balakrishnan and the Secretary General, Dr. Rajeev Sharma and dedicated efforts of Dr. Balbir Kaur Teja, Special Rapporteur that resulted in this useful output.

Dr. Savita Bhakhry, Deputy Secretary (Research), Shri Nishith, Assistant and Shri Shayandeb have also contributed to the final shape of this book. While it lists the existing gaps it also highlights good practices which could be important beneficially implemented by other institutions and stakeholders. It is hoped that the publication would be put to best intended use.

(J. S. Kochher)
Joint Secretary (Training)
NHRC

Introduction

Every human being has certain irreducible barest minimum needs such as right to fresh air, potable water, nutritious food, clothing, health, medical care and treatment, clean and hygienic living accommodation, proper sanitation, personal hygiene, speedy trial if involved in criminal offence, and so on. Deprivation from any one of these needs amounts to violence to the person. Human dignity is the quintessence of human rights. Every human being is entitled to be treated with dignity, decency and equality regardless of the fact that they are born differently, grow differently, have different mental makeup, thought process and life-style. Denial of dignity would mean denial of human rights.

A mentally ill person is neither a non-human nor a half human; he/she is as much a complete human being and is entitled to the same inalienable human rights as available to other normal human beings. He/she is entitled to be treated with dignity, decency and equality as any other human being and cannot and should not be discriminated against. He also has a right to rehabilitation and reintegration with family, community and mainstream society.

Mental illness represents a range of diverse conditions where serious infringement of human rights can occur from deprivation of a person's dignity and right to life, to complete denial of rights to lead a fulfilling life. Since a mentally ill person is unable to fend for himself/herself, having regressed into that state of body and mind where he/she has lost the insight into the essence of human existence, he/she is in need of social defence. Such a defence must be jointly provided by the caregiver members of his family as well as care givers of the mental health hospital, i.e. Medical Officers and paramedics. In case, the caregivers of the family do not rise to the occasion, the care givers of the hospital should not fail in helping the patients.

Human rights of the mentally ill at home

- The mentally ill person should be treated with dignity, decency, kindness and compassion;
- Information that someone at home has been afflicted by mental illness should not be suppressed on account of prejudices that such disclosure will adversely affect the interests of that person and image of the family;
- Mentally ill person should be taken to mental health hospital immediately without any delay for check-up, diagnosis and admission if considered necessary by the Psychiatrist/Clinical Psychologist.

- Once a decision is taken by the treating physician to admit mentally ill person as In Patient Department patient, family members and relatives of the patient should respect such a decision and volunteer to stay with the patient in open/family ward, furnish accurate postal address to hospital authorities at the time of admission and their relationship with the patient;
- Ensuring that after the person has been effectively treated and fit for discharge, he/she is taken home, treated kindly and given the best care and attention, ensuring strict and timely compliance with prescribed medicines to avoid relapse of illness;
- The family members should bring patient to the hospital for follow up and collection of medicines (normally they are issued for 30 days) and need to ensure drug compliance issued by the treating physician in the wake of such follow up;
- Family members should Infuse hope, faith and confidence in the mind of the recovering person all the time that he/she can be effectively treated, cured and can resume a normal life like in any other illness; extend cooperation to the psychiatric social worker follow-up home visits.

Human rights of the mentally ill at the hospital

- No person seeking help for mental distress or illness should be refused examination at the Out Patient Department (OPD) on any ground whatsoever;
- Similarly no patient should be refused admission as an inpatient if the same is considered necessary by the physician examining him/her;
- No mentally ill person or their caregivers should be subjected to any abuse or offensive treatment or treatment that borders on cruelty or torture; instead they should be treated with utmost civility, courtesy and consideration;
- No patient, howsoever violent or aggressive, should be brought with fetters and should be allowed to remain with fetters. If violence and aggression persists, the patient should be put under sedation and kept in an observation room till such time he/she is fully tranquillized and brought to the Medical Officer in the OPD for examination, diagnosis and a decision taken whether the patient should be admitted as an IPD patient;
- There should be proper seating arrangement for patients along with their family members/relatives and provision of clean potable water, toilet, newspapers (through a stand) and television; a hospital canteen in the OPD
- At the OPD there should be sufficient number of registration counters to cater to the needs of people in different age groups (adults, adolescents, elderly and the children) as also women and men;

- People at the registration counter should be given orientation and training to be civil, courteous and considerate with everyone seeking care, particularly the elderly;
- Entire information pertaining to personal history, family history, case history, nature of ailment etc., should be collected at the time of registration in a friendly and humane manner and family members/ relatives accompanying the patient should extend full cooperation to the process of collection;
- The drug dispensing unit should be located within the OPD premises for the benefit of outdoor patients;
- Many of the mentally ill persons brought to the OPD also suffer from other associated complications like appendicitis, cardio vascular and respiratory complications, complications relating to kidney, liver, pancreas, intestine, pelvis, prostate, urinary tract etc. These associated complications must receive due and timely attention. If facilities for investigation, diagnosis and treatment are not available in the concerned mental health hospital the patient should be referred to a general hospital for specialized treatment through a prior consultation and formal arrangement. The Medical Officer referring the case should maintain a proper liaison and coordination with the specialist in the general hospital in regard to progress in investigation, diagnosis and treatment;
- In case of critically ill patients the endeavour should be to save the life of the patient at any cost. This would involve maintaining a close and constant vigil over the condition of the patient from time to time;
- In case a decision is taken to admit a mentally ill patient in the hospital, certain rights accrue to patient in IPD. These include right to wholesome, sumptuous, balanced and nutritive food according to certain prescribed scales i.e. 2500 kilo calories for women and 3000 kilo calories for men; adequate quantity of water for washing, bathing, clean and potable water for drinking and cooking; personal hygiene including mechanized laundry and clean and hygienic kitchen, adequate number of clean toilets; books, journals, periodicals and newspapers in local language; recreation (television in the room, dance, drama, music, other cultural activities, games and sports); communication.

The mentally ill persons at home and in hospitals have certain rights which they are particularly vulnerable to abuse and violation of their rights. If a protective mechanism is not in place, they can be susceptible to abuse by anyone in society including family members, caregivers, professionals, friends, fellow citizens and even law enforcing agencies.

In a country like India, mental health care is not perceived as an important aspect of public health care. Hence, mental health legislation will play an important role in upholding the rights of mentally ill and ensuring them appropriate,

adequate, timely and human health care. The fundamental aim of mental health legislation is to protect, promote and improve lives and mental well- being of citizens. It also plays a vital role in laying down the terms and conditions of mental health care and protecting the rights of disadvantaged, marginalised and vulnerable people with mental disorders.

The available laws should address not only curative but also preventive, promotive and rehabilitative aspects. Legislation is needed to prevent discrimination against persons with mental disorders. Discrimination takes many forms, affects several fundamental areas of life and is pervasive. Discrimination and stigma may impact access to adequate treatment and care as well other areas of life, including employment, education, marriage and shelter. The inability to integrate into society as a consequence of these limitations can increase isolation experienced by individuals, which can in turn aggravate mental disorder. The presence of mental health legislation, however, does not in itself guarantee respect and protection of human rights until there is commitment from political and social structures as also the people concerned in implementation.

Role of Judiciary in protecting human rights of mentally ill persons

Since mental health takes a back seat and is largely ignored, public litigation and media exposure plays a role in highlighting gross violations of human rights. Judiciary therefore, plays a specific role in addressing some of the critical mental health care needs of the country. Supreme Court and State High Court decisions have tried to address the issues pertaining to denial of rights to mentally ill people.

The courts in India have held in a number of cases that mental health is an integral and inseparable part of health and have repeatedly extended that there lies a positive duty on the part of the Government to promote health and right to live with human dignity which are fundamental rights enshrined in Article 21 of the constitution of India. The guiding principles enunciated by the Apex Court in some of these judgements are referred as under:-

- In Hussainara Khatoon (No.1) vs. Home Secretary, Bihar, it was held by the Apex Court that “right to a speedy trial, a fundamental right, is implicit in the guarantee of life and personal liberty enshrined in Article 21 of the Constitution”. Speedy trial is the essence of criminal justice. These principles were reiterated in Abdul Rehman Antuley vs. R.S. Nayak in which detailed guidelines for speedy trial of an accused were laid down even though no time limit was fixed for trial of offences.
- In a public interest litigation (PIL), involving Veena Sethi vs State of Bihar case in 1982, the court was informed through a letter that some prisoners, who had been insane at the time of trial but had subsequently been declared sane had not been released due to inaction of the state authorities, and had remained in jail for 20 to 30 years. The court directed them to be

released forthwith, considering the requirement of protection of right to life and liberty of the citizen against the lawlessness of the state.

- In a Public Interest Petition Dr. Upendra Baxi vs. State of Uttar Pradesh & others was filed before the Hon'ble Court (1981) to enforce human rights of protective home inmates at Agra, UP, who were kept in abject dehumanized living conditions, the Hon'ble court issued various appropriate directions from time to time in order to ensure that the inmates of the Protective Home at Agra do not continue to live in inhumane and degrading conditions and that the right to life with dignity enshrined in Article 21 of the Constitution is made real and meaningful for them.

- In a set of Public Interest Petitions B.R.Kapoor & others vs Union of India and others (1983) and PUCL & Others vs Union of India & others (1983) filed before the Hon'ble Court regarding Shahdara Mental Hospital, Delhi, Hon'ble court observed that the Mental Hospital located at the capital of the country should be run by the Union of India and not by Delhi Administration. The Hon'ble court directed that the Mental hospital located at Shahdara should be modelled on the lines of similar psychiatric speciality obtaining at the institution run by NIMHAS at Bangalore, and also directed to examine as to whether the hospital could be attached to a teaching institution which has post graduation specialization in Psychiatry, Neurology and Neuro – Psychiatry. This led to the formation of the Institute of Human behaviour and Allied Sciences, IHBAS.

- In the case of Chandan Kumar Bhanik vs. State of West Bengal (1988) the apex Court observed: "Management of an institution like the mental hospital requires flow of human love and affection, understanding and consideration for mentally ill persons; these aspects are far more important than a routinized, stereotyped and bureaucratic approach to mental health issues".

- In the case of Sheela Barse vs. Union of India and others (1993) the apex Court observed that admission of non-criminal mentally ill persons in jails is illegal and unconstitutional; All mentally ill persons kept in various central, district and sub jails must be medically examined immediately after admission; Specialised psychiatric help must be made available to all inmates who have been lodged in various jails/sub jails; Each and every patient must receive review or revaluation of developing mental problems; A mental health team comprising clinical psychologists, psychiatric nurses and psychiatric social workers must be in place in every mental health hospital.

- The apex Court in its judgement in Rakesh Chandra Narayan vs. State of Bihar (1986) had laid down certain cardinal principles. These are: Right of a mentally ill person to food, water, personal hygiene, sanitation and recreation is an extension of the right to life as in Article 21 of the

Constitution; Quality norms and standards in mental health are non-negotiable; Treatment, teaching, training and research must be integrated to produce the desired results; Obligation of the State in providing undiluted care and attention to mentally ill persons is fundamental to the recognition of their human right and is irreversible.

The apex Court in Rakesh Chandra Narayan vs. State of Bihar case requested the National Human Rights Commission (NHRC) to be involved in the supervision of mental health hospitals at Agra, Ranchi and Gwalior w.e.f. 11.11.1997. It stated as under :

"Having dealt with this matter for some time, we have formed the opinion that a better method for supervision of the functioning of Agra Protective Home is necessary. Now that the benefit of the National Human Rights Commission (NHRC) with statutory powers under the Protection of Human Rights Act, 1993 is available and since most of the problems associated with the functioning of Agra Protective Home are such that they can be better dealt with by NHRC we consider it expedient to make this order to involve the NHRC in the exercise.It is likely that the pendency of this matter and the directions made by this court may have to some extent inhibited the NHRC in exercise of its ordinary functions relating to Agra Protective Home so far. The order we make herein will also have the effect of removing any such impression or inhibition"'

'We have today made an order in WP (Criminal) No. 1900/81 (Dr. Upendra Baxi Vs. State of U.P. and Others) requesting the " we now request the NHRC to be involved in the supervision of the functioning of Agra Protective Home to ensure that it functions in the manner as is expected for achieving the object for which it has been set up"

The Hon'ble court further observed " This matter pertains to the functioning of the Agra, Gwalior and Ranchi mental Asylums. We have today November 11th 1997 in Dr. Upendra Baxi vs State of Uttar Pradesh & others requested the NHRC to be involved in the supervision of the functioning of Agra Protective Home in the manner indicated in the order. We are of the opinion that the same kind of order needs to be made in this matter also relating to Agra, Ranchi and Gwalior asylums. Accordingly, we request the NHRC to perform this exercise in the same manner"

- The Hon'ble court vide order dated 12.5.2000 disposed of the Writ Petition (Dr. Upendra Baxi, observing "Now that the National Human Rights Commission is seized of the matter it will not be appropriate for this court to proceed any further in this writ petition. The petition is accordingly consigned to the records if and when the Commission requires any help or assistance from the court it is at liberty to make an appropriate application. The writ petitions are disposed of".

Initiatives taken by National Human Rights Commission

Upon being entrusted by the Hon'ble Supreme Court to be involved in the supervision of the functioning of three mental hospitals in Agra, Gwalior and Ranchi; and mandated under section 12 of the Protection of Human Rights Act 1993 to visit, notwithstanding anything contained in any other law for the time being in force, any jail or other institution under the control of the State Government, where persons are detained or lodged for purposes of treatment, reformation or protection for the study of the living conditions of the inmates thereof and make recommendations thereon to the Government, NHRC has adopted a totally open, transparent and participative style of monitoring the pace and progress of activities in the hospitals keeping the human rights dimension uppermost in view. It has hitherto used monitoring as a tool of correction and promotion of human rights of the mentally ill persons.

National Human Rights Commission prepared a Plan of Action for improving the conditions in mental hospitals in the country and enhancing awareness of the rights of those with mental disabilities. The significant initiatives taken by the Commission since the year 1997 are summarised below:

- The Commission on its part conceptualised and translated to action a Project in collaboration with NIMHANS Bangalore on 'Quality Assurance in Mental Health Care' in the country with Justice Shri V.S. Malimath, former Member of NHRC as Project Director and Dr. S.M. Channabasavanna, former Director and Vice Chancellor, National Institute of Mental Health and Neuro Sciences (NIMHANS) as the Principal Investigator along with a team of specialists as investigators. The objectives of the project were to analyse the existing status of mental health hospitals, shortcomings and inadequacies; comprehensive recommendations to achieve the object of ensuring quality mental health care in the country. The NIMHANS team took enormous pains to visit and intensively review the functioning of 37 mental health hospitals all over the country in a very short time.

The review ended with a series of recommendations including steps to improve physical facilities, treatment and care of patients, occupational therapy as a tool of rehabilitation, training and research, and community outreach programmes. The recommendations included immediate abolition of cell admissions; gradual conversion of closed wards into open wards; construction of new wards of smaller capacity (not more than 20) for use as open wards; streamlining admission and discharge procedure in accordance with provisions of the Mental Health Act, 1987; upgradation of investigation facilities; in service training of all staff members; providing each patient a cot, mattress, pillow, bedsheet and adequate clothing for change; improving supply of water and electricity; ensuring supply of nutritive food of 3000 kilocalories per day to each patient; developing occupational therapy facilities; improving recreational facilities; developing rehabilitation facilities including day care centres. The report on 'Quality Assurance in Mental Health' was published by NHRC and released by

Union Home Minister in June 1999. The report was sent to all the mental hospitals as well as to the Union Ministry of Health and the State Governments/ Union Territory Administrations for necessary follow up action. The States/ UTs were requested to apprise the Commission periodically on progress of implementation of the report, a matter which it continues to pursue till date.

Since June 1999, when the 'Quality Assurance in Mental Health' report was released, the Chairperson, Core Member in charge of mental health and other members as also Special Rapporteurs have been regularly inspecting and reviewing the activities of all the 37 mental health hospitals including GMA, Gwalior, IMHH, Agra and RINPAS, Ranchi to know their functioning as well as find out the conditions of mentally ill patients admitted therein for treatment. The human rights dimension of mental health has occupied a significant place in all these visits, reviews and inspections.

- The Commission constituted a Central Advisory Group (CAG) headed by its Chairperson with a view to suggest appropriate course of action in the area of mental health. The CAG included Secretaries from the Ministries of Health, Social Justice & Empowerment and senior Advocates of the Supreme Court. The CAG further constituted a Sub - Committee headed by a Member of the Commission, with representations from Secretaries of the Ministry of Social Justice & Empowerment and Department of Women & Child Development to advise it on the steps to be taken to rehabilitate patients who languished in the hospitals even after they were cured of mental illness.
- In 2003-04, the Commission constituted a core group on mental health. A series of recommendations made by the Core Group on Mental Health during 2007-08 included that the basic needs of mentally ill persons should be met and they should have access to all entitlements such as old age pension which are available to ordinary citizens.
- In 2003-04, another research project "Operation Oasis - A Study Related to Mentally Ill Persons was undertaken by the Commission in collaboration with Kolkata based NGO, SEVAC.
- The Commission formulated guidelines on reporting every death that took place in the three mental hospitals during 2003-04.
- In 2008-09, the Commission brought out the latest status report on health entitled "Mental Health Care and Human Rights".
- It made a Video documentary in Hindi and English highlighting various issues pertinent to comprehensive care of mentally ill in hospitals. The documentary also emphasised the responsibilities of all levels of care givers in the mental hospitals.
- The Commission urged the Medical Council of India and Ministry of Health & Family Welfare during 2008-09 to augment their efforts for meeting the

demand of adequate manpower in the field of mental health.

- During 2008-09, NHRC in collaboration with NLSIU and NIMHANS, Banglore organized a National Conference on Mental Health and Human Rights. Thereafter, five Regional Review Meetings on Mental Health were organized by the Commission during 2009-11 and a series of recommendations were made, such as, there is need to delegate powers to the Directors of Mental Health Institutions by their respective State Governments and there is also a need to ensure availability of free medicines to the patients. These recommendations were sent to all stake holders and its compliance is being monitored by the Commission.

It also needs to be understood and appreciated that many of the mental health hospitals are hangovers of the colonial era and are 100 to 150 years old (some even 200 years). Their problems and constraints remained unattended to for years. Their resources-both human, material and financial are extremely limited in relation to the long 'list of deficiencies and shortcomings. Mental health in the overall scheme of development in the Departments of Health of the State Governments does not receive the same priority attention as general health.

In such a scenario, the NHRC can only play the role of a promoter, facilitator and catalytic agent as also a watch dog. It cannot, however, substitute the primary role or mandate of State Governments to ensure mental health as a matter of human right to every individual. Besides, it is not one department but a host of departments and agencies who are stakeholders in the process. Hence, there is a need for a coordinated and concerted effort on the part of all stakeholders to ensure a dignified care and treatment system for the mentally ill persons in the country.

Physical Infrastructure

The Section 10 of Mental Health Act, 1987 clearly provides that every psychiatric hospital and psychiatric nursing home shall be maintained subject to conditions laid down in Rule 20 of the State Mental Health Rules, 1990 that – such hospital or nursing home is located in a building constructed with the approval of the local authority; the building where such hospital or nursing home is situated, has adequate floor space depending upon the number of beds and has sufficient ventilation and is free from any pollution which may be detrimental to the patients admitted in such hospital or nursing home.

Under these prescribed conditions there are certain functional space requirements which represent the irreducible, barest minimum needs for a modern mental health hospital and are, therefore, non-negotiable. These functional requirements are: OPD space which includes sitting space for patients and their relatives waiting to be examined; space for Medical Officers examining the patients; registration counter; waiting space at the registration counter; record room; a room to accommodate patients and their relatives coming from far off places and reaching hospital after OPD hours to enable them to avail OPD services on the next day; drug dispensing unit; space for air conditioned modified ECT with a recovery room; pathological laboratory; biochem laboratory; space for ECG, EEG, X-Ray, MRI, CT scan etc.; case conference room; IPD space including male and female closed wards; male and female open wards; paying wards; space for toilets/bathrooms in each ward; space for the MOs room and nursing sisters room in the In Patient Department; kitchen with arrangement for storage space (for vegetables, fruits and provision), room for cooks to change their aprons, space for electric kneader, platforms for cleaning, washing and cutting vegetables, space for making chapattis etc.; dining space in each ward; separate occupational therapy units for male and female patients; separate big hall for yoga, pranayam, meditation, prayer and recreation for male and female patients; library-cum-reading room for the patients; automatic laundry; separate space for teaching block including rooms for members of the teaching and treating faculty; lecture rooms; auditorium; convention centre for holding national and international seminars, symposia and workshops; conference room; conference room; psychological testing laboratory; library-cum-reading room for the faculty members; space for administrative block a composite unit comprising superintendent/ director's room; matron's room; room for head of the security establishment and mini parks.

The infrastructure should ensure a balanced combination of the arrangements for teaching, treatment, training and research as emphasized by the Supreme Court. In the light of above guidelines, the infrastructure found at the various hospitals across the country during inspections carried out by NHRC is described below

Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

The Institute of Mental Health, Hyderabad was initially leased from the Royal Air force of Nizam at the rate of Rs. 200 per acre but subsequently handed over to the Nizam's Government. It is an irony that the land and buildings have not been formally alienated in favour of the hospital. The original land owners are demanding restoration of land to their possession and have filed restoration suits in the Civil Court.

The total area of Institute of Mental Health Hyderabad was 48 acres, of which 2.4 acres had been taken over by the Municipal Corporation of Hyderabad and 1.5 acres by the Hyderabad Urban Development Authority (HUDA) for developing a nursery. Some land had been handed over to the forest department for developing the area. However, no landscaping had been done and no saplings had been planted in a planned and systematic manner.

There was no proper approach road to the hospital. The narrow approach road leading to the Superintendent's room and the administrative block was full of pot holes. All the pathways within the hospital premises connecting one department/ unit to another were full of red morrum soil and muddy. The unlevelled high and low lying areas were providing scope for accumulation of water and unclean and unhygienic surroundings. The hospital premises were full of outgrowths and these outgrowths could provide shelter to reptiles and adversely affect the safety of inmates.

The IMH had casualty and emergency services, ambulance facilities, a commodious waiting hall in the OPD but a very small registration room. The total bed strength of the IMH was 600 and there were no cells. It had family ward, open wards, closed wards, criminal ward and de-addiction ward, and a separate acute admission ward. These wards had adequate space, lighting and ventilation, but inadequate number of toilets. The kitchen block and dining halls in the wards were fairly spacious in size with adequate lighting but kitchen walls had holes, damaged floor and shattered windows. There was 24 hour supply of portable water. The IMH had occupational therapy units and two separate libraries for the staff and patients/family members.

Suggestions

- The future expansion plans of the hospital included landscaping of the hospital, construction of the planned new structures including modern kitchen, geriatric ward, child guidance unit, half way home, day-care centre, staff quarters, nurse's hostel, PG student's hostel, and a small guest house within the premises of the hospital.

- The subjudice dispute over ownership of IMH land needs to be addressed by the State Government of Andhra Pradesh with the highest priority. The Advocate General should be engaged to contest this land dispute on behalf of IMH. The endeavour should be in the direction of not causing any dislocation to the functioning of the hospital, however, without ignoring the rightful claims of the claimants over the hospital land. If necessary, the best legal brains of the country should be consulted to arrive at a just and fair solution which should be in the larger public interest.

Government Hospital for Mental Care (GHMC), Visakhapatnam (30th and 31st March, 2009)

The ownership of the land of Government Hospital for Mental Care, Vizag was with Department of Health, Medical & Family Welfare, Govt. of A.P. Hyderabad. Of the total land area of 47.92 acres, Hospital of Mental Care was allotted 15.38 acres.Other allotments were as under:

- Regional Laboratory -1.45 acres
- ENT hospital- 3.87 acres
- Chest & ID hospital -10.16 acres
- vacant site proposed for Cold Chain complex- 2.13 acres
- road area- 4.11 acres

The vacant land of 10.82 acres was planned to be sold and the sale proceeds were meant to be used for construction of new hospital buildings. The plan, however, was not implemented.

The new hospital building at an estimated cost of Rs. 12 crores had come under occupation since Feb. 2006. There was a large waiting space comprising three to four large verandas with benches and PVC moulded chairs for OPD patients/ family members. There was an administrative building, a laboratory, 12 consultation rooms for the OPD patients, an observation room to keep violent and aggressive patients for administering sedatives till they become normal, a drug dispensing unit, a small recovery room attached to ECT room.

All cells had been abolished and dilapidated wards had been demolished. The total bed strength of this hospital was 300. Of these, 220 beds were in closed wards and 80 beds in open wards. There was no congestion and overcrowding in the wards. There were 20 inpatients in each ward and the gap between the 2 beds was one metre. The toilet patient ratio was 1:1.6. All the wards were having good lighting and ventilation. There were separate occupational therapy units for male and female patients. Manovikas, a training and rehabilitation centre for the mentally ill had been started in the hospital premises on 15th August, 2007. Internal roads had been repaired and there was adequate provision of street lights. However, there were no staff quarters, no hostel for PG students within the premises of the hospital and the library was ill equipped.

Suggestions

- The NHRC team had also observed that GHMC Visakhapatnam needs a lot of open space to develop facilities for exercise, games, gardening and horticulture and recommended that the vacant land of 10.82 acres presently in possession of the Superintendent of the hospital should not be taken away from the institution for any other purpose. In accordance with the recommendations made by NHRC, Government may issue a formal order to allot the vacant land to the hospital for its future expansion and growth.

Institute of Human Behaviour and Allied Sciences Shahdara (IHBAS), Delhi (13th August, 2010)

Institute of Human Behaviour and Allied Sciences (IHBAS) had 100 acres of land with total built up area of 301326.42 square metres. The hospital had been equipped with many state-of-the-art infrastructures which included a centrally air conditioned academic block; a diagnostic block; two new buildings of neurology block and psychiatry block with centralized ICUs and private wards; a neurosurgery block with two operation theatres; a separate OPD block with 24 hour emergency services; waiting hall with toilet facilities for ladies, gents, physically and orthopaedically handicapped persons; registration room, medical record, drug dispensing room; pathological and biochemical laboratories; Yoga therapy and research centre; a canteen to serve tea and snacks to hospital staff and patients/ relatives; facilities for disabled persons; provision of dharmshala for family members/relatives of OPD patients.

IHBAS with total sanctioned bed strength of 500 had different types of wards including semi open wards (Male, Female) 20 beds each; open wards (Male, Female) 20 beds each; Child and Adolescent Ward – 10 beds; Chronic (Rh) Ward (Male Female) 20 beds each; Private Ward (Paying Ward) 05 beds; De-addiction Ward – 20 beds; Psychiatric ICU – 5 beds; Forensic Ward – 20 beds. It had a modular kitchen; adequate quantity of portable water and a RO plant; two separate libraries for officers, faculty members and ministerial staff and library for use of inmates; separate occupational therapy units for male and female inmates. IHBAS, Shahdara, however, lacked a proper landscaping and large geographical area (roughly 90 per cent) was not put to optimal use. As a result, a lot of space got covered by wild outgrowths.

The quality of the civil works and maintenance was not upto the mark despite IHBAS having its own full fledged civil and electrical engineering department responsible for repair and maintenance of the hospital due to lack of vigilance and surveillance to ensure quality of work. The problems observed included vertical and horizontal cracks, leakage and seepage, damaged pavements, uneven low lying open spaces where water could accumulate during rains.

Suggestions

- IHBAS should work out a plan for optimal utilization of the vacant space. The action plan should include a well- furnished convention centre at par with NIMHANS to host national and international conferences on mental health and neuro sciences. Such a convention centre has also been contemplated for RINPAS Ranchi. The action plan should also include a separate research block to enhance the scope and content of research activities in the area of mental health and neuro sciences besides a separate well-furnished teaching block comprising lecture theatres and seminar halls. There is also need to develop the existing residential area with market, playground and community hall to enable residents of the residential complex of IHBAS have access to better facilities for a modern living.
- A substantial portion of 100 acres of land was lying unutilized. It may be useful if IHBAS could, on the same model as RINPAS, Ranchi develop the unutilized area into an agricultural estate and grow fruits, vegetables in addition to maintaining a dairy and poultry unit and promoting pisciculture in a tank to be carved out of a portion of unutilised land. This would help in making IHBAS self - sufficient to a large extent and bring down its dependence on others for certain supplies.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

The 140 year old prison like structures and old buildings of Hospital of Mental Health Ahmedabad had been totally demolished and a new building with units/ sub units had come up in phases over a period of 10 years. The total area of 31,872 sq. metres of the hospital campus comprised of built up area -11,800 sq. metres, open area - 4751.0 sq. metres (within the hospital campus) and open land area - 15,321.0 sq. metres. The open land area could be used for future expansion and growth of the institution. The 10 green belts and parks had been built in the hospital land where patients of the open ward can sit with their family members and relax.

The hospital had well equipped emergency ward; commodious, well lighted and ventilated rooms for Psychiatrists, Clinical Psychologists and Psychiatric Social Workers; a well-equipped pathological-cum-biochemical laboratory but there was no canteen in the OPD. It had a total sanctioned bed strength of 317 with 5 closed for male and female patients and 2 open/family wards for male and female patients; separate acute patients ward, chronic patients ward, isolation psychiatric care unit, recovered patients ward; post ECT ward; and criminal ward. Each ward had on an average 20 to 30 patients. There were no paying or special wards. The rooms of the wards were well lighted and ventilated. There were 54 toilets and 50 bathrooms and provision of solar heating system. There were facilities of vocational therapy and separate library for patients and their relatives. The demolition of the old structures including the residential blocks had substantially

reduced the availability of staff quarters within the premises of the hospital.

The existing structures lacked architectural elegance and functional utility and there was very little landscaping and sylvan surrounding. Though the structures were not very old but suffered from structural deficiencies characterized by cracks, leakage and seepage. There was excessive seepage on walls and a number of horizontal and vertical cracks in the OPD, IPD, kitchen, dining hall and OT rehabilitation unit.

Institute of Psychiatry and Human Behaviour (IPHB), Goa (6th to 9th December, 2010)

A new Institute of Psychiatry and Human Behaviour (IPHB) was set up by amalgamating the Department of Psychiatry of Goa Medical College with the Mental Hospital at Altinho. The Institute of Psychiatric and Human Behaviour was constructed at Bambolim at an estimated cost of Rs. 3.5 crores to provide medical and mental health care services, teaching at undergraduate and post graduate level and conduct training and research in Psychiatry.

The IPHB Goa had a total land area of about 70 acres and total built area of 6850 sq. meters. There was no landscaping and the vacant space was full of wild outgrowths. The functional space of IPHB Goa included OPD waiting hall for patients and their relatives; Consultants and Residents cabins; Registration counter and waiting space at the registration counter; Record Room; ECG facility in observation/emergency room; Drug dispensing unit; Modified ECT/Recovery Room; Pathological Laboratory; Biochem laboratory; Psychological testing laboratory; Child Guidance Clinic; 2 separate open wards for male and female patients; 3 closed wards for female and 4 closed wards for male patients; Toilets/ bathrooms in each ward; Kitchen; Separate occupational therapy units for male and female patients; Rest rooms for MOs, para medical staff, nursing sister in each ward; Separate library-cum-reading rooms for faculty members and patients.

There was no proper approach road to the hospital. The main road from State Guest House/Circuit House to the hospital (a stretch of 12 kms) was full of pot holes and damaged at a number of points due to heavy rains. The vacant space between the main road and the hospital had not been paved and was full of pebbles. There was no proper parking shed for general public. There was no park inside the hospital for relaxation of inmates of open wards and their family members.

IPHB had taken up the work of landscaping, planting saplings suitable for the red morrum and gravelly soil of the hospital land and developing lawns through the office of the Dy. Conservator of Forests, Social Forestry, Parks and Gardens Division Panda Goa and Range Forest Officer Panaji.

Suggestions

- IPHB Goa should measure the physical space available for each functional

requirement of OPD, IPD, kitchen, store, and library and determine the adequacy of the same on a rational and scientific basis. The functional units including automatic laundry; yoga, pranayam, meditation, prayer and recreation centre; library-cum-reading room for inmates; physiotherapy centre; independent EEG, X-ray etc. should be created on priority.

- IPHB Goa needs to attend to the problem of cracks in some of the columns and seepages in some wall joints on priority. In a heavy rainfall zone, it is desirable to go in for roof treatment on a permanent basis with adequate outlet for discharge of rainwater and application of weather coat paint on the boundary wall, outer walls and roof to ensure that the rainwater does not go in.

Ranchi Institute of Neuro Psychiatry and Allied Sciences (RINPAS), Ranchi (27th to 29th January, 2010 and 24th to 26th February, 2011)

The land area in possession of RINPAS had reduced substantially from 500 acres to 300 acres due to encroachments by temple, mosques and Birsa Munda Agricultural University. Despite repeated prodding and goading the encroachments on land had not been removed.

RINPAS had a health information centre and better seating arrangement with provision of toilets and canteen in the OPD. It had a causality ward; pathology laboratory; psychological laboratory and physiotherapy unit, a well-furnished library. RINPAS had separate occupational therapy units for both male and female patients and a yoga centre. It also had fully furnished dining rooms and an RO plant.

There had been substantial improvement in the pace and progress of execution of civil works. A new teaching block had been constructed and became functional. The construction of new OPD building; Male and Female Casualty Block: Cafeteria; VIP Guest House; Boundary wall at the warder lane area; Special repair of boundary wall around agricultural estate; Septic tank, soak pit, chamber for toilets of male and female wards; 50 bedded male students hostel had been completed. The projects under way were Technical Block, Ladies Hostel, Cottages, Medical Library, Transit hostel and Modular kitchen etc, Special repair of Type D and E quarters, Drug Deaddiction Centre, Halfway Home, and Child Guidance Clinic for mentally retarded children. New projects including rain water harvesting system for every building of RINPAS, sewerage treatment plant had been approved by MC and renovation of toilets and bath rooms had been approved by the Works Sub Committee and awaiting the approval of MC.

Suggestions

- The issue of removal of encroachments on the land of RINPAS should receive serious and urgent attention of Government of Jharkhand. The Divisional Commissioner may consider the need for a firm and decisive

administrative action to deal with these encroachments and restoration of land required for future expansion to RINPAS after eviction.

- The Government should accord its sanction and make budgetary provisions for Technical Block, Ladies Hostel, Cottages, Medical Library, Transit hostel and Modular kitchen, Special repair of Type D and E quarters, Drug Deaddiction Centre, Halfway Home, and Child Guidance Clinic for mentally retarded children etc, which had been approved by Management Committee and estimates prepared by execution agency. The Department of Health and Family Welfare may also give its approval for new projects such as rain water harvesting system for every building of RINPAS and sewerage treatment plant approved by the MC and also select a suitable executing agency for execution of these projects in accordance with the norms of standardization of time, cost and quality control to minimize the cost of repair and maintenance. The works Sub Committee under the Chairmanship of the Deputy Commissioner, Ranchi needs to meet more frequently to identify the factors responsible for withholding commencement of the projects and find out ways and means to overcome them.

Government Mental Health Centre (GMHC), Thrissur (14th April, 2009)

The Government Mental Health Centre (GMHC) Thrissur had a land area of 14 acres and sanctioned bed strength of 361. GMHC had a waiting lounge and a veranda to accommodate OPD patients; two consultation rooms; one treatment room with provision of ECG; small sized rooms for clinical psychologist, psychiatric social worker and occupational therapist; a duty room for medical officer; staff nurses room; changing cum resting room for nursing assistants and attendants; spacious pharmacy; pathological and psychological laboratory. There were 7 old and 8 new blocks; 5 closed and 2 open/family wards; 1 forensic ward; 1 pay ward; 3 pavilion wards; two separate occupational therapy units for male and female patients; fully furnished dining halls and library for inmates. There was no well lighted and ventilated modular kitchen and there was no park in GMHC. Executive Engineer, PWD Buildings Division had been requested for dismantling two old blocks and the State Government had been simultaneously moved for provision of funds.

Suggestion

- GMHC Thrissur may use the vacant land available within the premises of hospital for future growth and expansion of the hospital including expansion of the library building by adding a reading room; staff quarters; day care centre; geriatric ward; child and adolescent guidance clinic; pathological and biochemical laboratory; and psychological laboratory. The State Govt. may allot additional 20 acres of Government land subject to its availability for future expansion and growth of GMHC Kozikode and if Govt. land is not available, the Govt. may acquire/purchase private land and give it to GMHC.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

Government Mental Health Centre Kozhikode had a total land area of about 20 acres at Kuthiravattam and total plinth area of 500 sq meters and built up area of 12000 sq. meters. The total land area of 20 acres for a hospital with bed strength of 474 and bed occupancy sometimes going beyond 500 was rather small in comparison with RINPAS, Ranchi with 500 bed strength and land area of 350 acres or IMHH, Agra with bed strength of 700 and land area of 172 acres. There was hardly any space for new structures as part of future expansion and growth of the institution. There was also no scope for carving out an open space to be developed into a park for patients and family members. However, care had been taken to develop flower beds and put flower plants wherever a little open space was available to create a sylvan surrounding. All the trees within the hospital premises had been numbered.

The hospital had offices of the superintendent, RMO, secretary and treasurer, clinical staff, nursing superintendent, stores superintendent, duty MO, medical officers; casualty/emergency ward; OPD block; OPD waiting hall with adequate sitting capacity; ill equipped medical record room; no ECG, EEG and modified ECT room. There were 7 closed wards, 2 open/family wards; 2 pay wards; 1 child psychiatry ward; 1 forensic ward; 1 chronic ward; kitchen without chimney; general library for professionals and patients; small pathological laboratory; behavioural ICU building; 9 open wells.

Suggestion

- Calicut is a coastal station and heavy rainfall zone. The civil structures being vulnerable to the saline effect of the sea wind will require heavy repair and maintenance expenditure. A sum of Rs. 7 lakhs budgeted for minor repair work in 2008-09 was too small and inadequate. The State Government may make appropriate provisions for repairs and maintenance of the GMHC Kozhikod.

Gwalior Manasik Arogyashala (GMA), Gwalior (2nd to 4th February 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

The building of Gwalior Manasik Arogyashala (GMA) was constructed in 1935 for 212 beds. GMA had inadequate seating arrangement for patients/relatives; a small sized congested record room; and a small sized library without separate reading room. It had no observation room to keep violent and aggressive patients and no emergency rooms for keeping patients arriving GMA after OPD hours for the night. GMA had two closed and two open wards, two halfway homes, ideal toilet patient ratio of 1:3.75 but no modular kitchen.

The land available within GMA premises was extremely limited and there was hardly any scope for future expansion. GMA required minimum extra land of 5

acres for construction of a teaching block, staff quarters and to meet number of other requirements of future expansion and growth of GMA such as a geriatric ward for the elderly; a child guidance clinic for children upto 18 years as in Juvenile Justice (Care and Protection of Children) Act; a physiotherapy centre for victims of reactive and rheumatoid arthritis and other physically and orthopaedically handicapped persons; a day care centre; a long stay home; a convention centre; a centre for yoga, pranayam, prayer and meditation. The Government land measuring 2.738 hectares allotted by collector of Gwalior to GMA in mouza mehra near Jagra revenue village in 2010 for its future expansion did not meet the requirements of GMA as it was located 20 kms away from GMA on a stretch of rocky and undulating landscape surrounded by hillocks without any approach road to the site.

The open drain carrying waste water in front of GMA had become a source of flies and mosquitoes. The other drain carrying the entire waste water coming from the sewers of Gwalior Municipal Corporation behind the halfway home was extremely unhygienic and source of pollution for all the 12 inmates of the home.

Suggestions

- The Collector Gwalior may locate and allot an alternate well developed suitable land of desired size not very far from GMA to enable it to meet some of its current barest minimum needs as also for future expansion and growth. These include a new teaching block to take up teaching in M.D. Psychiatry, M.Phil Clinical Psychology, Diploma in Psychiatry, Ph. D. in Psychiatric Social Work etc.; a Convention Centre; A 20 bedded Geriatric Ward; A 20 bedded Child Guidance Clinic; A 20 bedded Drug Deaddiction Centre; A long stay home; A day care centre; a Centre for Yoga, Pranayam, Prayer and Meditation and a Physiotherapy centre. The Director in-charge, GMA may be involved in the process of locating the alternative site.The Government may take such action on urgent basis on account of various reasons including GMA building was constructed 75 years ago on a very small area with provision for 212 beds only; increase in incidence of mental illness in Madhya Pradesh necessitating construction of new wards for which there is no vacant space within the existing premises; and directions given by the Hon'ble Supreme Court in Rakesh Ch. Narayan Vs. State of Bihar that teaching, training, treatment and research should go together in any modern mental health institution. The Government while allotting a piece of land should specify the purpose and time frame for its utilization to ensure provision of funds and better management of funds, better time management and better monitoring.
- The construction of a teaching block within the premises of GMA is an urgent and imperative need. A vacant plot measuring 2100 sq. metres lying adjacent to the OPD block and in front of the canteen may be used for construction of a multi-storeyed structure for the teaching block including

various teaching departments, laboratories and a new library along with a reading room. Based on the functional requirements of the teaching block, a good functional design should be prepared with the help of an experienced architect. After getting the design and estimates of construction prepared by PWD for the teaching block approved by the MC, the State Government should be approached for provision of funds for the said construction.

- The triangular open space near the male open ward measuring 787.50 sq. Metre in GMA should be developed into a mini park for relaxation of the patients with relatives in the morning and afternoon hours.
- The State PWD may be asked to cover the open drain and the Commissioner Gwalior Municipal Corporation may be requested to divert the flow of waste water somewhere else instead of allowing the same to flow through the open kutcha drain behind the halfway home.

Institute of Mental Health (IMH), Cuttack (4th and 5th July 2011)

IMH had been located on a small plot of land measuring 1.8 acres in an extreme corner of SCB Medical College. The space available for meeting the barest minimum needs of a small sized 60 bedded hospital was extremely limited and there was practically no scope for future expansion. The landscape of IMH had been much lower than the level of the road going in front of it. Since no paving of the surface had been done, the entire rain water had been entering the compound of the hospital.

The CPWD with a grant-in-aid of Rs. 1.51 crores provided by the Government of India had remodelled the old OPD and administration-cum Seminar block of the hospital to a modern OPD complex. The remodelled OPD complex had entrance verandah (open); OPD Waiting hall with 176 chairs; May I help you counter; 2 Registration counters; Chamber for data entry operator; Drug dispensing unit (old registration counter of OPD had been converted to a drug dispensing unit) for the time being; Psychiatrist room and Consultant's duty room; Assistant Surgeon's Consultation room accommodating 3 Assistant Surgeons; Office room accommodating Associate Professor and Assistant Professor; Library room; Conference room-cum-class room – cum-seminar room; Reading room; 2 Male and 1 Female ward.

The Ministry of Health and Family Welfare, Government of India had chosen IMH to be a Centre of Excellence and provided an outlay of Rs. 18 crores for civil works. The six storey structure with built up area of 100000 sq.ft. proposed under Centre of Excellence would be architecturally and aesthetically pleasing; commodious, airy and well lighted; functionally convenient and comfortable. The components covered under this included upgradation of existing facilities in the OPD and IPD, creation of a new teaching block, creation of laboratory facilities to strengthen investigation and treatment, canteen, trainees hostel, yoga and meditation centre, occupational therapy unit, attendants rest room, reading room

for patients, recreational therapy centre, landscape garden, other infrastructure development/interior development.

The rough cost estimates had been prepared and the final cost estimates, technical and administrative approval was awaited. The necessary approval of the competent authority had already been obtained for demolishing the old male ward for constructing the new six storey building. The six storey project was expected to be completed in all respects by end of October, 2013.

Suggestions

- IMH Cuttack is functioning at a much lower level than the level of the road going in front of it, the foundation of the six storey structure should, therefore, be raised sufficiently high at least 2.5' to 3' from the road level. The plan for new 6 storey structure in IMH Cuttack should include installation of a mechanized laundry for automatic cleaning, drying and pressing to ensure personal hygiene; construction of a new kitchen block, dining hall with dining table, and a canteen for supply of snacks to officers, staff, patients and attenders accompanying them. The open drain in front of the male and female wards of IMH Cuttack carrying waste water and other effluents has been a source of pollution. The same should be closed and state PWD should construct a pucca closed drain in its place.
- Secretary, Health may convene a separate meeting with Executive Engineer, CPWD Bhubaneswar to sort out all on going repair works of the old OPD Block. The repair of 6 year old twin fountains in the campus along with provision of connectivity between the old and new blocks as well as OPD needs to be completed without any further delay. The CPWD may be asked to furnish full utilization certificate for Rs. 1.51 Crore (Central Government funds) and Rs. 51 lakhs (State funds) allocated to it nearly 4 years ago.

Mental hospital (MH), Varanasi (5th July, 2010)

Mental hospital Varanasi had a total land area of 26.91 acres, of which barely 50 per cent was utilized. The structures were raised 200 years ago with lime and mortar without any DPC and roofing was done by tiling. Lighting and ventilation was inadequate; drainage and sewerage lines and drinking water pipes needed constant attention and outdated wood work had developed cracks at many points. The whole approach to repair and maintenance of the structures was adhoc, piece meal and unscientific due to adhoc, eractic and inadequate availability of funds for repair and maintenance.

Mental Hospital Varanasi with sanctioned bed strength of 331 had two closed wards and barracks. The kitchen was in a very bad and deplorable condition and there were no dining halls. The hospital also did not have its pathological laboratory. Against 100 plus officers and staff members there were only 28 staff quarters.

The hospital had constructed sheds with asbestos sheets to accommodate 50 OPD patients/family members. The construction of new OPD building and 30 bedded female family ward was likely to be completed in 3 months' time. The construction of separate boundary wall between IPD (female) and new OPD and Family ward and construction of a road in OPD and male IPD had also been completed. The construction of 50 bedded Male Ward and modular kitchen was likely to begin shortly. The deadline for the completion and handing over physical possession of OPD and Family wards was December, 2010 and IPD male ward was January, 2011.

The new OPD Block included registration room; 7 MO's rooms with attached toilet; waiting hall with a capacity to accommodate 50 patients/ relatives with 6 attached toilets and 4 Verandas with length of 14 metre and width of 3.5 metre with a capacity to accommodate 50 patients; The drug dispensing unit with attached store room; pathological laboratory with platform and provision for wash basin; ECT room with no recovery room; X-ray room including a dark room and a technician room and the courtyard of 13.45 metre x 15.15 metre to be developed into a garden in consultation with U.P. Horticulture Department. The quality of construction of new blocks was not up to the mark due to substandard bricks, brick work as well as joinery work and poor supervision. The paved drive ways had developed cracks due to poor quality of execution.

Suggestions

- The Mental Hospital Varanasi needs to make provision for recovery room; central store room for storing medicines; central record room; room for clinical psychologist; room for psychiatric social worker; seminar room for inter departmental consultations; conference hall; library; geriatric ward; child guidance clinic and central store room for storing food grains, vegetables, fruits etc. The authorities of Mental Hospital Varanasi may plan these basic components of physical infrastructure, prepare estimates of cost and get that approved by Government and take up the construction work in a phased manner depending on allocation of funds. Keeping in view the need for round the clock vigilance and surveillance and special care and attention for mentally ill persons Mental Hospital Varanasi should take up a phased programme for construction of additional staff quarters. The Mental Hospital Varanasi being old requires constant vigilance and timely repair to avoid any untoward incidents like collapse of structures. It may be desirable to prepare all repair estimates, get administrative approval/ technical sanction for them and carry out the repairs.

Institute of Mental Health and Hospital (IMHH), Agra (28th March to 30th March, 2011)

The IMHH, Agra had a total land area of 172.84 acres, of which 33 acres was farm land and around 30 acres lied outside the boundary wall and patches of the

land had been encroached by construction of temples and mosques. IMHH filed a civil writ under the Public Property Act.

The new double storey OPD Block had become fully functional in February, 2010. The construction of a 50 bedded male ward along with a courtyard, new overhead tank of 450 KL capacity, new central dining hall and boundary wall at Mathura road had been completed. The erstwhile building meant for occupational therapy had been converted into a teaching block. The office of Director and Additional Director visitor room and committee room etc. had been renovated.

The projects under construction were twenty Type IV residential quarters; a new ICU block; a new boys and girls hostel block; and grill fencing at OPD. A new well planned air conditioned and computerized ECT (electro convulsive therapy) block having a waiting room for the patients, pre ECT, actual ECT and post ECT room and equipped with all modern gadgets for observance of safety approved would be rated amongst the best in the country.

The 11 major project proposals including Department of Neurology - 20 bedded ward; Department of Child and Adolescent Psychiatry - 20 bedded ward; Department of Geriatric Psychiatry - 20 bedded ward; Rehabilitation medicine unit and day care centre; Department of Alcohol and Drug de - addiction unit - 20 bedded ward; three 51 bedded ward; Waiting hall with toilet (for the OPD); Canteen block; Halfway home; 18 Type III residential quarters; and 18 Type IV residential quarters submitted along with their estimated preliminary cost of Rs. 2026.78 lakhs had been approved by the Government of UP. The Government had also finalized UP Processing and Construction Cooperative Federation for construction work (UPCO PAXFAD) as execution agency but funds were to be released. The UP Jal Nigam had been assigned the job of carrying out annual maintenance and renovation of 15 items of work and the funds were to be released.

The infirmary had been functioning in a 150 years old building. It had 3 ward and 42 beds. There was profuse seepage in the wall and plaster of the ceiling was wearing off. IMHH had two separate libraries for faculty members and research scholars and the patients and air conditioned modern biochemical/ pathological laboratory equipped with State-of-the-art technology.

IMHH had 30 well lighted and ventilated wards with commodious rooms; a new 50 bedded male ward; a modular kitchen; a new central dining hall; a new overhead tank with capacity of 450 KL; RO plant with capacity of filtering 100 litres of water per hour; and two separate occupational therapy units for male and female patients.

There were 83 staff quarters for 402 staff members. A proposal submitted by IMHH for construction of new building with staff quarters involving an estimated cost of Rs. 12.58 crores to the Government of UP had been sanctioned but funds were be released. The IMHH has contacted NEDA Agra for solar lighting. The NEDA had processed the proposal and recommended to Government of U.P. but

approval was awaited. The IMHH was preparing an estimate for linking the sewer lines of IMHH with the main city sewer lines for approval of the Government of UP and also for release of fund.

Suggestions

- The Government of U.P must take timely and decisive action to remove all the encroachments around IMHH and on the land of IMHH for future expansion and growth of IMHH. The Special Secretary to Government may formally write to Revenue Department for issuing a formal order of alienation of the land in favour of IMHH Agra.
- The 11 major proposals in the pipeline submitted by IMHH Agra to the Govt of UP are related to the genuine needs of the institution. The funds may be placed at the disposal of IMHH to enable it to complete all the formalities and take up the work at the earliest. Since the IMHH is located in the outskirts of the city, there is a great need for more staff quarters to accommodate more

MOs, paramedics and staff nurses within the premises of IMHH to enable them to attend to routine as well as emergency duties more promptly and efficiently. The Government of U.P. should, therefore, release the grant on a high priority basis.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

The Institute of Psychiatry was located in a total area of about 2 acres. As a result of its merger with Bangur Institute of Neurology (BIN), Institute of Psychiatry was deprived of 6400 sq. ft. land as well its kitchen places, nursing hostel and east side of new building to accommodate neuro-surgery and neuro-medicine, OPD and neuro-genetic clinic of BIN. This reduced Institute's already limited space required for its genuine needs and restricted the scope for its future expansion and growth.

The majority of the buildings except one new building were old and were not well maintained. The new building had been converted into a teaching and training facility and record room. The total bed strength of the Institute of Psychiatry including 6 beds for de-addiction was 36 and there were only closed wards. There was no proper drainage; pavement was full of cracks and potholes.

The Institute of Psychiatry made no efforts to plan its functional requirements sequentially step by step over a period of time to convert the hospital into a fully equipped modern mental health institution. As a result the Institute of Psychiatry lacked most of the functional requirements which represent the irreducible, barest minimum needs for a modern mental health hospital. This Institute did not have observation/emergency room; rest shelter to accommodate patients who arrive hospital after the OPD hours for the night at the hospital; space for ECG, EEG, X-Ray etc. with equipment; space for modified ECT with a recovery room; library-

cum-reading room for patients; separate occupational therapy units for male and female patients; physiotherapy centre for physically and orthopaedically handicapped patients and for victims of rheumatoid arthritis; and yoga, pranayam, meditation and prayer for patients.

The Ministry of Health and Family Welfare, Government of India had declared the Institute of Psychiatry, Kolkata as a Centre of Excellence and sanctioned a grant of Rs 30 crores with works component of Rs. 18 crores. The Institute of Psychiatry did not have the space necessary for putting in place a number of new structures under the Centre of Excellence. To deal with the problem of extremely limited space within the hospital premises, Principal Secretary, Deptt. of Health and Family Welfare had planned to go in for a 10 storey structure within the available space to meet all the functional requirements of the hospital.

Suggestions

- The Institute of Psychiatry, Kolkata should take an administrative decision to dismantle those structures which are giving way to decay and posing problems of safety and security and cellular (prison type) structures which suffer from deficiencies of space, poor lighting and ventilation and replace the old structures with by new commodious and adequately lighted and ventilated structures where the inmates and functionaries will feel completely comfortable.
- The Institute of Psychiatry, Kolkata should plan its need based functional requirements on priority and to execute the plans within a definite timeframe, the Deptt. of Health and Family Welfare should be fully involved with the planning process and their concurrence obtained. The hospital management should also pay particular attention to create a disabled friendly environment within the new 10 storey structure. They should seek the help of a government architect and work out details for the same with him.

Out Patient Department

There can be no disagreement with the universally acclaimed truth that human dignity is the quintessence of human rights. Every human being is entitled to be treated with dignity, decency, equality and freedom regardless of the fact that they are born differently, grow differently, are different in their mental make up, thought process and life-style. Negation of this would mean negation of human rights. A person with mental illness is entitled to treatment with the same dignity and decency as any other human being.

Availability, accessibility, acceptability and quality are the core obligations and elements of the right to health. A mentally ill person is in need of special care and attention in the hospital for the simple reason that he/she is unable to fend for himself/herself. The responsibility for special care and attention also lies with the mental health care institutions. No person seeking help for mental distress or illness should be refused examination at the OPD on any ground whatsoever. Similarly, no patient should be refused admission as an inpatient if the same is considered absolutely necessary by the physician examining him/her.

Section 10 of the Mental Health Act, 1987 clearly provides that every psychiatric hospital and psychiatric nursing home shall be maintained subject to conditions prescribed in Rule 20 of the State Mental health Rules, 1990. Under these conditions the OPD should have minimum facilities for handling medical emergencies for outdoor patients; a large well lit and ventilated hall with sufficient number of chairs to seat persons seeking consultation and accompanying family members and provision of potable water, toilet, television, newspaper stand with provision for local newspapers, few journals and periodicals etc.; sufficient number of registration counters to cater to the needs of people in different age groups (adults, adolescents, elderly and the children) as also women and men; the data entry operator to computerize data relating to personal history, case history, family history, demographic profile etc.; record room for storage of case files of patients; a smooth arrangement to retrieve the case files in less time and sending them to the MO concerned for medical examination of the patient; drug dispensing unit; two emergency rooms (one for male and another for female) to keep patients who turn up after the OPD hours for the overnight to enable them to avail the OPD services next day; a well equipped Electro Convulsive Therapy (ECT) facility for sedating disturbed individuals in the outpatient (OPD) setting; Psycho diagnostic facilities; Pathological laboratory; X-Ray, ECG and EEG rooms; Physiotherapy centre; a canteen as an integral part of OPD to serve tea and snacks to the OPD patients and their family members/relatives.

The people at the registration counter, drug dispensing unit, pathological lab and other investigation centres should be given orientation and training to be civil, courteous, considerate to everyone seeking care, particularly the elderly; No mentally ill person or their caregivers should be subjected to any abuse or offensive treatment or treatment that borders on cruelty or torture, instead they should be treated with utmost civility, courtesy and consideration.

Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

IMH authorities had displayed three boards at the entrance of the OPD. Of these a big board in English was about Citizen's Charter, the hospital timings and services provided; second board consisting of eleven instructions in Telugu was meant for the patients relatives on the care, concern and attention towards a mentally ill person; and the third one related to the provisions of the Mental Health Act, 1987 along with admission and discharge procedures.

The casualty and emergency services and ambulance facilities were available round the clock in IMH Hyderabad. There was no congestion or overcrowding in the OPD as it had a commodious waiting hall with a seating capacity of 150 patients/family members at a time.

IMH followed a best practice of deputing a hospital employee to issue serial numbers to patients/family members at the pre-registration desk to facilitate them to get themselves registered in an orderly manner. The registration counter was manned by four staff nurses. They entered the relevant information manually in the absence of a data entry operator near the registration counter to feed the data relating to personal history, family history, case history and demographic profile of the patient into the computer. At the time of registration the entire relevant information was simultaneously entered in the main registration record, patient's case sheet, patient's medicine book and index card. The registration room was, however, very small and there was just one queue of patients irrespective of their age, sex and state of health. On the basis of the furnished information, the case history file of each patient was prepared and the same went into a folder containing about 400 files. These folders were kept in a rack. There were five racks in the registration room and each rack had about 20 folders. The relevant files were retrieved in a few minutes and sent to the MO to facilitate screening of patients.

The MOs had been attending the patients with kindness, compassion and consideration. On an average they spent 15 to 20 minutes on each patients (time spent was more on new patients and less on old patients). PG students were also playing a key role in screening, diagnosis and treatment of patients.

The medicines in the Out Patient pharmacy were kept in open and unlabelled racks. The Pharmacist assisted by four nursing students was dispensing the prescribed medicines within a minute or two to the patients/their relatives. IMH followed a best practice of deputing a staff nurse at the pharmacy counter to

explain the patients/family members/relatives about the contents of the prescription, dosage of the medicines, interval at which the medicines were to be taken, how relapse of mental illness could be prevented through better drug compliance and so on.

Suggestions

- The drugs were issued to OPD patients only for 15 days at a time. As a consequence of such a policy there was a high risk of relapse of mental illness due to non availability of these drugs at the district/sub divisional hospitals or at the PHC as well inability of BPL patients to make frequent trips to the hospital to collect their medicine due to their financial problems and absence of any public policy of recommending cases of BPL patients for free/concessional travel by rail/bus.

Government Hospital for Mental Care (GHMC), Vishakhapatnam (30th and 31st March, 2009)

There was a separate reception counter manned by a senior staff member of the hospital and two ward boys to receive and guide patients and their family members accompanying them. The waiting space in OPD comprising of three to four big verandas with benches and PVC moulded chairs kept in neat and orderly manner was big enough to accommodate about 100 patients/family members at a time. The other facilities provided in the OPD included cool drinking water, ceiling fans, wall fans and toilets but there was no provision of local newspapers and television set in the OPD.

A staff nurse and a head nurse was posted at the registration counter to register cases of mentally ill persons coming to OPD. There were 12 consultation rooms for OPD patients and an observation room to keep violent and aggressive patients after administering sedative till such time they become normal to get examined and receive treatment at the OPD. The average waiting time in the OPD had reduced substantially due to deployment of additional doctors drawn from other institutions to attend to the increasing number of outpatients at peak hours. The staff nurse at the drug dispensing unit was dispensing the prescribed drugs to the patients within five minutes.

There was no EEG machine for brain mapping. The number of beds in the recovery room attached to ECT room was much less than the number of patients who had been administered ECT every day.

The hospital had been running Community Psychiatric Services at Mother Teresa Home, Prema Samajam and Central Prison, Vizag besides holding identification camps for the physically and orthopaedically disabled on behalf of the Disabled Welfare Department. One psychiatrist of the hospital used to visit these Homes every month to render medical services and distribute medicines free of cost. Monthly visits were also being made to the Central Prison, Vizag to provide necessary follow-up treatment to the inmates and distribute free medicines.

The hospital had become the nodal institution for the district mental health programme extended to Vizianagaram district. The project was sanctioned in 1999 as a centrally funded scheme for 5 years but was actually commissioned in April, 2005. Staff for the project had been appointed but weekly visits started just one week before the visit of the NHRC team.

Suggestions

- GHMC Visakhapatnam needs to procure EEG machine on priority basis and also make arrangement for providing sufficient number of beds in the recovery room attached to the ECT room.

Institute of Human Behaviour and Allied Sciences Shahdara (IHBAS), Delhi (13th August, 2010)

The emergency services were available round the clock. Emergency block had 5 beds with full occupancy, OPD lab services; separate medical records section and educational material for patients. On an average 30 patients were seen in the casualty/emergency every day. A multidisciplinary team was providing emergency services in contingencies like acute psychosis, schizophrenia, alcohol and drug withdrawal. Case records were maintained of all patients. IHBAS had a 10 bed short observation facility (SOF) along with laboratory facilities. Patients were attended by Duty doctors including Junior Resident, Senior Resident Consultant on call and Nursing staff. The average duration of stay varied between 3 to 4 days. There was also a provision of dharmshala for family members/relatives of OPD patients. IHBAS had been providing a number of facilities to the disabled persons such as ramps in the hospital, lifts in the wards; wheel chairs and patient stretchers; housekeeping and security staff for helping the disabled persons.

The Psychiatry OPD was working on all days from 8.30 AM to 3.00 PM and daily outturn of patients varied from 1200 to 1300. The treatment for BPL patients was absolutely free and APL patients were charged at a nominal rate. A 150' x 200' sized waiting hall with 180 chairs had toilet facilities for ladies, gents, physically and orthopaedically handicapped persons. A number of boards and posters indicating the list of holidays, symptoms of various types of mental illnesses, line of treatment, do's and don'ts for patients/family members had been displayed on the walls of the OPD.

The registration counter was managed by 10 data entry operators (DEOs). There were separate registration counters for male, female, physically, orthopaedically and visually handicapped, senior citizens, convicts/undertrial prisoners and cases covered by reception orders from the Judicial Magistrates. The registration charge of Rs. 10 was collected from each patient. The DEOs were entering demographic details (name, age, sex, income, occupation, address, gist of the illness etc.) in the computer and all other details relating to personal history, family history, case history etc. relating to mental illness were entered by the medical officers in the patient's record manually. The registration was taking 5 to 10 minutes.

The medical consultation was conducted in a very organized and systematic manner and all patients were treated with civility and courtesy. The treating physician was examining 30 to 40 OPD patients every day and spending about 30 to 35 minutes on new patients and 15-20 minutes on old cases. The drug dispensing unit having five cabins and manned by required number of pharmacists functioned with optimal efficiency. Pharmacist took about 3 to 5 minutes for dispensing free medicines to one patient and free medicines were given for 60 days.

The Medical Record Department (MRD) had 7 rooms, 160 file racks and 190 file cabinets and was manned by 2 regular and 10 contractual employees. Medical records of patients were maintained in the record rooms serially, alphabetically and year-wise for quick retrieval, entry in the movement register and dispatch of the file to the MOs in the least possible time. All files were kept in file cabinet while medico legal cases pertaining to Court and jail were kept separately under lock and key. Pest control measures had been taken to keep medical record rooms free of pests. However, there was extensive seepage in these rooms.

IHBAS had a common canteen with separate seating arrangements for the hospital staff, patients and their relatives and the items served in the canteen included tea, coffee, cold drinks, different varieties of snacks, biscuits and chips and full meal. These items served at subsidized rates. The food/snacks served at subsidized rates were nutritionally very weak and were mainly catering to the taste and preference of North Indians.

IHBAS had well equipped laboratories to provide investigation facilities including X-ray; ultrasound; Colour Doppler, Carotid Doppler, Vascular Doppler; Echo cardiology; direct microscopy; serological/immunological tests; culture for urine/ pus, stool/sputum, CSF/blood/body fluid/AFB; elisa for HIV 1 and 2 antibodies, Hepatitis B surface antigen, HCV antibodies, Measles antibodies etc.; Neuro-psychopharmacological tests; pathological investigations. MRI facility had been outsourced to M/s Focus Imaging Centre Pvt. Ltd. And these facilities were provided free of cost to patients with income less than Rs. 3000 per month and at nominal rates to people having income above Rs. 3000. The investigation rates had been displayed at various points. There was a separate laboratory for psychological tests. All major psychological tests including objective, projective, rating scales, intelligence and personality tests, neuro psychological tests etc. were available in IHBAS.

Specialized OPD services provided on specific days of the week in the hospital were mental retardation clinic, child guidance clinic, tobacco cessation clinic, (Friday); drug addiction treatment and rehabilitation clinic (Wednesday and Friday); marital and psycho sexual clinic (Friday); epilepsy clinic (Tuesday); movement disorder clinic (Wednesday); neuro-behaviour clinic (Friday).

IHBAS had been successfully running Community Satellite OPD clinics services at Chattarpur (South); Jahangirpuri (North West); Dwarka; (South West); Timarpur;

(North) and Motinagar (Moti Bagh). The doctors in these clinics made an assessment of patients; made diagnosis; provided medicines; gave basic tips and counselling; promoted and encouraged rehabilitation of patients in the community; encouraged patients to come for follow up; referred those patients to IHBAS who required intensive case. IHBAS had future expansion plans of community outreach clinical services in 4 new districts viz. East Delhi, North East Delhi, Central Delhi and New Delhi. It had also been running special OPD Clinic for homeless persons at Jama Masjid area with an average turnout of 50 patients. Keeping in view the excellent services provided through OPD and positive outcome thereof similar services were planned for homeless and wandering mentally ill persons in Connaught Place, Nizamuddin, and near Old Delhi railway station area in the near future.

A core team of professionals from IHBAS had been providing technical support to Asha Kiran Home for the mentally ill in the form of screening of residents for psychiatric and physical health morbidity, assessment of psychosocial factors of the residents, internal conditions of home and staff stress related issues and feedback to restore the conditions and health of residents. IHBAS had been providing technical support to various agencies in the area of drug abuse. It also collaborated with various NGOs in the pursuit of treatment and rehabilitation of drug abuse affected population.

Suggestions

- Leakage and seepage developed in MOs rooms and falling plaster requires instant attention and immediate repair.
- Since the number of Psychiatrists, neurologists, clinical psychologists, Psychiatric Social Workers was low considering the heavy outturn of patients and time available at the disposal of professionals, the Director IHBAS should make out a case for sanction of additional posts on the strength of norms laid down by the ICMR as well as Rule 22 of the State Mental Health Rules 1990 and send it to Secretary Health and Family Welfare NCT of Delhi.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

Hospital for Mental Health Ahmedabad had a 6 room emergency ward, of which 4 rooms with beds were meant for the patients, one for MO's duty room and one for the nursing sisters. The rooms were well equipped with oxygen cylinder, suction machine, BP instrument, Torch and Refrigerator. The other items available in nursing sisters' room were medicines, injections, syringes (5 and 10 ml), needles, scalp vein, rubber catheters, oxygen mask etc. The patients admitted in the emergency wards were provided immediate care by the MO and nursing staff on duty. On an average 40 patients were admitted in the emergency ward per month and average duration of stay was 24 hours.

The registration counter located at the entrance of the OPD was manned by four persons having good communication skill to deal with both new and old cases. There were separate queues for convicts and UTPs whose cases were referred by the jail authorities, physically or orthopaedically handicapped, visually challenged, elderly persons and women with children. In the absence of computer facilities at the registration counter the basic data relating to name, address, sex, income, occupation, address and gist of illness of patient was entered manually and registration of each patient took about five minutes. There was no canteen near the OPD although restaurants were available outside the hospital premises.

The rooms of Psychiatrists, Clinical Psychologists and Psychiatric Social Workers were commodious with adequate number of chairs for patients and relatives. Appropriate IEC materials have been displayed on the walls of the room. The working hours for all doctors and para medical staff were 8 hours and services of all medical officers were available round the clock. The Superintendent and his team of doctors comprising Psychiatrist, Psychiatric Social Worker, Clinical Psychologist and staff of the hospital had been providing high quality treatment, care and attention to the patients. Consulting psychiatrist was spending 15 minutes, psychiatric social worker 20 minutes, clinical psychologist half an hour and general duty medical officer 10 minutes on each patient. Staff of mental health hospital was civil, polite, courteous, considerate and extremely humane in their behaviour. The hospital was conducting community satellite clinics only at Limdi and Surendranagar on every alternate Thursday.

This hospital had a well - equipped pathological - cum-biochemical laboratory and tests conducted included Haemoglobin count; TC; ESR; MP; RBC; Platelet count; Blood sugar; Blood urea; S. Creatimine; S. Cholestreol; S. bilirubin; S. electrolyte (lithium, sodium, potassium); Urine routine micro; Urine bile salt; and Bile pigment test. The hospital had signed an MOU with NABL accredited laboratory for all other investigations which could not be carried out in the hospital. Samples were collected in the hospital and transferred to the NABL laboratory.

Drug compliance was 100% in most of the cases due to excellent counselling at the OPD for patients/relatives about dosage and frequency of drugs and provision of medicines for 60 days as against 15 to 30 days in mental health centres elsewhere in the country. The hospital had been keeping a track of patients or relatives/family members who did not turn up for follow up and letters were sent to them to come and collect medicines. In case patients could not afford to come and collect their medicines, the medicines were sent by courier services to such patients. The Self Help Group namely, 'Saathi' visited the homes of the patients to provide counselling on the importance drug compliance.

Suggestions

- Hospital for Mental Health Ahmedabad should organise community satellite services to enable patients to come and receive OPD treatment at these satellite clinics.

Institute of Psychiatry and Human Behaviour (IPHB), Goa (6th December to 9th December, 2010)

The IPHB Goa had been running round the clock casualty/emergency services with one senior and one junior resident under the supervision of consultant. They were assisted by staff nurse, ward attendants and sweepers. The casualty ward was connected to all the wards and doctors hostel with telephone facility.

The waiting space of 64 sq. metres provided with 30 chairs and 3 benches could hardly accommodate 50 patients. Keeping in view the daily outturn of 100 to 150 patients in the OPD held from 9AM to 2 PM the OPD space was highly inadequate. There was provision of drinking water and television for the patients in the OPD but there was no newspaper stand with local newspapers. The canteen located adjacent to the OPD had 2 separate rooms for the faculty and staff of the hospital and for the patients and their relatives. The canteen services had been outsourced to a contractor and the rates fixed for tea and snacks were reasonable but not subsidized. The canteen served a variety of vegetarian and non vegetarian snacks/meals.

The rooms of the Senior and Junior Residents were small and congested. There was no provision of pre-registration counselling. A small sized registration counter was common for all patients irrespective of their age, sex and physical condition. In the absence of data entry operators, three registration clerks managing registration counter were recording basic information relating to name, age, sex, native address of the patients manually and all other details pertaining to family history, case history, personal history of the patient were entered by the Senior/Junior resident, as the case may be. The doctors spent about 30 to 45 minutes on new patients and 15 to 20 minutes on old cases. The pharmacist was taking 5 to 7 minutes to give medicines free of cost to each patient for 30 days at a time.

The 70 sq. metre record room with 36 steel racks was quite small and congested for maintaining 76000 case files. The case files of old and new patients were kept together number-wise and year-wise in the bundles of 100 cases in the racks. The patient was required to present the card issued to him/her when he/she came for follow up and the case file was taken out and sent to the Senior/Junior Resident, as the case may be.

There was an observation room to keep violent and aggressive patients and give sedation to make them tranquillized. They were examined by the senior/junior residents in the observation room itself. There was no arrangement for keeping patients and their relatives who arrived IPBH Goa after OPD hours for the night to enable them to attend OPD on the next day as exists in Thrissur Mental Health Hospital in Kerala.

There were well furnished and well maintained biochemical and pathological laboratories. All the required chemicals for carrying out biochemical and pathological tests were available. The routine pathological investigations carried

out in the laboratory were haemoglobin; total WBC count; differential blood count; ESR; SMP; VDRL; HBsAg; blood group; bleeding and clotting time; hepatitis count; urine and stool. The biochemical investigations conducted in the laboratory were fasting blood sugar; PP. blood sugar; blood urea; serum creatinine; CPK; ser bilirubin; S.Alk phosphatase; S. acid phosphatase; Total protein count; Alb/Glob ratio; SGOT; SGPT; Uric acid; S. sodium; Urinary creatinine clearance; *S. p*otassium; S. chloride; Prothromombin time; S. calcium; S. phosphorus; Magnesium; Lithium; Ser triglycerides; Ser cholesterol; HDL - cholesterol; LDL; VLDL; GGT; Serum amylase. The biochemist with the help of one laboratory assistant had been carrying out all routine tests well in time. There were certain operational constraints in both the laboratories. Against the sanctioned post of one biochemist, one pathologist and three laboratory assistants, there was only one biochemist and one laboratory assistant. The post of biochemist had no promotion avenues. The proposals sent in quick succession for filling up the post of Pathologist and laboratory assistants were without any tangible results. A number of additional equipment like flame photometer indented had not been received.

The psychological tests conducted in the Psychological testing laboratory were test of attention of concentration; test of intelligence; test of memory; neuropsvcholoclical test; personality and inter personal relationship. The main constraints in the smooth functioning of this laboratory were heavy workload, limited manpower on account of acute shortage of professionals in the cadre of clinical psychology, limited tools and equipment; and lack of access to latest software due to non-computerization.

The Child guidance clinic in IPHB Goa had been functioning once a week from 2.30 PM to 5 PM. The children in age group of 6-14 years and studying in local schools between Upper KG and Class VIII were brought to the clinic by parents/ single parents/relatives or were sponsored by educational institutions like Almeida School, Ponda where they were studying. The Interns, Residents and Clinical Psychologists were handling the cases of all children with kindness, compassion and commiseration, patience and resilience. The children to be examined at the child guidance clinic had to get themselves registered and their papers were prepared; physical parameters including height, weight etc. were checked; case history was recorded by the psychiatrist/clinical psychologist, as the case may be; certain IQ tests were conducted and on the basis of findings of IQ test the school authorities were advised to pay more attention to such students, counselling was given to the parents as to how to deal with the children and how to bring about positive improvement.

Suggestions

- The hospital authorities should go in for a new OPD Block like IMHH, Agra with adequate waiting space for patients and their relatives, adequate space in the rooms of Senior and Junior Residents and Consultants and provision of all facilities and amenities of potable water, canteen, television, newspaper stand with newspaper, conservancy facility etc.at the new OPD Block.

- The vacant post of pathologist and 2 posts of laboratory assistants may be filled up without any further delay. The recruitment Rules may be amended to provide promotion avenues for the biochemist. The additional equipment like flame photometer requisitioned by the biochemist may be procured and installed without delay.
- The biochemist should display the various facilities available for different categories of tests along with rates chargeable against each category of test from foreigners, employees of corporate houses/PSUs and all bank employees etc. on the walls of OPD and laboratory.

Ranchi Institute of Neuro Psychiatry Allied Sciences (RINPAS), Ranchi (27th to 29th January, 2010 and 24th to 26th February, 2011)

A mental health information centre had been providing basic information about various mental disorders since August 1999. RINPAS had a casualty block to accommodate patients coming from far off places and arriving hospital after OPD hours for the night to enable them to attend OPD on the next day. The relatives/ family members of patients could stay in Dharamshala. The OPD had better seating arrangement with provision of toilets and drinking water. A full-fledged canteen was running near OPD to serve tea, snacks, cold drinks and meals at reasonable rates.

The registration clerk was recording the demographic data including name, age, sex, whereabouts etc. and personal history, family history and case history of the patient was recorded by the PSW and students of Clinical Psychology. The patients registered in the OPD are being distributed among the MOs equally. The Psychiatric OPD was manned by Senior Residents, Psychiatrists and physicians. They spent on an average 30 to 45 minutes on new patient 15 to 20 minutes on old patient; Psychiatric Social Work OPD was manned by Psychiatric Social Worker trainee and Ph.D. scholar; and the Clinical Psychology was mainly manned by M.Phil/Ph.d scholars under the supervision Clinical Psychologist. They took about one to one and half hour to conduct personality/IQ test on patients. The Psychiatrists, Clinical Psychologists and Psychiatric Social Workers were patient, diligent and caring and treated the patients/relatives with civility, courtesy and consideration. The patients were given free medicines for one month.

RINPAS had its Pathology laboratory for conducting hematology and biochemistry tests. The Department of Clinical Psychology made a lot of efforts to build up the psychological laboratory and kept on adding new items of test. It had all necessary tools and equipment and software needed to undertake tests. This lab with 366 items for test had become the largest psychological laboratory among all the mental health care hospitals of the country where largest number of tests were conducted. The Physiotherapy unit located in a small room with few equipments was assisting physically and orthopaedically disabled persons.

The Superintendent of RINPAS had been recommending the cases of BPL patients for issue of free railway pass and concessional passes for their relatives. Railway accordingly was issuing free passes to the patients and 50% concessional passes to family members/relatives accompanying patients.

Medical teams comprising of Psychiatrists, paramedical staff and students were visiting LNJN Central Jail Hazaribagh once a month, Birsa Central Jail Ranchi once in fortnight and Nirmal Hirday and Chesier Home Ranchi once in fortnight. The Department Psychiatry was running Community Outreach Programmes through Satellite Clinics at Jonha, Khunti, Saraikala Kharsaon, Hazaribagh. NGOs like Nav Bharat Jagruti Kendra and Sanjeevani Gram Trust had been helping these Community Satellite Clinics in identification of patients and follow up.

RINPAS conducted the school mental health programme in Sherwood Academy Ranchi, Lorreto Convent, St. Thomas School Ranchi, Kendriya Vidyalay, Kaisal School, DAV Public School, St. Xavier's School, St. John inter College, St. Anne's Girls High School Ranchi during 2010-11. The main objective of conducting this programme was to help the students, parents and facilitate the teachers to understand/identify the problems of children who were mentally ill, or victims of substance abuse, and facing serious problems in terms of acquisition of cognitive, affective and psychomotor skills.

Suggestions

- In the new OPD Block the ground floor had been constructed. Steps should be taken to construct first and second floors at the earliest and the Government should make budget provision for the same.

Government Mental Health Cente (GMHC), Thrissur (14th April, 2009)

The average daily outturn of patients in OPD between 8AM and 1PM was 50 to 60. There was adequate seating arrangement for 25 patients in a well lighted and ventilated waiting lounge and another 30 patients in a veranda with marble benches. The other facilities and amenities available in the OPD were drinking water, toilets, newspapers and magazines and television.

The ground floor of new Psychiatry OPD block had two consultation rooms; one treatment room with provision of ECG; separate small sized rooms for clinical psychologist, psychiatric social worker and occupational therapist; a duty room for medical officer; discussion or consultation cum speciality clinic room; duty room for staff nurses and duty room for nursing assistants; and changing-cum-resting room for nursing assistants and attenders. There were 2 separate observations rooms with 10 beds each to accommodate male and female patients arriving hospital between 8PM and 8 AM.

There were three registration counters and the space in front of the registration counter was very limited. Priority was given to elderly, physically orthopaedically and visually handicapped persons and seriously disturbed patients. In the

absence of a data entry operator a staff nurse was entering demographic data relating to name, age, sex, income, occupation, address, gist of the illness etc. as well as case history, personal history and family history of the patients in the computer. GMHC Thrissur had a spacious well arranged pharmacy and pharmacist on an average had been taking 5 to 10 minutes for dispensing drugs. The drugs were supplied for one to two months. If any drug was to be used continuously and beyond this period the same was prescribed by the MO after an assessment of the status of health of the patient. The drug compliance was 100 per cent.

The investigations carried out free of cost for all categories of OPD and in patients included complete haemogram; blood sugar, blood urea, serum creatinine, serum protein, serum billirubin, SGOT, SGPT, ALP, S.cholesterol, serum lithium, serum sodium, serum potassium; Urine (routine examination). Intelligence tests, psychopathology tests, and personality tests were conducted in the psychological laboratory and on an average 14 such tests were conducted on Wednesday and Thursday. The problems faced in carrying out these test were a very small sized room of the clinical psychologist and non availability of computer and latest software.

Thrissur was one of the 125 districts covered under the District Mental Health Programme since 2000. The programme was conducted in outreach clinics at various Govt. hospitals, PHCs, CHCs, Taluk hospitals and also 3 clinics run by NGOs. Under DMHP Programme 27 Centres were covered on monthly basis. The team visiting these centres comprised of psychiatrist, clinical psychologist, psychiatric social worker, staff nurse, driver and attender. Drugs were dispensed free of cost at each centre and pathological/biochemical investigations were conducted in the laboratory of the Centre or in the laboratory of the hospital. There were around 12000 registered users of the DMHP facilities in the district.

Suggestions

- Keeping in view the increase in the out turn of 200 to 300 patients in OPD, needs to expand the waiting hall for patients . The CPWD may be requested to provide the entrance of the new OPD block with a proper enclosure to be used as a waiting space for patients and the attenders accompanying them.
- A full fledged Psychological Laboratory needs to be in place. Hospital needs to provide a much larger space to clinical psychologist to carry out psychological tests.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

The duty doctor (Psychiatrist/Medical Officer) was available round the clock in the casualty to attend emergency cases. Most of the seriously ill patients were sent to open wards along with their bystander/relative; patients admitted through

court were sent to forensic wards; and patients with medical/surgical co-morbidity were promptly referred to the respective departments of the Government Medical College Hospital.

The OPD was functioning in a separate building from 8 AM to 1PM with an average daily outturn of 100 patients. The waiting area of OPD had adequate arrangement to accommodate 110 patients/family members and also had the facilities of drinking water and toilets. However, there was no arrangement for newspaper/periodical and television. There was also no canteen within the premises of GMHC.

The Registration counter was manned by one staff nurse, 4 nursing assistants and 1 hospital attender/warder. In the absence of a data entry operator personal derails of patient relating to name, address, occupation and gist of illness were recorded manually. The services of Psychiatrists, Clinical Psychologists, Psychiatric Social Worker and one Staff nurse were available on regular basis in the OPD and one Asstt. Professor Psychiatry and 2 lecturers were coming twice a week on prescribed days from Deptt. of Psychiatry, Govt. Medical College, Kozhikode to attend OPD as well as IPD from 8 AM to 1 PM. Medical officer/specialist were recording details relating to case history, family history, personal history (to what extent mental illness is genetically loaded, and other relevant factors) and findings of the said examination were meticulously documented. The medical officers of the hospital were civil, courteous and considerate towards the patients and their relatives/family members. The decision about admitting a patient was taken by the concerned psychiatrist in a consultative manner. Medicines were given for a month. The drug compliance was poor because majority of the patients being from BPL families found it difficult to buy medicines or come again and again to collect medicine as they could not afford huge travel expenditure.

The functioning of medical records library was not satisfactory. There were only 6 racks of uneven height. Some records had been kept in these racks and some in the cupboards and the records kept in the bare cupboards were vulnerable to white ant attacks. The case files of OPD patients (both old and new) were not maintained because of inadequate medical records system. An OP book was issued to all out patients wherein the details of their illness and treatment were recorded. In a scenario of poverty, congestion and overcrowding of human settlements, it may not be easy to comprehend that OP records would be maintained by the patients and presented for follow up (Schizophrenia patients in a fit of rage may tear and throw away these records).

There was no full fledged pathological laboratory. A small clinical laboratory with one lab technician was providing basic investigation facilities. The biochemical tests conducted included Blood sugar (fasting and post prandial), Blood urea (renal function tests), Serum Creatinine, V.D.R.L. Serum Lithium Estimation. The computerized EEG machine was lying idle for want of an EEG technician. There was no arrangement for administering ECT in the Government Mental Health centre due to absence of anaesthetist. A proposal had been sent to the Govt. for

sanction of a post of anaesthetist on a regular and full time basis but the sanction had not been accorded. GMHC Kozhikode was not offering any community reach service.

Suggestions

- The Hospital may make some arrangement for newspapers/periodicals and TV sets in the waiting area of the OPD for patients and their family/relatives. The canteen facilities may be provided within the premises of the hospital to enable patients and their family members/relatives to have tea and snacks.
- GMHC , Kozhikode needs to have a full fledged Psychological Laboratory fully equipped with all the latest tools and access to the latest software for conducting projective tests (Rorschach, CAT etc.) personality evaluation, IQ assessment etc.
- There are a number of PHCs under Kozhikode district and efforts should be made to launch community satellite service centres in a few PHCs to start with.

Gwalior Manasik Arogyashala (GMA), Gwalior (2nd to 4th February, 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

There was no help/information counter to guide and escort patients and their attenders to their respective destinations. The average number of patients attending OPD was 100 to 125. The seating arrangement for the patients and their relatives was inadequate. As a result many patients/relatives had to stand or sit on the floor. The facilities available in the OPD included potable water and toilets. The MC had sanctioned a newspaper stand and a new LCD TV plasma screen and orders had been placed with LUN Bhopal for installation of TV in the waiting area of OPD. Canteen located close to OPD had been restarted. Since the authorities of Central Jail Gwalior refused to restart the canteen, GMA invited open tender. The highest bidder was selected to restart the canteen. The canteen, however, was supplying tea and snacks but no meals.

There was no provision to keep patients who reached GMA after the OPD hours for the night to enable them to avail OPD services on the following day. There was no observation room for keeping aggressive and violent patients for administering sedatives to get them tranquilized and allow them to rest till they become fit for examination by the MO.

There were two separate registration counters. There was no sanctioned post of the data entry operator on regular basis and software for recording personal history, family history and case history of the patients had not been developed. A data entry operator had been posted on deputation from the NIC against a vacant post of a staff nurse. However, he was working in the office rather than in the OPD. The treating physicians were courteous towards patients and were

spending on an average 5 to 10 minutes on old cases and 30 minutes to 1 hour on new cases depending on the peculiarity and complexity of the cases.

The record room of GMA was too small and congested. Even a small mental health hospital at Dharwad had a better record room in terms of space, number of racks and the meticulous manner in which records were maintained. Counselling at the time of registration, examination of patients by MOs and at the time of drug dispensing had not received the desired attention. The IEC material was conspicuous by its absence in the waiting hall, MOs rooms and drug dispensing room etc.

GMA had been providing various investigation facilities absolutely free for BPL patients and rates of charges from others depended on their respective income slab. GMA had the facility of administering modified ECT but the size of ECT room and recovery room was very small and these rooms were not air conditioned. The hospital also had X-Ray and ECG facility. The EEG machine was lying out of order and there was no EEG technician. The tests undertaken in the pathological laboratory of GMA included routine blood and urine examination; serum lithium examination; blood urea, blood sugar, widal test; serum creatinine, uric acid and rheumatoid factor. A separate laboratory for conducting psychological tests was established in the OPD in 2010 and psychological tests conducted in the psychological laboratory were 34.

GMA had been recommending the cases of BPL patients for free railway passes and their relatives for 50 per cent concessional rail fare tickets for five years. The State Government, however, had no such policy for providing concessional bus fare to patients and their relatives.

Suggestions

- The proposal for procurement and installation of a new EEG and creation and filling up of the post of EEG technician should be placed before the MC for its approval without any further delay.
- The ECT room and recovery room needs to be made air conditioned as the temperature shoots up to 45 degree to 46 degree Celsius in summer months in Gwalior.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

The CPWD with an amount of Rs.1.51 crores provided as grant-in-aid by the Government of India had remodelled the old OPD and administration-cum Seminar block to a modern OPD complex. The renovated OPD complex had entrance veranda (open); OPD waiting hall with 176 chairs and a raised platform so that the same could be used for conference on non OPD dates; May I help you counter; 2 registration counters; Chamber for data entry operator; Drug dispensing unit (old registration counter of OPD has been converted to a drug dispensing unit) for the time being; Psychiatrist room, Consultant's duty room,

Assistant. Surgeon's consultation room accommodating the 3 Assistant surgeons; Office room accommodating Associate professor and Assistant professor; Library room; Conference room-cum-class room – cum-seminar room; Reading room. There was no Pathological laboratory and Psychological laboratory. The daily outturn of patients in OPD varied between 200 and 300. The seating space and the overall arrangements made at the registration desk were inadequate. The canteen a make shift arrangement being very close to an open drain was functioning in a very unhygienic environment.

The patient case including his/her registration number, date, name and address, age, religion, economic status (BPL or APL), disease, informant's name and address was recorded manually. The Government had given its sanction for 7 data entry operators but data entry operators would be infructuous without computer and software. The record contents of patients were kept separately in a 4 page loose sheet. The drug dispensing unit located in the old reception/ registration room was hardly two minute walk from registration counter and MOs rooms was managed by 3 pharmacists and one medical attendant. There was no staff nurse.

IMH had an observation room where aggressive and violent patients were kept and tranquilized with the help of sedatives but this room was not an integral part of the OPD due to lack of space in OPD. Since observation room was in the Ward, the violent and aggressive patients were not brought back to the OPD. ECT room and recovery room were not air conditioned and modified ECT had not been administered. There was no ECG and EEG facility due to non availability of ECG and EEG equipment. ECG, EEG and X-ray equipment were to be procured under the Centre of Excellence proposal. The post of EEG technician had been filled up and the incumbent had been sent for training.

Mental Hospital (MH), Varanasi (5th July, 2010)

The Mental Hospital Varanasi had no casualty and emergency services. The daily average turnout of mentally ill patients in the OPD had gone up from 80 to 90 in 2007 to 120 in 2010. A temporary shed had been constructed to accommodate about 50 to 60 patients at a time but there was no proper arrangement for supply of potable water and toilets for patients/family members accompanying them. However, a new OPD Block was under construction.

There was no sanctioned post of a data entry operator on a regular basis and in the absence of a data entry operator, there was no proper arrangement for collecting, compiling and analysing the basic data pertaining to personal history, family history, history of illness, demographic profiles of the patients. There was no separate record room.

There was no pathological laboratory in the hospital. All blood and urine profiles were sent to Pandit Deendayal Upadhyay Hospital for investigation and report. There was no X-Ray machine even though a post of radiologist had been

sanctioned. The hospital authorities had sent a proposal for creation of the post of an anaesthetist, pathologist, lab technician, X-ray technician, EEG and ECG technicians to DGHS and Deptt. of Medical Education. The sanctions were awaited. There was no provision of modified ECT in the hospital. The Hospital was not running any community services.

The construction of the new OPD was under progress. The new OPD Block included Registration room; 7 MO's rooms with attached toilet; Waiting Hall with a capacity to accommodate 50 patients/ relatives with 6 attached toilets and 4 Verandas with length of 14 metre and width of 3.5 metre with a capacity to accommodate 50 patients; Drug dispensing unit with attached store room ; Pathological laboratory with platform and provision for wash basin; ECT room with recovery room; X-ray room including a dark room and a technician room and the courtyard of 13.45 metre x 15.15 metre was to be developed into a garden.

Suggestions

- Since the X-ray, ECG, EEG and modified ECT facilities are being created, the space as well as equipment installed will be infructuous without having the requisite manpower in position. It is, therefore, urgent and imperative that the posts of technicians are sanctioned and recruitment process completed at the earliest to put the space and equipment into optimum use.
- It is desirable to set up a canteen to serve tea and snacks for the patients/ relatives as well as staff. A list of available items along with their respective prices needs to be displayed.
- The ECT room to become a self contained unit must have a fully air-conditioned recovery room with at least 10 beds.

Institute of Mental Health and Hospital (IMHH), Agra (28th to 30th March, 2011)

The ICU was functioning in the post ECT room in the infirmary building and a separate ICU building was under construction. The daily average outturn of patients in OPD had gone up from 77 in 2005 to 178 in 2010. A double storeyed new OPD block had become functional in 2010. The block was commodious, well lighted and ventilated. The waiting halls were commodious and airy with all required facilities and amenities. However, the very large outturn of patients sometimes going beyond 200 used to overtake the space and result in congestion. Most of the rooms in the first floor (except the research wing) were vacant due to delay in commissioning of Child Guidance Clinic, Geriatric Ward etc.

The registration was done from 8 AM to 12 Noon. The registration slip contained Patient code number; Date; Name of the patient; Age/Sex; Son/wife/daughter of x; Name of the village, district and State patient hails from; Voucher number; OPD registration number; Validity of the drug prescribed for 1 to 3 months. The post of data entry operator was to be created soon. Meanwhile, the registration

counter was managed by a ministerial staff trained in date entry. There was only one counter for male, female and elderly patients. The hospital had not adopted the Dharwar model of record room. A team was scheduled to be sent to Dharwar to study Dharwar model of the Record Room.

There was an imbalance between the number of patients and that of medical staff in the OPD due to large number of vacancies of psychiatrists, clinical psychologists and psychiatric social workers. Since there were few MOs to attend to large number of patients, the waiting period went up to 4 hours.

The pharmacist was taking about 2 minutes to dispense the medicines according to the prescription. The family members were asked to closely monitor drug compliance by the patients and to come for review at least 3 to 4 days before the medicine get exhausted. The drugs were issued for 2 months keeping in view the distance, cost involved in travel and condition of the patient.

The modified ECT was administered in the presence of anaesthetist, one medical officer, staff nurse and attendants. The patient had to undergo all essential investigations related to blood and BP etc., a thorough check up in the ward and countercheck by the MO before administering ECT. Consent of the patient was obtained prior to administering ECT. It took on an average 15 to 20 minutes for recovery of the patient. The care, attention and professional handling of patients was excellent. There had not been a single casualty while administering 60,000 ECTs during the last 10 years.

The old X-ray unit was in full operation at the infirmary. A provision had been made for a new X-ray unit in the new OPD building for the benefit of OPD patients. The X-ray machine was to be procured from funds provided under the Centre of Excellence. The air conditioned modern biochemical/ pathological laboratory equipped with State-of-the-art technology had started functioning. This was capable of undertaking and completing all important biochemical tests and submitting timely reports. The number of investigations had increased from 71 in 1996 to 44160 in 2010.

Patients were coming from far off places by rail/buses. Majority of them being from BPL families had to take loan to meet travel expenses. The Director IMHH recommended the cases of BPL patients and their family members for free/ concessional travel permit to the railways and the recommendation issued by IMHH were entertained by the railways. The Director was, however, handicapped in issuing such recommendation for travel by buses. The U.P. Road Transport Corporation Authorities might not entertain such recommendations in the absence of a state Policy.

A proposal submitted by the hospital authorities for a separate canteen building, a waiting hall with a toilet complex for the relatives of the patients and a vehicle stand involving an estimated cost of Rs. 406.52 lakhs in June, 2010 had been approved by Government of U.P. but the grant was to be released. A big hall near the OPD building had been used as canteen till the construction of a full fledged canteen building.

IMHH started community mental health services at Community Health Centre Farah, Community Health Centre Bah and Ram Krishna Mission Hospital, Vrindaban but due to shortage of trained psychiatrists the health centres at Farah and Bah had been discontinued. A team comprising of a psychiatrist, a DNB student, a clinical psychologist, a psychiatric social worker and staff nurse had been visiting the clinic once a month at Vrindaban to provide training to medical and para medical personnel at Community Health Centre and Primary Health Centre; diagnosis and treatment of psychiatric disorders; follow up visits; psychotherapy; community education; individual/family counselling; free distribution of medicines; participation in health fairs and exhibitions. The team made 12 visits at Varindaban in 2010 and provided community health services to 1906 patients.

IMHH can alternatively adopt the pattern of IHBAS Delhi having two separate waiting halls for registration and OPD. A very large waiting hall duly covered by a canopy in IHBAS had a capacity to accommodate around 200 patients/ attenders prior to registration. There was an equally large waiting hall for paitens/ attenders to accommodate patients waiting after their registration for screening and medical advice.

Suggestions

- A separate post of a pathologist should be sanctioned for the laboratory. The biochemist in-charge of the laboratory may be deputed for a week to IHBAS, Delhi to study the working of their laboratories for introducing some of the innovations of IHBAS in IMHH Agra.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

The daily average outturn of patients in OPD from 8 AM to 3PM was 115. Medical students had been attending OPD from 9 AM to 2 PM. The registration counter was managed by two clerks and all entries relating to name, age, sex, address, name of the informant/care giver etc. were made manually in the absence of a computer and data entry operator and were kept in the file of the patient. There were separate case files for each patient and these files were kept in the OPD office under the charge of a clerk. Retrieval of files was done on request. The confidentiality of files was fully maintained and only treating team had access to records. There was a good seating arrangement for the patients/family members in the waiting hall but facilities like drinking water, conservancy and recreation were quite inadequate.

All the cases of the new patients were examined by Junior Resident. On an average Junior Resident spent 45 minutes to examine the new patients and record his/her personal history, family history and case history. The patient was then referred to the consultant who after discussion with the Junior Resident decided the line of treatment. The old cases were examined and disposed of by Junior Resident along with RMO within 20 minutes and the serious cases were

referred to the consultant for disposal. The old patients used to come for consultation and follow up including collection of medicines or because of relapse of illness. A patient after his/her examination in the OPD was admitted in the IPD only after a group discussion. The child guidance clinic provided services once a week to autistic and mentally retarded children.

There was no pathological and biochemical laboratory in the Institute. There was no facility for doing X-Ray, ECG, EEG, screening for Hepatitis B and HIV. Modified ECT was not administered because there was no anaesthetist. Psychological tests like RIBT, TAT, IG test, BGT, CAT were conducted. Psychotherapy and psychological education was provided to the patients. Cognitive functions and diagnostic psychological tests and routine investigations were done free of cost but special investigations were charged.

Suggestions

- Adequate facilities should be provided in OPD and patients may not be charged for services including investigations. Steps should be taken to improve record keeping; develop a biochemical/pathological laboratory to undertake all relevant investigations; direct ECT should be replaced by modified ECT; There should be an increase in the number of trained staff for the OPD and a post of an anaesthetist, X-ray technician, EEG and ECG technician and laboratory technician should be sanctioned.
- The timings for medical students to attend OPD may be extended upto 3PM as the classes of medical students are held either in the early hours of the morning or in the late afternoon, there is no clash in timings of classes and their attendance in the OPD up to 3PM.

Living Conditions of Patients in Mental Health Centres

People with mental disorder are particularly vulnerable to abuse and violation of their rights. They are often isolated, stigmatised, discriminated, humiliated, and marginalised. They often end up in unhygienic and inhumane living conditions either in the community or in the mental hospitals with increased likelihood of human rights violation. The Mental Health legislation plays a vital role in laying down the terms and conditions of mental health care; ensure appropriate, adequate, timely and humane health care services; protect, promote and improve the lives and mental well being of citizens; helps to protect the human rights and dignity; and reintegrate persons with mental disorders into the mainstream of the society. It also provides a legal framework for addressing issues such as admissions, treatment, care in the institution and discharge; civil, political, economic, social and cultural rights; and implementation of mental health policy and programmes.

A mentally ill person does not become a non person merely on account of disabilities. They have a right to be treated in the Government hospitals and of decent and dignified life as inpatient without any discrimination. Their human rights flow from the fundamental right to life as in Article 21 of the Constitution which includes right to treatment, medical care, clean and hygienic conditions for living accommodation and environmental sanitation, food, potable water, personal hygiene, recreation, accesses to information, clothing, and right to ventilate etc. These are certain irreducible barest minimum needs and deprivation of any one of these amounts to violation of human rights of the person.

The living conditions of patients staying in the mental health care centres should have the following dimensions:

Psychiatric services: The admissions and discharge are to be made by strict observance of the provisions of Mental Health Act, 1987 and Rules framed thereunder. In accordance with the rules: Patients eligible for admission are those who are 17 years and above. All decisions relating to admission and discharge are taken by a small group of medical officers. No patient should be refused admission as an inpatient if the same is considered necessary by the physician examining him/her. The findings of medical examination and pace of progress of recovery is meticulously documented, medical records kept in safe custody and updated by medical records librarian. Frequency of rounds by MOs and Staff nurses and time spent with patients to establish emotive bond with patients and by-slanders to instill hope and faith in patients and that all is not lost and life can be restarted afresh.

Physical Conditions: Space available, adequate light and ventilation in closed wards (separate for male and female); family wards (separate for male and female); private paying wards (separate for male and female); accommodation available for the MO and the nursing staff at a point adjacent to the ward; an auditorium for holding cultural events, Patient toilet ratio and Patient fan ratio.

Inpatient Services: Tidiness of wards, adequacy of dresses, change of dress and linens, and privacy of patients.

Supportive Services: Telephone service; separate occupational therapy unit for male and female patients; patient's library-cum-reading room-cum-recreation centre, recreational and cultural activities; and a large hall for yoga – pranayam – meditation.

The state/mental health care hospital has a fundamental obligation to recognise and protect the right of mentally ill patients to be treated with dignity and decency without any discrimination. The hospitals need to create conditions for realisation of the above mentioned barest minimum irreducible needs of the patients to assure a decent and comfortable life to mentally ill inpatients. The quality norms and standards in mental health are non-negotiable. The basic aim of this study is to examine and evaluate the level of satisfaction of living conditions (environment), quality of treatment of patients admitted in the hospital and protection of their above mentioned human rights in different mental hospitals under the following heads:

1. Psychiatric Services, Physical Conditions and Inpatient Services

The Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

All admissions in IMH were made by strict observance of the provisions of Mental Health Act, 1987 and Rules framed thereunder. The patient admitted were 17 years and above and all decisions relating to admission and discharge were taken by a small group of medical officers. Majority of the patients (95%) were admitted as voluntary boarders.

Patients admitted in both open and closed wards were examined within 24 hours of admission. All body vitals on the basis of such examination were recorded in a separate register opened for each patient. Nursing staff duty hours were spread over three shifts and in each shift, 2 staff nurses and 1 head nurse were posted to each ward. They were taking two rounds in the morning, one in afternoon and one in night and also regular supervisory rounds at short intervals. The duty medical officers and staff nurses used to take daily round in the closed ward and enquired about the medical condition of patients by spending adequate time with each patient.

The cases of all mentally ill persons associated with physical ailments were referred to Osmania General Hospital, Hyderabad. Patients staying in the open wards of the hospital were sent with their attendants and ward boys of the hospital accompanied the patients staying in closed ward and stayed with them in shifts during their entire stay and treatment in the General Hospital.

The Institute of Mental Health, Hyderabad had total sanctioned bed strength of 600 with bed occupancy rate of 45 to 49%. It had different types of wards including family wards, open wards, closed wards, criminal ward, de-addiction ward and a separate acute admission ward. These wards were well lighted and ventilated and had adequate space between two beds. The toilet patient ratio was 1:6 in open wards and 1:8 in closed wards as against 1:5 recommended by Prof. Channabasavanna Committee.

IMH needs to construct more toilets in both the wards to comply with recommended toilet patient ration of 1:5 by Prof. Channabasavanna Committee.

All patients had been provided with cots, mattress, pillow and bed linens. The patients in the open/family wards were permitted to wear clothing of their choice. The Family members/attendants of the patients had been provided with low height steel cots with storage facility. These cots were donated by the organizing Committee of the IPS South Zone Annual Conference.

All wards were cleaned every day. Cleaning of toilets in open wards had been outsourced to an Agency and the sanitation and personal hygiene in closed ward was maintained by the hospital staff. There was adequate number of sweepers to clean the wards. The bed linens were changed twice a week.

The patients were getting discharged after recovery within a short span of time due to advancement in Psychotic and Neurotic drugs The average duration of stay for patients was 2 to 3 weeks. However, female patients were not welcomed back in the fold of the family even after they had recovered and fully fit for discharged. There were 21 female patients who were fit for discharge but nobody turned up to take them home. The absence of psychiatric social workers was a major handicap in organizing home visits, establishing contact with family members and effective follow up of rehabilitation and reintegration of female patients into the family setup. There were 22 deaths during a period between 2005 and 2010. Most of the deaths were natural except one which was a case of suicide by hanging.

Government Hospital for Mental Care (GHMC), Vishakhapatnam (30th and 31st March, 2009)

Majority of the admissions were voluntary and only 5 per cent were through court orders. The three levels involved in the process of admission were Junior and Senior Psychiatrist and the final decision was taken by Chief Psychiatrist. Patients were normally admitted directly to the wards whereas homicidal or violent patients were kept in single rooms with attached bathrooms and other facilities for 1 to 2 days till their aggression was controlled.

The Nursing Superintendent had been taking morning rounds of all wards from 10.30 a.m. onwards to enquire about the overall status of health and wellbeing of all inmates. She thoroughly checked the case records and was paying special attention to the cleanliness and enquired about the quality of food.

All cells had been abolished and the number of open wards increased from 2 to 4. The total sanctioned bed strength of GHMC was 300, of these 220 beds were in the closed wards and 80 beds in the open wards. The bed occupancy rate was 84% with 266 beds occupied in 2008. There was no congestion or overcrowding in the wards as there were 20 patients in each ward and the gap of one metre was kept between two beds. The toilet patient ratio of 1:1.6 was excellent in terms of recommended ratio of 1:5 and fan patient ratio of 1:1 was also extremely good. All wards were well lighted and ventilated.

Each patient was provided with a cot, mattress and adequate number of bed linen. The sanitation work had been entrusted to an out sourcing agency. The sanitary workers swept and squab hospital premises and also cleaned the toilets and kept them dry.

The discharge slip of patients admitted under court orders was issued u/s 40 of Mental Health Act, 1987 on the recommendation of the Discharge Committee which reviewed these cases every month. Intimation of decision taken to discharge the patient was sent to the family and simultaneously to the Government. In case family members did not turn up the court was approached for arranging escort. Recently Government. of AP has issued orders to take the help of the Collector for providing escort to send back the discharged patients after treatment to their respective homes.

The hospital had sent many long stay patients to their homes or to State managed NGO homes. However, 10 fully recovered patients were languishing in the hospital for more than one year due to lack of willingness on the part of family members to take them home; no response to the letters sent at the given address and difficulties in tracing the family due to furnishing wrong address. Majority of such patients wished to stay in the hospital for good for shelter and safety reasons.

There were 34 deaths between 2002 and 2009 and every death was had been audited. The concerned unit chief, duty medical officer, duty PG doctor, duty nursing staff, duty working staff etc. were summoned and the process of resuscitation and emergency care to save life were audited. The cause of death and preventive measures taken were recorded.

Three NGOs were members of the Hospital Development Society headed by the District Collector. These organizations contributed significantly in the sphere of education and entertainment of the inmates and can also help in establishing a Halfway Home for the patients. However, no serious efforts had been made to establish a Halfway Home with the involvement of NGOs.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August, 2010)

The total number of Inpatients increased from 2227 in 2005 to 3113 in 2009. Once a decision was taken to admit a patient a good deal of pre-admission

counselling was given by the examining MO. The Psychiatric Social Worker also played a very useful role in talking to the patients, ascertaining their difficulties and resolving them.

All medical examination records of patients pertaining to checking of weight; notifying loss/gain of weight; blood pressure (recorded three times daily); blood counts and blood profiles were maintained properly after his/her admission in the ward by staff nurses under supervision of the resident doctors.

A series of measures launched by IHBAS to bring quality assurance in inpatient services included post OPD/evening rounds by consultants; rounds on extended weekends or holidays; attendants keeping continuous vigilance/surveillance of high risk patients; compendium of clinical rating scales; standard operating procedures; and patient staff group meetings.

An innovative measure taken by IHBAS was patient staff group meetings held on monthly basis for an hour to resolve issues related to day to day problems through coordinated efforts; to explain treatment related issues to the patients and their family members; and to discuss the opportunities in the making after discharge of the patient and follow up plan. The participants in the meeting were all patients of the wards who were fit to participate; family members/care takers of the patients admitted in the ward; members of the treating team, SR, JR, staff nurse, psychiatric social workers etc.; dietician, civil and electrical engineer; housekeeping supervisor; and security supervisor along with ward consultants. The minutes of the meeting were recorded in the PSGM register of the ward and a copy of the same was forwarded to the PSGM coordinator.

IHBAS, Shahdara had total sanctioned bed strength of 500 and bed occupancy rate of 81 per cent with 326 beds occupied in 2009. It had Semi- open Wards (Male, Female) 20 beds each; Open wards (Male, Female) 20 beds each; Child and Adolescent Ward - 10 beds; Chronic (Rh) Ward (Male Female) 20 beds each; Private Ward (Paying Ward) 05 beds; De-addiction Ward - 20 beds; Psychiatric ICU - 5 beds; Forensic Ward - 20 beds.

The hospital involved the families of the patients in treatment and rehabilitation of patients by pre-admission counselling and pre-discharge counselling, psycho educative sessions for the family/care givers. As a result, average duration of their stay had reduced 3 to 4 weeks.

The wards were mopped every day to ensure tidiness. Patients bed sheets and linens were changed on every alternate day and clothes were changed every day. There was adequate supply of mattresses, linen and blankets etc. for all patients.

Despite best of intentions and efforts the number of long stay patients was 25 in 2005 and 28 in 2009 and long stay of patients may be attributed to clinical and psychological factors. Clinical issues related to diagnosis, management or comorbid medical disorder and Psychosocial factors included lack of willingness on the part of family members to cooperate in the long term treatment plan and

tendency to dump the patient in the wards primarily due to stigma and discrimination.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

The admissions in HMH Ahmedabad were governed by the Mental Health Act, 1987 and around 80 per cent of admissions were voluntary. HMH Ahmedabad had not been collecting any charges from any patient except when somebody wanted to pay voluntarily.

The hospital had a well-equipped nursing station with examination room equipped with oxygen cylinder, suction machine, medical trays and trolley, medicines (psychotic, neurotic and general). A thorough medical check-up of patients was done soon after their admission. They were subjected to laboratory tests at an interval of every four months. The results of the initial and subsequent check-ups/ tests were recorded in the patient's file opened soon after his/her admission. A weekly general health check-up was done for all the patients and physically sick patients were examined on daily basis. The administration of medicines to the patients was closely monitored.

The Superintendent and RMO were taking daily as well as surprise rounds and mental health professionals were taking daily rounds. The MOs were taking a complete round in their respective wards according to a predetermined schedule every morning to evaluate the condition of patients, prescribe special diet if needed and ensure proper maintenance of personal hygiene. They were also attending their wards in the evening for 2 hours to examine newly admitted patients and write case notes; prescribe medicines; fill the diet sheet for the day. They also made sure that the entire patient related data was written in indoor case paper in readable medical terminology. They also attended to the assigned work in emergency ward. The staff nurses looked after the patients since their admission through medication and care, rounds, maintaining patients register up-to-date etc. Nurses and Matron/Overseer were taking round after every four hours. There were male and female attendants to take care of the patients and the attendant patient ratio is 1:10.

The mentally ill patients having other health related complications such as appendicitis, cardio-vascular complications, respiratory complications, illness associated with ear, nose, throat, eye etc. were transferred to Civil Hospital, Ahmedabad. The patient requiring such transfers was given first aid by the MO/ duty doctor, ambulance was arranged and the patient was transferred with the help of a ward attendant. The mental health hospital monitored the health status of these patients.

The hospital with total sanctioned bed strength of 317 had 217 beds for male and 100 for female patients and bed occupancy of 70% with 222 beds occupied in 2010. The hospital had acute patients ward (separate male and female); chronic patients' ward (separate male and female); isolation psychiatric care unit (separate

male and female); recovered patient's ward (separate male and female); family ward/open ward (separate male and female); closed ward (separate male and female); and criminal ward under maintenance. There were no paying or special wards. Family members were allowed to stay with patients in the family/open wards. There were 20 to 30 patients in each room. The toilet patient ratio of 1:5 was adequate in terms of the prescribed norms and fan patient ratio of 1:1 was excellent. The rooms were well lighted and ventilated

All patients had been provided with cots, proper bedding and lockers to keep their personal belongings. Patients were provided with five dresses and sufficient number of linens. Patients dresses were changed daily or whenever required and linens were changed on alternate days. The relatives staying with the patients in the open ward were given vacant beds or alternatively were provided with bedding facilities.

The average duration of stay of patients was 10 days in family/open ward, 70 days in acute patient wards and 3 months chronic patients ward. Decertification was done by the hospital authorities and discharged patients were sent with relatives, occasionally sent with hospital escort and rarely sent home alone. There were only 10 long stay patients languishing in the hospital from 2 to 10 years due to 2 patients admitted 10 years back had not shown any signs of improvement and were unmanageable at home; one deaf, dumb and illiterate patient totally incapable of communicating about his address and other 7 patients went home on being discharged but came back and got readmitted due to relapse and behavioural and social disorders. The total number of deaths between 2006 and 2010 was 9, of these 7 were natural deaths and 2 were suicides.

Institute of Psychiatry and Human Behaviour (IPHB), Goa (6th to 9th December, 2010)

Each patient admitted in the hospital was medically examined by taking his weight, conducting blood, urine and other special investigations and the results his/her weight, conducting blood, urine and other special investigations and case file for each was opened and maintained properly. The weight of the patients was checked once a week on every Sunday. The resident doctors were examining inpatients every day. The Matron used to take three rounds in a week and 2 Assistant Matrons were taking daily rounds. Except one inmate others were found to be mute.

The treating physicians and staff nurses should spend more time with inpatients and engage them in conversation to enable and facilitate them to speak out their feelings and concerns.

The mentally ill patients having other health related complications such as appendicitis, cardio-vascular, respiratory, kidney, chest, lungs, ENT, eye, or gynaecology complications were referred to Goa Medical College for special

treatment and such referred cases by IPHB were attended by GMC on top priority due to good liaison and coordination between GMC and IPHB.

The IPHB, Goa with sanctioned bed strength of 190 and bed occupancy rate of 78 to 85% between 2005 and 2009. The hospital had 4 closed wards for male and 3 closed wards for female patients with 20 beds in each ward; one open ward for male and one for female patients with 16 beds in each ward; 12 beds in mentally ill prisoners ward (8 beds for male and 4 for female patients); 4 beds in the ECT room common for both male and female patients and 2 beds in casualty room common for both male and female patients. The hospital having 140 beds in closed wards and 32 beds in open wards was just contrary to the recommendations made by Prof. Channabasavanna Committee in 1998-99 that all the closed wards should progressively be converted to Open/family wards. The management of IPHB had made no effort to move in the suggested direction of opening more and more open/family wards.

IPHB management should make efforts to move in the direction of opening more family/open wards as suggested by Prof. Channabasavanna Committee in 1998-99.

All wards were well lighted and ventilated and had attached toilets and bathrooms. The beds had been arranged at a reasonable distance of 1 metre from each other. The toilet patient ratio was 1:8 against the recommended ratio of 1:5. The fan patient ratio was 1:2.

All wards were kept tidy round the clock with immaculately neat, tidy and dry toilets and bathrooms. The cleaning of wards, toilets, bathrooms, surrounding areas etc. had been outsourced. A small bed side table was provided to each patient and a stool had been provided for relatives to sit. The relatives of the patient in the absence of any alternate arrangement had to sleep on the floor. Each patient was provided with 3 sets of linens, a mattress with pillow and pillow cover, and a blanket.

The total number of patients languishing in IPHB for 1 to 10 years was 65. A detailed analysis of causes and factors contributing to the long stay of patients were an admixture of addresses not known of patients admitted on the strength of the orders of the magistrate; some patients not showing any signs of recovery, no relative and no social support.

The total deaths between 2005 and 2009 were 24 (19 male and 5 female). A detailed report of every death was received from the consultant treating the patient who died. A death meeting was held at Goa Medical College, Bambolim on every fourth Friday of the month to analyse the causes and factors contributing to death and draw a conclusion whether death was avoidable and whether the best possible efforts were made to save the life of the patient but could not be saved due to circumstances beyond control.

Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS), Ranchi (27th to

29th January 2010 and 24th to 26th February 2011)

The percentage of voluntary admissions in the hospital had gone up from 91% in 2001-02 to 96% in 2010- 11. The total number of patients admitted and discharged was more or less evenly matched. During the period between 2001-02 and 2010-11 around 14 to 22 per cent of admissions of patients were readmissions due to poor drug compliance resulting in relapse of mental illness. The average length of stay of indoor patients in RINPAS declined from 79 days in 2005-06 to 61 days in 2010-2011. The patients admitted in RINPAS had been coming from Jharkhand and other states like Bihar, West Bengal, Orissa, Chattisgarh, U.P, Arunachal Pradesh, Madhya Pradesh and Maharashtra but majority of the patients came from Jharkhand and Bihar.

All cases of female patients weighing less than 40 kgs need special investigation to find out the reasons for their low weight and they should also be provided special diet.

The regular medical examination of inmates was conducted and medical examination results were entered in the registers. However, the major area of concern was that the weight of several female patients was less than 40 Kgs.

The total sanctioned bed strength of RINPAS was 500 and bed occupancy remained below the sanctioned bed strength except two years when it was 506.06 in 2001-02 and 527.66 in 2010-2011. All wards were open/family wards except prison ward which a closed ward.

Patients are provided with cots, linen, pillows and blankets. Patients clothing were changed every day and linens were changed on alternate day. Majority of female patients were wearing hospital uniform of salwar kameej.

RINPAS had 92 long stay patients and the long stay of patients had been attributed to wrong addresses furnished by family members while admitting their patients, inability of wandering mentally ill persons picked up by the police from the streets and brought to RINPAS with the reception order from a judicial magistrate to furnish their address, and patients not responding to treatment due to chronic nature of ailment.

The escape of patients from the RINPAS had come down from 15 in 2001-02 to 1 each in 2008-09 and 2009-10 and 2 in 2010- 2011 mainly due to dramatic change in the atmosphere of the hospital brought by policy of openness along with care and attention. The number of deaths of patients between 2001-02 and 2010-2011 varied from 2 to 10 each year. The death audit revealed that utmost care was taken and every effort was made to save the lives of the patients and not a single death took place on account of negligence.

Government Mental Health Centre (GMHC), Thrissur (14th April, 2009)

The hospital strictly followed the procedure for admission and discharge as laid down in Mental Health Act, 1987. The decision relating to admission and

discharge was taken by group/team and not by an individual in isolation. Mentally Retarded children were not admitted in GMHC. All patients after admission were subjected to medical examination and findings of medical examination as well as pace and progress of recovery were meticulously documented. The chronic patients had to undergo certain prescribed investigations once in six months. All medical records had been kept in safe custody and were updated by the Medical Records Librarian.

Superintendent and Nursing Superintendent had been had been taking daily round of the wards in rotation. Medical Officers in charge of the wards was taking a detailed round at least twice a week. A sanitary team was taking a round on every Tuesday. The Monitoring Committee had been visiting the hospital once a month and giving instructions, if any. There was no major communication barrier as most of the MOs and staff could speak and understand Tamil in addition to Malayalam.

A general Medical Officer had been attending to all cases of physical ailment and complications including appendicitis, cardio vascular complications, infections in the respiratory track, immunological disorders in GMHC and on his recommendations, all such cases were referred to District Headquarters hospital for further investigation, admission and treatment. The hospital staff of GMNC maintained effective liaison with the consultants handling these cases.

GMHC, Thrissur a 361 bed hospital had 5 closed wards and 2 open wards. The wards were commodious, well lighted and well ventilated. There was no overcrowding and a gap of 2 to 3 feet was maintained between beds. However, pavilion wards with 40 to 50 young, adolescents, adults and elderly patients bundled together by combining beds due to shortage of space were unmanageable. There was an ideal toilet patient ratio of 1:5 and ceiling fans had been provided in all the wards but fans were not moving with normal speed because of low voltage. Family members/relatives were allowed to stay with the patients in both male and female family wards.

The trend of more closed and less open wards in GMHC Thrissur should be reversed to comply with the recommendations made by Prof. Channabasavanna Committee of having more open/family wards and less of closed wards.

To comply with Prof. Channabasavanna Committee's recommendation that every ward should be small, compact and manageable strength which should not exceed twenty inmates, GMHC needs to go in for small, compact and manageable wards by reorganizing the wards regrouping of the inmates. The Superintendent needs to draw the attention of Executive Engineer (Electrical) to the problem of fans not functioning properly in the wards.

Patients were provided with a bed, mattresses, adequate number of linen and the dresses. The bedside lockers were provided to the patients in the family wards, if available. All the wards are cleaned in the morning and evening with disinfectants and kept neat and tidy.

The number of patients languishing in the hospital from 6 months to 34 years was 163. The long stay of patients in the hospital had been attributed to chronic ailments which required prolonged treatment and some chronic patients not responding to treatment despite best possible measures; difficulty in tracing the addresses of patients admitted through orders of the court; reluctance on the part of family/relatives to take back the cured patients. Mortality figures varied from 5 to 17 between 2004 and 2008. This was a matter of deep concern even though the procedure established by law (informing police, conducting enquiry, arranging autopsy etc.) was followed.

A drug de-addiction ward with 8 family rooms, recreation/group therapy area, nurses' station, toilets and other amenities had been constructed with central assistance in 2006-08 but was awaiting formal inauguration. This ward had a separate perimeter wall and gate to isolate these patients from others as also to prevent absconding and easy access to substance abuse.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

All new patients except court admissions were directly admitted in family wards where a relative was allowed to stay with the patient. A complete medical examination of patients was done within 24 hours of their admission and the results of the said examination were recorded and records were maintained. Most of admitted patients were treated and discharged within 2 to 3 weeks. However, patients requiring more intensive care were transferred to closed wards and treated there till they became fit to be managed as outpatients.

The patients were attended by 5 Psychiatrists, 2 Clinical Psychologists, 1 Psychiatric Social Worker, 1 Ophthalmologist, 1ENT surgeon, 1 Physical Medicine Specialist and 1 Clinical Pathologist. The frequency of rounds in the Closed Wards was generally once a week but serious cases were examined more frequently by the Unit Medical Officer. Unit chief/unit medical officers were taking daily round of open wards and patients on dangerously ill list were evaluated daily/twice a day depending upon the need.

The mentally ill persons with associated complications (cardio vascular, respiratory etc.) were sent to Govt. Medical College Calicut along with an attendant and a detailed letter. Normally all cases referred to Governmet. Medical College Hospital were entertained without any difficulty. Patients were admitted without any preconditions and their investigations and treatment was free of cost.

The hospital with sanctioned bed strength of 474 had 7 Closed Wards (more than 50 beds each); 2 Family Wards (35 inmates each); 2 Pay Wards (one closed for renovation and another constructed recently was awaiting electricity connection); 1 Child Psychiatry Ward (10 beds); 1 Forensic Ward and 1 Chronic Ward. Paying ward had no extra facility except for a separate room with attached toilet. All rooms in the wards were well lighted and ventilated due to large windows in the

rooms. The toilet patient ratio was 1:5 and all commodes in the toilet were Indian. The fan patient ratio was 1:3. The bed occupancy of 540 in 2007 and 525 in 2008 exceeding sanctioned bed strength caused acute congestion and overcrowding. As a result some patients had to sleep on the floor. The 4 old wards were in a terrible state of disrepair.

The large sized pavilions accommodating 40 to 50 patients each were quite unwieldy. The management of a large sized pavilion accommodating an admixture of young, adolescents, adults and elderly inmates with variegated characters, temperaments and personalities was extremely difficult. There was no mechanism for classification and segregation of patients according to age, intensity of ailment (mild, sever, chronic), prognosis and temperament (withdrawn, aggressive and normal).

GMHC, Kozhikode should make efforts to reduce the number of beds to 20 in each ward to comply with the recommendations of Channabasavanna Committee report that the size of the ward should be small, compact and manageable with number of beds not exceeding 20 in each ward.

The block exclusively meant for keeping violent and unmanageable patients in open wards had been designed as per recommendation of NHRC. This block had 6 patients - 3 male and 3 female patients. Each block consisted of an enclosed room for the bystander in front and a single room behind the enclosure to accommodate the violent patient and both rooms were separated by a steel door. Once acute symptoms were controlled and patients started showing improvement in their disposition they were shifted and integrated with the normal patients in the family wards.

There were 460 long stay patients on 31 March 2009 and long stay varied from 1 to 15 years. The long stay of patients may be attributed to patients not responding to treatment due to chronic ailments; reluctance on the part of family members/relatives to take them home even after their full recovery; non availability of correct address of family members due to furnishing wrong addresses at the time of admission; patients admitted involuntarily through Court orders and patients remained unidentified as their whereabouts were not known; very limited rehabilitation facilities available in the Govt. Rehabilitation Centre (ASHA Bhawan) Kozhikode; and extremely limited number of NGOs willing to take up rehabilitation of mentally ill persons. Despite increased number of admissions and high occupancy rate, there was no suicide between 2006 and 2008.

Gwalior Mansik Arogyashala (GMA), Gwalior (2nd to 4th February, 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

The MOs were examining all inmates regularly and their medical examination included body weight, BP, blood and urine profiles. A number of patients were having low body weight and they could be victims of undernourishment or malnutrition.

The hospital authorities should pay special attention including special diet to patients having low body weight as they may be more vulnerable to secondary infections on account of having less resistance to fight infections.

GMA with total sanctioned bed strength of 212 had bed occupancy rate of 99.3 in 2008 and 91 per cent in 2010. It had 2 closed and 2 open wards (one each for male and female patients). There was no congestion in the wards. In conformity with the recommendations of Prof. Channabasavanna Committee not more than 20 beds were put in each block and the gap between two beds was approximately of one metre. The improved patients had been provided with small cupboards to keep their personal belongings in both male and female wards. There was ideal bed patient ratio of 1:1, fan patient ratio is 0.75:l and toilet patient ratio of 1:3.75. To meet the requirements of elderly persons, physically and orthopaedically challenged persons, persons who are victims of rheumatoid arthritis, austeo-arthritis and austeo porosis with low density of bones and damaged connective tissues 3 WCs had been installed in the male and 4 WCs in the female wards. There were 2 separate halfway homes for male and female patients. The male halfway home had been shifted to the male closed ward due to on going construction work.

The relatives and family members staying with the patients in the open wards had to put up with lot of discomfort and inconvenience. They had to sleep in extremely limited space on bare and damp floors in winters and had to walk a considerable distance to reach some restaurant to take their meals outside the hospital. The Commissioner Gwalior Municipal Corporation informed the Management Committee about Ramroti Yojana/Night Shelter under which accommodation could be made available to relatives of the patients along with others in 2 halls of Dharamsala having 22 beds, 3 latrines and 2 bathrooms on payment of nominal rent of Rs. 2 per bed and Rs. 5 per meal.

In view of the low rent and concessional meals under the new scheme of Ramroti Yojana introduced by the Government, the accommodation available in the 2 halls may not remain vacant. It may be desirable to keep the said accommodation or at least 15 out of 22 beds reserved for the relatives of the patients.

There were 41 long stay patients in the closed wards in 2010 and their stay varied between 2 to more than 15 years. The long stay of patients had been attributed to unknown whereabouts of patients brought by police with reception orders from the CJM; patients not showing any sign of recovery due to chronic ailments; reluctance on part of family members to shoulder responsibility of rehabilitation of fully recovered patients.

There were 23 deaths in closed wards and 5 deaths in open wards from 2005 to 2010 and the number of escapes was 7 in closed wards and 386 in open wards during the same period. GMA had been auditing each and every death to establish whether death was natural or unnatural; whether death was avoidable or unavoidable; whether all possible efforts were made to save human life. The

death audit revealed that all possible efforts were made to save human lives but lives could not be saved due to the poor condition in which the patients were admitted and they could not recover.

Akhil Bharatiya Samajik Swasthya Sangh (M.P. branch) a registered NGO of standing had been running a halfway home with 12 female inmates within the premises of GMA for psycho-social rehabilitation of treated and controlled mentally ill persons. GMA had provided the necessary accommodation and had also been bearing the cost of food, drugs and dresses of the inmates of halfway home run by the NGO. The halfway homes run by NGOs are normally funded by the Ministry of Social Justice and Empowerment. However, since the inception of the activity of managing the halfway home by the NGO in question, protracted correspondence had been going on with the Ministry of Social Justice and Empowerment but Ministry had not given any grant - in - aid except the solitary grant of Rs. 1.86 lakh provided in 2006-07. In accordance with the extant instructions and procedure a joint Director of the Department of Panchayatiraj, Government of M.P. is required to inspect the NGO before making recommendation for sanction and release of grant-in-aid in favour of the NGO. Despite repeated requests such an inspection had not taken place due to bureaucratic hassles.

The NGO managing the halfway home has appointed a number of functionaries on a full time basis and their salary and allowances are paid. NGO is also meeting some other incidental expenses like cost of raw materials for the vocational skill training programme. Keeping all these points in view the Divisional, Commissioner may impress upon the Secretary, Department of Panchayatiraj for deputing the Joint Director of the department on urgent basis for carrying out an inspection, assessing the genuine requirements of the institution for managing the halfway home and formulate a proposal for recommending to Government of India, Ministry of Social Justice and Empowerment for sanction and release of required grant-in-aid in favour of the NGO.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

IMH Cuttack with bed strength 60 patients had two open wards one each for male and female patients. The bed occupancy was of 27 patients in male and 29 patients in female wards. The patients admitted in excess of the bed strength had to sleep on the floor. The beds had been placed close to each other contrary to the norm of keeping a gap 1 metre between 2 beds and the patient toilet ratio was far less than the required ratio of 5:1.

There is a need to construct additional toilet block adjacent to male/female ward to bring patient toilet ratio to the desired level.

The bed strength 60 had been raised 100 per cent 120 and extra 60 beds sanctioned recently with the concurrence of Finance Department were meant for Geriatric; Paediatric; Emergency; Forensic; Rehabilitation.

The family members/relatives staying with the patients were not provided even

with stools to sit beside the beds of their patients and standing for long hours in the congested place besides being difficult also demotivated them to stay with the patient. There was no toilet facility for attenders of the patients and other Class III and Class IV staff of IMH.

Some provision of resting place along with toilets may be made for Class III and Class IV staff in the new civil work proposed to be taken up by the State PWD.

The bed sheets provided to patients were of very inferior quality and the condition of the mattress was no better. The copra was coming out from some of the coir mattresses. The Superintendent and IMH had no say in the matter as the mattresses, bed sheets, towels, pillows and pillow covers as these items were purchased supplied by the Superintendent, SCB Medical College for IMH, Cuttack.

The floors of the wards were untidy because of the filth and dirt of the shoes of persons coming in and going out of the wards and the inadequate number of sanctioned posts of the sweepers.

The arrangement for scientific disposal of biomedical wastes was not satisfactory. SCB Medical College Cuttack being responsible for disposal of biomedical waste had hired an agency 'Medi-aid' for this purpose but the said agency was not paying sufficient attention to collect the injectable syringes and hospital waste etc. The bins provided by SCB Medical College to IMH were grossly inadequate. Since Medi- aid was not collecting and disposing off the biomedical waste regularly, the disposable wastes were accumulating and polluting the environment and adding to the discontentment of the public. The superintendent IMH had drawn the attention of the Principal, SCB Medical College to the unsatisfactory state of affairs and Superintendent of SCB Medical College had issued a show cause notice to the agency concerned for its laxity and inaction.

While outsourcing per se is not objectionable but ways and means have to be found to ensure adequate accountability of the outsourced agency. The Superintendent, SCB Medical College needs to pay proper attention to the disposal of biomedical waste. The process of disposal of biomedical waste should be carried to its logical conclusion by changing the existing agency by a better performing one. The disposal of biomedical waste of IMH may be incorporated while planning construction of a new six storey block.

The Ministry of Health and Family Welfare Government of India sanctioned an amount of Rs. 8 lakh for setting up of a Drug Deaddiction Centre in 1995. It took 8 years to complete the construction of a simple structure and the centre was formally opened in 2003 without sanctioning the essential staff and providing any equipment, furniture and accessories. The required number of posts had not been sanctioned and necessary equipment had not been procured and installed. There were no attenders or sweepers attached to the centre except 4 security personnel.

The full strength of medical and para medical staff for the drug deaddiction centre as also the requisite tools and equipment may be sanctioned on an urgent basis; Considering the sorry state of affairs of the Drug Deaddiction Centre, it may be suggested that the State Government should invite HOD, Department of Psychiatry, AIIMS, New Delhi to visit the centre and advise on how to make the centre optimally functional; which additional posts need to be sanctioned; and what additional tools and equipments need to be procured and installed; Superintendent, IMH held a discussion with Dr. Vivek Benegal, Professor, Drug Deaddiction, NIMHANS for organizing OCD training (Obsessive Compulsory Disorder) for the faculty of IMH in NIMHANS. He was to send a proposal to Government to this effect.

In view of the paucity of its own space to keep long stay patients for rehabilitation Superintendent IMH Cuttack had sent a proposal for launching a rehabilitation unit for long stay patients with Mission Asra, another good and reliable NGO located in the outskirts of Khurda sub division about 28 kms from Bhubaneswar.

The proposal made by the Superintendent, IMH for starting a rehabilitation unit for unclaimed long stay patients under the auspices of Mission Asra, yet another credible and committed NGO in the outskirts of Khurda town, 28 kms from Bhubaneswar may be approved by the Government and approval order be communicated to enable Superintendent, IMH to proceed further.

There were 6 natural deaths due to cardiac arrest, cardio respiratory failures and septicaemia shock, diabetic crisis between 2006 and 2011 but there was no unnatural death during the said period.

Mental Hospital (MH) , Varanasi (5th July, 2010)

Mental Hospital Varanasi with sanctioned bed strength of 331 had total bed occupancy of 269. There were two closed wards and barracks. The construction of a 30 bedded female family ward was under progress and the construction of a 50 bedded male ward and a modular kitchen was likely to become functional within a short time. The toilet patient ratio was 1:5.

There were 4 criminal and 17 noncriminal long stay patients and the long stay of patients had been attributed patients not showing any sign of recovery due to their chronic ailments; whereabouts of wandering patients admitted through court orders were not known; wrong addresses furnished by family members of patients at the time of admissions; reluctance on the part of family members to take charge of patients after their full recovery; delay in arranging a police escort by concerned jails for transfer of such parties.

There were 55 deaths between 2003 and 2010 of these 28 were criminals and 27 non criminals. These deaths had not taken place in the mental hospital but in Government. hospitals where their cases were referred for specialized treatment. A detailed post mortem report was prepared in the prescribed format and sent to NHRC. The cause of death in case of convicts or UTPs was investigated by

a Magistrate. If the convict or the UTP had come from another district the investigation was conducted by the Magistrate of that district. The investigating Magistrate did not come to Varanasi where the death had taken place but summoned the medical officer of the mental hospital who referred the case for specialized treatment or the treating physician of the hospital where the patient was treated or both and conducted the investigation at a place far away from the place of occurrence. It was causing severe dislocation in the functioning of the hospital when a MO was summoned and remained away for days together due to acute shortage of medical staff.

There was no drug de-addiction ward attached to the hospital. There is only one drug de-addiction ward under the Department. of Psychiatry in Banaras Hindu University. The Director may depute one of the staff members preferably a Senior MO to go and study the set up in Banaras Hindu University and get the basic inputs on physical space, tools and equipment and manpower both medical and para medical, work out the administrative and financial implications and formulated a self-contained proposal. The said proposal may be sent to Government of India for funding through the State Government.

Institute of Mental Health and Hospital (IMHH), Agra (28th to 30th March, 2011)

The admissions in IMHH Agra had increased from 2589 in 2006 to 3103 in 2010. There was a homely environment of IMHH. The staff nurses had been taking daily rounds to enquire about wellbeing of inmates.

The infirmary with 3 wards and 42 beds was mainly catering to the needs of those mentally ill patients who had associated physical illnesses like fever, vomiting, loose motion, dehydration, side effects of the medicine etc. The infirmary was functioning in a 150 old building without DPC. There was profuse seepage in the wall and the plaster of the ceiling was wearing off. There was no proper room for MO or for the sister in-charge and there wards had no intercom facility.

A decision should be taken to demolish all the three wards in infirmary as this building being 150 years old is beyond repair. The Director IMHH should take this proposal to the Works Sub Committee of Management Committee, discuss all the pros and cons of the proposal and bring it before the MC for a final decision. In the meantime the damaged electric switches at many points should be repaired immediately and these rooms should be fitted with intercom for internal contact in case of emergency.

The cases related to cardio vascular complications, respiratory diseases (asthma, pneumonia, bronchitis, bronco-pneumonia etc.), other associated complications related to ENT, orthopaedics, general surgery etc. were referred to S.N. Medical College or District Headquarters hospital. The overall attitude, approach and general response of S.N. Medical College was not very positive towards referred cases.

There should be better understanding, coordination and cooperation between IMHH and S.N. Medical College. The Director, IMHH may address a letter to Director General, Health Services (DGHS) requesting for his intervention in general and for sorting out issues of different norms of medical ethics adopted by S.N. Medical College for all referral cases by asking for provision of drugs and services of attendants etc as a precondition for entertaining and attending to all referral cases and discharging a patient in the middle of the treatment on some alibi or pretext.

IMHH had sanctioned bed strength of 838 patients and average bed occupancy varied from 427 to 632 between 2006 and 2010. There were 30 wards and each ward complex consisted of a ward, toilet, bathroom and dining hall. All wards were neat, well lighted and ventilated and well netted windows. The toilet patient ratio was 1:8. The new 50 bedded male ward had a courtyard with ten stone benches for use of patients and their family members.

The recommendation made by Prof. Channabasavanna Committee relating to toilet patient ratio of 1:5 in 1998-99 is yet to be implemented. The toilet patient ratio of 1:8 needs to be improved to the recommended norm.

There were separate open wards for male and female patients and children below 18 years were also admitted in the open (family) ward. The proposal for the geriatric ward sent to Ministry of Health and Family Welfare, Government of U.P. had been sanctioned but funds were yet to be released. Meanwhile, geriatric patients were admitted in the open ward along with family members.

The rooms were commodious, well lighted and ventilated. There was no congestion as distance between two beds was of one metre. Each patient was provided with a bed side locker. Each ward had sufficient number of cots, beds with mattresses and blankets, fans and desert coolers. The beds as well as mattresses and bed covers were of good quality and had been maintained neat and clean. The relatives of the patients were provided with a separate bench to sleep. The general health status of the inmates was very good.

The average stay of patients was 10 to 13 days in the open wards and 54 to 101 days in closed wards. The number of escapes had come down from 16 in 2006 to 8 in 2010. The number of long stay (2 or more than 2 years) patients was 88 in 2010. The steps taken by IMHH to reduce long stay included to record and document correct postal addresses; address letters to family members/guardians at the address so collected and also encourage literate patients to address letters to their guardians/family members and PWS to assist illiterate patients in this effort.

To facilitate the transition of effectively treated and substantially recovered patients from IPD to home and community a Half Way Home was established in 2000 and had been managed departmentally.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

All the admissions including both voluntary and court directed had been made by the psychiatrist. The number of patients admitted was 80 in the Psychiatry department and 29 in Drug De - addition ward in 2009. The number of patients discharged from Psychiatry Department was 72 and from Drug De - addiction ward was 29 in 2009. The number of patients discharged was more or less the same as admitted in the hospital.

The members of the treating team had been taking 3 to 4 rounds including an evening round. Every morning and evening vital signs were checked and recorded. During morning and evening rounds examination of mental status of all patients was done on a regular basis. A psychiatrist was available on call for 24 x7. From the time of admission families were psycho educated and counselled.

The mentally ill patients suffering from other associated complications like appendicitis, cardio vascular, respiratory, ENT, opthalmological, orthopaedic, renal failure, and complications arising out of prostate enlargement leading to prostate cancer were referred to referral hospitals for specialized treatment. The Institute of Psychiatry was maintaining close liaison and coordination with all departments of IPGMER and only a referral letter was sufficient to entertain patients referred by the Institute. The treating team of the Institute kept a constant touch with the referral hospital and held discussions with the physicians/surgeons of IPGMER for management of patients on both sides. The same was true for any psychiatric emergency which occurred in the case of patients who had been admitted for treatment of general illness in any other department of IPGMER.

The total bed strength of the Institute of Psychiatry including 6 beds for de-addiction was 36 and there were closed wards and some paying wards. The patient bed ratio was 1:1, toilet patient ratio was 1:3.5 and fan patient ratio was 1:1.4. There was adequate stock of cots, mattresses, linen, pillows and blankets but there no facility to keep patient's belongings.

The closed wards should be replaced with family/open wards, the buildings should be maintained properly. Steps should also be taken to provide facility to patients to keep their belongings.

The total cost per patient was Rs. 65 per day, of which Rs. 43.06 was spent on food and the rest on liveries and medicines. The patients admitted by court order were not required to pay anything whereas rest of the patients had to pay except for food which was free for all inpatients. The wards were cleaned once in a fortnight, uniform of patients were changed daily and linens were changed once a week. There was no privacy for the patients. All patients were allowed to write letters to their family members and talk to recognized social agencies.

The average stay for patients had come down from 4 to 6 weeks to 2 to 3 weeks. There were occasions for a longer stay up to 3 months partly due to recurrent illness and partly due to refusal on the part of family members to take back their

patients. There had not been any case of suicide, homicide, violence and escape. There was one death of an epilepsy patient with other associated complications in 2009. The medical staff of the hospital made best efforts but could not save the life of the patient. Death audit was conducted in all cases with the help of a consultant.

2. Barest Minimum Needs of the Patients

A mentally sick person has certain human rights which flow from the fundamental right to life as in Article 21 of the Constitution. These human rights are irreducible barest minimum needs which include wholesome, sumptuous and nutritive food according to certain prescribed scales; adequate quantity of portable water for drinking and water for cleaning, washing, cooking, bathing , flushing the toilet; personal hygiene and sanitation etc. The state/mental health care hospital in case of inpatients has a fundamental obligation to recognise these barest minimum needs of mentally sick patients and try to meet these needs as deprivation of any one of these amounts to violation of human rights of the person. The quality norms and standards in mental health are non-negotiable. The position as it stands in different mental hospitals has been analysed under the following heads:

i) Right to food

The right to food has a number of dimensions such as certification of the nutritive value of food by a dietician/nutritionist; arrangement for providing special diet to inmates suffering from communication diseases; place where food is being cooked; manner of cooking food; storage of food after it is cooked and before it is transported; method of transportation of food; manner of service of food with a human touch; upkeep and maintenance of kitchen as well as dining hall; personal hygiene of cooks; medical examination of cooks; place where food items have been stored; manner of storage of food items.

Availability of wholesome, sumptuous and nutritive food according to certain prescribed scales; food served for breakfast, lunch and dinner is a balanced combination of carbohydrate, protein, oil/fat, trace minerals and vitamins; to ensure that the food is balanced and wholesome and nutritious as per the established and recommended standards the services of a dietician should be engaged to verify and attest that the food being served conforms to a minimum of 2500 kilo calories for women and 3000 kilo calories for men; the per capita allocation for food in monetary terms conforms to the above nutritive value.

Food should be cooked in clean and hygienic environment in a modern kitchen having adequate space light and ventilation; adequate number of exhaust fans and chimney; tiling on the wall upto a height of one metre; platforms for washing, cutting and storing vegetables before being cooked; adequate number of taps inside the kitchen; adequate mechanisation like electric kneader and chapatti-making machine; the vegetables should not be cut on the floor and chapattis not made on the floor; flyproof wiremesh all around, flyproof automatic closing doors, floors made of an impermeable material; LPG and hotplate.

Cooked food should be properly stored in stainless steel containers and served soon after cooking in steel utensils; cooked food should be transported by a trolley and not manually as in the case in most of the hospitals; food should not be exposed or served in the open space; dining facilities including dining hall and dining tables should be available and designed to ensure there is no over crowding and that it is not too far from where the inpatients reside and that the service is smooth and prompt; washing of hand and feet of patients before they settle down to food to ensure personal hygiene; serving of food with a human touch to ensure that while old, infirm and disabled patients are assisted to take food, there is no wastage of food; Soft music should be played at the time of serving food;

Care must be taken to check the food quality to ensure that it is not under-cooked or burnt; the timing for breakfast, lunch, evening tea and dinner should be such that the gap between two consecutive meals is not too long; the menu should be prepared for the whole week but should be altered daily to ensure variety; separate menu for those not doing any physical activity and those engaged in physical activity in the occupational therapy units; the dining room and tables should be kept clean and free of flies and cockroaches;

Proper arrangement should be made for medical examination of cooks once in six months; scientific storage of food grains (rice, wheat, atta, flour, besan, suji, idli, rawa, sugar, edible oil, condiments/spices, fruits and vegetables with arrangement for adequate lighting, ventilation and pest control; storage of LPG cylinders; change of aprons for cooks.

The position as it stands in different mental health institutions is as under:

The Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

There was a dietician to oversee the process of cooking and serving food. Diet Indent book and diet distribution registers were maintained. According to dietician assessment, the nutritive value of served food to the patients was 3339.3 kilo calorie per patient per day against an allocation of Rs. 28 per day. The timings for serving breakfast, lunch and dinner were: breakfast 7 AM to 8 AM, lunch 12 Noon to 1 PM and dinner 6 PM to 7 PM. This was leaving a huge gap of 12 hours between dinner and breakfast which might cause gastric problems.

It is difficult to accept that the nutritive value of food is 3339.3 kilo calorie with barely an allocation of Rs 28 per patient per day towards diet unless the food grains, vegetables and fruits are available at throw away prices. The dietician needs to work out the nutritive value measurable in kilo calorie separately for all the components/items allotted/consumed in breakfast, lunch and dinner and paste it on the walls of the kitchen and dining hall.

The hospital does not have any agricultural estate like RINPAS Ranchi and is buying food grains and other essential commodities from the open market at high prices. Keeping in view the limited purchasing power of allocation of Rs 28 per

patient per day, Principal Secretary Health may takes up the matter with Principal Secretary, Department of Food and Civil Supplies for arranging food grains at controlled prices from PDS at controlled prices to the hospital.

The kitchen block and dining hall in the wards were fairly commodious and had adequate light. The kitchen, however, did not have an ideal location which could be central to the wards where food would be transported. Kitchen walls had holes, floor was damaged at a number of points and windows were shattered. There were only two exhaust fans and there was no chimney, fly proof wiremesh all around and flyproof automatic closing doors. Vegetables were cut on tables as there were no properly installed platforms fitted with water taps for washing vegetables. The arrangement for storage of food grains, sugar, edible oil, condiments/spices, fruits and vegetables was neither adequate nor scientific. The central store room was small and storage of many food items partly on the platforms and partly on the floor made it rather congested.

Hospital authorities need to attend repair work of the kitchen repairs and leakage in the dining hall on urgent basis. Chimney and requisite number of exhaust fans need to be installed. Adequate arrangement should be made for storage of food grains and dry ration, fruits and vegetables in separate compartments and kept on platforms rather than on the floors.

Food was transported from the kitchen by trolleys to the inmates block/wards and served soon after its preparation. There was leakage of water in the roof of the dining hall and in the absence of benches in the dining hall patients had to sit on the floor to take their food. The relatives/family members of the patients were either bringing their food from outside or cooking themselves in the hospital premises.

A dining hall needs to be constructed for all wards and furnished with table and chairs/benches.

Government Hospital for Mental Care (GHMC), Vishakhapatnam (30th and 31st March, 2009)

The patients were provided breakfast, lunch and dinner and there was no provision for morning or evening tea. The Government of Andhra Pradesh increased the diet charges from Rs. 20 to Rs.28 per patient for providing diet consisting of 2400 kilo calorie, protein - 80 grams and fat - 30 grams. The family members staying with the patients in the family ward had to make their own arrangements for food. Some of them must be managing with the food supplied to the patients and causing further reduction of patient's intake. The gap of 12 hours between dinner and breakfast might cause gastric problems.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara 13th August, 2010)

The IHBAS strived to provide safe, hygienic and nutritive food to inpatients of the Institute. The entire process of cooking and distribution of food was supervised

by two dieticians and one officer incharge of the kitchen. The daily budget allocation for food was Rs. 50/- per patient. This compared favourably with the scale fixed by most of the other mental health hospitals. Within this broad scale, IHBAS had introduced therapeutic diet scales such as normal diet, semisolid diet, diabetic diet, salt restricted diet, low fat diet, high protein diet, high carbohydrate diet, high fibre diet, liquid diet. The nutritive value of food worked out to 3000 kilo calories, Protein 94 gm, fat 58 gm and carbohydrates 550 gm. The calorie percentage of Carbohydrate - 71%, Protein - 12% and Fat - 17% was in order. Special festival diets were served on Republic Day, Holi, Independence Day, Dusserah, Diwali, Idul Fitr and Christmas.

The Kitchen had a concrete chimney, 10 exhaust fans and tiling on the walls upto the height of 1 metre. Separate large plastic trays were used to wash vegetables and vegetables were cut on wooden blocks over marbled surface counters and were cooked directly after cutting and washing. Electric dough kneader and chapatti making machines were available in the kitchen.

Food once cooked was transported through food trolleys from the kitchen to the various wards and served to the inpatients in the dining area/pantry in the wards under supervision of the staff nurse present during service of each meal.

There were 10 cooks who were assisted by 6 attendants employed on contract basis in the kitchen. The medical examination of cooks was done twice a year. There was a gas plant adjacent to the kitchen for supply of gas. IHBAS was procuring rice, sugar, atta, pulses, spices/condiments and edible oil etc. for a month from Kendriya Bhandar on the basis of requisition sent every month. Most of the perishable commodities (milk, milk products, vegetables, eggs) were kept in the refrigerator at 5º to 8º Celsius temperature.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

A model diet chart (both routine diet and special diet) prescribed by Government of Gujarat for patients of all State Mental Health Hospitals fully meet the norms prescribed by ICMR. Daily per capita diet expenses of Rs. 54.30 compared very well with diet expenses incurred by other mental health hospitals elsewhere in the country. A Diet Committee was monitoring the tidiness of kitchen, diet quality and all other diet related activities in the absence of a dietician. The quality and nutritive value of food prepared in the kitchen was checked by the RMO and in his absence by the present MO.

The food should have more leafy green vegetables. Fried items like puri and pakoras may be avoided.

The Central Kitchen conformed to all the norms and parameters. Food was served on dining tables and chairs placed in large sized dining halls. The patients used to remove their slippers outside and wash their hands and feet before having food. However, the gap dinner served at 6.30 PM and breakfast at 7.30 AM might cause gastric problems.

Institute of Psychiatry and Human Behaviour (IPHB) , Goa (6th to 9th December, 2010)

The per capita expenditure of Rs. 50 incurred on food per day was better than many other State managed hospitals. Food served was a balanced combination of carbohydrate, protein, oil fat, trace minerals and vitamins. Fish a rich source of protein had been served 5 days a week in both lunch and dinner. The nutritive value of food ranging between 2800 and 2900 Kilo Calorie was ideal. The menu was changed every day. The patients were served only rice and no chapaties. The sanctioned post of dietician, however, was lying vacant since inception and in the absence of a dietician it was difficult to certify the nutritive value of food.

The kitchen was quite commodious and had a large hall with sufficient number of platforms for cutting and washing vegetables. There was a separate store room for storing rice, sugar, condiments, jagri etc. for one month but the space for storing these provisions was rather limited. The kitchen had sufficient number of exhaust fans but there was no chimney or outlet for smoke. There was no separate room in the kitchen for cooks to change their aprons.

The cooked food was carried through trolleys in stainless steel containers and was served in the respective wards. There was no dining hall either common or attached to a ward and in the absence of a dining hall patients were taking their food on the floor. There was no board in the kitchen to display quantities of ration issued from the provision store and consumed to ensure transparency.

A dining hall needs to be constructed for each ward; A provision should be made for special diet for diabetic and other seriously ailing patients; Efforts should be made to introduce chapatti in the menu which in addition to carbohydrates had other nutrients. This should be done notwithstanding the fact that culturally rice is preferred to chapatti in Goa.

Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS), Ranchi (27th to 29th January, 2010 and 24th to 26th February, 2011)

RINPAS was incurring per capita expenditure of Rs. 48.26 on diet per day and the menu prescribed for inmates ensured a balanced combination of protein, carbohydrates, oil-fat, trace minerals and vitamins. The nutritive value of food was estimated at 2623.4 kilo calorie. A provision of special diet was made for diabetic, low weight and those patients who required special diet. There was also a provision of special meals on festive occasions and on Independence Day, and Republic Day etc.

The food was served to patients in commodious, neat and tidy dining halls on low height dining tables in a neat, orderly and disciplined manner. MO was incharge of smooth service of food with a human touch He was assisted by one Psychiatric Social Worker, two staff nurses, one warder and one jamadar. The patients were asked to remove their foot wears outside the dining hall and wash their hands and feet before settling down for their meals. In the absence of a

dietician it was difficult to know the nutritive value of the food served to the patients.

Government Mental Health Centre (GMHC), Thrissur (14th April, 2009)

The per capita scale of diet was Rs. 44.43 per day. The nutritive value of food was estimated at around 2900 kilo calorie and diet supplied was adequate in terms of carbohydrate, protein, oil/fat but inadequate in terms of iron. Special diet was prescribed by the dietician to the ailing persons.

The iron rich items including Coconut dry, cumin seeds, lotus stem dry (Kamal kakdi), poppy seed, turmeric, niger seeds (blank til), mango powder, cauliflower greens, Bengal gram leaves, cow pea leaves, radish leaves, mustard leaves, spinach, beet green, mint, soyabean, water melon seeds, horse gram, Bengal gram, bengal gram dal, Bengal gram roasted, black gram dal, moth beans, dry peas, roasted peas subject to availability need to incorporated in the menu:

GMHC, Thrissur did not have a well lighted and ventilated kitchen. There were only two exhaust fans and no chimney. The hospital was using cooking gas, biogas and steam for cooking. Firewood was used only in emergency outside the kitchen in a separate space. Tiling had been done on the wall of the kitchen upto one metre. There were 2 fly proof windows but they were not cleaned regularly. There were platforms for washing, cutting and storing vegetables before cooking. The kitchen had a water storage tank to store the desirable quantity of water needed for cooking, cleaning and washing. The kitchen had four steam cooking steel drums for cooking and one big vessel for cleaning and draining the rice water; separate large vessels for cooking fish and mutton and seven aluminium vessels for storing cooked food.

A chimney and minimum number of 4 exhaust fans need to be installed in the kitchen.

All dry food items including rice, sugar, edible oil etc., and vegetables and fruits were stored in a separate enclosure which did not have the adequate light and ventilation and kept on the floor. The kitchen floor was regularly cleaned with cleaning fluids and bleaching powder and cooking utensils were cleaned with soap powder and washing soda. There were six permanent cooks and dietician was the overall in-charge of the kitchen.

Vegetables and fruits should be kept in a well lighted and ventilated separate compartment and should be kept on the shelves above the ground level rather than being kept on the floor.

The food was transported from the kitchen to the dining areas of the wards and most of the wards had dining tables. The food was served under the supervision of the Head Nurse and Nursing Assistants. The suggestions of the patients were solicited by the superintendent during his weekly rounds and were implemented to the possible extent.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

The Head nurse was in-charge of dietary department including cooking of food and storage of provisions. The sanctioned post of a dietician was lying vacant. The components of diet sanctioned per patient per day were rice 450 gm, wheat 200 gm, sugar 22 gm, Bread 100 gm, vegetables 200 gm, coconut oil 12 gm, big onion 14 gm, dal 14 gm, tea dust 3 gm, salt 42 gm, Jaggery 50 gm, green gram 85 gm, Bengal gram 28 gm, tropic, curry powder 10 gm, milk 300 gm. There was an arrangement of serving special diet after eight days of admission. The scales of special diet were Sunday - one boiled egg; Monday - 50 gm. Mutton; Tuesday - one boiled egg; Wednesday - 70 gm. fish, Thursday - one boiled egg; Friday - one boiled egg, and Saturday - 70gm. fish. The dietary schedule in GMHC Kozhikode was: tea with milk 5.30 AM; Wheat kanji/Rava Upama 8 AM; Bread (100 gm) and milk 200 ml 10.30 AM; Rice and curry 1 PM; Black tea 4 PM; and Rice Kanjhi with Puzhukku (tapioca with pulses) 7 PM.

The work environment in the kitchen was stuffy. Cooking gas was used as the main fuel. There is no chimney in the kitchen. Ceramic tiles had been fixed upto a sufficient height. Cutting of vegetables was done on one platform and washing on another platform. The food grains and other provisions (sugar, salt, oil, condiment etc.), green vegetables and fruits etc. were stored in independent storage space. Food grains were procured from government agencies at controlled prices and sufficient quantities were stocked.

There were 8 regular cooks working in two shifts in the kitchen. The cooked food being stored in tinned copper vessels before serving was not a healthy arrangement. Cooked food was transported through food trolleys from kitchen to the various wards in closed containers and served in dinning halls under direct supervision of Head Nurse in-charge of respective ward. In the absence of a dietician, it was difficult to certify the nutritive value of food.

A chimney and more exhaust fans need to be installed in the kitchen and food should be stored in stainless steel utensils rather than in copper vessels before serving.

Gwalior Mansik Arogyashala (GMA), Gwalior (2nd to 4th February 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

The scale of diet per patient per day remained unchanged at Rs. 34 despite a steep rise in prices in general and food prices in particular. There is a very strong possibility of reduction in nutritive value of food served to inmates due to food inflation. This in turn would contribute to undernourishment or malnutrition of inmates.

The hospital kitchen was rather small and without proper light and ventilation. There were no exhaust fans, chimney, fly proof wire mesh, fly proof automatic closing doors and platform for cutting and washing vegetables. There was no electric kneader and chapatties were made on the floor. GMA sent a proposal

along with a detailed project report to the Department of medical Education, Government of M.P. for allocation of funds for construction of a new modular kitchen but Government's decision was awaited. The cooks had not been provided with the aprons and the status medical examination of cooks was unclear.

Patients were served food in dining halls. There were no food trolleys for transportation of food from kitchen to different wards. The menu was changed every day and there was no restriction on the quantity of food served to the patients. The timings of food served to patients were: breakfast - 8.30 AM, lunch - 1 PM and dinner - 6.30 PM. There was no sanctioned post of dietician in GMA and in the absence of a dietician it was difficult to certify the nutritive value of food served to the inmates.

Food trolleys should be procured without any further delay for transportation of food from the kitchen to the wards.

GMA continued to buy all its primary food articles from the open market at much higher prices than PDS rates. Food grains (rice, wheat, atta, flour, suji, besan, sugar, jagri, condiments as also vegetables) were kept on the floor.

The Government needs to make suitable arrangements for allowing GMA to procure all essential commodities (rice, wheat, atta, sugar, pulses, condiments etc.) from PDS at much lower prices than the prevailing market prices; Food grains (rice, wheat, atta, flour, suji, sugar, besan, jagri, condiment etc., as also vegetables) should be stored in separate compartments and kept on platforms under controlled temperature. The room where these items are stored should be adequately lighted and ventilated; Anti-termite and pest control measures should be taken to protect the food grains from pest/insect attack.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

The Government had revised diet charges from Rs. 20 to Rs. 50. IMH Cuttack was dependent on the kitchen of SCB Medical College for provision of food to its patients. The arrangement of food coming from the kitchen of SCB Medical College was not a very satisfactory arrangement. IMH had patients with different dietary needs due to different ailments but could not meet the requirements of special food for its patients as food supplied from kitchen of SCB Medical College was of uniform pattern. The food used to get cold in the process of transportation. The IMH had no control over the quality of food served to its inmates in the absence of its involvement and supervision in the kitchen of SCB Medical College. With the revised diet charges IMH Superintendent could have planned a better menu to meet the varying dietary needs its patients.

The IMH should plan its own modular kitchen independent of SCB Medical College on the same pattern of IMHH, Agra under the Centre of Excellence. The food should be transported in steel pipe trolleys from kitchen to the wards. This should simultaneously be followed by construction of the required number of dining rooms furnished with tables with benches/chairs as may be considered appropriate to suite the local situation.

In the absence of a dietician it was difficult certify that the food served from the kitchen of SCB Medical College was wholesome and nutritious, whether the same represented a balanced combination of carbohydrates, protein, oil/fat, trace minerals and vitamins and whether the nutritive value of food conforms to 3000 kilo calorie for men and 2500 kilo calorie for women.

Mental Hospital (MH), Varanasi (5th July, 2010)

The scale of diet per patient per day had been revised from Rs. 20 to Rs. 35. The FCI had discontinued supply of rice and wheat to mental hospital Varanasi on the strength of permit since March 2007. Despite the assurance given by District Magistrate (DM) the supplies had not resumed. Food grains continued to be supplied by government approved contractor at higher rates than PDS rates.

The DM needs to take necessary action to resume supplies essential commodities including food grains, rice, sugar, pulses etc. from PDS at much lower price than the prices at which these items are supplied by the Government approved contractor.

The kitchen building of Mental Hospital Varanasi was in a very bad shape. The kitchen was not well lighted and ventilated and the standards of cleanliness inside the building required to be improved. The post of cooks was lying vacant and there was no sanctioned post of Kahar (helper). The Director had sent a proposal for sanctioning 7 posts of cooks but no sanction had been received.

The proposal submitted by Director for sanctioning 7 posts of cooks may be sanctioned and vacant posts of cooks need to filled up on urgent basis .

The food was transported from the kitchen to barracks manually in the absence of trollies. Food was served on the floor as there were no dining tables. There were two different timings of serving food in summers (March to October) and winters (November to February). The tea was served only in the morning and there was no provision for serving tea and snack in the evening. The dinner was served to early between 4PM and 5 PM to inmates both in summers and winters. As a result, inmates used to feel hungry in the night and a huge gap between dinner and breakfast was likely to give rise to gastric problems.

Trollies need to be procured without any delay for transportation of food from kitchen to the barracks and Dining rooms need to be provided with dining tables and chairs.

Institute of Mental Health and Hospital (IMHH), Agra (28th to 30th March, 2011)

The food served to the inmates in IMHH was wholesome, sumptuous and nutritious. The nutrient value of food had been estimated at 3177.56 kilo calorie for male and 2969.56 kilo calorie for female patients. The menu was changed every day and food served was a balanced combination of carbohydrate, protein,

oil/fat, vitamins and trace minerals. Special meals comprising of Kabuli channa/ rajma/peas, paneer, karhi was served once a week and on festival days. Special diet comprising of egg, milk and bananas was also prescribed for malnourished, low weight patients and other patients who were in need of special diet.

The modular kitchen developed by IMHH is a model to be emulated by other mental health hospitals. The kitchen block was well lighted and ventilated and on the whole presented a neat and tidy look. It had wall tiling up to a height of one metre; fly proof wire mesh all around, fly proof automatic closing doors; 3 chimneys and 8 exhaust fans to provide an effective outlet for smoke. It was spacious to accommodate all activities of modern kitchen including scientific storage of food grains (rice, wheat, atta, flour, besan, suji, idli, rawa, sugar, edible oil, condiments/spices, fruits and vegetables and storage of cylinders in a separate room. There were separate platforms for cutting, washing, and storing vegetables before being cooked. The food was prepared in big aluminium vessels and chapatties made on wire mesh were better shaped, soft and of good quality. The food after being cooked was filled in stainless steel containers and sent to outer counter platforms from where food was packed in containers and transported to various wards by patients and attendants. There were two permanent cooks and 15 outsourced personnel excluding 4 female patients and 2 male patients who were also engaged in the kitchen because of their liking for kitchen work. All cooks were wearing aprons and were subject to medical examination at regular intervals.

The food should be cooked and stored in the stainless steel containers which do not gather dust rather than aluminium vessels.

The new central dining hall with built up area of 500 square feet was very spacious and well lighted and ventilated and had the capacity to accommodate 152 patients. There was a big room at the entrance with attached toilet for washing hands. It had a provision for rain water harvesting. The male ward had another dining room with total capacity to accommodate 100 patients.

Even though IMHH, Agra did not have an agricultural estate like RINPAS Ranchi, it had started a new activity of kitchen gardening in the female ward under the supervision of the Rehabilitation Counsellor. As part of this activity patients had planted seasonal vegetables like spinach, cabbage, cauliflower and the total production of vegetables was estimated at 33053 kg during 2009 and these vegetables were used for consumption of inmates. This had helped IMHH kitchen to become self-sufficient to some extent.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

IOP Kolkata did not have a proper and efficient way of managing rights of inmates to wholesome, nutritious and balanced diet. The food was provided by a contractor appointed by the Government. The said contractor was cooking and serving food from the kitchen of SN Pandit hospital. Under this arrangement,

Institute of Psychiatry was not in a position to certify the nutritive value of food measurable in kilo calorie, tidiness of kitchen and dining hall.

The Institute had assigned the responsibility to the Nursing Superintendent to ensure that the food served was sumptuous, hot and nutritious; food served had a balanced combination of carbohydrates, protein, oil/fat, trace minerals and vitamin; food was prepared in a neat, orderly and hygienic manner; patient's preferences and tastes were taken into account while designing the menu for breakfast, lunch and dinner. The supervision of the Nursing Superintendent was not quite effective.

The food was served in the dining hall of the Institute of Psychiatry and timings of serving food were: morning tea with biscuits 06.30AM; breakfast 08.00 AM; lunch 12:00 PM; evening snacks 6PM and dinner 8PM. The food served in terms of quantity was inadequate and the nutritive value of food varied between 1500 and 1800 Kilo Calorie whereas the nutritive value of food for an able bodied adult should not be less than 2500 Kilo Calorie.

The Institute of Psychiatry should develop its own modular kitchen on the similar pattern of modular kitchen of IMHH, Agra. Pending the construction of its own kitchen, steps should be taken to exercise proper supervision and strict control over the contractor who is bringing food from kitchen of S.N. Pandit hospital; improve the overall quantity and quality of food; and check wastage and leakage of resources in the whole process of outsourcing.

ii Right to Portable Water

Right to Potable Water requires adequate and effective access to portable water which includes the source of water must not be **c**ontaminated; adequate quantity of water stored in the overhead tank to make per capita availability of 135 litres of water to each patient per day as required by established norms for drinking, cleaning, washing, cooking, bathing, flushing the toilet; proper arrangement of distribution of water to all parts of hospital through linking the overhead tank to all the wards through pipes and a sub-tanks installed for each ward; the proper cleaning of overhead tanks by application of the state-of-the-art technology with mechanized dewatering sludge removal, high pressure cleaning, vaccum cleaning, antibacterial spray and ultraviolet radiation; samples of water collected at an interval of a quarter or at least six months and sent to Public Health Laboratories to test and certify that the water is free from chemical and bacteriological impurities, excess of iron, calcium, sodium, sulphur, magnesium and floride and has no colour, hardness, turbidity and alkalinity; setting up of a RO (Reverse Osmosis) plant to ensure provision of pure water to the patients.

The position as it stands in different mental health institutions is given below:

The Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

IMH had 24 hour supply of potable water through a direct line from the

Hyderabad Metro Water Supply and Sewerage (HMWS&S) Department. In lieu of a piece of land made available by IMH to HMWS&S for construction of their reservoir the HMWS&S had ensured 24 hours supply of portable water to the hospital. Water samples had been drawn regularly at appropriate intervals and sent to the Institute of Preventive Medicine Hyderabad for testing and certification and no adverse remarks had been received by the Institute.

Geysers and solar heaters had been installed in all the wards to ensure supply of hot water for inmates in winter. Water coolers had also been provided in some parts of the hospital to ensure supply of cool potable water in summer months.

Government Hospital for Mental Care (GHMC), Vishakhapatnam (30th and 31st March, 2009)

The right of inmates to cool and potable water had been recognized and fulfilled by the Government Hospital for Mental Care Visakhapatnam. The Municipal Corporation of Visakhapatnam supplied nearly 2 lakh litres of fresh water to the hospital every day. Potable water was provided to all the wards in stainless steel containers with tumblers. Drinking water was placed at the entrance of the ward to provide easy access to every patient. One water cooler with aqua-guard water purifier had been provided in the family ward block. Proposals for purchase of 3 more water coolers with aqua-guards had already been sent to Government for providing cool drinking water in every block.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August, 2010)

The adequate quantity of potable and non-potable water was available both at the source, storage as well as distribution point. The drinking water being treated through RO Plant was free from all bacteriological and chemical impurities. The Over Head tanks (both main and sub tanks) had been cleaned at specified intervals. There was a provision for supply of hot water for bath of inmates in winter. Water coolers had also been installed for supply of cool water in summer months.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

There was no scarcity of water as the hospital had its own bore-well and two overhead water tanks and one sump with capacity of one lakh litres each. There were 12 sub tanks with a storage capacity of 10,000 litres each and each hospital building (including wards) had a separate overhead tank. The cleaning of the main overhead tank was done once in every 3 months and that of sub tanks and sump every month. The samples of water were regularly drawn and sent for test at the Ahmedabad District Laboratory of Gujarat Water Supply and Sewerage Board. The water so tested had confirmed that it was potable (free from chemical and bacteriological impurities). All wards were having water coolers with RO systems for drinking water.

Institute of Psychiatry and Human Behaviour (IPHB), Goa (6th to 9th December, 2010)

Water was available in sufficient quantity for drinking, cooking, cleaning, washing, bathing and flushing. The water tanks were cleaned regularly. Samples of water were drawn and sent regularly for testing in one of the approved testing laboratories of PWD. The test reports had confirmed that water was free from chemical and bacteriological impurities and was fit for consumption.

Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS), Ranchi (27th to 29th January, 2010 and 24th to 26th February, 2011)

The RINPAS had ensured access to clean potable water of the desired quantity and quality with arrangements of proper storage and distribution of water. Water samples were drawn at periodic intervals and sent for testing to PH laboratories and water storage tanks were cleaned according to State-of-the-art technologies. RINPAS had a Mineral Water Plant with a capacity of filtering 100 litres of water per hour. Mineral water was collected in containers from this plant and distributed to all wards. All wards had been provided with water cooler.

Government Mental Health Centre (GMHC), Thrissur (14th April, 2009)

The Municipal Corporation Thrissur was the main source of water supply to the hospital. GMHC Thrissur also had a tube well and 4 open wells in its campus. Water was pumped to the main sumps from where it was stored in over head tanks and supplied to storage tanks of the wards. As per the requirement of 135 litres per head for cooking, cleaning, sweeping, washing, bathing, flushing and drinking, the hospital required 48735 ltrs of water every day. The MHC Thrissur experienced shortage of water during summer months. Samples of water had been drawn and sent to PH laboratory for water analysis once in every 6 months.

A proposal submitted by the Superintendent to ground water authority for another tube well to tide over the problem of short supply of water during summer should receive immediate attention of the ground water authorities and Health Department should sanction an amount of Rs 40,000 for the bore well and place it at the disposal of the ground water authorities at the earliest.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

The daily water requirement of the hospital had been estimated at around 65,500 litres. The hospital got sufficient quantity of water from Kerala State Water Supply Authority and had 9 open wells in the hospital premises. Samples of water had been drawn at periodic intervals and sent to Regional Analytical Lab, Kozhikode for chemical and bacteriological analysis. No impurities had been found.

Gwalior Mansik Arogyashala (GMA), Gwalior (2nd to 4th February 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

The construction of new overhead tank with a capacity of 3 lakh litres at an estimated cost of Rs. 17 lakhs had been completed but could not be handed over to GMA due to delay in installation of submersible pump by the public health engineering department as well as delay in laying pipelines for distribution of water.

Public Health Engineering Department may make new overhead tank of 3 lakh litres capacity and fitted with submersible pump operational without any further delay.

The samples of drinking water were drawn and sent to PSM Department, GR Medical College Gwalior for chemical and bacteriological examination. The testing report confirmed that one of the four samples drawn from OPD was found to be bacterially contaminated and, therefore, not potable.

The water could be contaminated at the source, storage tank, or at the distribution point. The GMA confirmed that water storage tanks were cleaned regularly by using State-of-the-art technology with mechanized dewatering sludge removal, high pressure cleaning, vacuum cleaning, anti bacterial spray and ultra violet radiation. It implied that water was not contaminated at storage point and could be contaminated either at the source or at the distribution point.

GMA needs to check whether water is contaminated at the source or at the distribution point and thoroughly investigate the causes of contamination of water and take corrective measures accordingly.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

It was difficult to say that water supplied to the patients and the relatives was potable. Samples of water were not drawn and sent for test to an approved PH testing laboratory although there was no dearth of such testing laboratories at Cuttack.

There was no RO plant to ensure supply of potable water to MOs, para medical staff, patients and their attenders round the clock. The State Government had, however, accorded its sanction for installation of a RO plant in July 2011. The Budget provision of Rs. 13,73,546 had also been made for installation of RO plant. The plan and estimates prepared by the State PWD had been sent to the Director of Health Services for administrative approval. After the said approval PWD would install the RO plant.

Mental Hospital (MH), Varanasi (5th July, 2010)

The water had been supplied from a tube well through pipes to different barracks. It was bleached and stored for use in a storage tank. The daily requirement of water for total sanctioned bed strength of 331 patients at the rate of 135 litres

per patient per day worked out to 44685 litres and with the storage capacity of 50000 litres of the overhead tank filled thrice a day appeared to be more than adequate. However, it was difficult to say that the water was potable because samples of water supplied in the hospital had never been sent to an approved PH laboratory.

Institute of Mental Health and Hospital (IMHH), Agra (28th March to 30th March, 2011)

IMHH had made adequate arrangement for storage and distribution of water. A new overhead tank of 450 kilo litre capacity had been functioning since 2010. The overhead tank had been connected to the sub tanks to ensure adequate flow of water to the wards, kitchen, laundry etc. for drinking, cleaning, washing and flushing the toilets. The overhead storage tanks were cleaned regularly. An incinerator and computerized auto clave had been commissioned for discharge of biochemical waste as per WHO norms. The water samples drawn once in 6 months had been sent for testing in an approved PH laboratory to ensure that the water stored and distributed conforms to the scientific parameters.

The Reverse Osmosis is the latest technique by which drinking water is effectively filtered to purge it substantially of all bacteriological and chemical impurities. The RO Plant of the hospital had a capacity of filtering 1000 litres of water per hour. It was functioning for 8 hours daily to provide portable water to the patients. Filtered water was taken out in large storage containers and supplied to different wards and departments.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

The water was available in adequate quantity but it was not possible to certify its portability as samples of water were not drawn and sent at regular intervals to public health laboratories for testing that the water was free from bacteriological and chemical impurities; excess of iron, sodium, sulphur, magnesium, calcium and floride.

iii) Right to Personal Hygiene Environmental Sanitation

Right to Personal Hygiene means provision of mechanized laundry facilities for cleaning and pressing of clothing; collection of clothing at 8 AM and delivery after washing and pressing on the same day at 5 PM; supply of hot water for bath of inmates in winter; supply of hair oil/shampoo/soap in adequate quantity to inmates; proper arrangement for haircut; changing bed-sheet, pillow cover, linen at appropriate intervals; provision of anti - lice, anti - bug, anti malaria measures etc.; adequate toilet facilities; clean and hygienic kitchen; cleaning and disinfection of floors, pantry, dining hall, dining tables and toilets; diesel smoke through a fogging machine and preventing water logging. .

The position of personal hygiene and environmental sanitation in different mental health institutions is given below:

Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

The hospital was equipped with an automated laundry with 2 sets of washing machines, hydro extractors, dryers and pressing equipment. The laundry Staff was collecting patients clothing at around 8 AM and delivering them after 2-3 days. Each inpatient was provided with five pairs of uniforms. The linens were changed on every alternate day. There were separate barbers for male and female patients to take care of the shaving, haircut, cutting of nails etc.

The hospital authorities need to take anti-lice, anti-bug and anti-malaria measures.

To create a neat, tidy, dry and healthy physical environment within the hospital premises, Superintendent of the IMH Hyderabad should discuss the problem of outgrowths and uneven landscape (high and low) with officials of the State PWD to get the entire area properly paved with required number of outlets for discharge of accumulated rainwater and removal of outgrowths

Government Hospital for Mental Care (GHMC), Vishakhapatnam (30th and 31st March, 2009)

Nursing Superintendent was taking a round of all the wards every morning from 10.30 a.m. onwards to enquire about the wellbeing of inmates. She was taking attendance of sanitary workers and paying special attention to the cleanliness of the wards and inmates. There was no mechanized laundry. The hospital had engaged a dhobi on contract basis. He was collecting clothing of inmates at 10.30 a.m. on every alternate day and delivering them on the next day. His washing of cloths at a space behind the kitchen was contrary to the principles of personal hygiene as that could lead to water logging and seepage of soap water to the kitchen. Proposal for mechanized laundry had been sent to the State Govt. but had not received any response. There were no male and female barbers to take care of the shaving, haircut, cutting of nails etc. of male and female inmates.

A male and female barber needs to be engaged for shaving, hair and nail cutting of the inmates.

Sanitation work of the hospital had been entrusted to an out sourcing agency on a monthly payment of Rs. 85,000. The sanitary workers were supposed to clean, sweep, squab the hospital premises; clean and keep toilets dry; and clean plates after breakfast, lunch and dinner. In the absence of any sanctioned post of gardeners two Sanitary Inspectors were deployed to look after the garden. Keeping in view the charter of their duties, the number of 24 sanitary workers for 15 wards was quite inadequate.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August, 2010)

The wards were mopped daily to ensure tidiness. Patients clothing were changed daily and bed sheets and linens were changed on every alternate day. Anti-lice shampoos and oils were applied every week. Anti-bug and mosquito repellents were sprayed in all the wards every night.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

Right to privacy of all patients was respected. The nursing staff monitored the tidiness of the wards. There was adequate water for all purposes. Patient dresses were changed daily and linens were changed on alternate days. The different measures taken for ensuring personal hygiene of patients included anti-lice, anti bug, anti malaria and use of mosquito repellents etc. The patients were given Medicare shampoo and lycil for anti-lices, preventive/ prophylactic medicines (chloropine 2 tablets in a week). Male and female barbers had been appointed for taking care of haircut, shaving etc. of patients. Diesel smoke through a fogging machine was spread and measures for preventing water logging in the hospital were also taken. However, profuse leakage and seepage all over may give rise to serious problems of personal hygiene.

Attention should be paid to drainage and sewerage, proper upkeep and maintenance of all structures.

Institute of Psychiatry and Human Behaviour (IPHB), Goa (6th to 9th December, 2010)

The patients were given bath every day and bed sheets were changed on alternate day. A male barber was shaving and cutting hair of male patients regularly by using a separate blade for each patient and taking antiseptic precautions. Total shaving of head of each patient was done as a matter of routine unless medically advised otherwise. Similar grooming of female patients was carried out with the help of a female barber. Anti-lice measures were taken.

The wards were kept tidy round the clock with immaculately neat, tidy and dry toilets and bathrooms. The Pesticide services had been provided throughout the year in each ward and all other sections of the hospital on regular basis. Anti-malarial spray and fogging had been carried out by the Directorate of Health Services.

Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS), Ranchi (27th to 29th January, 2010 and 24th to 26th February, 2011)

RINPAS took meticulous care to ensure personal hygiene of its inmates by keeping them kempt and tidy. Patients were given bath daily and their clothes were changed every day and linen on alternate days. Patients preferred to wear hospital uniform. The patients were asked to wash their hands and feet before

sitting for food. The RINPAS had mechanized laundry of 200 kg capacity for cleaning, drying and pressing of clothings of inmates.

Government Mental Health Centre (GMHC), Thrissur (14th April, 2009)

Patients were given bath daily and their dresses were changed every day. Anti-lice treatment was give once in 2 months and at short intervals, if necessary. Anti-bug disinfectants were applied once in 3 months. There was a mechanized laundry. The clothing were collected in the morning and delivered next day morning. Hospital provided a soap of 75 gram and 40 gram oil per week to every inmate. All the wards were cleaned in the morning and evening with disinfectants and kept neat and tidy. The toilets were cleaned and kept dry, neat and tidy. There were Indian commodes in the wards and adequate quantity of water was available to flush the toilets.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

Patients were given bath daily and their clothes were also changed every day. There was regular arrangement for their hair cut and shavings. Anti-lice measures were taken once in three months. Most of the inmates of the wards preferred to remain semi-clad on account of hot and humid climate.

GMHC had a mechanized laundry with washer, squeezer and drier. Clothing of the inmates were collected from all the wards in the morning and returned to the wards after washing and drying in the morning of next day morning.

Gwalior Mansik Arogyashala (GMA), Gwalior (2nd to 4th February, 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

The wards were cleaned four times a day. Patients dress and linens were changed every day. Two male and 1 female barbers were employed for regular hair cutting, nail cutting and shaving of inmates. GMA did not have its own mechanized laundry and the laundry services had been outsourced. The management of laundry service was not satisfactory in GMA. The outsourced agent would be more concerned with maximizing his profit than rendering quality service at the cost of his personal profit. The GMA had been taking anti lice, anti bug and anti-malaria measures. Gwalior Nagar Nigam had taken up fogging for mosquitoes four times a day.

The toilets and bathrooms must be kept neat, tidy and dry to avoid any occasion for fall of an elderly man or woman. The steps leading to toilets and bathrooms should not be too steep to pre-empt the possibility of fall.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

IMH did not have its mechanized laundry to collect, clean, press clothing of inmates. The clothing of patients were collected for washing and pressing by SCB

Medical College and delivered to the IMH wards. There is no provision of hiring the services of barbers for male and female patients in the Institute and there were no barbers for haircutting of inmates.

With a view to ensure hair cutting services, it is necessary to engage the services of 2 barbers, one for male and another for female patients.

The canteen was functioning very close to an open drain in a very unhygienic environment. The floors of the wards were untidy because of the filth and dirt of the shoes of persons coming in and going out of the wards and the inadequate number of sanctioned posts of the sweepers.

An open drain in front of the male and female wards was a source of pollution. The heavy accumulation of water during the rains was making the overall surrounding untidy. The waste water flowing through the open drain and carrying the effluents had been producing stench apart from breeding flies and mosquitoes. The arrangement for scientific disposal of biomedical wastes was not very satisfactory. The outsourcing agency hired by SCB Medical College, Cuttack was not regularly collecting and disposing off the biomedical waste. The bins provided by SCB Medical College to IMH were grossly inadequate in relation to the requirement. As a result the disposable wastes were accumulating and polluting the environment and adding to the discontentment of the public.

Steps may be taken to construct additional toilet block adjacent to male/female ward to bring patient toilet ratio to the desired level.

The kucha open drain needs to be closed. A pucca closed drain should be constructed in its place. Since the CPWD had declined to take up this work, the PWD should be persuaded to take up the work at the earliest in the larger interest of health and personal hygiene of all inmates. Secretary, Health may write formally to Works Secretary on urgency of the work to be done by the PWD.

The disposal of biomedical waste of IMH may be incorporated while planning construction of a new six storey block. In the meantime the existing agency may be changed with the better performing one to carry the process of disposal of biomedical waste to its logical conclusion.

Mental Hospital (MH), Varanasi (5th July, 2010)

There was no mechanized laundry in the mental hospital Varanasi and the laundry services were provided manually by a single old washer man. The services of single washer man for 331 bed hospital were quite inadequate. There was delay in delivery of clothes as washer man was finding it difficult to cope with workload. The DGHS had been moved for sanction of 3 washer men but there was no response.

Since this is a 200 year old hospital it is not known if the sewer lines have been scientifically laid in the beginning, there are only soak pits, whether the hospital sewer has been connected to the main sewer of Varanasi city, whether they have

been inspected and need replacement. The hospital authorities need to consult the Public Health Engineering Department to get this inspected.

The toilets need to be cleaned daily to keep them dry and tidy. Since there are only 13 sweepers the work seems to be difficult till sufficient number of sweepers is engaged.

Institute of Mental Health and Hospital (IMHH), Agra (28th March to 30th March, 2011)

There was a mechanized laundry (comprising of washing machines, dryers and irons). There were 6 workers including 4 regular employees and 2 employed on contract basis. Clothing of the patients, bed sheets, pillow covers etc. were collected from the wards twice a week at 8 AM in the morning and delivered in the evening of the next day. The laundry was functioning satisfactorily and the whole operation was hygienic. It also ensured economies of scale (due to bulk handling of clothes and other items). The patients were given bath regularly in hot and cold water according to the season. Two barbers had been engaged for haircutting and shaving. Adequate measures had been taken for anti lice and anti bug management.

There was no sewerage line in IMHH campus linking it to the main sewer line of the city. Soak pit and septic tank had been provided for every building/ward. These were subject to wear and tear and their maintenance was also problematic.

A proper planning should be made for linking the sewer lines of IMHH with sewer line of the city on a permanent basis. While doing such a planning the sewer lines of IMHH should be kept at a higher level than the city sewers, if not, the dirty waste water from the city sewers will enter the sewer lines of IMHH. In case the sewer lines of IMHH are found to be at a lower level then all the sewer lines may be dismantled and new sewer lines should be laid at a much higher level than the sewer lines of the city.

The toilet patient ratio of 1:8 needs to be progressively improved to 1:5 as recommended by Prof. Channabasavanna Committee in 1998-99.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

The wards were cleaned every fortnight. The patients were given bath daily, their dresses were also changed every day and linens were changed once a week. The shaving of the head for male patients was done once a month and haircut of female patients was done once a week. Anti lice and anti mosquito measures had been adopted.

3. Supportive Services:

The supportive services include separate occupational therapy unit for male and female patients; telephone service; patients library-cum-reading room-cum-recreation centre, recreational and cultural activities; and a large hall for yoga –

pranayam – meditation. The supportive services available in different hospitals are given below:

i) Occupational Therapy Units

The occupational therapy plays a significant role to promote unity, solidarity, discipline, bonhomie concentration and creativity. The occupational therapy is a tool of acquisition of market relevant skills/trades for social and economic rehabilitation of patients after their treatment and full recovery. The skill training helps to develop right attitude towards work and develop respect for dignity of labour; promote physical and mental well-being of inmates and constructive development of human mind, promote gregariousness, a sprint of fellowship, a cooperative way of living, group adjustment and solidarity; promote and develop capacity for sustained hard work; help to build habits of concentration, steadiness, regularity and precision in work; impart and improve work skills; help to awaken the self-confidence and self-reliance of inmates; impart an occupational status and thus instil a sense of economic security among inmates; keep inmates gainfully employed in meaningful and productive work. Hence it restores the functionality of the patients and facilitates their reintegration into the family, community and society by making them productive.

The functioning of occupational therapy units for male and female patients in different mental health centres is as under:

The Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

There were no separate occupational therapy units for male and female patients in IMH for skill training, behavioural therapy and economic rehabilitation. The OT unit in the hospital was equipped to impart trades/skills in carpentry, cover making, candle making and weaving but that was non-functional due absence of any sanctioned post of OT instructor, arrangement for procurement of raw materials and sale of finished products and there was correspondingly no arrangement for payment of some remuneration to the inmates.

Government Hospital for Mental Care (GHMC), Vishakhapatnam (30th and 31st March, 2009)

The hospital authorities had started Manovikas a training and rehabilitation centre for mentally ill persons in the hospital premises on August 2007. Manageable patients were drawn from the wards and sent to Manovikas every day and were engaged in tailoring, making candles, soft toys, paper plates and pot painting pots etc. Government of India has sanctioned a sum of Rs. 34.00 lakhs for construction of a full-fledged occupational therapy unit in GHMC Vishakhapatnam.

The State Govt. should monitor the pace and progress of construction of the unit which will be taken up by APHMHIDC.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

The hospital had started the facility of vocational and occupational therapy for male and female patients. Vocational skill training was also made available to economically poor relatives/family members of patients. The occupational therapy had 3 components namely, therapeutic; recreational; and vocational. There are 2 separate OT units with a total capacity of 50 male and 30 female patients. The skills were imparted in groups by technically qualified and trained instructors in their respective fields. The vocational skills comprised of tailoring, embroidery, weaving and spinning (including door mat weaving); carpentry; making and binding files; making liquid soap, bathing soap, phenyl, tooth powder, rakhis, greeting cards, agarbattis, candles, chalk sticks, paper dish and cups; polishing and coloring wood and iron and screen printing.

The raw materials were procured from the open market according to the Purchase Policy of Government of Gujarat and the rates of the end products to be sold in the market were fixed by a committee set up by the hospital. The products were also displayed in exhibitions, melas and other prominent stalls put up in the city from time to time. There was a substantial turnover of incense stick (sandalwood), black phenyl, liquid soap, detergents, rakhis, and products of printing, binding, tailoring and embroidery units. The items like file making and file binding besides meeting the requirements of hospital were also sold to other Govt departments of the Gujarat.

The NGOs had been providing collaborative support and help by providing sewing machines and other equipment required for translating a particular skill to action. In 2009-2010 the hospital in collaboration with HR department of Gujarat university imparted vocational and occupational therapy in 10 trades to 227 male and 142 female patients as also to 46 relatives/family members of the patients. Among the trained patients, 119 patients were earning good income at home by harnessing the skills learnt and 50 fully recovered patients managed to find placement in various institutions.

The sale proceeds of Rakhis were estimated at Rs.25000 and Diwali dias at Rs. 1.5 lakh in 2009-2010. Bank accounts of the patients involved in producing these items for sale in the market were opened in their respective names and fifty per cent of the sale proceeds were deposited in the name of patients and remaining fifty per cent was used for various welfare activities of the inmates of the hospital wards. The training imparted at the OT had enabled patients to earn an amount of Rs. 1000 per month and thereby rehabilitate them.

Institute of Psychiatry and Human Behaviour (IPHB), Goa (6th to 9th December, 2010)

There was no exclusive occupational therapy unit for male patients. The limited space of 130 sq. metres of male OT unit appeared to be cluttered up with too many activities and items as the same was used as a recreation hall as well as

a store room for storing old, unused and damaged furniture and other articles. The number of male patients participating in the OT unit was limited. The skills/ trades imparted to male inmates were limited such as folding of printed materials received from a printing press etc. The male inmates engaged in manual labour in the OT unit were not paid any remuneration.

The occupational therapy unit of female patients was fairly commodious but there was dense outgrowth near this unit. The number of women patients participating in OT was impressive and the female Instructors were taking genuine interest in imparting training to inmates. A number of skills/trades were imparted to female inmates and the end products produced by them included table tops, pillow covers, flower baskets, centre table tops, coconut shell carving, wax candles, sea shell, show pieces, paper bags, chair lining, bed covers etc. These items were attractive and of functional utility.

Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS), Ranchi (27th to 29th January, 2010 and 24th to 26th February, 2011)

RINPAS had two separate occupational therapy units for male and female patients and training was imparted in a number of market relevant skills/trades by professionally qualified and dedicated instructors. The instructors had been making sincere efforts to guide patients and develop optimum level of skills and capabilities of inmates through skill training to enable them to lead a productive life in the community after their discharge from the hospital.

The female occupational therapy unit was attended by 53 female patients and the items produced in the female OT unit comprised of Pitanjali mala, paper bag, garland (paper and plastic), table mat, laces, shawl, basket (made of grass and paper), salwar - kurta suit, children wear, mat, table cloth, knitting, embroidery, lemon pickle and mushroom. The male occupational therapy unit was imparting training facilities in tailoring, carpentry, painting, welding (gas and electric), smithy, caning, weaving, book binding, printing (digital), paper bag and envelope making, soap (cake and detergent) making and computer training.

The end products produced in OT units were displayed in Jharcraft mela and Durga Pooja Festival. The paper bags were used for distribution of medicines and in the canteen of RINPAS. The inmates were paid according to their level of skill and performance. The skilled inmates were paid Rs. 20 and unskilled Rs 10 per day and those who just came and sat were given Rs 2 per day to motivate them and inculcate the habit of work.

The productive efficiency of inmates and their wholehearted participation in the above mentioned skills/trades had made RINPAS self sufficient in certain products like file covers, registration forms, envelops etc. and also to earn substantial revenue by sale of items produced in OT unit.

Government Mental Health Centre (GMHC), Thrissur (14th April, 2009)

The main aim of skill training through the OT units was to improve the employability and productivity of the inmates and paving the way for a decent livelihood after their discharge from the hospital. GMHC, Thrissur had separate occupational therapy units for both male and female inmates. The instructional lessons had been given by qualified and experienced instructors on a variety of trades/skills to about 30 to 40 male and female patients. The skills in which training was imparted included soap & detergent making, candle making, flower pot making, book binding, paper cover making. The end products produced in both the units were toilet soap, detergent powder, note book, registers, artificial flowers, candles. The volunteers of Christian Missionary Centre, a local NGO nearby were imparting free training to the inmates in candle and cover making. Another private agency 'Creative expressions' was providing free training to inmates in flower making, handicrafts and art works. They also assisted in marketing the products. The hospital also extended rehabilitation services like cultivation of tapioca, Jam, plantain, turmeric etc. A daily remuneration of Rs. 20 was paid to each patient for their involvement in the OT units.

The raw materials used in OT units were procured by Hospital development society and Society for occupational Therapy – Rehabilitation. The products produced in the OT unit were disposed of through a retail shop run by the patient hospital was purchasing soap and detergent used in mechanized laundry and patients from the OT units. The price of the products produced in OT units was fixed by occupational society on no profit basis.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

The occupational rehabilitation unit had been functioning in GMHC Kozhikode since its inception. The male OT unit had been functioning under the Institute of Mental Health and Neuro Sciences (IMHANS) another Govt. mental health institute situated inside the same campus. The total number of male inmates engaged in OT activities was around 75 and OT unit had primarily been involved in note book making (of various sizes), book binding, offset printing, offset plate making, medicine cover making, cleaning and winnowing of grains, lamination work, cartoon making. The basic raw material (paper) for these activities had been obtained from Hindustan Paper Mills. Workers were getting a percentage of sale proceeds depending on the quality of work and the output related remuneration might go up to Rs. 220 per day. Despite high percentage of humidity and too much congestion male inmates were soulfully engaged in these avocations. Most of the products had been rated as good in terms of their standardization and quality control.

There was no exclusive occupational therapy unit for female patients and all occupational therapy activities were ward based. The 75 female inmates were involved in medicine cover making, book binding, tailoring, and spinning. The OT

in GMHC Kozhikode did not aim at bringing out the imagination, ingenuity, creativity and resourcefulness of the inmates. The selection of skills/trade was done without ascertaining the aptitude, preference and interests of female inmates and also without conducting a market survey to assess the marketability of products.

Gwalior Mansik Arogyashala (GMA), Gwalior (2nd to 4th February, 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

The space in both the male and female occupational therapy units was extremely insufficient and the post of male occupational therapist was lying vacant. There was no worthwhile engagement or involvement of inmates in the occupational therapy. In the absence of a trained occupational therapist, the Psychiatric Social Worker was imparting occupational therapy to male inmates. The products made by inmates did not indicate their names and the date on which they were made. The skills/trades imparted were mostly traditional and very few of them were market relevant. There was no marketing of end products because of their limited number and products were not market relevant.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

IMH had no separate occupational therapy units for male and female patients for imparting skill training and using such skills for rehabilitation of patients after their treatment and discharge from the hospital.

Mental Hospital (MH), Varanasi (5th July, 2010)

There were no well organized occupational therapy units for inmate. The OT unit of the hospital had 5 looms and 35 patients were participating in the OT unit and no new skills/trades had been introduced. No worthwhile activities had been taking place in the OT unit. The inmates were not paid any remuneration contrary to the practice elsewhere. The additional sanctioned posts of Instructors had not been filled.

Institute of Mental Health and Hospital (IMHH) , Agra (28th to 30th March, 2011)

IMHH had two separate occupational therapy units for male and female patients to provide vocational skill training and 22 male and 33 female patients were participating in the occupational therapy and vocational training units in 2010. The factors determining the number of inmates participating in OT units were socio cultural background, aptitude, preference and interests and extent of recovery of inmates.

The skills imparted to male patients included tailoring, weaving, carpentry, candle making, envelope making, chalk making and donas making, spiral binding and lamination. The tailoring unit was stitching male and female uniforms, caps and apron needed by the hospital. The weaving unit had 2 rooms and after receiving

proper training patients could easily make 25-30 small size durries in a month. The durries made by them were of different shape, size and colour and conspicuous for their artistic workmanship. The carpentry unit became non-functional due to retirement of the concerned instructor and post lying vacant thereafter.

In view of high demand for Kalin than durries, IMHH Agra may progressively switch over from durries to kalin and explore the possibility of engaging a resource person from Bhadoi, Varanasi, Mirzapur or Sonbhadra for teaching the skill of weaving kalin.

The post of the instructor of carpentry should be filled up at the earliest for continuity of the skill that patient has learnt.

The female patients were provided training in tailoring, embroidery, painting, craftwork including jute bags, jute mats, paper items, waste material, dried leaves, and artificial jewellery. The artificial jewellery unit was an extension of the female OT. The instructor from Jan Shikshan Sansthan (an NGO supported by the Ministry of HRD, Government of India) was imparting training to the female patients in making a wide range of artificial jewellery items such as necklace, bangles, earrings, payals etc. The female patients were also trained in cooking and washing. The raw materials were procured from the open market and products were also sold in the market on demand or during fairs and festivals. The patients participating in these activities were paid remuneration @ Rs. 25 per day.

The occupational therapy room in IMHH Agra was very hot on account of asbestos roof. A false ceiling needs to be done to provide relief to participants of OT from the oppressive summer heat. The cracks developed and profuse seepage in the walls of OT rooms needs prompt attention of U.P. Jal Nigam for repair and maintenance.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

There were no occupational therapy units for imparting skills/trades to the inmates and there were no rehabilitation programme and community based service. However, an elaborate plan for occupational therapy and social skills training was underway to expedite speedy recovery and rehabilitation of the patients.

ii) Telephone services

The telephone is the primary means of communication or a window for establishing contact with the outside world. Besides being useful for day to day work, it is of great importance for the relatives/family members of patients to enquire about the condition of their patients from hospital authorities and other relevant information about mental health centres.

A PABX with requisite number of lines with one telephone line provided in each

ward gives access to relatives of patients to communicate with their patients or enquire about their well being from the Medical Officers and Nursing staff. In case of mental health centres not having a PABX and telephone operators, well trained attendants are deputed to receive messages from the relatives of patients and pass them on to MO in-charge or staff nurse and after getting a feed back from them make return calls to apprise family members about health condition of their patients. A provision of a mobile phone with SIM facility to all regular staff including doctors helps in forming a closed user group.

The intercom facility within the hospital premises between MOs, MOs and staff nurses, technicians and other supervisory staff; between MOs and library; and intercom connection with Central Store, Central Kitchen, Emergency Services, Automated Laundry Services, OPD, IPD, OT etc. ensures better coordination amongst different Departments and medical and para medical staff and better functioning.

The availability and functioning of telephonic facilities in different Mental Health Centres is given below:

The Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

The 12 years old telephone system in the Institute had become totally non-functional. It was reported that all formalities for installation of a new telephone system (BSNL centrex) had been completed, payments made and the new system was expected to be installed shortly.

To make the new telephone system functional, two vacant posts of telephone operators need to be filled.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August, 2010)

The hospital had a PABX with 500 lines. Every ward had been provided with one telephone. Patient relatives could call on this number and communicate with the Medical Officers, Nursing staff and patient concerned. All regular staff including doctors had been provided with a mobile phone with SIM card facility forming a closed user group.

Institute of Psychiatry and Human Behaviour (IPHB), Goa (6th to 9th December, 2010)

The messages from relatives of Inpatients were received by telephone operator and passed on the same to staff nurse in IPD. The staff nurse collected the messages, analysed them and transmitted to the patients. She used to make return calls to the relatives of patients to answer their quarries and send messages from the patients, if any.

Government Mental Health Centre (GMHC), Thrissur (14th April, 2009)

The telephone facilities were available and all wards of GMHC were connected by intercom. A public call (coin box) booth was available in the OPD for use of patients and relatives. Relatives were free to communicate with inmates and bystanders through incoming calls.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

The hospital had both telephone and intercom facilities.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

There was one landline telephone installed in the room of the Superintendent and the Superintendent had no stenographer to receive telephone calls or note down the messages. Superintendent was required to go out of his room quite often to perform his official jobs and in his absence there was no arrangement for receiving calls and recording message and sending response. There was no PABX in the hospital.

Mental Hospital (MH), Varanasi (5th July, 2010)

There was only one telephone in the office of the Director and there was no PCO. The PCO was not installed inside the hospital due to apprehensions that a public call booth inside the hospital premises might encourage outsiders to enter the hospital to make telephone calls and that might not be desirable from security point of view.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

There was one telephone in the office of the Superintendent and another for use of subordinate office staff. There was no arrangement to receive calls from family members/relatives of the inpatients or to pass on the required information about the well being of the patients to their relatives.

iii) Recreational and Cultural Activities

The recreation activities are an important means to bring about improvement in the psychological and emotional status of mentally ill persons. It brings inmates together, promotes social solidarity, rapport and bonhomie among them and encourages one to share the joy and sorrow, laughter and tears of another. Recreational and cultural activities include television in the room, dance, drama, music and other cultural activities to bring out the histrionic talent of the inmates, yoga, meditation, pranayama, picnic, indoor and outdoor games and sports.

Steps taken by different mental health centres to promote daily activity programme for indoor patients, improve recreational facilities and promote privacy of the patients are given below:

The Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

The IMH Hyderabad had provided television sets, FM radio and music system for entertainment of patients in the wards. There existed some provision of indoor games in the wards.

Government Hospital for Mental Care (GHMC), Vishakhapatnam (30th and 31st March, 2009)

The only indoor game available for recreation in GHMC Visakhapatnam was Carom board. There was no arrangement for other games like volley ball, basketball and badminton because in the absence of sufficient number of wardens the patients cannot be brought out for security reasons. There was no worthwhile activity relating to dance, drama and music or any other activity to bring out the histrionic talent of the inmates.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August ,2010)

Indoor and outdoor games, radio, TV and computer were available for recreation of the patients. The picnic activities were organized for long stay in-patients to provide recreation, enhance social skills and facilitate reintegration into family and community. During 2009-10, two such picnics were organized in winter to Lodi Gardens and Nehru Park in New Delhi.

Yoga Therapy and Research Centre (YTRC) in IHBAS was established in 2007 in collaboration with Morarjee Desai National Institute of Yoga, New Delhi. A yoga physician assisted by one male and one female yoga instructor was teaching yogic exercises to those patients who were considered fit enough to do yoga. Printed booklet on yogic techniques and benefits of Yogasans and Pranayama were given to the IPD patients on their discharge to enable them to practice the same at home.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

The Colour TV sets had been provided in all male and female wards. A central music system playing music in a soft and subdued manner helped to cool ruffled nerves of the patients. Indoor and outdoor games had been organized regularly with good participation of inmates. All national and important religious festivals and cultural activities were celebrated with colour and gaiety. Patients in a group of 50 to 60 were sent to multiplex theatres once in four to six months for movies. Yoga, pranayam, prayer and meditation classes as also daily physical exercises had been organized in the hospital.

Institute of Psychiatry and Human Behaviour (IPHB), Goa (6th to 9th December, 2010)

There was no space for yoga, pranayam, meditation, prayer etc. The cultural

activities were organized in the male Occupational Therapy unit. Patients had been participating actively in games like musical chairs, passing the parcel and different types of one minute games.

IPHB had been holding various competitions like fancy dress, drawing, singing and rangoli during festivals and mental health week. Festivals like Ganesh Chaturthi, Diwali, Christmas and Institute Day were celebrated with active participation of patients.

Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS), Ranchi (27th to 29th January, 2010 and 24th to 26th February, 2011)

The RINPAS like IHBAS, Shahdara Delhi had been taking out male and female patients along with officers, students and staff posted in different wards for picnics. This provided good outing and relaxation and rejuvenation to the dampened spirits of inmates.

The patients were encouraged to participate in celebrating Independence Day, Republic Day, Durga Puja and in other fairs and exhibitions. They also participated in the annual sports day. The television sets and indoor games had been provided in both male and female wards and some outdoor games were also available for inmates.

The Medical Officer (Psychiatrist) was conducting yoga therapy sessions including relaxation, physical exercises, and pranayama in yoga therapy unit for 20 to 25 manageable male and female patients for one and half hour. Each patient had been attending seven sessions. Patients attending yogic exercises regularly were given a chart to follow at the time of their discharge from RINPAS.

Gwalior Mansik Arogyashala (GMA), Gwalior (2nd to 4th February, 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

GMA had been organizing recreational and cultural activities regularly in respective wards and had made a provision of Yoga, pranayam, meditation and prayer facilities for the inpatients. The inmates participated in national festivals and also took part in cultural activities. The GMA had appointed two gardeners to look after greenery of the surrounding.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

IMH had no leisure-cum-recreation room for Inpatients with facilities for indoor games; Prayer-cum-meditation-cum-yoga-cum-pranayam room.

Mental Hospital (MH), Varanasi (5th July, 2010)

The recreational avenues for the inmates included volley ball, carom and chess. These avenues had to be consistent with lock up timings. There was no park inside the hospital where inmates can sit with their relatives and relax in the evening hours.

Institute of Mental Health and Hospital (IMHH), Agra (28th March to 30th March, 2011)

All wards had been provided with colour TVs. The cultural and recreational avenues promoted by IMHH included both indoor and outdoor games like carom, chess, ludo, cards and outdoor sports as cricket, volleyball, badminton; annual sports organized for the patients along with employees and staff members of the hospital on Republic Day every year; screening of good, entertaining, educational movies and movies with serious moral lessons at the auditorium equipped with LCD Projector; cultural programmes organized by the Cultural Committee of IMHH; prayers, bhajans and kirtans at the Sarvadharma Parthana Ghar; outdoor picnics for patients; celebration of other festivals like Id, Bakrid, Basanta Panchami, Holi, Hariyali Teej, Rakshya Bandhan, Dusserah, Karva Chauth, Deewali, Janmashtami, Christmas etc.; celebration of various other awareness programmes like World Mental Health Week through role plays, nukkad nataks, street theatres, skits, simulation exercises etc. The Director, MS, faculty members, GDMOs fully participated in these events along with the patients.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

The television sets and indoor games like carom board were inadequate. The sports and indoor games, yoga, exercises and other cultural activities were run by the nursing staff with limited equipment.

iv) Library Services

Library provides a window to the outside world to broaden inmates' horizon and keep them abreast of the latest changes and developments. A library with books, journals, periodicals and newspapers for patients and family members/relatives staying with them provides access to information of interest and relevance to their lives and eventually to their empowerment.

The library service would mean a fully furnished library exclusively meant for patients and their family members. The library for the patients/family members primarily caters to preferences and interests of patients and provides them access to reading material including light reading story books, magazines, periodicals and newspapers in their local language. Library also provides opportunities to patients to express one's creativity through writing and explore and enhance inherent potentials of patients.

The library facilities provided by different mental health hospitals for indoor patients are given below:

The Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

IMH Hyderabad had a separate library for inpatients and their family members and newspapers in English and Telugu were provided to inmates in the wards.

Government Hospital for Mental Care (GHMC) , Vishakhapatnam (30th and 31st March, 2009)

GHMC Visakhapatnam had no separate library to supply of books, newspapers and periodicals to inmates. However, newspapers were sent to activity halls in the blocks for the benefit of inmates.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August ,2010)

IHBAS Shahdara had a separate library for patients and their relatives. The library for inmates had been established in occupational therapy block. Daily Newspapers, fortnightly and monthly magazines were supplied in all the wards regularly.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

HMH Ahmedabad had a separate library and reading room for inmates where English and Gujarati newspaper, magazine and books were provided for light reading.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

GMHC Kozhikode had a general library stuffed with popular periodicals meant for use of patients in Malayalam such as Malayali Manorama, Matrubhumi Weekly, Deshabhimani Weekly etc. The general library was functioning under the auspices of Kerala State Library Council. The library and reading room had been placed under the charge of a staff member and was used by the inmates, bystanders and hospital staff.

Gwalior Mansik Arogyashala (GMA), Gwalior (2nd to 4th February, 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

GMA Gwalior had a separate library for inmates but there was no indication of the extent to which it was used by the inmates or the extent to which the books, journals etc. were updated on the strength of preferences and interests of the inmates.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

IMH Cuttack had no library for patients/their relatives and they were not even provided with a single Oriya newspaper. There was a small separate reading room with few books but that was not an integral part of the library.

Mental Hospital (MH), Varanasi (5th July, 2010)

MH Varanasi had no library-cum-reading room for patients. The newspapers and weekly magazines were kept with attendants in the barracks. The use of the

same by the inmates was rather restricted. The literate and numerate inmates in the IPD wanted to read books, journals and periodicals of their interest and relevance but living in a controlled environment, they found it difficult to articulate their preferences and interests in this regard.

Institute of Mental Health and Hospital (IMHH) , Agra (28th to 30th March, 2011)

IMHH Agra had a separate library for the patients and magazines like Champak, Chandamama, Nandan and Sarita were available for literate patients.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

IOP Kolkata Most of the inmates being literate were interested in acquiring knowledge, information and skills through books, journals and periodicals according to their preferences and interests.

v) Power supply

The hospital authorities need to make arrangements for uninterrupted supply of electricity in the hospitals to make stay of patients and their family members comfortable in open as well as close wards; carry out necessary investigations; provision of continuous supply of water; security of inmates etc. The power situation in different hospitals is given below:

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August ,2010)

Total electric load of 1400 Kilo Watt was fully utilized in IHBAS Shahdara. There had never been an occasion when consumption exceeded the load. Problems of interruption and tripping were non-existent. Two dedicated DG sets of 625 KVA had been installed to provide power backup in an event of load shedding.

Government Mental Health Centre (GMHC), Kozhikode (12th to 15th April, 2009)

In the absence of a dedicated diesel generator, GMHC Kozhikode faced the problem of load shedding, interruptions and tripping.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

There was frequent interruption and tripping of power supply in Cuttack. The lack of proper arrangement to ensure stability and durability of supply of electricity had made the stay of patients/family members extremely uncomfortable due to extreme heat and humidity of summer months.

In view of acute problem of load shedding, interruptions and tripping the Government had given its sanction for installation of a transformer at an estimated cost of Rs. 933980. This may improve voltage but will not restore complete stability and durability of power supply.

Mental Hospital (MH), Varanasi (5th July, 2010)

There was acute problem of load shedding. The UP State Electricity Board had sanctioned new transformer with 50 KWA.

The Director should get the installation work of the new transformer executed under his personal supervision.

Institute of Psychiatry (IOP) Kolkata (27th November, 2010)

The power supply was adequate and there were no problems of interruptions and tripping. However, the hospital had no dedicated DG set to deal with problems of power interruptions and tripping.

Human Resources

The incidence of mental illness is on the increase and 450 million people are estimated to be suffering from neuro-psychiatric conditions worldwide. According to projections made by WHO, anxiety and depression will emerge as the world's single largest killer by 2020. The human, material and financial resources are grossly inadequate to effectively deal with this huge burden of psychotic and neurotic disorders. This leaves a treatment gap of more than 75% in many countries with low and lower middle incomes. In India the absolute number of persons suffering from mental illness comes somewhere in the vicinity of 70 million. The treatment gap in India has been attributed to low levels of awareness about symptoms of mental illness, lack of rational and scientific temper resulting in myths and stigma, lack of access to information on the facilities for treatment available in State managed hospitals/private hospitals/clinics and lack of knowledge of the tangible benefits arising out of timely treatment.

The norms laid down by ICMR and as quoted by Dr. S.P. Agarwal, former DGHS, Government of India in his compilation captioned the 'Mental Health Resource Map of India 'Mental Health – an Indian perspective 1946 – 2003' of 2004 for sanction of Psychiatrists, Clinical Psychologists and Psychiatric Social Workers are: Psychiatrists 1.0 per 1,00,000 population; Clinical Psychologists 1.5 per 1,00,000 population; Psychiatric Social Workers 2.0 per 1,00,000 population; Psychiatric nurses 1.0 per 10 Psychiatric beds.

The minimum staff requirement for every psychiatric hospital or psychiatric nursing home with 100 beds had been laid down in Rule 22 of the State Mental Health Rules 1990 which had been framed in pursuance of the requirement u/s 14 of the Mental Health Act, 1987 are Medical Officer having recognized degree of MBBS 1:50, GDMO 1:25; Psychiatrist – 1:100, Assistant Clinical Psychologists – 1:100 and Psychiatric Social Worker- 1:100; Occupational Therapist; Staff Nurses - 1:10; Sweepers – 1:10 and attendants 1:5.

In view of the prescribed norms of ICMR and Mental Health Act 1987, there is acute shortage of skilled mental health professionals in India. As against an estimated requirement of 11,500 Psychiatrists, 17,250 Clinical Psychologists, 23,000 Psychiatric Social Workers, we have 3000 Psychiatrists, 500 Clinical Psychologists, 400 PSWs and 9000 Psychiatric Nurses. The existing training infrastructure in the country produces approximately 320 Psychiatrists, 50 Clinical Psychologists, 25 PSWs and 185 Psychiatric nurses per annum.

The major concern is the gap between the human resources needed on account of the growing demand for mental health services and the available resources. The median number of psychiatrist, Clinical Psychologist, Psychiatric Social Worker and Psychiatric nurses is 0.2, 0.03, 0.03 and 0.05 per 1,00,000 population respectively. This is nowhere near ICMR norm of 1 Psychiatrist, 1.5 Clinical Psychologist, 2 Psychiatric Social Workers per 1,00,000 population respectively and 1 Psychiatric nurse per 10 psychiatric beds.

In Rakesh Chandra Narayan Vs. State of Bihar and Others (WP Civil No.339 of 1986) the Apex court in its judgement dated 17.5.1994 had indicated that teaching, training, research should go side by side with treatment and social and occupational rehabilitation of the patients. The main objective of setting up of mental health hospitals should be to provide medical and mental health care services; provide optimal undergraduate and post graduate teaching as required by the University; and conduct training and research in Psychiatry. A mental health hospital should have a close knit team of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses.

Pursuit of excellence had never been the hallmark of mental health centres in India. There is no evidence of any planned, imaginative and determined efforts to excel in teaching, research or training, and far less in treatment, prime indicator of success of a mental health institute.

The human resource position in different Mental Health Centres of India is given below:

Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

The IMH Hyderabad was grossly understaffed. Against 305 sanctioned posts both permanent and temporary only 239 were in position and 63 posts were vacant. According to Rule 22 of State Mental Health Rules 1990 IMH with sanctioned strength of 600 beds was entitled to 6 Clinical Psychology and 6 Psychiatric Social Workers but had only 2 Clinical Psychologists and no Psychiatric Social Workers. In the absence of any psychiatric social workers it was not possible to undertake home visits, impart family counselling and provide correct feedback to the hospital authorities on the status of patients who had been treated, recovered, discharged and sent back home.

The Sanctioned posts of biochemist and laboratory technician, dark room assistant, two occupational therapists, two telephone operators, electrician Gr. II, two lady tailors were lying vacant. Since the number of female nursing orderlies was much less than the required number, the FNOs were finding great difficulty to manage the workload.

State Govt. should sanction 4 more posts of Clinical Psychologist, requisite number of posts of Psychiatric Social Workers and 30 more posts of staff nursed; appoint a full time qualified technicians on a regular basis; fill up vacant posts of two occupational therapists, two telephone operator, one electrician- Grade II and

all class IV urgently and create a few supporting posts of electricians and two more posts of pharmacists. Salary and allowances of contract staff nay be reviewed and revised. The annual uniform allowance and monthly washing allowance for Nurses and Class IV staff may be raised suitably and residential accommodation need to be provided to all the nursing staff.

IMH Hyderabad should start Ph.D and M.Phil Programmes. There should be a separate in-service quota for the staff nurses of IMH for admission in Psychiatric courses to be started in the hospital. Staff nurses of the hospital need to be provided Psychiatric training by organizing in-house training programme with the help of resource persons from the Osmania Medical College and Hospital. Accommodation should be provided to all PG students of the Institute.

Government Hospital for Mental Care, (GHMC), Visakhapatnam (30th and 31st March, 2009)

In a mental hospital, psychiatrists, clinical psychologists and psychiatric social workers constitute a team and one is incomplete without the other. Staffing pattern in GHMC Visakhapatnam was incomplete in the absence of psychiatric social workers. The clinical psychologists and psychiatrists in position were not in the desired ratio prescribed by ICMR. The availability of 15 Psychiatrists was well in excess of actual requirements, whereas there was only one post of clinical psychologist and that too was filled up on the contractual basis. A proposal for creation of 5 posts each of clinical psychologists, psychiatric social workers and psychiatric nurses for psychosocial care had been submitted to Govt. and the sanction was awaited.

The MOs were engaged in the Govt. Hospital for Mental care on contractual basis with a fixed remuneration upto Rs. 15,000 per month and that remuneration was also not disbursed in time. The contract was required to be renewed but the Superintendent did not have the power to renew the contract as the powers to renew contract vested with Government. No norms and parameters for continuance/extension of posts had been laid.

Against 204 sanctioned posts 57 posts were vacant and the vacant posts included 2 Class I, 4 Class II, 14 Class III and 37 posts of Class IV. Proposal for filling up the vacant posts of Director-1, Biochemist-1, EEG Technician-1, Psychiatric Social worker-1, Occupational Therapist-1, Plumber-1, Electrician-1, Attendants class-IInd-9 and Driver-1 had been submitted to the Director, Medical Education, Government of A.P. Certain posts including carpentry Instructor-1, Plumber-1, Electrician-1, Borewell driver-1, Female attendant-1, Dhobi-2, Barber 1 and Watchman-1 sanctioned earlier were discontinued due to ban orders imposed by Govt.

In accordance with norm fixed by ICMR and WHO, 1 staff nurse per shift is needed for 10 patients and for 300 beds hospital 90 staff nurses were needed for 3 shifts. Against this requirement there were only 54 nurses (42 staff nurses,

11 head nurses and one nursing superintendent). The shortfall of 36 staff nurses posed a major problem for scientific deployment of nursing personnel. Similar problem was faced in respect of attenders. For 15 wards and 300 patients the minimum requirement of attenders as per ICMR norms is 90 for three shifts but only 44 posts of class II attenders had been sanctioned and effective strength of attenders available was 29 as 13 sanctioned posts were vacant and 2 were deployed for electrical and plumbing work.

GHMC Visakhapatnam had started P.G diploma in psychiatric medicines in 1978 with annual intake of 2 students and P.G. degree in psychiatric medicine in 1984 with annual intake of one student. The number of seats fixed initially had not increased. According to MCI norms the number of seats in diploma and P.G. course could be increased to 12 and 6 respectively. Government of Andhra Pradesh increased the number of seats in PG degree in psychiatry from one to six in 2002 but the sanctioned seats could not be filled as the MCI inspection had not taken place. Hospital had been providing Psychiatric orientation programme for one month to B.Sc. nursing students according to a prescribed curriculum but M.Sc. nursing course was not available.

In-service training of one week was provided periodically to the nurses, ward boys and non-psychiatrist doctors with a view to improve their skills in mental health. However, none of the 54 authorised nurses including 12 head nurses and 42 staff nurses of the hospital had been trained in psychiatry. A proposal for deputing staff nurses for psychiatric orientation at NIMHANS, Bangalore was under consideration. There was no institutional arrangement for imparting training to Class III and class IV staff to make them more civil, courteous and considerate towards the patients. Similarly there were no programmes for imparting functional literacy to non-literate and non-numerate sanitary workers and patients.

The Government may approve the proposal submitted for 5 posts of clinical psychologists and 5 posts of psychiatric social workers and issue orders. The vacancies of occupational therapist, social worker, bio-chemist, EEG technician, Dy. Overseer, carpenter instructor, plumber, electrician, bore well driver, librarian need to be filled up at the earliest. The Government may consider the revival of posts which are absolutely essential for the mental health hospital but discontinued due to ban orders and issue formal orders for their continuation. Considering the increase in the number of patients and increase in requirement of drugs there is an imperative need to sanction two additional posts of pharmacist. Government may consider filling up the post of an anaesthetist for administering ECT at the earliest. The Director, Medical Education, Government. of A.P. may sanction two posts of garners at the earliest as their services are required for developing new areas and also providing facilities for occupational therapy.

State Government should implement its decision announced in January 2002 to increase the number of seats in Diploma and PG course in Psychiatry and vigorously pursue the matter with MCI and Ministry of Health & Family Welfare, Government of India. The State Government should run regular orientation

courses to sensitise the nursing staff and attendants about treatment and care of mentally ill persons. Psychiatric training may be imparted to nurses by creating in-house training facilities. The proposal of deputing staff nurses for psychiatric orientation at NIMHANS, Bangalore may be put into action without any further delay. A proper programme should be chalked out to impart functional literacy to sanitary workers and patients who are non-literate and non-numerate.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August, 2010)

In the Department of Psychiatry there were 100 sanctioned posts, of these 54 were filled up and 46 were vacant. The sanctioned posts included Professors - 3, Additional professors - 4, Associate professors - 8, Assistant professors - 15, Senior resident - 26 and Junior resident – 44. The 54 incumbents in position were Professors - 2, Additional professors - 1, Associate professors - 5, Assistant professors - 4, Senior resident - 18 and Junior residents – 24. In the Department of Clinical Psychology, there were 28 sanctioned posts of Pofessors - 1, Additional professors - 1, Associate professors - 1, Assistant professors - 3, Clinical psychologist - 10, Occupational therapist – 6, Occupational therapist attendant - 4, Psycho-clinic-cum lab assistant – 2. The 21 filled up posts included Professors -01, Additional professors - Nil, Associate professors - 1, Assistant professors - 2, Clinical psychologist - 10, Occupational therapist - 2, Occupational therapist attendant - 3, Psycho-clinic-cum lab assistant - 2 and 7 sanctioned posts were vacant. In the Department of Psychiatric Social Workers against 14 sanctioned posts of Professors - 1, Additional professors - 1, Associate professors - 2, and Psychiatric social workers - 10, the 11 members of staff in position were Professors - 1, Additional professors - Nil, Associate professors - 2, and Psychiatric social workers - 8 and 3 posts were vacant.

The large number of vacant posts could be attributed to poor scale of pay and better options available elsewhere; the acute shortage of professionals in all the 3 cadres; and the non-pensionable nature of jobs.

IHBAS had become a centre of excellence in academic and research activities covering PG courses in Psychiatry including MD and DNB; and PG courses in Clinical Psychology and Neurology; Research projects undertaken with the help of international and national funding agencies like WHO, ICMR, IEA and CSIR; Conferences/Symposia/Workshops attended, papers presented and published; and books and other publications brought out by the Deptt. of Psychiatry, Clinical Psychology, Pharmacology, Pathology, Neuro Chemistry, Epidemiology, Medical Anthropology, Radiology, Neuro-anaesthesia.

During the period between 1997 and 2003, out of 18 candidates enrolled for DNB 14 had completed the course and 17 candidates enrolled for MD Psychiatry from 2003 onwards 7 had completed and 4 candidates were under training. In Clinical Psychology, 60 candidates had completed their PG courses and 30 students were trained. In case of Neurology, 3 candidates had completed their PG courses

and 5 were trained. There were 15 vacancies for M.Phil in the Department of Clinical Psychology for the academic session 2010-12 and one vacant post in DM Neurology for the academic session 2010-13 and no vacancy in MD Psychiatry and DM Neurology for the academic session in 2010-13.

The number of publications brought out by IHBAS during the financial year 2009-2010 was: Psychiatry - 13; Neurology - 7; Pharmacology - 11; Pathology - 8; Neuro chemistry - 5; Epidemiology - 2; Radiology - 8; Medical Anthropology - 2; Neuro Anaesthesia – 6; and Clinical Psychology - 13.

Since the number of Psychiatrists, neurologists, clinical psychologists, Psychiatric Social Workers was low considering the heavy outturn of patients and time available at the disposal of professionals, the Director, IHBAS should make out a case for sanction of additional posts on the strength of norms laid down by the ICMR as well as Rule 22 of the State Mental Health Rules, 1990 and send it to Secretary, Health and Family Welfare, NCT of Delhi accordingly.

Hospital for Mental Health Ahmedabad (20th August, 2010)

The hospital for mental health Ahmedabad was rich enough in respect of human resources. Right from the HOD/Superintendent down to the last care giver in the hierarchy had warmth, bonhomie, civility and courtesy. The HOD/Superintendent being imaginative and innovative had brought a qualitative change in the functioning of the hospital and enhanced its credibility and total image. He had established an emotive bond with a large number of good, reliable and committed NGOs. The staff nurses were kind and compassionate.

The number of 4 Psychiatrists, 8 General Duty Medical Officers (GDMO), 2 Clinical Psychologists and 4 Psychiatric social workers was less than the prescribed norms of ICMR. With the nurse patient ratio of 1:10, the required number of staff nurses should be 93 for 3 shifts but the hospital had only 49 staff nurses with one matron. There were 4 technicians, one each for ECG, EEG, X-ray and Biochem laboratory. There were 10 persons in administrative staff (2 posts had been abolished and 1 was vacant). There were 138 Group D employees including 75 Attendants, 24 Security Guards, 39 Sweepers (17 regular and 22 contractual).

A private anaesthetist and general physician were attending the hospital as visiting consultants. Modified ECT was administered on every alternate day to about 10-12 patients and the anaesthetist was paid @ Rs. 75 per patient with a minimum amount of Rs. 750 per day. The post of an anaesthetist had been advertised by the hospital management but there was no response due to acute shortage of professionals in this cadre. The practice of posting the Residents doing MD in Psychiatry to this hospital for 3 months had also been discontinued.

The Board of Visitors (BOV) helped the hospital in establishing contact with the concerned university to start M.Phil in Clinical Psychology. The hospital had started Diploma course in Psychiatric nursing (DPN) from September, 2009. This

would promote human resource development in psychiatric nursing and would increase the number of qualified and trained staff nurses for the hospital. Five staff nurses had been trained in Psychiatric nursing at NIMHANS Bangalore and the rest had been trained by creating in-house training facilities by hospital management.

The 21 sanctioned posts lying vacant for some times in various categories should be filled up without further delay.

The State Govt. had issued orders for affiliation of Hospital of Mental Health Ahmedabad with Medical College and Hospital for 2 seats of MD Psychiatry but Hospital authorities does not appear to be enthusiastic about such affiliation and teaching cannot commence (as it has commenced at Ranchi, Jaipur, Goa, IHBAS, NIMHANS) unless the affiliation order is fully implemented. Principal Secretary, H&FW may ask authorities of Medical College and Hospital to take immediate action.

Institute of Psychiatry and Human Behaviour (IPHB), Goa
(6th to 9th December, 2010)

The Group A and B posts were sanctioned and filled up by the Public Health Department through Goa Public Service Commission and Group C and D posts were filled up by the IPHB as and when the vacancies occurred after obtaining NOC from the Department of Personnel. The posts were advertised in local newspapers through the Department of Information and Publicity and the names were forwarded by the Employment Exchange, Margao and Panaji.

There were 16 sanctioned posts in Group A, 5 in Group B, 147 in Group C and 148 in Group D and the posts lying vacant in different Groups were 4 in Group A, 1 in Group B, 10 in Group C and 4 in Group D. The 2 posts of lecturers and 2 posts of clinical psychologists had been filled up on contract basis because of non availability of staff due to shortage of officers in the cadre and poor scale of pay. Filling up of these sanctioned posts with heavy responsibility on contract basis was demoralizing and demotivating because the remuneration in the contractual appointment was much lower than regular employees and the incumbents against contractual posts were not eligible to residential accommodation and other facilities and amenities.

The Matron, Assistant matron and staff nurses constituted the primary group of care givers in IPHB. There were one Matron, two Assistant matrons, 54 Staff nurses and 12 Ward sisters. The staff nurses had been getting their nursing allowance, washing allowance and uniform allowance as per government rules. There were no staff quarters for nursing staff within the hospital premises. Nursing staff was provided with the transport facilities for dropping from the hospital to the bus stand and vice versa.

The IPHB was affiliated to Goa University and had PG teachers, two seats for three years course of MD and two seats for two years course of DPM. These

seats were offered purely on merit to students who had passed their MBBS from Goa Medical College or alternately to those who had cleared the All India Entrance Examination. To increase the number of seats of MD, IPHB had approached MCI for inspection. IPHB was also conducting lectures in Psychiatry for the undergraduates/MBBS students of Goa Medical College and for B.Sc. Nursing students of the institute of Nursing Education.

The hospital management had been organizing workshops from time to time and encouraging faculty and staff members to participate in these workshops. The various training workshops organized by IPHB in 2009 and 2010 were 2 ten day each workshop on 'Preparing to Standardize Nursing Practice' organized at the Institute of Nursing Education, Bambolim in February, 2009 were attended by 2 Asstt. Matrons and 12 ward sisters; ten day workshop on 'Care in Emergency' at INE Barnbolim, organized by TNAI Goa Branch in June, 2009 was participated by 2 staff nurses; two day workshop organized on 'Pre-retirement' at GIRDA Ella Form, Old Goa in June, 2009 was attended by Asstt. Matron and Ward Sister; A workshop on the 'Hazards of the Mercury and its safe disposal' organized by Goa Desc Resource Centre at Ceritas Holiday Home, St. Inez Panaji on 25th July 2009 was attended by 2 staff nurses; Matron and Assistant Matron attended a lecture on 'Breakdown to break through' at Goa Medical College, Library Auditorium on 16th September, 2009; two staff nurses attended three day 'Human Rights in Mental Health Nursing Practice' at Convention Centre, NIMHANS Bangalore in October, 2009; Assistant Matron attended a two day programme on 'Public Health and Sanitation' in May, 2010 at the Lecture Hall, GIRDA; In-service training programme was conducted in IPHB for Group D employees in 6 groups from 10th November 2009 to 5th March, 2010. One nursing staff was sent for psychiatric training every year and six nursing staff had undergone such training.

Ranchi Institute of Neuro Psychiatry and Allied Sciences (RINPAS), Ranchi (27th to 29th January, 2010 and 24th to 26th February, 2011)

The recruitment rules for selection of Director RINPAS on regular basis (as against the existing adhoc arrangement) had been finalized, notified and advertisement inviting applications had also been issued on 27.2.11 but the qualifications for the post were not clearly spelt out in conformity with the norms and criteria prescribed in Rule 20(F) of the State Mental Health Rules, 1990. Pending selection of a full time incumbent Dr. Amul Ranjan Singh, Professor and Head Department of Clinical Psychology had been appointed as Director in-charge of RINPAS.

The number of sanctioned posts in RINPAS was less than the prescribed norms. The filled up positions were less than the sanctioned posts. There were 285 vacancies. The vacancy position in different Groups was: Group A - sanctioned posts 76, filled up17 and vacant 59; Group B - sanctioned posts 40, filled 17, vacant 23; Group C - sanctioned posts 319, filled up 203 and vacant 116, and Group D - sanctioned posts 215, filled up 128 and vacant 87. The large number of vacancies affected treatment, teaching, training, and research adversely and also caused discontentment among faculty.

According to the prescribed staff nurse patient ratio of 1:10, attendant patient ratio of 1:10 and warder patient ratio of 1:5 under Rule 22 of State Mental Health Rules 1990, RINPAS should have 150 staff nurses, 150 attendants and 300 warders for three shifts. RINPAS had 130 sanctioned posts of nurses, 96 were filled up and 34 vacant; 212 sanctioned posts of warders, 72 were filled up and 140 vacant and the sanctioned strength of ward attendants was nowhere near the prescribed norms. A proposal for 100 additional posts of ward attendants duly approved by MC was sent to the Government but approval was awaited.

The large number of vacancies could be attributed to inadequate budgetary outlays; delay in Government approval for advertising posts and making budgetary provisions; delay in fixing interview dates or shifting interview dates; not holding interviews for promotion to several posts for a long period; issuing advertisements either without specifying the eligibility criteria or changing it unilaterally calling for inquires and delaying the process of selection.

The State Government had withdrawn the nursing welfare allowance of Rs 1600 in 2008 on the ground that RINPAS could not introduce a scale higher than the prevailing scale of the State cadre. Such a stand taken by the State Government appeared to be unreasonable because the nurses in RIMS continued to get their welfare allowance of Rs. 1600/. The uniform allowance for nurses continued to be Rs. 700 in RINPAS whereas the Central Government has revised the uniform allowance to Rs.3000 on the basis of recommendations made by Sixth Pay Commission. The monthly washing allowance of Rs 50 was also quite low.

With the completion of teaching block, availability of funds and faculty members of good calibre, there had been a spurt in academic activities in RINPAS. The Group A included both administrative and faculty posts. The administrative posts in Group A included 1 Director, 1 Medical Superintendent, 1 Dy. Director and 1 Chief Medical Officer. The faculty position in different Departments was: the Department of Psychiatry - 1 Professor and Head, 1 Associate Professor, 1 Assistant Professor; Department of Clinical Psychology - 1 Professor and Head, 3 Associate Professor, 1 Assistant Professor; Department of Psychiatric Social Work - 1 Associate Professor and Head, and I Assistant Professor. The posts in Group B included 3 Medical Officers, 1 Opthalmologist, I Pathologist, 1 Lecturer in Yoga and Philosophy, 10 Psychiatric Social Worker, 1 Clinical Psychologist, 7 Research Officers, 1 Nursing Tutor and 9 Senior Residents.

The number of filled up seats and additional seats sanctioned for various courses were: MD Psychiatry – 1; DPM – 1; Ph.D in Psychiatry - 2 (two additional seats have been sanctioned); Ph.D in Clinical Psychology - 2 (two additional seats have been sanctioned) M.Phil in Clinical Psychology – 6 (six additional seats have been sanctioned); M.Phil in Psychiatric Social Work – 6 (six additional seats have been sanctioned and were proposed to be double during 2011-12); Diploma in Psychiatric Nursing (DPN) 3 seats had been filled up against 6 sanctioned seats. Efforts had been made to increase the number of seats in M.D. Psychiatry from 1 to 2 and also DPM from 1 to 2. The main reason for 3 seats lying vacant

in DPN was lack of incentive for nurses to join DPN due to marginal difference in pay and allowances between nurses with DPN qualification and nurses without DPN.

The continuation of a large number of vacant posts of Assistant Professors for a long time had an adverse effect on the teaching programmes of RINPAS. To make good this shortfall in manpower, RINPAS was banking heavily on the faculties of Central Institute of Psychiatry (CIP) and Regional Institute of Medical Sciences (RIMS); hiring the services of retired Professors on payment of honorarium @ Rs. 200/- per day; the professional services of the Principal of a Nursing College at Kolkata for teaching and training in Psychiatric Nursing.

There had been a significant spurt in training activities in RINPAS. The number of nursing students coming to RINPAS for B.Sc, M.SC, GNM and NGO had progressively gone up during the last few years. The total number of persons trained in the Department of Psychiatric nursing had gone up from 78 in 2007 to 409 in 2010. The number of persons provided training in different courses in 2010 were M.Sc. Nursing 4, B.Sc. Nursing 121, GNN 279; NGO 5. Similarly the Department of Clinical Psychology of RINPAS provided training to 25 students of PG Diploma in Clinical Psychology from the Institute of Psychological Research and Services, Patna from 19th January 2010 to 28th January 2010; 8 students of M.Phil in Clinical Psychology from Psychology Deptt., Kolkata University from 16th November to 15th December 2010; 5 students of PG Diploma in Clinical Psychology from SH Institute of Agriculture Technology and Sciences, Allahabad (a deemed University) for one month; 4 students of PG Diploma in Counselling and Psychotherapy from BHU, Varanasi for 4 months. Medical students from RIMS, Ranchi and Pataliputra Medical College, Dhanbad had been receiving basic orientation in RINPAS. There was, however, no provision of in-house training and refresher training for the staff of RINPAS. The staff nurses were not provided any psychiatric training.

Department of Psychiatry produced 34 papers and attended 22 conferences; Department of Clinical Psychology brought out 70 papers and attended 5 conferences; Department of Psychiatric Social Work produced 28 papers and attended 6 conferences in 2009-2010. The Professor and Head of the Department of Psychiatry had published 3 books/papers, contributed 2 chapters in publications brought out by others, attended 7 professional conferences and was holding 4 key posts in Professional Associations. Equally impressive had been the performance of his other colleagues in the Department of Psychiatry. Professor and HOD, Department of Clinical Psychology presently holding the charge of Director RINPAS on adhoc basis had successfully completed 3 research projects in 2009-10 and two research projects were in progress. Among 18 Ph.D. scholars guided by him 12 had got their Ph.D, degree till Jan 2011. Similarly, 5 scholars under his guidance had completed their M-Phil and submitted dissertations in 2009-10 and dissertations by another 7 scholars were in progress. Under his guidance 4 journals dedicated to action research in the field of Clinical Psychology were published in 2009-10.

A corrigendum to the original notification clearly prescribing the qualifications for the post of the Director in conformity with the norms and criteria prescribed in Rule 20(F) of the State Mental Health Rules, 1990 need to be issued. The Government may restore nursing welfare allowance withdrawn in 2008.

The problem relating to scale of pay and allowances of PSWs needs special attention and consideration. Fourteen posts of PSWs were created according to the new staffing pattern of 15th May, 2004 and were advertised in the pay scale of Rs. 6500 - 10,500 equivalent to the scale of pay for the post of MO. Following the notification of Central pay scale to revise the above scale of pay to Rs. 8000-13,500 the scale of pay of MOs was upgraded. The PSWs in IHBAS, Delhi, GMA, Gwalior have also been fixed in the revised scale of pay of Rs. 8000- 13,500 but the scale of pay of Rs 6500 – 10500 for PSW in RINPAS remains unchanged. This needs to be reviewed and the scale of pay of all the 14 PSWs may be revised to Rs 8000 - 13,500/- as is in vogue in IHBAS, Delhi and GMA, Gwalior.

The one seat for M.D. Psychiatry is quite low in comparison with a much smaller institute like IMH, Cuttack already having 2 such seats and 2 additional seats likely to be sanctioned bringing the total to 4. RINPAS needs to make efforts to increase the number of seats in M.D. Psychiatry.

Government Mental Health Centre (GMHC), Thrissur (14th April, 2009)

There were 155 sanctioned posts in GMHC Thrissur, of which 142 incumbents were in position and 13 posts were vacant. Superintendent had no powers to fill up any post as recruitment to all posts was done by higher authorities through State Public Service Commission. GMHC Thrissur had intimated the vacancy position to higher authorities but had not received any response despite repeated reminders. As a result, the hospital authorities had been managing the work of the institution by appointing people on daily wage basis and incumbents against the posts of Sergeant and 4 security posts had been employed on daily wages.

The hospital management had been paying special attention to provide training and orientation to all officers and staff members. Hospital had been conducting in-service training programme in psychiatry and psychiatric nursing every year for various categories of staff with the help of in - house staff as well as medical officers and field staff from other institutions. The clinical psychologist had contributed a paper captioned: 'Development of sexual preference behaviour scale which was awaiting publication in the Indian journal of clinical Psychology'. The hospital was to start DPN and DNB in Psychiatry to strengthen teaching; set up a full fledged training centre fully equipped with audio-visual aids for starting a number of training programmes for Group A, B, C and D employees.

Government Mental Health Centre (GMHC), Kozhikode

GMHC, Kozhikode did not have a close knit team of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses. According to the Mental Health Resource Map of India (Mental Health – an Indian perspective

1946 – 2003) GMHC, Kozhikode was entitled to 23 Psychiatrists, 15 Clinical Psychologists, 12 Psychiatric Social workers, 48 Psychiatric nurses. Except 46 well trained psychiatric nurses short by only two of the prescribed norms, GMHC, Kozhikode did not fulfil any of the above norms. Against 13 sanctioned posts of Psychiatrists only 5 Psychiatrists were in position and these 5 Psychiatrists were holding Diploma in Psychological Medicine (DPM) and not a single one had MD in Psychiatry. Against 4 sanctioned posts of Clinical Psychologists only 2 were in position and of these two, one resigned for personal reasons while the second one was transferred without posting a substitute. There was only one Psychiatric Social Worker. There were 4 security guards at the main gate and they guarded the premises in 3 shifts. There was no arrangement for patrolling in the premises due to limited number of security guards.

Teaching and training at HMHC were closely interlinked. PG students had been coming from Medical College, Calicut on rotation basis to attend OPD on Tuesday and Friday and treating patients from 8 AM to 1 PM on other days in the wards. One Assistant Professor, Psychiatry and 2 lecturers were coming from Medical College to attend ward duty. Nursing students (B.Sc/M.Sc nursing and diploma in general nursing) from Govt. Colleges were coming for 30 days training. On an average 4 to 5 batches and each batch comprising of 30 nursing students were coming to GMHC in every year for training.

Research remained a grey area so far as GMHC was concerned. The faculty had not contributed even a single paper in national or international seminars/ symposia, national/international journals and had not chaired a technical session in any of these events. The academic environment of research was missing in the absence of a medical library.

Gwalior Manasik Arogyashala (GMA), Gwalior (2nd to 4th February, 2009, 21st to 24th February, 2010 and 29th January to 1st February, 2011)

GMA was on a weak wicket as far as human resource management and human resource development was concerned. The recruitment rules for the selection of a full time Director of GMA had not been framed. Government had been managing GMA since 2007 by appointing a Professor and Head of the Department of Gajaraja Medical College as Director in - charge in addition to her substantive charge. This was contrary to provision of Rule 20(F) of State Mental Health Rules 1990.

As per the norms laid down in Sub Rule (1) of Rule 22 of State Mental Health Rules 1990, GMA with sanctioned bed strength of 212 was entitled to 9 Psychiatrists, 9 Clinical Psychologists and 9 Psychiatric Social Workers and 60 staff nurses for a three shift operation. The number of sanctioned posts of psychiatrists, Clinical Psychologists and Psychiatric Social Workers was nowhere near GMA's entitlement and the number of incumbents in position was much lower than the sanctioned posts.

The overall vacancy position was quite disturbing. There were 72 vacant posts in Group A, B, C and D. The vacancies in Group A included Director - 1, Deputy Director - 1, Assistant Professor Psychiatry - 4, Assistant Professor Clinical Psychology -1, Assistant Professor Psychiatric Social Work - 2; vacancies in Group B were Medical officer - 8, Psychiatric Social Worker - 1, Clinical Psychologist - 1, Radiographer - 1, Nursing Superintendent - 3, Pharmacist Gr. II - 3; Vacancies in Group C included Nursing Sister - 1, Staff Nurse - 32, Matron 3, Laboratory Attender 1, Electrician - 1, Upper Division Clerk - 1, Lower Division Clerk - 1, Occupational Therapist (male) - 1, and Laboratory Technician - 1; and vacancies in Group D included Attender - 3, and Sweepers - 3. The large number of vacancies had been attributed to the delay in issuing advertisement for inviting applications from eligible candidates for direct recruitment and delay in convening meeting of the Departmental Promotional Committee for promotion of suitable candidates. Despite requests and repeated reminders to Department of Health and Family Welfare, Government of Madhya Pradesh and to the Director, Medical Education and Training, these posts had not been filled. The Director, Medical Education and Training had authorized the Director in - charge GMA to go in for a walk in interview for filling up the vacancies of laboratory attender - 1, electrician - 1, upper division clerk - 1 and lower division clerk – 1.

The GMA had been imparting regular training in mental health to nursing students. The total number of nursing students to whom training was imparted in mental health increased from 413 in 2005 to 1317 in 2010. The GMA, however, was weak in imparting psychiatric training to staff nurses. GMA had neither deputed any staff nurse outside to undergo psychiatric training nor had created any in-house training facility. It had hardly made any serious efforts to provide either induction or refresher training to any other officer or staff member including paramedics and technicians.

The faculty members had been taking keen interest in the sphere of research by contributing papers, making presentation and published papers. The Psychiatric Social Worker, Dr. Nand Kumar Singh had completed his Ph.d, attended 9 seminars/conferences, presented *2* papers and published 3 papers. The Senior Psychiatrist and former President Indian Society of Psychiatry, Dr. S.B. Joshi had been regularly attending the annual conferences hosted by the IPS; chairing technical sessions and contributing papers**.** The Clinical Psychologist, Shri Lakshminarayan Rathore was a guest speaker at MLB PG Government College in the Department of Psychology and delivered a lecture on mental health awareness among adolescents. He also presented a topic captioned 'Mental Health Act, 1987' on mental health day. Dr. Gautam Anand, MD (Psychiatry) a gold medallist in anatomy with 4 years teaching experience had written and published 5 papers in international and national journals.

The Assistant Professor, Clinical Psychology Dr. Ranjeet Kumar contributed a chapter in a book captioned 'HIVIAIDS awareness among nursing trainees - psychological and neurological aspects' written by Deepti Mishra, J. Mahato and

S.N. Sahoo and published by New Century Publications, New Delhi. He also contributed an article captioned 'Rorschach profile of mania patients' in 'Journal of Projective Psychology and Mental Health'. He participated in CIPCON 2010 Indian Psychiatric Social Central Zone Conference at Chattisgarh and participated as a co-investigator in an international research project commissioned by the World Psychiatric Society to study the prevalence at typology of functional somatic complaints in depression in patients with first episode unipolar depression.

The GMA is in dire need of a full time Director corresponding to the qualification laid down in Rule 20(F) of State Mental Health Rules, 1990 and serious efforts must be made in that direction. The posts of radiographer, nursing superintendent, matron, and pharmacist Gr. II and nursing sisters being in the state cadre the decision to fill these posts lie with the Director, Medical Education and Training. Since the Director in-charge, GMA had already written to Director, Medical Education and Training along with profiles of eligible candidates, the DME&T may convene a meeting of the DPC and fill up the vacancies by way of promotion. The matter relating to a large number of 72 vacancies persisting for such a long time should be placed before the MC and sub committee of the MC in charge of personnel. The Commissioner as Chairman of the Managing Committee needs to impress upon the Department of Medical Education to fill up 72 vacant posts in GMA at the earliest.

Since the staff nurses were reluctant to go all the way to NIMHANS Bangalore due to long distance, high cost of living, language difficulty, GMA needs to create in-house facilities for such training or alternatively depute staff nurses to IMHH Agra or RINPAS Ranchi to receive such training. Efforts should be made to promote and encourage both pure and action research.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

IMH Cuttack made no planned, imaginative and determined efforts to excel in teaching, research or training, and far less in treatment. The Government had sanctioned some professional posts of 5 Psychiatrists, 4 Clinical Psychologists, 4 Psychiatric Social Workers, 1 Psychiatric Nurses, 2 Anaesthetists and 1 Diagnostic Radiologists. The advertisements inviting applications had been issued. The sanctioned order of 2 Assistant Professors and 2 Psychiatric Social Workers had been referred back to Government for correction of certain anomalies in pay scale. Similarly the sanctioned order of 2 anaesthetists and 1 radiologist had also been referred back for correction of anomalies in pay scales and re-designation of posts. Both these proposals had been pending at government level. The Department of Health and Family Welfare had agreed to upgrade the post of Assistant Professor Clinical Psychology to Associate Professor Clinical Psychology but the meeting of DPC had not been held.

The Superintendent and 6 faculty members including 4 psychiatrists and 2 clinical psychologists had been taking both undergraduate and PG classes. The students from the National Institute of Rehabilitation Olatpur (Bachelors of OT

and Physiotherapy) were also attending classes conducted by the faculty of the Institute.

The number of seats of MD Psychiatry had been raised from two to three and further increase to four would only be possible on the recommendation of the MCI New Delhi. PG students of Psychiatry had been interviewed and selected by a PG Selection Committee headed by DMET, Principals and Superintendents of 3 Medical Colleges. Consequent to the implementation of the recommendations of the Sixth Pay Commission, the basic pay and allowances of the PG students doing M.D. Psychiatry had increased substantially but continued to be lower than PG students of AIIMS New Delhi and PGI Chandigarh. The PG students had been getting a stipend of Rs. 23,680 in first year, Rs. 24,560 in second and Rs. 25,580 in third year. There were seven PG students and their services were utilized both in the OPD and IPD. They normally stayed in the hostel but there were some exceptions of few staying outside the hostel.

The Academic Council of Utkal University had recommended affiliation of new courses of M. Phil in Clinical Psychology and M.Phil in Psychiatric Social Work. To get the required number of seats sanctioned in M.Phil Clinical Psychology, IMH was required to approach RCI for its inspection. Since IMH did not meet RCI's condition of Department of Clinical Psychology to be headed by an Associate Professor and having 2 permanent faculty members it could not apply for inspection. The post of Assistant Professor, Clinical Psychology sanctioned by Government earlier had since been upgraded to that of an Associate Professor was lying vacant because the DPC could not meet to select the incumbent through promotion. It was observed that that students after acquiring the degree of MD Psychiatry either leave the state or were unwilling to serve the State due to poor scale of pay and low incentives.

There was no institutional arrangement for deputing medical or para medical staff for orientation and training to outside institutions like NIMHANS, Bangalore due to certain inherent limitations including likely dislocation to the work of Institution due to the deputation of limited available staff in various categories; general reluctance on the part of staff to go out for training due to their lower income and likely dislocation to the family due to their longer period absence on account of training; and logistic and linguistic constraints.

A proper sitting arrangement needs to be made for professionals recruited against the sanctioned posts as and when they report for duty. Since civil works are in a state of flux and no space is available in the existing IMH building, DMET, Dean, Principal/ Superintendent SCB Medical College and Superintendent, IMH should meet and explore the possibility of arranging the much needed space. They may also be provided with computers. The Department of Psychology needs a laboratory and 43 equipments involving an estimated cost of about Rs. 17 lakhs (the list had been furnished by Associate Professor, Clinical Psychology). This may be sanctioned under Centre of Excellence.

The anomalies in the pay scales of psychiatric social workers, anaesthetists and radiologist may be removed and re-designation of the post of anaesthetists and radiologist done at the Government level. The revised sanction orders may be issued to enable the Superintendent, IMH to issue advertisement for selection to the posts.

The DPC should meet and finalize the selection to the post of Associate Professor, Clinical Psychology without any further delay because it is only after the selection and joining of the incumbent the Superintendent, IMH/DME&T can invite the Rehabilitation Council of India for inspection for the M.Phil course.

Mental Hospital (MH), Varanasi (5th July, 2010)

The staffing position of the hospital was not very satisfactory. Against 109 sanctioned posts in different categories, 95 had been filled up and 14 were vacant. Against its entitlement of 13 sanctioned posts of MOs as per the prescribed norms, the hospital had only 3 MOs including the Director. Of the total 6 sanctioned posts of psychiatrists, 4 had been filled and 2 were lying vacant.

According to the minimum staff requirement norms notified under the Mental Health Act, 1987 in the Government of India Gazette 31.5.2007 the barest minimum staff requirement of Mental Hospital Varanasi was GDMO – 6 (male 4 and female 2); Clinical Psychologists - 3; Occupational Therapist - 3; Psychiatric Social Workers - 3; Staff Nurses - 33. The sanction for clinical psychologists, psychiatric social workers and occupational therapists had been received, and the sanction for 6 posts of GDMOs was awaited. The sanction for 33 posts of staff nurses had been received but with a rider that they would be paid a consolidated amount of Rs. 15,000 per month and the posts would be filled up through an NGO. These conditions appeared to be a difficult proposition. Against 50 sanctioned posts of attendants 47 were in position and against the minimum requirement of 30 sweepers and sweepresses for ensuring cleanliness of the hospital only 14 posts had been sanctioned and 13 were in position. Of the 8 sanctioned posts of Pharmacists 3 pharmacists and 4 Chief Pharmacists were in position and one post of Prabhari Adhikari Pharmacist lying vacant was to be filled up on promotion from the existing incumbents of Chief Pharmacists. The Director could make a reference to the DGHS for filling up posts but had no powers to fill up these posts. The posts of Administrative Officer and Finance/ Accounts Officer had not been sanctioned. The sanctioned posts of one Assistant and one LDC were lying vacant. The Director was not competent to fill up these posts.

On the basis of the recommendations of NHRC the hospital authorities had made a request to the State Government in 2007 to sanction various posts including 1 Anaesthetist, 1 Pathologist, 1 Lab technician, 1 X-ray technician, 1 EEG technician, 1 Record keeper but the State Govt. had not taken any decision.

Similarly the hospital authorities had made a request to the State Government to

sanction some posts on outsourced basis. These included 3 Washer men, 1 Barber, 3 Drivers, 7 Cooks, 17 Sweepers, 1 Tube well operator, 1 Electrician, 1 Data entry operator, 6 Gate keepers, 2 Peon, 2 Mali and 1 Plumber. The Govt had not communicated its sanction.

There was no arrangement for sending the faculty and staff members for orientation and training. There was no Institute of Public Health in U.P. like the Institute of Public Health, Maharashtra at Nagpur for imparting such training.

Institute of Mental Health and Hospital (IMHH), Agra (28th to 30th March, 2010)

There was acute shortage of personnel in all the grades in IMHH. According to prescribed norms, IMHH was entitled to 9 psychiatrists, 9 clinical psychologists, 9 psychiatric social workers, 18 MOs and 90 staff nurses. The number of sanctioned posts was nowhere near the minimum requirement and the number of persons in position was much less than the sanctioned posts.

There were 155 vacancies in Group A, B and C. Against 105 sanctioned posts in Group A and B only 22 had been filled and 83 were vacant and against 173 sanctioned posts in Group C 47 had been filled, 54 outsourced to a manpower agency and 72 were vacant. All Group D posts had been outsourced. Against 28 sanctioned faculty positions only 6 had been filled up and 22 were vacant. In the Department of Clinical Psychology, IMHH had 2 senior clinical psychologists and 1 junior psychologist and sanctioned posts of 1 Associate professor and 4 Assistant Professor were vacant. In the Department of Psychiatric Social Work the hospital had 11 sanctioned posts of PWS, of which 4 were in position and 7 posts including 1 Associate Professor, 1 Assistant Professor were vacant. In the Department of Psychiatric Nursing all the sanctioned posts including 1 Associate Professor, 1 Asstt Professor and 2 nursing tutors were lying vacant. The staff nurses were not available in adequate number for ward duties, emergency duties, drug dispensing unit, library-cum-recreation centre and there were more male and less female staff nurses whereas a number of chronically ill patients in the female ward needed greater care and attention. In view of shortage of staff, a recently retired Medical Superintendent had been appointed as Associate Professor on contract basis and one clinical psychologist was also engaged on contract basis.

The deficiency of manpower resulting from persistence of a large number of vacant posts over a long time had serious implications for human resource development and management, time management and treatment of mentally ill persons within IMHH Agra and outside. The potential of the faculty could not be exploited to the fullest extent by sending then to attend training programmes, workshops and conferences at national and international level due to deficiency of staff and fear of dislocation to treatment due to their frequent absence from the hospital. The IMHH, Agra was required to cater to the requirement of mentally ill persons at the Central Jail, Agra; District Jail, Agra; Sisters of Charity (once a

month); City Clinic (twice a week on Monday to Friday); Female Protection Home (Agra Nari Niketan); Bal Sangrakshan Griha (Agra Children's Home) once a week. The psychiatrist attending to the problems of the mentally ill in Nari Niketan Agra once a week had stopped going and a psychiatrist was deputed only on call due to limited number of psychiatrists and constraints of time and too many competing claims. IMHH professionals were finding difficulty to attend on request to training of professionals for a mental health hospital at Dehradun. The PWS with 7 vacancies of 11 sanctioned posts could not do justice to their onerous duties and responsibilities of writing case history of new patients; attending to specific tasks assigned as part of ward duties; counselling patients (both OPD and IPD); attending Satellite Clinic at Vrindaban; home visits; organizing group meeting of patients in the ward.

The DGHS may delegate powers to the Director for filling up the posts of Assistant and LDC and also Prabhari Adhikari Pharmacist on promotion from existing incumbents of Chief Pharmacists.

Director IMHH Agra had taken all possible steps for affiliation of IMHH with Dr. B.R. Ambedkar University, Agra. He had deposited Rs. 15 lakhs towards security and had submitted a proposal for starting M.D. Psychiatry (2 seats); M.Phil and Ph.D. in Clinical Psychology (10 seats); M.Phil and Ph.D in Psychiatric Social Work (10 seats); and Diploma in Psychiatric Nursing (20 seats). This proposal was recommended by a three Member Expert Panel constituted by the Vice Chancellor of Dr. B.R. Ambedkar University on 25.1.08; approved by Academic Council of the University on 24.2.09 and Executive Council (Syndicate) on 25.2.09; forwarded to the Hon'ble Chancellor of the University for approval. He gave his approval on 15.9.10 and sent back the proposal to State Government and had been pending with Deptt. of Medical Education and Deptt. of Higher Education since then for formal approval due to bureaucratic red-tapism.

A teaching block carved out by conversion of some old Blocks and had 2 auditoria, 2 halls, 4 lecture rooms and 3 seminar rooms with facilities for audio visual presentation. The teaching block could not be put to proper use for the last 2 years. The seminar room had been utilized for seminars, case conferences, journal club, short case, clinical teaching of PG students (DNB) and guest lectures.

The Rehabilitation Council of India New Delhi gave its recognition to IMHH for 10 seats of M.Phil in Clinical Psychology. The MCI and the Ministry of Health and Family Welfare, Government of India had accorded their approval for 2 seats of M.D. in Psychiatry while the Rehabilitation Council of India had approved 10 seats for M.Phil in Clinical Psychology, 10 seats for M.Phil in Psychiatric Social Work and 20 seats of PG Diploma in Psychiatric Nursing. However, teaching could not commence in the absence of formal approval of the Deptt. of Higher Education and Deptt. of Medical Education for affiliation of IMHH with Dr. B.R. Ambedkar University.

National Board of Examination New Delhi had accredited IMHH for DNB Psychiatry since January, 2008 and DNB programme comprised of seminar once a week; case conference once a week; short case once a week; journal club once a month; and classes as per requirement. The students were also posted in OPD, IPD, Emergency, Satellite Clinic at Vrindaban and City Mental Health Clinic, Agra. They were also sent to NIMHANS, Bangalore for training in child and adolescent psychiatry, drug deaddiction and neurology. Two primary and two secondary students had already appeared in their DNB final examination and the first batch had already completed its training in December, 2010. IMHH had been imparting one month's training to nursing students from different colleges and also giving trainee nursing students an opportunity to work in the OPD, family wards, closed wards. The mental health orientation was given to one batch of staff nurses in July, 2010.

In the Department of Psychiatric Nursing, there was no sanctioned post of Professor and HOD and the sanctioned posts of one Associate Professor, one Asstt. Professor and two Nursing Tutors were lying vacant. Since the voluntary retirement of Asstt Professor in March 2011 the training classes of B.Sc and M.Sc nurses had come to a grinding halt. The posts of nursing tutors were advertised but the selected candidates did not join.

The IMHH had been engaged in research activities mainly to identify the root causes and remedial measures of mental health. An independent unit had been established to promote research projects to carry out action oriented research on burden of care, quality of life and total well being, cognitive functioning, projective techniques, substance abuse, stressful life events, psychopathology, rehabilitation, personality, gender differences, paid work activities, geriatric psychiatry, stigma and insight. Under the aegis of the research unit 10 Research projects in Psychiatry and 14 Research projects in Clinical Psychology had been completed successfully; 6 Ph.ds had been awarded in Psychiatry; 86 papers had been presented in different professional conferences and 45 had been published in the journals of psychiatry and other allied sciences. The action oriented research proposal titled, 'Effects of remunerative jobs on Psychopathology and Psycho social functioning of hospitalized chronic schizophrenic patients' sponsored by Indian Council of Medical Research (ICMR) New Delhi will be co-authored by Director and CEO and Principal Investigator, Research Officer and Co Investigator, IMHH.

IMHH needs to estimate the total amount required for filling up 155 posts in Group A, B and C request the Government of U.P. for making necessary budget provision.

In view of Supreme Court's direction, involvement of NHRC, changes already brought about and the strides and break through achieved in research, the State Government of U.P. and Government of India should treat IMHH as specialized apex institution like NIMHANS, Bangalore. To enable IMHH to get the services of well qualified professionals the scales of pay, allowances and perks of faculty and staff should be revised and brought at parity with their counterparts in comparable institutions.

In view of natural justice and policy of the Government the scale of pay for the Director IMHH Agra may be revised to Rs. 26,000 in the old scale and consequently to Rs. 80,000 as per recommendation of Sixth Pay Commission to bring it at parity with other comparable Institutes like Neuropsychiatry and Allied Sciences Ranchi, National Institute of Mental Health and Allied Sciences Bangalore, Sanjay Gandhi Post Graduate Institute Lucknow, All India Institute of Medical Sciences Delhi, Institute of Human Behaviour and Allied Sciences Delhi and Rural Institute of Medical Science, Saifai.

In the face of all positive and encouraging developments the proposal/ recommendation duly approved by the Hon'ble Chancellor for affiliation of IMHH Agra with Dr. B.R. Ambedkar University should be cleared by the Department of Medical Education and Higher Education, Government of U.P. without any further delay.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

There were 35 vacancies in Group D, 1 vacancy in Group C and 1 vacancy in Group A. There was no clerical staff in the Institute. The lone pharmacist of the hospital was assisting the Superintendent. The Superintendent despite being the administrative Head of the Institute did not have a stenographer as there was no sanctioned post of the stenographer.

There were 9 Psychiatrists, 1 Clinical Psychologist but no Psychiatric Social Worker. Of the 9 Psychiatrists, 2 had been directly recruited by Government and 7 had been brought from the Medical College. There was no psychiatrically trained nurse. There were 10 general nurses and supportive staff. The staff structure was highly inadequate and ward staff was not trained in mental health. There was lack of motivation among the staff due to absence of training, poor work culture and monotony of the job.

It was suggested by Prof. Channabasavanna team in the publication 'Quality Assurance in Mental Health' that a proper academic wing should be formed for post graduate education (MD/DPM), Diploma in Psychiatric Nursing (DPN) for nursing staff. This institute had the potential to become a regional psychiatric training centre for the whole region.

There were 4 sanctioned seats in MD Psychiatry. The Institute had applied for increasing the number of seats to 6 and MCI's approval was awaited. The Institute of Psychiatryc would start M.Phil in Psychology, M.Phil in Psychiatric Social Work and Diploma in Psychiatry Nursing Course only after vacation of its occupied space by BIN.

Administration and Financial Management

The Superintendents of Mental Health Centres are responsible for day to day functioning of the institutions. Administrative powers include powers to sanction posts, fill up posts by advertising, shortlisting of candidates and holding interviews, powers to purchase necessary items needed for functioning of the hospital. Prof. Channabasavanna Committee had recommended in 1998-99 that the Medical Superintendent should be given more administrative and financial powers for smooth functioning of the institutions. It had further recommended that Medical Superintendent must be given power to accept donations in cash and kind to improve the functioning of Mental Health Centres.

The budgetary allocation is a primary tool of growth of an institution. The Mental Health Institutions are meant for providing health and medical care to the poorest, most deprived and disadvantaged sections of the society. It has certain genuine institutional needs which could be both recurring and non-recurring. The starting point in preparation of a budgetary framework is identification of genuine needs, converting the same to a rough assessment of the funds which will be needed to fulfil the needs and reflecting the said requirement of funds in the budgetary framework. As far as non-recurring items (furniture, fixtures, tools, equipment) are concerned, the cost can be worked out on the basis of prevailing rates in the market. Similarly the cost of certain recurring items (drugs, food grains, linen, clothing, chemicals etc.) can also be determined with reference to the prevailing market rates or the rate contract price if a contract has been made for supply of certain items.

An attempt has been made to examine the administrative and financial powers of Superintendents/Directors/Managing Committee/Sub committees of different Mental Health Centres and financial management in different mental health care centres. Hospital-wise details are given below:

The Institute of Mental Health (IMH), Hyderabad (19th and 20th July, 2010)

Medical Superintendent of IMH Hyderabad had financial power for giving administrative sanction upto only Rs. 10,000. This is a pittance (considering the sharp spiralling prices of all commodities and rapid decline in the purchasing power of the money.

The budget of IMH had increased substantially from Rs. 200 lakh at the time of Prof. Channabasavanna Committee's visit (1998-99) to Rs. 317 lakh in 2004-05 and Rs. 7.08 Crore in 2009-2010.

Keeping in view the number of new structures including open wards, a 10 bedded casualty–cum-emergency service, separate acute admission ward, and drug-deaddiction ward etc., additional funds should be allocated for their proper repair and maintenance.

Additional budget provision may be made for landscaping of the hospital, construction of the planned new structures including modern kitchen, geriatric ward, child guidance unit, half way home, day-care centre, staff quarters, nurse's hostel, PG student's hostel, and a small guest house within the premises of the hospital.

Government Hospital for Mental Care (GHMC), Vishakhapatnam (30th and 31st March, 2009)

The administrative and financial powers delegated in favour of Superintendent of GMHC Visakhapatnam were inadequate. He had no powers to sanction new post, fill up existing sanctioned posts and issue orders for continuance of posts year after year. He even could not sanction purchase of certain journals. He had to route all such proposals through the Director, Medical Education. These procedural bottlenecks caused not only enormous problems in carrying on the day to day activities in a smooth and uninterrupted manner but also crippled the initiative and functional autonomy and adversely affected the efficiency of management of the hospital.

The mandatory Visitors Board provided u/s 37 of Mental Health Act, 1987 had not been constituted. A Hospital Development Society constituted by Government of Andhra Pradesh since 7.9.1998 with the District Collector as Chairman and medical professionals, self-help groups, public representative, principal of medical college, executive engineer, APHMIDC, RMO, MP, social workers and ex-students of the hospital as members had been discharging the functions of the Board of Visitors.

The NHRC team observed that the said society cannot really ensure compliance with the provisions of the Act relating to monthly joint inspection by not less than 3 visitors to examine the state of the administrative matters relating to admission & discharge and living conditions. The Govt. of Andhra Pradesh had, however, not taken the necessary action in this regard.

The State Govt. should formally constitute the Board of Visitors which is mandatory u/s 37 of Mental Health Act, 1987.

Institute of Human Behaviour and Allied Sciences (IHBAS), Shahdara (13th August, 2010)

IHBAS Shahdara had been established as an independent and autonomous body like NIMHANS Bangalore under the administrative control of Department of Health and Family Welfare, Government of NCT of Delhi. Administrative and financial powers has been delegated in favour of Executive Council IHBAS and Director IHBAS and both have been authorized to sanction and fill up posts and incur expenditure on civil works, procurement of drugs and other miscellaneous items.

The Board of Visitors constituted on 20.9.2002 had been holding monthly meetings on Saturday within the hospital premises and conducting regular inspection of IHBAS and submitting its reports to the Chairman of the State Mental Health Authority.

The other responsibilities discharged by IHBAS included court attendance as and when required; responding to all queries from the Court as also addressing the Court; certification for psychiatric disorders; special medical board for the disabled and issue of disability certificates.

The budget for IHBAS showed serious imbalance. The expenditure of Rs. 3484.43 lakhs in 2005-06 and 3574.96 lakhs in 2006-07, was far in excess of allocation of Rs, 2500 lakhs in 2005-06 and Rs.2700 lakhs in 2006-07. In the subsequent two years, the allocation was stepped up by 60% to Rs 4000 lakhs in 2007- 08 and Rs. 4000 lakhs in 2008-09 but the expenditure of Rs. 4110.57 lakhs in 2007-08 and Rs 4071.25 lakhs in 2008-09 again remained marginally in excess of the allocations. It is, however, not known how the deficit was met. In 2009-10, allocation was further stepped up by 12.5 per cent to Rs 4500 lakhs but the expenditure of Rs.4190.11 lakhs was less than the allocations.

It is not known how had IHBAS been working out its requirement of funds for a particular year under different heads (recurring and recurring); whether it was making a provision of 5 to 10 per cent increase for various components of recurring and non-recurring expenditure while projecting its requirement of funds before government of NCT of Delhi; and whether it had made out a strong case while presenting its budget and revised estimates for a particular year before the Executive Council headed by the Chief Secretary NCT of Delhi for approval without taking recourse to any unilateral cuts to enable management to meet irreducible barest minimum needs of IHBAS.

Hospital for Mental Health (HMH), Ahmedabad (20th August, 2010)

Board of Visitors comprising of a Chairman and ten members had been constituted for Hospital of Mental Health Ahmedabad on 10.1.1991 as per resolution of Government of Gujarat. The chairman of BOV was Principal Judge or nominee City Civil and Session Court Bhadra Ahmedabad; and its members were Commissioner Health Government of Gujarat or nominee HOD Psychiatry B.J. Medical College; I.G.P. Prison or nominee Superintendent Central Prison Ahmedabad; Commissioner of Police Ahmedabad or nominee P.I. Crime Branch; Metropolitan Magistrate Court No 12 Ahmedabad; Medical Officer Central Prison Ahmedabad; Disability Commissioner Government of Gujarat; Mayor Ahmedabad Municipal Corporation; Bishop St. Xavier's Church Ahmedabad; Psychiatric Social Worker Hospital for Mental Health Ahmedabad; and Secretary Gujarat Sarvar Mandal Ahmedabad.

The BOV recommended for formation of two Committees i.e., hospital's internal death Committee with RMO, Matron, Psychiatric Social Workers and overseer as

members and the VC (Visitors Committee) death Committee with RMO, representative of Police Commissioner, Crime Branch and Bishop as members. Whenever an indoor patient dies in the hospital premises, the internal death committee of hospital had to prepare and submit a death audit report to the VC death Committee for forming its opinion and recommending an action to be taken on the same. HMH rehabilitated around 20 patients in 2009-10 with the special recommendation of BOV.

The hospital authorities had been issuing disability certificates to mentally ill persons. These certificates constitute a base for considering their applications by the Railway Authorities or Gujarat Road Transport Corporation Authorities for issuing concessional travel tickets and can also be used for the purpose of pension.

The size of both plan and non-plan budgetary allocation showed an improvement during the last two years. The two items which registered substantial increase in expenditure were diet charges and linen. The daily diet charges had gone up from Rs. 35 to Rs. 54 per head and the increase in linen may be attributed to the revised norms prescribed in 2007. The actual expenditure in relation to budget allocation was 100 per cent.

The hospital for mental health had established beyond doubt its excellent credentials within and outside Gujarat. This was evident from the fact that a large number of patients coming from Rajasthan, Madhya Pradesh, Haryana, Delhi, Uttar Pradesh, Uttaranchal, Punjab, Jammu and Kashmir, Assam, Meghalaya, West Bengal, Bihar, Chattisgarh, Andhra Pradesh, Jharkhand, Orissa, Tamil Nadu, Maharashtra and Karnataka to this hospital had been treated and rehabilitated by the hospital staff between 2005 and 09. However, allocation of funds for medicine over the years showed a marginal increase from Rs.1970000 to Rs. 2364120 in 2009 - 10 and this amount was grossly inadequate compared to budgetary allocation of Rs. 30 lakhs made to IMH Cuttack a much smaller hospital of 60 beds.

The earlier trend of higher bed occupancy and less OPD patients has been reversed during the last five years. The hospital besides providing free medicines to OPD and IPD patients is also required to supply free drugs to the central jail, beggars home, Nari Niketan, Community Satellite Clinic at Surendranagar and so on. Adequate budget provision should be made for a full fledged geriatric ward and Child Guidance Clinic with a sensory unit. All these requirements need to be kept in view while fixing budgetary outlay. The budgetary allocation to Hospital for Mental Health Ahmedabad needs to be enhanced to a minimum of Rs. 32 lakhs to enable the hospital authorities to discharge a number of obligations.

Institute of Psychiatry and Human Behaviour (IPHB), Goa
(6th to 9th December, 2010)

There was no Managing Committee for day to day management of the hospital. The powers of the Head of the Department were delegated to the Director in 1981. Professor and Head, Department of Psychiatry, Goa Medical College

functioned as the Director of IPHB from 1980 to 2001 and Dean of Goa Medical College in addition to his duties had been functioning as the Director of IPHB since 2001.

The Medical Superintendent was over all in-charge of administration and was responsible for day to day management and smooth functioning of IPHB but no administrative and financial powers were delegated in his favour. He also performed the duties of a Public information officer under the RTI Act 2005, Public grievances officer and Public relations officer. A Professor and Head of the academic section was responsible for managing PG courses like MD and DPM while the Deputy Director (Administration) headed the Administrative section and worked under the overall control of the Director.

The Board of Visitors (BOV) was constituted u/s 37 of Mental Health Act, 1987 read with Rule 26 of Mental Health Rules, 1990. The members of BOV were the Director/Dean of IPHB Bambolim; Director Health Services Campal Panaji; IG Prisoners Collectorate Building Panaji; Additional District and Sessions Judge NDPS Court Mapusa; Medical Superintendent IPHB Bambolim; Director Social Welfare Panaji; President North Goa Advocate's Association Bar Room District Court Margao; Advocate Somnath Patel Uddi Goa Velha Ilhas; Dr. Digambar Naik C/o Vrundaban Hospital, Peddem, Mapusa. The BOV used to meet on every 4th Thursday of the month at the IPHB, Bambolim. The important decisions taken at the meetings of the BOV included recommendations for enhancing per capita diet rate from Rs. 22 per day to Rs 50; to change the phenol producing fishy smell with a disinfectant having good fragrance for the wards; list of patients admitted and discharged during the previous month and the list of activities carried out at IPHB in the previous month to be reviewed every month; and to make conference hall air-conditioned. Hospital authorities had already taken action BOV's above mentioned recommendations.

The Goa State Mental Health Authority was reconstituted u/s 4 of Mental Health Act, 1987 read with Rule 3 of Mental Health Rules, 1990 on 13.10.09 with Secretary Health – chairperson; Special Secretary/Joint Secretary and Director Health Services – official members; Dr. Pramod Salgonkar, Social Worker – Member; Shri P.K. Chakraborty, Clinical Psychologist, Shri Damodar Kukalekar, Psychiatrist - non official members; and Medical Superintendent IPHB, Bambolim as Member Secretary. The Goa State Mental Health Authority entrusted the work of rehabilitation of chronic patients to Psychiatric Social Workers IPHB; sanctioned an amount of Rs. 2.6 lakhs for Goa Psychiatric Society for 2007 and 2008 to run a distress helpline. Since the society could not provide 24 hour helpline service within two years time the work of starting distress helpline was entrusted to IPHB Goa; recommended an increase in per capita diet expenses per day Rs. *22 to Rs 35* (this has since been revised to Rs. *50* per patient per day) and computerization of IPHB (preparation of software for various sections had since been completed and computer training was imparted to staff of IPHB); and approved Goa State Mental Health rules *2008* and sent to Ministry of Health and Family Welfare for approval in *2009.*

The management of IPHB could not spend the entire amount of budgetary allocations made during different years and consequently a huge surplus/savings was left with the hospital. For example against the budgetary allocation of Rs. 606.40 lakhs in 2007 - 08 the expenditure of 541.40 lakhs resulted in budgetary surplus/savings of 65 lakhs; in 2008 – 09 its budgetary surplus was 437.04 lakhs as expenditure of 844.68 lakhs was less than its budgetary allocation of Rs. 1281.72 lakhs and again in 2009-2010 the expenditure of 1002.11 lakhs against budgetary allocation of Rs. 1111.74 lakhs resulted in budgetary surplus/savings of Rs 109.63 lakhs. There was no proper justification for suddenly doubling the allocation in 2008-09 and then reducing by Rs. one crore in 2010. The probable reasons for expenditure falling short of budgetary allocations could be no proper planning and monitoring of expenditure and asking for higher amounts then needed by inflating needs.

The hospital authorities attributed the lower expenditure and savings/surplus to inordinate delay in execution of projects by PWD due to problems and constraints arising out of drawings not being finalized by the Chief Architect; administrative approval was accorded and expenditure was sanctioned by the Government but funds were placed at the disposal of PWD and for some programmes administrative approval and sanction of expenditure was awaited; and the hospital could not purchase a new vehicle due to ban orders. Since the ban order had been lifted, the MS proposed to purchase one more vehicle during 2010-1 1 at an estimated cost of round Rs.7 lakh.

Ranchi Institute of Neuropsychiatry & Allied Sciences (RINPAS), Ranchi (27th to 29th Janaury, 2010 and 24th to 26th February, 2011)

The Board of Visitors (BOV) was constituted u/s 37 of Mental Health Act, 1987 read with Rule 26 of Mental Health Rules, 1990. The BOV comprising of Dr. R. K. Gupta, Psychiatrist (retired Dy. MS CIP); Dr. A.N. Verma, Associate professor, Department of PSW RINPAS; Mrs. Jyoti Beck, Nursing tutor RINPAS; Director RINPAS and Convener had been meeting once in every month.

The Managing Committee with Divisional Commissioner as chairman, Director RINPAS as Member Secretary and Secretaries Department of Health and Family Welfare Government of Jharkhand and Bihar, Deputy Commissioner Ranchi, SSP Ranchi, Director Rajendra Institute of Medical Sciences Ranchi, Vice Chancellor Ranchi University, Vice Chancellor Agriculture University Ranchi as members and Ex - Director NIMHANS Bangalore and neurophysician as honorary members had been holding its meetings at regular intervals and managing the hospital. There were eleven Sub committees looking after the different areas like accounts, purchase, rehabilitation, welfare, appointments, works, hospital, academic, ethics and medical education and these sub committees had also been meeting regularly.

The State Government of Jharkhand had substantially enhanced the budgetary outlay for RINPAS from Rs. 11 Crores in 2009-10 to Rs. 19 Crores in 2010-11.

The financial status of RINPAS as on 31.12.10 with a closing balance of Rs. 10.31 crores appeared to be quite comfortable compared to Rs 5 crores in January, 2010. RINPAS after meeting all its expenses under the appropriate heads had a total corpus (both fixed deposits and savings bank account) of Rs. 10.31 Crores in 4 nationalized banks.

Government Mental Health Centre (GMHC), Thrissur (14th August, 2009)

Superintendent of GMHC Thrissur had no powers to fill up group A, B, C & D posts. Superintendent was evaluating the work, conduct and performance of Medical officers; Nursing Superintendent was evaluating the work, conduct & performance of the Staff nurses, Nursing assistants and Hospital attendant and RMO and Lay secretary was evaluating the work, conduct and performance of all other categories of staff. Superintendent was also holding a monthly conference of all officers and staff of the hospital.

There was no Managing Committee vested with full administrative and financial powers as in the case of IMHH, Agra, GMA, Gwalior and RINPAS, Ranchi. However, a Hospital Development Society (HDS) had been constituted on adhoc basis with District Collector as chairman and 13 members drawn from different field to take important decisions and supervise the management of the hospital till a separate Governing Body and Executive Committee of the Hospital Development Society was reconstituted. This HDS had been meeting once in three months under the Chairmanship of District Collector and exercised all powers and discharged all the duties and responsibilities entrusted to them under the existing procedures and orders. A monitoring Committee constituted by Kerala High Court with District Judge its Chairman was meeting on second Tuesday of every month to evaluate the activities and performance of the hospital. The hospital, however, did not maintain any document about functioning of The Hospital Development Society and Hospital Monitoring Committee.

The GMHC Thrissur needs to keep records of functioning of the Hospital Development Society and Hospital Monitoring Committee. The documentation should comprise date, time and venue of meetings; minutes of meetings; extent of implementation of decisions taken in these meetings.

The Superintendent of GMHC Thrissur had financial powers to incur daily expenditure of Rs. 500 and annual expenditure of Rs. 20,000.

The amount was highly inadequate and needed to be increased substantially in the interest of better operational efficiency of the hospital. The ceiling limit needed to be enhanced to at least 5000 per day.

Drugs worth Rs 1477973 were supplied by KMSCL whereas drugs worth Rs 168725 were procured locally in the same year. Superintendent had already submitted the drug requirement of hospital worth Rs 20 lakhs for 2009-10.

There should be more liberal, uninterrupted and uninhibited flow of funds both from Central and State Government for District Mental Health Programme; Food

management including renovation and modernization of kitchen; Water management; Health, hygiene & sanitation management; Drug management ; Physical infrastructure management; Wards management; psychiatric and support services; Record keeping and computerization; and OPD management.

Gwalior Mansik Arogyashala (GMA), Gwalior (2nd to 4th February, 2009; 21st to 24th February, 2010 and 29th January to 1st February, 2011)

Government of Madhya Pradesh accorded autonomous status to GMA by a gazette notification in 1994. The autonomy means Managing Committee having full administrative and financial powers; Director or Chief Executive having full powers of the head of the Department and he/she need not to look up to Director Medical Education and Training and Secretary/Principal Secretary Department of Medical Education for each and everything. He/she should be free to function and incur expenditure on genuine needs of the institution according to approved scales. A Managing Committee was constituted with the Divisional Commissioner as Chairman and Collector/DM, SP, Secretary PH and FW or his/her representative, a female nominee of the State Government, Principal Gajaraja Medical College and Director GMA as members. The notification also provided for constitution of 7 Sub Committees.

The autonomy, however, remained a myth in the absence of a specific order for delegation and exercise of specific administrative and financial powers in favour of Director GMA as had been done in case of 5 medical colleges. The power to create Class I, II, Ill and IV posts continued to remain with the State Government and Director GMA was allowed to fill up Class Ill and IV posts only after getting permission from the State Government and following the existing government rules which involves a lot of paper work and takes a lot of time. All purchases like drugs, tools and equipment were couched with and circumscribed by a number of restrictions (like no purchase can be made after 31st January of a year) without any rationale. The Director had no powers to purchase even journals and periodicals for the library. The routine matters pertaining to GPF, DPF, anticipatory pension and GIS had to be routed to Treasury through Dean Gajaraja Medical College. According Autonomous rules outsourcing can only be done against vacant posts and autonomy rules permit outsourcing of security and cleaning works but not the jobs of attendants. Since outsourcing of work of attendants does not figure in the autonomy rules, MC had no powers to permit Director GMA to outsource a particular category of job.

The Divisional Commissioner may impress upon the Department of Medical Education through Managing Committee for delegation of required administrative and financial powers in favour of Director GMA to fill up posts in B, C and D categories; to sanction their leave, increment, Provident Fund, reimbursement of medical claims; to purchase all items which involve recurring and non - recurring expenditure such as tools, equipment, furniture, drugs, books, journals, food and all other consumables.

The autonomy rules should provide for outsourcing of job related to genuine needs of the institution. GMA with sanctioned bed strength of 212 should have

126 attendants for three shifts according to mental health regulations and norms but had only 42 sanctioned posts of attendants with which it became extremely difficult to manage. Autonomy Rules need to be amended to authorize MC to accord permission to the Director to engage 84 additional attendants to meet the genuine needs of the institution.

Director GMA had no option other than placing his/her entire drug requirement with 50 suppliers with whom the contract rate had been signed on quarterly basis. The faculty members expressed apprehensions and concern about the current drug policy of government. Some of these concerns included non inclusion of most of the essential drugs in the rate contract; a distinct possibility supply of spurious drugs or drugs of reduced potency due to lower contract rates. Government purchase rules not permitting GMA to indent drugs for more than 3 months might give rise to a situation of artificial scarcity.

There was no full time Director for GMA. The recruitment rules for the appointment of a full time Director had not been framed and no serious efforts had been made to appoint a duly qualified Psychiatrist as a the Director. According to Rule 20 (F) of the State Mental Health Rules, 1990, the Supervising officer in-charge of a psychiatric hospital should be a duly qualified person having post graduate degree in psychiatry recognized by the Medical Council of India. However, Director in charge of GMA was Professor and head of the Department of Anaesthesiology.

Director in-charge had been coordinating and balancing between the pressure of work in her parent department as Professor and Head of Anaesthesiology and that of GMA. She started her routine by taking rounds in OPD and IPD (both closed and open wards of GMA) from 9 AM to 10.30 AM and then going to the her parent department. She used to come back in GMA at around 3 PM to attend office work and dispose of pending matters till 6 PM. In case of any emergency she used to give directions on telephone to MO on duty.

This part time arrangement had been continuing since September 2007. Despite a departure from the statutory provision it was working smoothly without much dislocation on account of a fine balance of time management between the dictates of the job in the parent department and those of the work in GMA, a totally devoted and committed Director in charge, and fully motivated faculty members and staff willing to contribute their best to GMA under the leadership and direction of Director in-charge.

The existing part time arrangement may be allowed to continue but simultaneous efforts should be made to search a professionally qualified, experienced and trained incumbent with a vision for appointment as a full time Director, GMA.

The Divisional Commissioner and Chairman of the Managing Committee despite being saddled with important administrative responsibilities had evinced keen interest in the affairs of GMA. He was extremely positive, proactive and responsive to the genuine needs of GMA and as Chairman of the Managing Committee had

taken a number of decisions in the meetings of the MC for the betterment of the GMA.

There was a huge gap of Rs 1 to 2 crores recorded between 2005-06 and 2009-2010 between resources required to meet genuine basic needs (both recurring and nonrecurring) of GMA and funds provided by the Government. To meet its genuine needs GMA had been drawing the required amount as loan from the Rogi Kalyan Samiti which had been constituted in the GMA and recouped the loan as and when funds were received from the Government of M.P. The Rogi Kalyan Samiti had built the corpus by collecting funds from the institutions which sponsored nursing students for training in GMA at the rate of Rs. 1500 for general nursing, Rs. 2000 for B.Sc nursing and Rs. 3000 for M.Sc nursing.

This adhoc arrangement was perceived to be a highly unsatisfactory as it did not take into account the genuine needs of a public utility service institution. The practice of borrowing from Rogi Kalyan Samiti and recouping the same as and when funds were received from Government involved a lot of accounting problems and in case GMA failed to recoup the loan amount fully due to grants received from Government were not according to GMA's needs, it would be a slur on the image of an autonomous institution.

The main reason for disparity between the amount allocated and the expenditure incurred by GMA was allocation of Rs 250 per patient per day. This amount was highly outdated and unsatisfactory in view of a substantial rise in prices of all commodities such as drugs, food, linen, raw materials for OT, films for x-ray and chemicals for the pathological laboratory, fuel and lubricants etc. The IMHH Agra and RINPAS Ranchi had increased scale of expenditure to Rs, 500 per patient per day and RINPAS proposed to raise the amount to Rs 1000. The Director GMA had made a request to the Director medical education and training for raising the per capita scale of expenditure and the matter was raised specifically in the meeting convened by Chief Minister, Madhya Pradesh to discuss the management problems of all hospitals of M.P. but the scale of allocation remained unchanged.

In view of the general inflation and food inflation and higher per capita allocation prevalent in other Institutions, the per capita allocation per day should be enhanced adequately.

The filling up of a large number of vacant posts and conversion of all contractual posts (except the lone post of Assistant Professor Psychiatry) and implementation of recommendations of the Sixth Pay Commission would involve additional financial expenditure. Keeping in view all these aspects, the Managing Committee of GMA had made a detailed proposal for grant-in-aid amounting to Rs. 5,92,85,000 for the financial year 2010-2011. Against the amount sought, a sum of Rs.3.20 crores was sanctioned and Rs. 2.85 Crores (less than 50% of what was asked for) had been released till January 2011. This amount was highly inadequate to meet day to day functional needs of the hospital and financial management became extremely difficult.

The Commissioner may impress upon Department of Medical Education and Training to accord early sanction for the entire amount of Rs. 59285000 grant - in - aid duly approved by the MC to enable GMA to meet its day to day needs.

Institute of Mental Health (IMH), Cuttack (4th and 5th July, 2011)

The Institute of Mental Health Cuttack was not autonomous. It continued to be an appendage of SCB Medical College for all practical purposes. It was dependent on the latter for cooked food and delivery of cooked food by attendants to the inmates in the wards of IMH; beds, mattresses, linen, bed sheets etc.; pathological/ biochem laboratories for investigation; collection and disposal of bio medical waste; collection, cleaning, washing, pressing and delivery of clothing of inmates; routing all administrative proposals from IMH to Government in Health and other departments, routing sanction and release of funds from Government to IMH etc. All these factors contributed to complications and delay. There was no standardization and quality control of the products like bed sheet, mattress etc. The Superintendent IMH was helpless in all these matters as he could not enforce accountability because contractors supplying these materials as per some rate contract were appointed by SCB Medical College and they could not be changed by the Superintendent IMH even if they were found sloppy in discharging their duties.

There may have been some justification for its dependence on SCB Medical College in the beginning but in the present complex world of operations where decisions have to be taken and executed with lightning speed, such a culture of helpless dependence becomes counterproductive. In the current scheme of things IMH emerging as a Centre of Excellence and also in conformity with the directions of the apex Court, autonomy is the need of the hour, a Managing Committee and a few sub committees like academic, works, purchase, diet, recruitment, training, monitoring and evaluation need to be constituted.

The IMH continued to remain under the control of multiple authorities. It was accountable to DHS for financial matters; Director Medical Education and Training (DMET) for academic activities; Superintendent SCB Medical College for all administrative and financial matters relating to the management of the Institute. This led to dualism in supervision, accountability and control. Such dualism dividing the responsibility was not conducive to the smooth functioning of an institution like IMH Cuttack.

It may be suggested that Superintendent IMH is a Head of the Deptt. of Psychiatry in addition to being the administrative head of the Institute should not be subject to the control of multiple authorities (like DHS, DMET, Principal, SCB Medical College). This leads to dualism which is not conducive to the functioning of any public utility service institution. The Superintendent should be made accountable to one major Head of Department i.e. either DHS or DMET and not to both.

There was no Managing Committee with a scheme of delegation of administrative and financial powers. There were only two sub committees (academic and purchase). All major policy decisions were taken by the Principal of SCB Medical College in consultation with the Superintendent on a day to day basis. The IMH had sent a proposal to Government for constitution of Managing Committee and 8 Sub Committees for administration, purchase, library, academics, training, ethics, RTI, works programmes and environment. Government approval had been received for constitution of 8 sub committees but their powers and functions were not clearly laid down. The orders for constitution of a Managing Committee had not been received and in the absence of MC to coordinate the activities of sub committees, the eight sub committees would become infructuous.

Government should take an early decision on constitution of a Managing Committee under Chairmanship of Divisional Commissioner, Cuttack (on the same pattern of IMHH, Agra, GMA, Gwalior and RINPAS, Ranchi as duly approved by the Hon'ble Supreme Court) with delegated powers for smooth functioning and discharging responsibilities on day to day basis. Government order should clearly indicate the correlation between the Managing Committee and the 8 Sub Committees on which a GO has been issued. The duties and responsibilities of the Sub Committees should also be clearly indicated.

There should be proper liaison and coordination between IMH and SCB Medical College for specialized treatment of mentally ill persons having associated complications of cardio vascular, respiratory and other ailments. When cases of a mentally ill persons having associated complications are referred by IMH to SCB Medical College for specialized treatment, the SCB Medical College should have no objection to entertain all such cases but the expenditure incurred on certain investigations carried out needs to be met by IMH and the further follow up action on the same will have to be taken by Superintendent IMH. The two institutions should work out a proper arrangement with the approval of the Government.

The annual budgetary allocations had increased substantially from Rs. 67 lakh in 1966 the beginning of the Institute to Rs. 1,55,73,000 in 2010-11. The budgetary allocations made in time were adequate enough to meet all the requirements of IMH and there was no deficit and hospital faced no problem on that count.

The allocation made under drugs had been raised from Rs. 15 lakhs to Rs. 30 lakhs and a sum of Rs. 15 lakh each was allotted to the departments of Psychiatry at Berhampur or Burla.With a steep rise in outturn of 200 to 300 patients per day the hospital was finding it difficult to meet the drug requirement of patients even with enhanced annual allocation of Rs 30 lakhs. With the increase in drug allocation the IMH enhanced supply of free medicines to OPD patients simultaneously from 10 days to 30 days.

The drug budget of IMH Cuttack needs to be enhanced from Rs. 30 lakhs to Rs.

45 lakhs and a similar review should be conducted for Department of Psychiatry at Burla and Berhampur and decision may be taken to raise this amount in their case as well. The funds should be made available in time to avoid any dislocation in drug management.

The objections raised by internal audit party for procurement of drugs by the Superintendent were not sustainable. The Superintendent of IMH as head of the Psychiatry department and head of the institution had to decide the source and adopt a procedure for procurement of drugs in the best interest of the institution. The audit team should not have picked holes in the procedure for procurement followed by the Superintendent IMH if the same was in conformity with the guidelines of Government.

Mental hospital (MH), Varanasi (5th July, 2010)

There was no Managing Committee to oversee the day to day management of the hospital and various areas of interest. There were no small sub committees to look after different areas of interest.

Board of Visitors (BOV) was constituted for Mental Hospital Varanasi. The members of BOV comprised of District Judge as chairman; District Magistrate, Chief District Medical Officer, Senior Superintendent Central Jail, and Director Mental Health Hospital as official members; and Dr. S.M. Daud, Smt. Mandavi Prasad Singh, Shri Padmakar Choubey as non official members. BOV was holding its meeting once in 3 months, declaring a number of persons medically fit for discharge and advice/recommendation of the Board was acted upon.

Institute of Mental Health and Hospital (IMHH), Agra (28th to 30th March, 2011)

The Hon'ble Supreme Court decided in 1994 to take away administration and management of IMHH from the State Government of U.P. and to make it an autonomous institution to enable it to progress well in a decentralized and effective manner with minimal interference of Government. In compliance with the order of Hon'ble Supreme Court the Government of U.P. notified mental hospital, Agra as an autonomous institution in 1995 and the Institute had been registered as a Society under the Society Registration Act, 1860 in 1996. The Government of U.P. also constituted a Managing Committee under the Chairmanship of Divisional Commissioner Agra and a number of Sub Committees (Personnel, finance, works, drugs, other purchases etc.) for effective functioning and development of the institute. The main limitation in the smooth functioning of the MC was the frequent transfer of the Divisional Commissioner, the Chairman of the MC and other official members like the DM and SP.

The MC and the sub committees under the MC had been meeting regularly and held 34 meetings between 1996 and 2011and took relevant and useful decisions within the ambit of their delegated powers and made significant contribution to the overall smooth and better functioning of IMHH.

The Director of IMHH had been the Chief Executive Officer of the institution but no additional administrative and financial powers were delegated to him to make any adhoc /contractual appointment of professionals to carry out different items of work or to make any emergency purchases.

The IMHH receives grant or grant-in-aid from Government of U.P. These grants, however, were not made on a regular basis. The Ministry of Health and Family Welfare had recognized IMHH as a Centre of Excellence along with 10 other institutions in the field of mental health and sanctioned a grant of Rs 30 crores comprising of Rs. 18 crores for civil works, Rs 3 crores for staff and Rs 9 crores for tools, equipment, library books, development of software etc.

There was a huge gap between the genuine needs of IMHH for funds and the funds actually made available to it. The funds were provided in four instalments and funds were not released timely. For example IMHH incurred an expenditure of Rs. 1092.51 lakhs in 2008-09 but a sum of Rs. 1077.87 lakhs was made available in 2009-10 and against an expenditure of Rs. 1166.84 lakhs incurred in 2009 -10 the amount made available in 2010-11 was Rs. 1124.52 lakhs only. Authorities of IMHH on account of limited budgetary provisions had been facing difficulty in doing justice to all the 4 areas of teaching, training, research and treatment.

There should be a regular review of funds received vis a vis expenditure incurred at the end of every month. The Director, Addl. Director, MS and Finance officer should hold a monthly meeting to review the actual requirement of funds for IMHH in relation to increase in number of patients, cost of food, clothing, medicines, various other recurring items of expenditure and should place the genuine financial requirement of IMHH before the Finance Committee of MC and the MC should ensure the timely availability of required funds.

It is conceded that a patient is a patient everywhere and has a fundamental right to be treated in an institution of his/her choice. The treatment charges (both OPD and IPD) will have to be borne either by the patient or by the concerned State Government. A number of mentally ill persons from Delhi, Rajasthan, Jharkhand, Gujarat, Jammu and Kashmir, Punjab, Haryana, Uttarakhand, Madhya Pradesh, Bihar, Chattisgarh, Himachal Pradesh, West Bengal, Manipur and Karnataka had availed the facility of indoor treatment at IMHH Agra during the period between 2000 and 2010. The total outstanding dues from Delhi, Rajasthan, Jharkhand, Gujarat,J &K, Punjab, M.P., Bihar, Uttarakhand and Karnataka amounted to Rs. 8935750 but the response of these States like Delhi had been lukewarm. In the absence of regular and timely release of grant-in-aid by the Government of U.P. IMHH found great difficulty to meet expenditure on patients of other states from its limited financial resources.

The treatment cannot be refused merely on the ground of budgetary and financial constraints. The non payment of dues by the concerned states whose patients are availing the facility of treatment at IMHH is a violation of the direction of the

Hon'ble Supreme Court. The charge was being levied to the concerned State Government as per Hon'ble Court's orders only. This aspect should be brought to the notice of the defaulting States. The matter should first be taken up demi-officially at the level of Chief Secretary and subsequently at the level of Hon'ble Chief Minister with their counterparts.

As per directions of Supreme Court a consolidated charge @ Rs. 250 per patient per day calculated on the basis of number of indoor patients was levied by IMHH Agra on the concerned State Government to which the patient belongs. Government of U.P. enhanced the charge from Rs 250 to Rs. 500 per patient per day w.e.f. 16.1.2007. The MC in its meeting held on 26.8.2009 resolved that the levy money should be released on the basis of sanctioned bed strength (838) of IMHH rather than the number of indoor patients and the levy money should also be enhanced automatically by 15% in view of rise in prices and annual increment in the salary of the employees. The proposal was pending with Government of U.P. for issue of orders.

Institute of Psychiatry (IOP), Kolkata (27th November, 2010)

The Government of West Bengal had not issued any orders for conferring autonomous status in favour of Institute of Psychiatry. Consequently the Superintendent of the Institute remained merely a figure without delegated powers. On account of limited administrative and financial powers, the Superintendent of the Institutes was terribly handicapped in discharging his responsibilities and for smooth day to day functioning of the Institution.

There was no board of Management. However, a Management Committee called Rogi Kalyan Samiti had been formed to look after the day to day management of the hospital. This Committee comprised of Assistant Director of Health Services (Mental) as chairman; Supdt. of the Institute as convener and Secretary; Administrative Officer of Institute of Post graduate Medical Education and Research (IPGME&R) and Drawing and Disbursing Officer (DDO) as Joint Secretary; Local MLA, local Municipal Counsellor, Officer-in-charge Bhawanipur PS, Nursing Superintendent, MO of IOP Kolkata, representative of IMA, representative of IPS, Assistant. Engineer PWD (Civil), Assistant Engineer PWD (Electrical) as members. The Rogi Kalyan Samit was required to meet once in 2 months and it devoted most of its time in the meetings to the issue of construction of new 10 storyed building.

Steps should be taken to constitute a Board of Visitors as required u/s 37 of Mental Health Act, 1987 read with Rule 26 of State Mental Health Rules, 1990

The whole approach to management of the Institute of Psychiatry had been adhoc and persistence of many shortcomings and deficiencies inhibited the smooth management of the Institute. The decision of the Government of West Bengal allowing the identity of the Institute to be subsumed in BIN and renaming it as Bangur Institute of Neuroscience and Psychiatry (BINP) had given a terrible

jolt to the institution. As a result of this decision the Institute of Psychiatry had become a Department of Psychiatry of Bangur Institute of Neuro Science and Psychiatry which in turn was under the administrative control of Neurology and all the administrative and financial powers had been shifted to the secretary Bangur Institute of Neuro Sciences (BINP) and no powers had been left with the HOD Psychiatry.

The Superintendent had a ridiculously low permanent advance (as low as Rs. 6). He had the powers to make local purchase upto Rs 500 per item at a time. He had powers to float tenders upto Rs. 100000 but was authorised to decide on quotations upto Rs. 20,000.

There was no fixed budget allocation for the hospital. Money was given from time to time depending upon its requirement. Donations were not received in cash or kind. The drug budget had been increased from Rs10 lakhs to Rs 15 lakhs.

The Ministry of Health and Family Welfare, Government of India had declared the Institute of Psychiatry, Kolkata as a Centre of Excellence (one out of 11 in the country) and sanctioned a grant of Rs. 30 crores in favour of the Institute for furtherance of development and growth of the institution. The first instalment of the grant amounting to Rs. 5.28 crores had been released in the name of the Institute of Psychiatry, Kolkata on 5.11.2009 when it did not exist.

A fixed budget should be allocated for IOP and adhocism in matters of financial management should be removed. The hospital may be permitted to receive donations in cash or kind.

Conclusions and Recommendations

In pursuance of the directions given by the apex court, National Human Rights Commission has adopted a totally open, transparent and participative style of monitoring the pace and progress of activities in the hospitals keeping the human rights dimension uppermost in view. Successive Chairpersons, Core Members in charge of mental health and Special Rapporteurs of the Commission have been regularly inspecting and reviewing the activities of all the 37 mental health hospitals including GMA Gwalior, IMHH Agra and RINPAS Ranchi to know their functioning as well as find out the conditions of mentally ill patients admitted therein for treatment. Such reviews are being conducted in a totally participative and communicative manner. Considerable amount of time is being spent in interacting with the patients and their relatives, staff nurses, other para medical staff, warders, junior and senior MOs and the Superintendent/Director and wrap up meetings whenever possible with the Chief Secretary, Health Secretary, Secretary, Medical Education, Director Health Services etc.

The present compilation is based on the reports of visits and reviews conducted by Special Rapporteur Dr.Lakshmidhar Mishra of 13 Government run Mental Health Care Centres including IMH Hyderabad, GHMC Vishakhapatnam, IHBAS Shahdara, HMH Ahmedabad, IPHB Goa, RINPAS Ranchi, GMHC Thrissur, GMHC Kozhikode, GMA Gwalior,IMH Cuttack, MH Varanasi, IMHH Agra, IOP Kolkata during 2009 and 2011. The visits and reviews were conducted in a structured manner with a lot of advance planning and preparation. To start with, the dates of visit and review were always fixed in consultation with the State Government and with that of the Directors of Mental Health Care Centres; Secondly, to make the visit participative and consultative, a detailed questionnaire was prepared and circulated to the Directors of these hospitals sufficiently in advance to enable them to respond to the points raised therein. Thirdly the responses were discussed threadbare and cross validated by undertaking spot visits to various units including Registration counter; OPD; Drug dispensing unit; Male and female wards in the IPD (both closed and open wards); Library-cum-documentation centre; Occupational therapy; Modified ECT (including recovery room); Biochemical and pathological laboratory; Kitchen block and dining rooms; RO plant; Mechanized laundry; Incinerator; Teaching block etc. Finally review reports were sent to the State Governments by the Commission with a request to report compliance on all the major action points.

There have been a number of positive fallouts of such reviews made by the Commission and Special Rapporteur Dr Lakshmidhar Mishra for correction and promotion of human rights of mentally ill persons. Some of them are mentioned below:

Improvement in physical infrastructure of several mental health hospitals has taken place by way of construction of new OPD blocks; provision of adequate sitting arrangement in the OPD for the patients and their relatives; provision of potable drinking water, toilet, recreational avenues for patients and their relatives waiting for several hours in the OPD; provision of a separate observation room for violent and aggressive patients needing sedation and observation in the OPD Block; Registration counter, record room and drug dispensing unit close in close vicinity of the OPD Block; provision of separate sitting space for Psychiatrists, Clinical Psychologists and Psychiatric Social Workers for examination of patients; development of software for computerization of demographic data, personal history, family history, case history of patients; construction and commissioning of a new and fully equipped teaching block (as in RINPAS, Ranchi); facilitating affiliation to the local university and intervening proactively in the matter of sanction of seats in MD Psychiatry (as in IMHH, Agra); construction of new library block and extension and modernization of existing blocks; emphasizing the importance of e-connectivity between the library and other departments for easy access to the storehouse of knowledge (as in RINPAS, Ranchi); construction and commissioning of a fully air-conditioned modified ECT room as well as recovery room; Improvement in toilet patient ratio from 1:11 to 1:6; New wards (both male and female) are being constructed to remove congestion and overcrowding with all modern facilities and amenities;

Provision of new tools and equipment to the existing pathological and psychological laboratories to take up new tests; progressive addition of new specialities (ENT, Opthalmology and dentistry) (as in RINPAS, Ranchi and IMHH, Agra); addition of a Physiotherapy Unit for physically and orthopedically handicapped and those who are victims of immunological disorders (as in RINPAS, Ranchi);

Construction and commissioning of separate dining hall with dining tables; provision of soft and subdued music (as in GMA, Gwalior) from selected educational Hindi films in the dining hall which will have a salutary effect on inmates and will soothe their ruffled nerves; construction of a new modern kitchen block (as at IMHH, Agra) with provision of chimney, exhaust fans, separate platforms for washing and cutting vegetables, electric kneader, chapati making machine, a clean and hygienic environment in which food is being cooked, stored and served hot with a humane touch; Significant improvement in the scale of diet, nutritive value of diet and wholesomeness of diet has taken place in IMHH, Agra and RINPAS. Ranchi. Improvement of water storage capacity by installation of new storage tanks (as in GMA, Gwalior and in IMHH,

Agra); Use of the latest state-of-the-art technology (mechanized dewatering sludge removal, high pressure cleaning, vacuum cleaning, anti-bacterial spray and ultra violet radiation) for removal of silt and cleaning of the overhead water storage tanks; samples of water are being collected and sent to approved public health engineering laboratories to ensure that water is free from chemical and bacteriological impurities, excess of iron, calcium, sodium, sulphur, magnesium and floride and has no colour, hardness, turbidity and alkalinity; Construction and commissioning of modern laundry units with arrangements for collection of linen and clothing of patients in the morning and delivery of washed, dried and pressed clothing in the evening; Installation of incinerator (as in IMHH Agra) for scientific disposal of hospital waste;

Separate occupational therapy units are being provided for male and female patients with separate Instructors and new skills/trades (as in RINPAS, Ranchi) are being added; In GMA, Gwalior cooking skills in culinary varieties are being imparted to make them self sufficient in terms of rehabilitation after they are discharged from the hospitals; Introduction of yoga, pranayam and meditation (as in GMA, Gwalior) is having a salutary effect on the body and mind of the inmates.

However, it needs to be understood and appreciated that many of the mental health hospitals are hangovers of the colonial era and are 100 to 150 years old (some even 200 years); their problems and constraints remained unattended to for years.

There exists a gap between human, material and financial resources needed on account of the growing demand for mental health services and the available resources. According to established norms we need Psychiatrists 1.0 per 1,00,000 population; Clinical Psychologists 1.5 per 1,00,000 population; Psychiatric Social Workers 2.0 per 1,00,000 population; Psychiatric nurses 1.0 per 10 Psychiatric beds. As per the above mentioned norms there is acute shortage of skilled mental health professionals in India. As against an estimated requirement of 11,500 Psychiatrists, 17,250 Clinical Psychologists, 23,000 Psychiatric Social Workers, we have 3000 Psychiatrists, 500 Clinical Psychologists, 400 PSWs and 9000 Psychiatric Nurses. The existing training infrastructure in the country produces approximately 320 Psychiatrists, 50 Clinical Psychologists, 25 PSWs and 185 Psychiatric nurses per annum. Similarly we have 61521790 major and minor mental disorders for which we have only 20893 beds in Government sector and 5096 beds in the private sector.

The other problems that remained unattended to for years included archaic structures which need to be replaced by new modern, well lit, ventilated and aesthetically pleasing structures with a sylvan surrounding; leaking roofs, eroded floors, overflowing toilets and broken doors; irrational practices like locking up the patients and serving dinner at 5.30 pm before lock up; treating patients not returning from leave and absconding patients as discharged; bringing patients to

hospitals in ropes or fetters; inadequate investigative facilities due to lack of proper staff and equipment. M modern investigation like CT scans, ultrasounds etc are unavailable in these hospitals and in some hospitals these services are available on payment of user charges; linen is usually inadequate in some hospitals; some patients lie on floor; facilities like yoga, pranayama, meditation, indoor as well as outdoor games are missing in most mental hospitals; vocational and rehabilitation facilities are still rudimentary and there is lack of workshops, equipment as well as proper trained staff; high proportion of long stay patients in the hospital not because of treatment related reasons but because their families have abandoned them; low nutritive value of food served due to lower scale of diet per patient per day; wide gap between timings of breakfast and dinner; absence of dieticians to certify the nutritive value of food; small kitchens without proper lighting and ventilation, chimney and exhaust fans in some hospitals; samples of water not drawn and sent to approved PH laboratories by some hospitals; some hospitals did not have mechanized laundries and barbers for male and female patient; absence of information, education and communication material displayed on the walls of hospitals.

In view of certain problems/shortcomings/gaps observed by Dr. Mishra during his visits to 13 Government run Mental Health Centres, we may make the following recommendations to improve the present status of Physical infrastructure, OPD conditions, Living conditions of IPD patients, Human resources, and Administration and financial management of mental health care institutes.

Physical Infrastructure

The infrastructure of Mental Health Hospitals should ensure a balanced combination of arrangements for teaching, training, research and treatment as emphasized by the Supreme Court.

- A Board in bold and bright letters giving the name of the Government Mental Health Institutions, its exact location, distance from the bus stand, railway station, airport, other important landmarks of the town to enable mentally ill persons and family members/relatives accompanying them particularly those coming from outside to find the location of the hospital without any difficulty; names of the Superintendent and other faculty members, their official room numbers and telephone numbers; name and telephone no of the official to be contacted in emergency should be displayed at the bus stand, railway station, and all important places of the town.
- A proper layout plan of the hospital showing location of various structures within the main institution along with an incumbency chart (since inception of the institution) should be displayed at the entrance of the hospital, OPD and in the Superintendent's room.

- A wide publicity should be given to make the Government mental health centres known to world outside, procedure for admission and discharge and facilities available for treatment by way of advertisements in local and national dailies and through talks/curtain raisers/quizzes in AIR and Doordarshan. The hospital authorities should carry conviction to the families of the patients that they need to draw a line of distinction between faith healers, private practitioners and a State run mental health hospital in terms of cost, convenience, humane treatment, pace and progress of recovery etc.

- IMH Hyderabad, IHBAS Delhi, HMH Ahmedabad, IPHB Goa, RINPAS Ranchi, MHC Thrissur,IMH Cuttack, and IMHH Agra should seek the services of a professionally qualified and experienced arboriculturist to prepare a proper layout plan for removal of weeds and other outgrowths; provide a proper landscaping along with a good drainage system for discharge of water and develop a lush green mini park by planting species in neat and orderly manner which can thrive in the particular soil and climate to enhance greenery of the area for the benefit of the patients and their family members who can come out in the afternoon and relax in these mini parks. In addition to adding soil nutrients to facilitate good growth, anti termite treatment should be added to ward off white ant menace. All the pathways in the hospital premises should be paved properly and uneven gradients should be levelled.

- The success of civil works programme under the 'Centre of Excellence' Project would depend on planning of time schedule; material planning; quality of building materials; financial planning; and labour discipline and productivity; stringent vigilance and surveillance over the pace and progress of expenditure and quality of work, and maintaining continuity of operations to ensure that the buildings completed are architecturally and aesthetically pleasing, functionally convenient and comfortable from the point of working and living. The strict time schedule should be observed in respect of administrative approval and approval of the final estimates; date to begin construction work; and completion of entire project in all respects (civil, electrical, PH, fittings and furnishings) within a specified period from the date of starting the construction work to ensure that the gestation period is not prolonged; escalation of cost does not go beyond permissible limits. Since IMH Hyderabad, IHBAS Delhi, IMH Cuttack, IMHH Agra and IOP Kolkata had been chosen under the Centre of Excellence, Secretary, Health of Andhra Pradesh, Delhi, Orissa, UP and West Bengal may convene a meeting of Secretary Works, Chief Engineer, PWD/executive agency and Government Architect to discuss various components of the civil work to speed up the pace of work. The Expert Committee should be formed under the Chairmanship of Works Secretary to monitor, supervise and coordinate all components of civil works. The said Committee may work out the

schedule of visits to the work site and decide the format for monitoring. The Committee should monitor the pace and progress of work from time to time and report to Secretary of the administrative department for issue of direction regarding corrective measures, if any.

- To ensure quality of original work and repair and maintenance of the building the engineering personnel should be more vigilant. They should take special care of all future constructions to ensure correct ratio between cement, sand, chips (1:1½ :3) for all RCC works; good quality DPC; grading plaster or china mosaic after the roof has been cast and adequate curing. They should also attend to the problem of vertical and horizontal cracks, leakage and seepage.

- Quality construction of new structures and quality repair and maintenance of the existing structures should receive priority attention. To ensure quality of original work and repair and maintenance of the building the State Government and hospital authorities should select an agency (not necessarily confined to PWD or CPWD) known for its impeccable track record of quality construction, controlled gestation period, controlled cost escalation and timely delivery.

- The physical possession of new structures completed in all respects should be handed over to the Directors of Mental Health Centres only after a thorough verification, preferably through a Committee, to ensure that civil, electrical and PH components of the structure are complete in all respects without any defects/deficiencies; the engineers of PWD, PHD and Electrical should attend to any defect/deficiency which went unnoticed even at the time of handing over physical possession or thereafter; an annual maintenance contract should be signed with PWD, PHD and electrical wings for proper maintenance.

Outdoor Patient Department

- Mental Health Centres should display three boards similar to those displayed by IMH Hyderabad at the entrance of the OPD. Of these a board in English should be about Citizen's Charter, the hospital timings and services provided; second board consisting of eleven instructions in local language needs to be meant for family members of the patient on the care, concern and attention towards a mentally ill person; and the third one should spell out the provisions of the Mental Health Act, 1987 along with admission and discharge procedures.

- Mental Health Care Hospitals should set up a pre-registration desk at the main entrance of the OPD as has been done by IMH Hyderabad and depute a hospital employee to issue serial numbers to the patients to facilitate them to get themselves registered in an orderly manner. A staff nurse may be deputed on the similar lines of IMH Hyderabad to provide

preregistration counselling to patients/family members to get familiarize with the process of registration and about the contents of the prescription, dosage of the medicines, interval at which the medicines were to be taken, how relapse of mental illness could be prevented through better drug compliance. These hospitals also need to set up information/reception counters manned by a senior staff member of the hospitals and two ward boys on the similar pattern of GHMC Visakhapatnam to receive patients and their attenders on arrival at OPD with Civility, courtesy and decorum and guide/escort them to their respective destinations such as registration counter, MOs rooms, drug dispensing unit, canteen and Superintendent's room. Staff at the reception counter should be trained to be civil, courteous and considerate towards the patients. They should speak in a soft and subdued tone and should not raise their voice. Similarly these hospitals should open a mental health help/information centre on the same pattern of RINPAS Ranchi to provide basic information about various mental disorders to patients and their family members.

- To organize registration systematically the best practice of separate registration counters/queues for male and female, physically or orthopedically handicapped and visually challenged, old and infirm persons, convicts/ Undertrial prisoners and cases covered by reception orders from the Judicial Magistrates prevalent in IHBAS Shahdara and Government Hospital for Mental Health Ahmedabad and priority given to elderly, physically orthopaedically and visually handicapped persons and seriously disturbed patients in GMHC Thrissur needs to be adopted by other mental hospitals.

- With increase in incidence of mental illness and consequent increase in number of mentally ill persons, it is necessary and desirable to create a data base for analysis and drawing conclusions. To accomplish this task State Government should sanction adequate number of posts of data entry operators for all hospitals except IHBAS Shahadra which already had sufficient number of data entry operators and also make available sufficient number of computers to these hospitals for computerizing the case history, family history, personal history, demographic profiles etc. A psychiatric social worker may also be posted to prepare a proper case history of every patient on the basis of registration data. While registering and filing, care and precautions should be taken to maintain strict secrecy and confidentiality about each and every case and research scholars may be allowed to study these cases but should not be permitted to make use of them for any type of publication.

- A software need to be designed urgently for different sections of the Mental Health Centres. NIC or State Computer Application Centres may be approached and requested to prepare the computer software for OPD, admission/discharge, medical central store, drugs dispensing centre, record room, accounts section, IPD, kitchen and dining hall, library-cum-reading

room, OT units, modified ECT, X-ray, ECG, and EEG. The Department of Health and Family Welfare need to give its approval expeditiously and make budget provision.

- The patient's record room needs to be reorganized at par with the record room of Dharwad Mental Hospital. Accordingly, record room needs to be located in a very large hall (50'x40') with the required number of sky lights, proper arrangement for adequate light and ventilation and protection from outbreak of fire, pests, heavy rain etc. There should be adequate number of good quality steel racks of 10' height and 3' width with required number of compartments. All the files of old and new patients should be allotted one hospital serial number, arranged and maintained alphabetically and year wise in steel racks. A team of officers may be deputed to the Mental Health Hospital Dharwad to study the upkeep and maintenance of records under ideal conditions and on the basis of that model the record room should be equipped and made functional.

- The drug dispensing unit should be an integral part of the OPD and located near the OPD. Keeping in view the poverty and illiteracy of the OPD patients a nurse may be detailed at the registration counter or the drug dispensing unit to counsel the patients/attenders about prescribed drug, dosage, interval in which the drug is to be taken, advantages of continuous drug compliance and dangers of relapse of illness due to non-compliance.

- There is high risk of relapse of mental illness due to non availability of prescribed drugs at the district/sub divisional hospitals or at the PHC and the BPL patients inability to make frequent trips after 15 or 30 days to the hospital for collecting their medicines due to their financial problems and absence of a public policy for recommending cases of BPL patients/family members for free/concessional rail/bus tickets. In consideration of these limitations hospitals issuing drugs for 15 or 30 days need to issue drugs for 60 days as is done in IHBAS Shadara and Hospital for Mental Health Ahmedabad.

- Government Hospital for Mental Health Ahmedabad has been keeping a track of patients or relatives/family members who do not turn up for follow up and send letters to them to come and collect medicines. In case patients express their inability to come and collect their medicines, hospital sends medicines by courier services to such patients. Hospital of Mental Health Ahmedabad had involved 'Saathi' to visit homes of the patients to provide counselling on the importance drug compliance. The management of other hospitals need to follow a similar practice and involve Self Help Groups for making home visits and providing counselling for better drug compliance.

- The treating physicians/MOs should clearly explain to illiterate patients and family members while prescribing drugs, the dosage and the interval at which the drugs should be taken with the help of signs/symbols what

constitutes sunrise, noon and evening so that the attenders to the patients could understand and internalize these timings (breakfast, lunch and dinner). They may also advise the patient to come to the hospital at least 2 to 3 days before the prescribed drugs get exhausted and drugs.

- The case files of all the patients attending OPD should be evenly distributed among all the psychiatrists, clinical psychologists, Psychiatric Social Workers and General Duty Medical Officers to ensure better attention to patients and also to reduce the waiting time.

- Most of the mentally ill persons coming to hospitals from far off places with one or two family member/relatives are below poverty line. The hospital authorities should make similar arrangement as in vogue in many mental hospitals including IMHH Agra, GMA Gwalior and RINPAS Ranchi to recommend cases of BPL patients for free or concessional travel by train. The recommendation should be sent to railway authorities with full details of the patient/family members/relatives for necessary action. State Governments, however, have no such policy to provide concessional bus fare to patients/relatives.

- The Mental Health Centres need to administer modified ECT in the same way as has been done by IMHH Agra. Modified ECT should be administered in the presence of anaesthetist, one medical officer, staff nurse and attendants. A thorough check up of the patient including essential investigations related to blood and BP etc. needs to be done in the ward and countercheck by the MO before administering ECT. Consent of the patient should be obtained before administering ECT.

- Government Mental Health Hospitals need to arrange two separate rooms with 10 beds each to keep those male and female patients who come from far off places and reach hospital after OPD hours for the night to enable them to attend OPD on the next day as has been done by IHBAS Shahadra, RINPAS Ranchi, GMHC Thrissur.

- The Mental Health Centres need to make provision of Dharamsala for relatives and family members of the patient to spend the night on similar lines of IHBAS Shahadra and RINPAS Ranchi.

- Substance abuse being a major malaise and source of multiple forms of mental illness needs to be handled on a war footing and on multiple fronts with multiple measures. The measures to tackle this problem include vibrant and proactive mental health education programme for the family, teachers and students in the school and the workers at the work place; stringent measures for enforcement of excise laws like deterrent punishment for growing and consuming marijuana, canabi, poppy, opium as also for consumption of illicit country made liquor; and opening of drug de addiction wards as integral part of mental health hospitals for withdrawal and stabilization of victims of substance abuse.

- There is a strong need for information, education and communication package. Well illustrated IEC materials need to be displayed on all the walls of OPD to remove ill perceived notions about mental illness, drive home the point that mental illness is not a curse, not a fatality but fully correctable with patience, perseverance, kindness & compassion. Such materials should be designed in a workshop of creative thinkers, writers & artists in simple local language with main focus on the nature and characteristics of the ailments (Schizophrenia, bipolar affective disorder, Schizo affective disorder, psychosis, depression etc.) dos & donts for the patients with special emphasis on drug compliance. The IEC package should also inform people and particularly the BPL/low income families the dangers of going for private treatment at prohibitive cost and the advantages of going in for treatment in a Govt. Mental Health Centre where the treatment is free; highlight the dangers/risks of delayed diagnosis of the ailment; discourage practices related to discrimination, stigmatization and denial of mentally ill persons; bring out clearly and convincingly the dangerous consequences of addiction to drugs/alcohol; highlight the usefulness of drug compliance. The Institute of Psychiatry at Jaipur has developed excellent IEC materials in Hindi and Marathi respectively. Medical Superintendent of different mental health centres may depute concerned officials visit Psychiatric Centre, Jaipur to study as to how imaginative and creative efforts made in this direction have yielded good results and how similar models can be developed and adopted.
- A School mental health programme should include designing curriculum, course content and textual materials for sensitization of parents, teachers and students separately through a workshop, teachers training, and motivation of parents and students. Such a programme has been launched in Tamil Nadu about a year ago. Directors of Mental Health Centres may depute an officer to Chennai to visit the Institute of Mental Health at Kilpack Chennai, study the contours of the programme launched in Tamil Nadu in 2009-10 and report on how is it going, what has been the impact so far and how this can be replicated in other hospitals.

Living Gonditions of IPD Patients

1. Psychiatric Services, Physical Conditions and Inpatient Services

- To create a better therapeutic environment in the wards, the number of rounds of the Superintendent, other medical officers and Nursing Superintendent as well as time spent with patients should be increased. The pace and progress of recovery of a patient who is reticent, withdrawn and not communicative should be closely monitored by the hospital authorities and all out efforts should be made by MOs and staff nurses during the course of their rounds to make the patient open up.

- The beds of two patients should be arranged side by side in such a manner that communication is there between them even if one of them should have social communication skill and the other one is withdrawn and has difficulty in opening up. This would help the latter to open up and improve his communication skills.
- A ward in the Mental Health Hospitals is an amalgam of patients with diverse socio-cultural background, temperament and demeanours. There is wide variation in the forms of mental illness and the circumstances which provoked them or contributed to their illness. There cannot be a single strategy to deal with these patients in terms of behaviour therapy. A set of different strategies needs to be devised for different patients. One such strategy to deal with depression could be to encourage all literate patients to write in their own hand to their near and dear ones as they can pour out their feelings and hospital authorities should post such letters. The PSW should assist illiterate patients in writing letters. A cell phone from hospital establishment may be made available to the patient and assist them to talk to his/her near and dear ones. These strategies if implemented in right earnest could provide a lot of relief to the patients who are starving for the love and affection of their family members but cannot easily reach them.
- The hospital authorities should identify and harness the literate, skilled, creative and imaginative patients who have recovered substantially for creating a literate environment as also for instilling hope and faith in the minds of other patients who are unable to read and write and, therefore, unable to have a widow to the outside world through books, journals and periodicals; Mental Health Centres authorities need to devise an arrangement by which a literate and comparatively healthier person should read out newspapers with proper pause and rhythm to illiterate inmates so that this could become a source of information as well as enrichment; A sincere attempt should be made to do batching and matching of unlettered and functionally literate persons in the ratio of 1:1 or 5:1:, as the case may be (subject to availability of such persons) so that the functionally literate could impart instructional lessons in functional literacy and numeracy to their unlettered counter parts. Books and magazines should be purchased for patient library on the strength of their preferences.
- The Mental Health Centres should follow an innovative measure taken by IHBAS to hold a patient staff group meetings on monthly basis for an hour to resolve issues related to day to day problems through coordinated efforts; to explain treatment related issues to the patients and their family members; and to discuss the opportunities in the making after discharge of the patient and follow up plan. The participants in the meeting are all patients of the ward who were fit to participate, family members/care takers of the patients admitted in the ward, members of the treating team, SR, JR, staff nurse, psychiatric social workers etc., dietician, civil and electrical

engineer; house keeping supervisor; and security supervisor along with ward consultants. The minutes of the meeting were recorded in the PSGM register of the ward. A copy of the same was forwarded to the PSGM coordinator.

- Music has a remarkable effect on the minds of people in general and particularly on mentally ill persons. With this central objective in mind Mental Health Centres may make a suitable arrangement to play a few selected songs (which have a richness of human appeal) from a few selected Hindi films including Dosti, Insaniyat, Jagte Raho, Mother India, Bandini, Meri Surat Teri Aankhe, Do ankhe Barah haath, Ashirwad, Anand, Anupama, Parineeta, Devdas, Baiju Bawra, Mamta, Guide etc. Gwalior has made a modest beginning in playing music in soft and subdued manner for mentally ill persons. Directors of different mental health centres may consider it appropriate to depute an officer to GMA Gwalior to study the impact of music on the mend of inmates and take a decision to implement the suggestion accordingly.

- The mental illness relapses due to discontinuation of medicines or not taking drugs in the prescribed manner. This problem of non compliance of medicine needs to be handled through strong and effective counselling by doctors both at the time of admission as well as the time of discharge; Psychiatric Social Workers need to meet patients/family members after their discharge in the OPD as well as to make frequent home visits to provide drug related counselling; a package of IEC materials highlighting the importance of drug compliance needs to be displayed on the walls of the OPD and IPD of the hospital building.

- A close liaison and coordination should be maintained on the status of health of the patient between the MO of mental hospital and the treating physician of the referral hospital. The physician in-charge of treatment of the patient at the referral hospital should keep MO of the mental hospital posted with latest developments relating to the patient.

- There may be physically and orthopaedically challenged persons with damaged connective tissues who may find it difficult to squat on an Indian commode. Since it is not advisable to do so, there should be provision of at least 1 to 2 Western commodes in every ward.

- To solve the problem of long stay of patients, following steps should be taken to deal with the problem of stigma, lack of family support to mentally ill persons and refusal to accept them when they are discharged from the hospital:

  a) While admitting the patients, Mental Health Centres need to record full particulars of not only of his/her immediate family members as is being done at present but also of close relatives and one or two

prominent members of the community. In case family members do not respond to intimation sent by the hospital to get their patients discharged after their full recovery, these persons may be contacted to put justified moral pressure on the family of the patient to take back their fully cured mentally ill patients.

b) To collect and document correct postal addresses; address letters to family members/guardians at the address so collected and also encourage patients to address letters, if literate, to their guardians/ family members and if not, assisted by PSW in this effort.

c) It is cruel to keep completely treated and fully recovered patients locked all the time when they can provide useful assistance in some branches of the hospital. Superintendent may find some jobs for fully recovered patients on nominal remunerations within the hospital to rehabilitate them.

d) A multi-pronged drive should be launched with the help of Psychiatric social workers to trace the correct address of the patients and to carry conviction to the family members and relatives regarding acceptability of and re-integration of cured patients into the family mainstream. To accomplish this task, Psychiatric Social Worker should be in place in prescribed ratio and they should conduct home visits and impart counselling.

- The hospital authorities should take measures to bring down the number suicides by maintaining a constant vigilance and surveillance over the inmates on the one hand and creating conditions to instil in them a zest and joy for living. Shri Sri Ravi Shankar's Art of Living Foundation may be involved in this process.

All possible efforts should be made to save the life of the patient. If, however, despite best efforts the life could not be saved, the cause of death should be accurately recorded. The report specifying the cause of death should be submitted to the Chief Medical Officer of the Government Hospital for scrutiny and acceptance. Death audit must be conducted at appropriate level to investigate not only the causes of death but also to ensure that all possible efforts have been made to save human life in all contingencies – natural and unnatural, normal and abnormal.

- Government Mental Health Centres should chalk out a perspective plan to highlight the urgent and imperative need for day care centres and half way homes. The State Govt. should also take an initiative of identifying good, reliable and committed NGOs who have the experience and professional expertise in management of halfway homes, short stay homes and day care centres and involve them in accomplishing the task of setting up of half way homes and day care centres and rehabilitation of the patients before reuniting with the community and their families.

- The mentally ill patients who cannot fend for themselves and need support of family members/relatives, the latter have a right to stay comfortably so long as they stay in the hospital as care givers of mentally ill persons. The family members should be provided with low height beds which could be pushed below the main bed of the patient for sleeping on the same pattern of IMH Hyderabad. They may also be provided with a cupboard for keeping their personal belongings.

- Interpersonal communication between Supdt, MOs and nursing staff and also between the hospital staff and inmates need to be encouraged by organizing conferences at regular intervals to facilitate them to meet and discuss latest changes and developments in the field of psychiatry, clinical psychology and psychiatric social work. Guest speakers may also be invited to speak to the faculty to enlighten them so as to keep themselves abreast of latest changes and developments. The interaction with patients need to be encouraged by increasing the number of rounds, more time spent with the inmates, getting patients response by asking them questions in a polite and friendly manner.

2. Barest Minimum Needs

i) Right to food

- Mental Health Centres except IHBAS Shahdara which is having a modular kitchen need to renovate their existing kitchen block on the model of IMHH Agra with installation of a chimney to ensure an outlet for smoke; requisite number of exhaust fans for better ventilation; fixation of tiles up to 1 metre; fixation of fly proof wire mesh all around and fly proof automatic closing doors; floors made of an impermeable material; separate platform for cutting and washing vegetables with an outlet for water to go out; adequate number of taps inside the kitchen; a large sized cooking range/ LPG hotplate and micro oven; an enclosure made out of stainless steel with a temperature controlling device to store food in a scientific manner to serve hot food; cooking and serving utensils made of stainless steel; gas bank and room for changing aprons. The Mental Health Centres may depute their officer in-charge of kitchen to IMHH, Agra to study the planning and architecture of the new kitchen block and replicate it in their respective hospitals with modifications, if any, to suit their local conditions.

- To ensure good quality of food management, the Mental Health centres should take certain measures which include procurement of food grains of standard quality; scientific storage of food grains and grocery items (rice, atta, pulses, edible oil, sugar, condiments, salt), fruits, vegetables and eggs separately in a clean, well lighted and ventilated room and kept on clean platforms under controlled temperature. Anti-termite and pest control measures should be taken to protect the food grains from pest/insect attack.

- To introduce better transparency the hospital management should display information relating to the food articles in store; items issued from central store in the presence of officer in-charge of the kitchen after making entries in the issue register; how much has been utilized for cooking; what food items have been cooked and is it according to the prescribed menu and needs of different patients on the board near the kitchen.

- Food should be prepared in an environment of total hygiene and cleanliness, free from dust, fume, pest etc. All cooks must be medically examined in every quarter and should be provided with aprons. Food should neither be over cooked nor under cooked. Cooked food should be transported from the central kitchen in stainless steel containers through trolleys and served in well lighted and well furnished dining rooms with low height dining tables and chairs with human touch. The elderly, physically and orthopaedically handicapped patients who are incapable of taking their food on their own need to be helped. The inmates should be persuaded to wash their hands and remove their shoes/chappals outside the dining halls before taking their food by keeping water in the drums at a convenient point outside the dining hall/ward along with soap and towel to ensure personal hygiene. Soft and subdued music (preferably devotional songs from Yesudas renderings) should be played in all the wards at the time of inmates taking their food to create a joyous environment.

- Right to wholesome, sumptuous and nutritious diet is the basic right of all patients and there should be no compromise with this right by way of imposing a ceiling on the cost of diet. To ensure sumptuous, balanced, wholesome food and that the nutritive value of food conforms to minimum 2500 Kilo Calorie for women and 3000 Kilo Calorie for men as recommended by NHRC team, the State Governments needs to review and revise per capita allocation on food in monetary terms per day from Rs 28 in IMH on food in monetary terms per day from Rs 28 in IMH Hyderabad and GHMC Vishakapatnam, 34 in GMA Gwalior and 35 in Mental Hospital Varanasi to the prevailing rate of around Rs 50 in most of the hospitals including IHBAS Shahdara, IPHB Goa, IMH Cuttack, Rs 54 in GHMH Ahmedabad, Rs 48 in RINPAS Ranchi, Rs 44 in GMHC Thrissur and GMHC Kohzikode. The prescribed scale of diet of Rs 50 per day is consistent with cost of food articles and conforms to the special status of patients (TB, jaundice – hepatitis, gastroenteritis, low weight, low haemoglobin count etc.). All female patients weighing less than 40 kgs should be provided special diet.

- To ensure that the food is balanced, wholesome and nutritious as per the established and recommended standards, the respective State Governments may sanction a post of a dietician for GMHC Vishakapatnam, GMHC Ahmedabad, GWA Gwalior and fill up the sanctioned post of a dietician for IPHB Goa, GMHC Kozhikode for overseeing the quality and quantity of food and to verify and attest that the food being served conforms to a

minimum of 2500 kilo calories for women and 3000 kilo calories for men. Pending this, services of a dietician/nutritionist should be requisitioned on payment of a small honorarium from any other hospital managed by Central/State Government to certify the nutritive value of food. The hospital authorities of IMH Cuttack and IOP Kolkata may also seek the services of a qualified and experienced dietician independent of SCB Medical College and S.N Pandit Hospital on part time basis to certify the nutritive value of food served from SCB Medcial College Cuttack and by the contractor from the kitchen of SN Pandit Hospital Calcutta.

- The Mental Health Centres need to reorganise the timings for breakfast, lunch and dinner to minimize the gap between different meals. The ideal timings of serving food should be bed tea 7 AM; breakfast 7.30 AM to 8.30 AM; lunch 12.30 to 1.30 PM; afternoon tea with snacks 4 to 4.30PM; and dinner 8 to 8.30 PM.
- Mental Health Centres should develop agricultural farm/kitchen garden by involving comparatively strong and skilled patients to work in the farm for raising vegetables, food grain crops, fruits and vegetables etc. on RINPAS Ranchi and Agra model to become self-sufficient to the extent possible with the available agricultural land within the premises of the hospitals.
- The recent initiative taken by the Government of Kerala to sanction free food to the patient attendants as an incentive for attendants to stay with patients in the family wards is a commendable welfare measure, which needs to be emulated by the Government of other states.
- The Mental Health Centres may start the community kitchen for attendants of the patients to stop family members staying with patients in the family wards from managing with food supplied to patients.

ii) Right to water

- IMH Hyderabad, IPHB Goa, GMHC Thrissur, GMHC Kozhikode, GMA Gwalior, IMH Cuttack, Mental Hospital Varanasi, and IOP Kolkata need to set up RO (Reverse Osmosis) plant to ensure provision of pure water to the patients on the same pattern of IMHH Agra, HMH Ahmedabad, IHBAS Shahdara and RINPAS Ranchi. Prnding that management of these hospitals may install aqua-guards as in GMHC Vishakhapatnam.
- IMH Cuttack, Mental Hospital Varanasi, and IOP Kolkata need to make an institutional arrangement under which samples of water should be drawn at an interval of 6 months and sent to an approved PH testing laboratory for test and certification that water is free from chemical and bacteriological impurities and it is also free from excess of iron, sodium, calcium, magnesium and floride. In case bacteriological and chemical impurities are found, the corrective measures should be taken to remove the impurities. The Secretary Health and Family Welfare of respective States should write

to Secretary Housing and Urban Development to issue instructions to CE, PH to institutionalize the above arrangement.

- The overhead tanks are required to be cleaned regularly with the state-of-the-art technology with mechanized dewatering sludge removal, high pressure cleaning, vacuum cleaning, anti bacterial spray.
- All Mental Health Centres should prepare IEC materials on scientific storage of water; scientific distribution of water and scientific consumption of water (without causing any wastage) in simple bolchal Hindi and display that all over.

iii) Right to Personal Hygiene Environmental Sanitation

- Personal hygiene of all inmates in its totality starts from the kitchen and goes to the wards, dining hall and dining table, OT, toilet, library and assembly places. To ensure personal hygiene various steps which need to be taken include two sets of aprons, cap and nasal mask for cooks; provision for hot water in the kitchen; thorough cleaning of utensils with detergents after cooking; mechanized laundry for quality services; changing bed sheets and pillow covers every alternate day; provision of a female barber for female mentally ill persons; supply of adequate quantity of soap, detergents etc. to the inmates for washing their clothing manually during the interregnum i.e. till mechanized laundry operation gets ready; and adequate quantity of oil and lifebuoy soap for taking bath etc.; thorough cleaning of toilets with detergents and chemicals to keep these clean and tidy.
- A mechanized laundry is a composite unit comprising of one washing tumbler, one drier and one iron for pressing. Three workers is the minimum requirement of the automatic unit. To ensure personal hygiene of inmates and prevent skin diseases GHMC Vishakhapatnam, HMH Ahmedabad, IPBH Goa, GMA Gwalior, IMH Cuttack, Mental Hospital Varanasi, IOP Kolkata should run their own mechanized laundry with arrangements for automatic cleaning, drying and pressing of clothing as manual laundering leads to accumulation of water and an unclean and unhygienic environment. The clothing should be collected at 8 AM and delivery after washing and pressing on the same day at 5 PM. The respective State Governments may also sanction the requisite manpower.
- To promote personal hygiene of the inmates, IMH Hyderabad, IHBAS Shahdara, RINPAS Ranchi GMHC Thrissur, GMHC Kozhikode and IMHH Agra need to monitor the functioning of the automatic laundry to ensure that the clothing of the inmates collected in the morning at 8 AM are delivered after washing and pressing in the evening at 5 PM on the same day.

- Since there are elderly and chronically ill patients whose connective tissues might have been damaged due to attack of osteoarthritis or osteoporosis and who may find it difficult to squat on an Indian Commode which is also medically inadvisable, steps may be taken to provide a few western commodes by way of conversion for use of such persons. These patients also need to be escorted to the toilets either by the bystanders in the family/open ward or by attenders in the closed ward so that the risk of slipping, falling down and getting into a situation of brain hemorrhage could be averted. Such patients may be singled out and care may be taken to provide such support.

3. Supportive Services:

i) Occupational Therapy Units

The state governments may take cognizance of the recommendation made by Prof. Channabasavanna Committee way back in 1998-99 that rehabilitation services have to be improved and implemented without any further delay by revival of the OT Unit.

IMH Hyderabad, GMHC Kozhikode and IOP Kolkata needs to plan two separate occupational therapy units for male and female patients.

State Government of Andhra Pradesh and Orissa needs to sanction two posts of occupational therapists for male and female occupational therapy units for IMH Hyderabad and IMH Cuttack. The State Govt. of Andhra Pradesh, Goa and Madhya Pradesh should take steps to fill up two vacant posts of male and female occupational therapists in GMHC Vishakhapatnam, IPHB Goa and male occupational therapist in GMA.

While making a selection of occupational therapist such human resources should be selected who have the aptitude for training mentally ill persons under specific situation and conditions. The occupational therapists after their selection should be given a brief orientation on how to deal with mentally ill persons, how to manage Occupational therapy units with optimal efficiency, how to bring out the imagination, ingenuity, creativity and resourcefulness of the inmates and how to make hospitals self-sufficient by meeting some of their genuine needs like beds, envelops, file covers etc. along with rehabilitation of the patients.

The selection of inmates for participation in OT must be done carefully by keeping in view socio-cultural background, aptitude, preference and interest, physical and mental state of inmates and occupational skills/trades must primarily cater to the aptitude, preference and special needs of the inmates rather than the needs of the hospital.

The pace and progress of learning the vocational skills/trades by inmates should be closely monitored; their reaction to the entire process of skill

training should be recorded on a day to day basis and ways and means of invigorating slow learners should be explored.

The patients who are doing exceedingly well in skills imparted like knitting, tailoring and embroidery may be appointed as master trainers to oversee the work of other trainees. This may inspire and get more female patients involved in Occupational Therapy Units.

Hospital authorities need to diversify occupational therapy activities in accordance with the market needs, individual preference, aptitude and interest to ensure better rehabilitation of the patients. To achieve a break through in the direction of expansion /diversification, hospital authorities should undertake a survey amongst inmates participating in OT to ascertain their artisan background, the skills/trades already learnt by them and the new skills/trades they would like to learn.

A market survey needs to be conducted to ascertain marketability of products and remunerative aspect before selection of skills/trades for imparting training. The market relevant skills need to be selected and developed rather than continuing to impart training in traditional skills/ trades. The survey should be followed by listing of tools, equipment and raw material which are needed to start a vocational skill training programme; a list of artisan inmates who would be involved in the project; end products; time span involved; likely cost; outlets for sale of finished products; and payment of wage. The hospital authorities may introduce a number of new skills/trades such as file covers, envelopes, file boards, cartons (medicine boxes), candles, wooden toys, photo frame etc.

Remuneration for the inmates should be scientifically fixed and must be reasonable. The remuneration of Rs 10 for semi skilled and Rs 20 for highly skilled inmates engaged in occupational therapy units was quite low for their contributions. The rates of remuneration may be enhanced reasonably to motivate them to give their best and encourage other patients to participate in the OT unit.

The occupational therapy units in Mental Health Centres provide only a small entry point and the skills imparted need to be sustained, refined, sharpened and upgraded after the inmates have been effectively treated, discharged and joined the main stream society. The hospital authorities needs to maintain a close liaison and coordination with the concerned Departments of the State Government and send a list of inmates along with skills/trades in which they have specialized to the GM, DIC or Small Industries Development Corporation. The State Government needs to complement and supplement this process by pursuing a policy of securing the involvement of District Industries Centre, Small Industries Service Institute and various other vocational skill training institutes for sharpening the skills learnt at OT units of the hospital.

The products made by inmates should bear their names along with the date of their manufacture. This would give them a sense of identity and recognition and would boost their morale and motivate them to contribute more and do better.

Mental Health Centres need to emulate the example of Thiruananthapuram where a bakery unit stated under occupational therapy has been providing employment to the cured patients of the mental Hospital.

Pllanned and Coordinated efforts should be made for marketing of products produced in the OT units by occasionally displaying the products in fairs/ exhibitions. A good response would encourage them to produce more and motivate other inmates to participate in occupational therapy. The sale proceeds should partly be put in the welfare fund and partly in the savings bank accounts opened in the names of inmates as their remuneration. While the proceeds of the welfare fund needs to be utilized in various welfare activities for the inmates of the hospital and the amount lying in the bank account of the inmates should be handed over to patients at the time of discharge in the same manner as has been done by HMH Ahmedabad.

ii) Telephone services

There are occasions when relatives/family members ring up to enquire about status of health of their patients admitted in the hospital. An arrangement needs to be institutionalized by installing a telephone in the emergency room and number made available to the relatives/family members of the patient to facilitate them to make enquiries about the health conditions of their patient from time to time. A literate attender who is empathetic and sensitive may be assigned the responsibility of receiving outside calls. He/she should be provided with a diary, a brief orientation of receiving calls from the relatives/family members properly by noting down the caller name, telephone number and his/her relationship with the patient and also to record the message accurately. The message should be handed over to the MO/staff nurse in charge of the ward at that very time and MO should pass on information relating to the health/condition of the patient to the attender who received the call for passing it on to the relative/ family member of the patient on the same lines as is done in IPHB Goa.

To overcome the barrier of communication Mental Health Centres need to install PABX with 10 lines to start with and expand it subsequently to 50 lines with sanction/joining of newly recruited staff on the pattern of IHBAS Shahdara. The Superintendent of mental Health Centres should formally contact BSNL to get cost estimates, engage suitable agencies for installation of PABX and the Department of Health and Family Welfare of respective States should accord administrative approval at the earliest. The State Governments should sanction the post of receptionists to receive the incoming calls, record message and send a proper response on same

pattern of IPHB Goa. Mental Health Centres may follow the practice prevalent in IHBAS Shahdara and provide a mobile phone with SIM facility to all regular staff including doctors to form a closed user group.

iii) Recreational and cultural activities

Mental Health Centres may emulate the example of RINPAS Ranchi and IHBAS Shahdara and initiate the practice of taking out male and female patients along with officers, students and staff posted in different wards for picnics to provide them good outing and relaxation and to rejuvenate their dampened spirits of inmates.

Soft and subdued music has a stabilizing effect on human mind in general and on the mentally ill persons in particular. The Superintendents of different hospitals may learn from the good experiment launched by GMA Gwalior and make a beginning in their respective hospitals.

Prayer and meditation have a tremendous stabilizing effect on human body and mind. Hospital authorities may consider of trying this by deputing a faculty member to mobilize patients and bring them to the hall and initiate them into prayer and meditation.

The patients should be encouraged to participate in annual sports day, celebrating Independence Day, Republic Day, Durga Puja and other fairs and exhibitions. The television sets and indoor games need to be provided in both male and female wards and some outdoor games may also be made available to inmates.

Yoga, meditation and pranayama etc. need to be planned and organized in a systematic manner for disciplining body, mind and spirits of inmates to reduce stress on individuals and family members. The scientific norms need to be adopted for selection of patients for yoga sessions and success stories arising from yoga therapy should be documented. Since the avenues for doing yoga, pranayama and meditation are not available in most of the hospital due to absence of yoga teachers the hospital authorities should take an initiative and make a beginning to start yogic exercises for patients who have been effectively treated and have substantially recovered by hiring services of a yoga professional on payment of some honorarium.

Hospital authorities may promote cultural and recreational activities on the pattern of IMHH Agra. The avenues need to be promoted include both indoor and outdoor games like carom, chess, ludo, cards, cricket, volleyball, badminton; annual sports for the patients along with employees and staff members of the hospital on Republic Day every year; screening of good, entertaining, educational movies and movies with serious moral lessons; cultural programmes like prayers, bhajans and kirtans at the Sarvadharma Parthana Ghar; celebration of other festivals like Id, Bakrid, Basanta Panchami, Holi, Hariyali Teej, Rakshya Bandhan, Dusserah, Karva Chauth,

Deewali, Janmashtami, Christmas etc.; celebration of various other awareness programmes like World Mental Health Week through role plays, nukkad nataks, street theatres, skits, simulation exercises etc. The Director, MS, faculty members, GDMOs may also participate in these events along with the patients.

The male recreation centre should be put under the charge of a male organizer. He should motivate literate and numerate male inmates to read out newspapers and explain the contents thereof to their counterparts who cannot read and write. A similar experiment may be carried out in the female recreation centre as well. The matching and batching should be done between literate volunteers willing to teach to their unlettered counterparts. A beginning may be made to impart functional literacy and numeracy with the help of State Resource Centre under the Directorate of Adult Education.

Against the backdrop of lack of social communication resulting in social isolation the hospital authorities should try to reduce social isolation by making totally unlettered inmates functionally literate with the help of those inmates who are functionally literate, have an urge and inclination to teach and are expected to stay in IPD for a reasonably long period; identifying and encouraging individuals having good communication skills and capable of making others feel at home by being informal and friendly, unconventional and unorthodox to engage others in good conversation and thereby assisting them to open up.

iv) Library services

Hospital authorities may plan a separate well lighted and ventilated library with well-furnished reading rooms with adequate number of tables and chairs for patients and also make books, journals, periodicals, newspapers available to patients and their family members. In view of a separate library for patients a separate functionary for organizing the infrastructure and services for the patient's library need to be sanctioned expeditiously by the respective State Government.

A census needs to be organized to ascertain the preferences of literate patients who have undergone treatment and are on the fast track of recovery and their relatives for particular books, periodicals and other reading materials. The patient's library may be strengthened on the basis of the findings of this Census.

The hospital authorities should identify and harness the literate, skilled, creative and imaginative patients who have recovered substantially for creating a literate environment as also for instilling hope and faith in the minds of other patients who are unable to read and write and, therefore, unable to have a widow to the outside world through books, journals and

periodicals. The hospital authorities may implement this experiment on the similar pattern of GMA, Gwalior in the larger interests of patients.

v) Power supply

The hospital authorities need to make arrangements for power back up through DG sets to ensure stable supply of electricity and to deal with problem of interruptions, disruption and tripping. A DG set of the appropriate capacity should be installed at an appropriate point within the premises of mental health centres to deal with the problem of power breakdown and resultant dislocation, inconvenience and discomfort.

The hospital authorities must enter into an annual maintenance contract with the manufacturer of the DG set and renew it every year to ensure its timely repair and maintenance. In the event of breakdown of the DG set only an authorized professional vendor duly authorized by the manufacturing company should attend to the repair work.

The State Government should delegate powers to purchase diesel to the Directors of Mental Health Centres to ensure timely supply of adequate quantity of diesel to keep the DG set keep going. In view of sharp rise in price diesel, the contingency amount kept for this purpose should be enhanced.

All loose connections should be thoroughly checked to avoid any possibility of short circuit and any impending disaster.

Human Resources

The human element adds vitality and strength to an institution. There should be a proper staffing pattern by sanctioning essential posts and filling up the sanctioned posts lying vacant for a long time. A proper training should be provided to staff as training is an important input of human resource development. There is imperative need for both induction and refresher training for all categories of personnel in Group A, B, C and D.

The Principal Secretary, Health and Family Welfare and Director General of Health Services of the State Government should assure the hospitals of their irreducible barest minimum (both recurring and non recurring) in the form of the required budgetary allocations; continuity of tenure of the HOD/ Superintendent; fulfilling manpower planning according to the genuine needs of the institution; human resource development through effective orientation and training and striking a balance between cultural antiquity with professional modernity on all fronts.

One Additional Director should be appointed in the State Directorate of Health to look after the area of mental health exclusively. One general physician needs to be appointed in each mental health centres to manage the physical health problems of mentally ill persons.

The Government may issue a GO to delegate additional administrative and financial powers to Directors of different mental health centres making adhoc/ contractual appointment of professionals to carry out different items of work and to make emergency purchases.

A close knit team of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses should be built by filling up all vacant posts of psychiatrists, clinical psychologists and psychiatric social workers at the earliest. Under the proposal of Centre of Excellence of the Ministry of Health and Family Welfare, Government of India a provision of Rs. 3 Crores had been envisaged for sanction of a prescribed number of posts in the field of psychiatry, Clinical Psychology and Psychiatric Social Work. These posts need to be sanctioned in their entirety to operationalize the proposal at the earliest.

Taking a clue from the principle of autonomy as pronounced by the apex Court and being implemented by RINPAS, Ranchi, IMHH, Agra & GMA Gwalior, power to recruit all categories of posts in Group C and D should be delegated to the Director/Suptd, and Govt. should retain the prerogative to recruit all posts in group A and B including the Director/ Superintendent. The procedure in vogue for selection of Group C and D posts need to be streamlined. The power to issue advertisement for all the vacant posts in Groups A, B, C and D may be delegated to the MC to avoid delay in obtaining government approval. These posts may be sanctioned according to the approved norms by the Government but powers to fill them up by issue of open advertisement, inviting applications, short listing and eventual selection through interview may, in the larger public interest, be delegated to the MS who is responsible for the smooth functioning of the hospital. Once the advertisement has been issued the process of receiving and screening applications and short listing candidates need to be expedited and dates for holding interviews should be fixed and the dates fixed should not be changed.

The employees of mental hospitals should be treated as civil servants. In the wake of the direction of the Supreme Court in WP (Civil) No. 339, 1986 Rakesh Chandra Narayan Vs. State of Bihar and Others on 17th May, 1994, Shri M.S. Dayal, the then Secretary, Ministry of Health and Family Welfare, Government of India had submitted a report to the apex Court in which he had recommended that all the employees of RINPAS, Ranchi should be treated as civil servants of the State Government. The Court accepted this recommendation and in pursuance of the orders of the Court all the employees of RINPAS Ranchi had been treated as civil servants. The employees of other hospitals should be notified as civil servants by respective state Governments on the similar pattern.

The hospital represents an essential service and the incumbents may not do justice to the service if they are not assured of the irreducible barest minimum facilities and amenities. It hardly needs to be stated that a contractual arrangement in an educational - cum - treatment - cum - research institution is anathema to a policy of balanced human resource development and management. It is

anathema to the morale and motivation of employees. The contractual appointment may, therefore, be terminated and replaced by regular appointment with time scale of pay and other perks which go with such posts in other similar institutions.

The terms and conditions of licence under Mental Health Act, 1987 should be strictly implemented. It should be examined if a condition regarding charging of reasonable consultation fees could be incorporated in the said licence as private medical practitioners running mental health nursing homes have been fleecing the poor patients who are simple, gullible and unpretentious about wily machinations of these practitioners.

While prima facie there is no serious objection for outsourcing various posts, but indiscriminate outsourcing regardless of the perennial nature of work vis-a-vis work which is sporadic, causal and intermittent in nature is always objectionable. The issue of productivity, discipline and accountability has to be kept in mind. These issues can be ensured to some extent by punctuality of attendance of contractual employees; issuing Identity cards to them for entering the hospital premises; giving them a job card listing out their duties and responsibilities; deputing someone responsible to oversees their attendance, volume of work assigned to the agency and work completed within the stipulated period; quality of work - good or indifferent or sloppy; ensuring their disciplined and overall accountability and disbursement of their wages and devising some mechanism to enable them to ventilate their grievances.

The pay scales of the post of Professor, Associate Professor, Assistant Professor and Lecturer should be reviewed and revised to attract talent. The Psychiatric Social Work should be provided with a vehicle or TA/DA for making home visits to meet the discharged patients and assess the status of their reintegration and rehabilitation. The State Governments may review and revise, if necessary the uniform allowance, washing allowance, transport allowance. The risk and night duty allowance may also be provided suitably.

Nursing staff in IPHB Goa has been provided with the transport facilities for dropping from the hospital to the bus stand and vice versa. The other hospitals may also adopt this best practice of IPHB Goa.

To stop the problem of brain drain, the State Governments should frame a rule similar to the Government of Maharashtra that those passing out from different mental health centres with MD in Psychiatry will have to serve the respective States for at least one year.

The mental health education is of immense significance in the context of pervasive presence of quacks, faith healers and charlatans. To save simple, unsuspecting and guileless rural folk from being cheated and exploited by such unscrupulous people a package containing a few essential messages should be prepared and disseminated through print and electrical media.

There is an urgent need for institutionalizing the arrangements for orientation and induction and refresher training for both medical and para-medical staff. It may be suggested that the in-house facilities should specifically be created to impart training to medical and para medical staff in the larger public interest. Wherever necessary, resource persons/professionals from outside may be inducted to enhance the content and quality of orientation. A calendar of training should be drawn for providing basic induction training for a longer period followed by orientation/refresher training for a short period. Training should be a recurrent activity and not a onetime activity. The content, process and impact of training should be evaluated by Institutes of social science research of repute and standing and their suggestions should be incorporated for future programmes.

There is an urgent need for psychiatric training for all the staff nurses. A complete calendar of psychiatric training should be drawn up for all the staff nurses and the entire process of deputing staff nurses for such training should be completed in about 2 years time at the maximum by deputing 2 staff nurses every year for such training. In addition to using in-house infrastructure created for training, the mental health centres should contact professional training institutions in and outside the city to tie up training with those institutions. Primary thrust of training of Staff nurses, Nursing Assistant should be to make them more civil, courteous, considerate, kind and compassionate in their day to day dealings with the patients, their family members and relatives.

The State Govt. should also strengthen in-house training facilities and run orientation courses to provide behavioural training to all male and female nursing orderlies or attenders to sensitise them about problems of patients and to train them to be more civil, kind, compassionate and considerate towards all patients and their family members/relatives. A calendar of training for all categories of personnel should be drawn indicating the name of the institution where the training will be imparted, duration of training and arrangement for evaluation of content, process and impact of training.

In an age of knowledge where today's innovation becomes stale tomorrow and one is overtaken by the tide of sweeping changes and development it is necessary and desirable to provide an exposure to the faculty and staff members to seminars, symposia, workshops, national and international conferences, brain storming sessions etc. for keeping them abreast of the latest changes and improvements in the field of psychiatry, clinical psychology and psychiatric social work, for refining and sharpening the human resource and for enlarging their mental and social horizon.

The management of mental health centres hospitals should adopt a positive and proactive policy exposure to all faculty members to write, present and publish papers in various psychiatric and clinical Psychology journals, preside over technical sessions when invited, deliver talks in AIR and Doordarshan in simple and intelligible local language on various forms of mental illness, diagnosis and

treatment and remove doubts, misgivings and prejudices about mental health. The entire period should be treated as official duty.

A continuous institutional interaction and exchange of ideas between the faculty members of different mental health centres need to be established by computer connectivity between these institutions. A separate website of each hospital need to be created and all research papers published by the faculty members should be put on the said website.

The hospitals should take up a school mental health programme on priority basis. The programme should comprise of designing curriculum for school mental health programme, visiting homes and educational institutions and sensitizing parents, teachers and children about pernicious effects of drug addiction and how to overcome the same.

To facilitate teaching and research there should be a well furnished and well equipped modern library with a full time librarian. The modern library would mean two separate libraries for the members of the teaching and treating faculty and for the patients and their family members. The library for faculty members should have books in the field of philosophy, psychology, religion, social work, mental health, pure science, applied science, medicine, neurology, art, literature, history, geography, modern psychiatry, child psychiatry etc., the journals and periodicals may primarily be in the area of psychiatry and neuro sciences. The reading room of this library should be fully furnished and equipped where research scholars/students pursuing courses in M.D. Psychiatry, M.Phil, Clinical Psychology, M.Phil, Psychiatric Social Work can spend time in going through books, thesis, journals/periodicals, data stored in the computers etc. The library for the patients/family members should primarily cater to preferences and interests of patients and should have both light reading story books and magazines. There should be well established e-connectivity between the library and the various departments of the Institute to facilitate the faculty members of different departments to have easy access to books/journals of reference value. The library should remain open from 9 AM to 6 PM and the Superintendent should encourage the faculty members to spend more time in library. Views of faculty members should be constantly elicited on purchase of new books and journals as also for strengthening library services.

Administration and Financial Management

It is necessary and desirable to delegate administrative and financial powers in favour of Medical Superintendent to make him more effective in discharging his day to day duties and responsibilities. Administrative powers should be delegated to superintendent to enable him to fill up Group C and D posts.

In the pattern of IMHH Agra, GMA Gwalior and RINPAS Ranchi the State Governments should take a decision to make other Mental Health Care Hospitals autonomous, issue orders for constitution of a Managing Committee (MC) and a

number of Sub Committees (personnel, HRD/HRM, Civil works, drug procurement, food, therapeutic management of patients) and issue simultaneous orders for delegation of administrative and financial powers in favour of the MC and Sub Committees as also the Superintendent to facilitate the decision making process smooth and timely execution of decisions taken. This will reduce paper work; bring down helpless dependence of the Superintendent on the State Government on each and every issue and enhance power, authority and image of the Superintendent which is essential for promoting and sustaining discipline in the organization.

The financial powers of the Medical Superintendents for giving administrative sanction should be enhanced to at least Rs. 20,000 to enable Superintendent to purchase drugs, tools and equipment and food items on a day to day basis. It may further be suggested that the powers for direct procurement of drugs upto Rs. 50,000 at a time of emergency may be delegated to the Superintendent.

The Government needs to streamline the entire procedure for budget provision (both BE and RE), sanction and release of funds. The grant or grant-in-aid must correspond to rise in prices, increase in number of patients, cost of food, clothing, medicines, other recurring items of expenditure and the rising gap between expenditure incurred and grant-in-aid received needs to be bridged., if not, management of the hospital will become a serious casualty.

The budgetary allocations and expenditure should correlate to genuine and irreducible barest minimum needs of mental health centres. Hospitals should correctly identify such needs; convert them into monetary figures; get them approved by MC (when constituted) and sent to Government through the Head of the Department for incorporation in BE and RE as the case may be. Since the budgetary estimates (both recurring and non recurring) are based on the genuine requirements of the institution, no unilateral and arbitrary cuts should be made by Head of the Department/Government as such cuts are likely to cause avoidable dislocation in the management of the hospital. The expenditure should be planned and regulated from the beginning of the year to ensure full and proper utilization of the budgetary allocation without leaving any surplus.

Directors of mental health centres should exercise round the clock vigilance and surveillance over the pace and progress of utilization of funds to ensure that the funds sanctioned for a specific purpose are spent for that very purpose without any deviation or diversion.

There are certain serious limitations in the existing policy of raising a bill and release of funds. Bills cannot be raised till expenditure has been incurred; payment to various suppliers cannot be made unless the grant-in-aid is received. There will be a serious problem of credibility of mental health centres if payments are not made in time. The admitted patients who are fully dependent on these hospitals will be put to a lot of hardship if suppliers stop supplying essential commodities due to non payment of their dues. Lesser funds and

delayed availability of funds may cause serious dislocation in the smooth management of the hospital. To facilitate settling of accounts of numerous suppliers of commodities to mental health centres on a day to day basis, the funds should be released either in one single or at best two instalments.

The audit team should not raise flimsy objections. For the smooth management of the institution all financial matters should be discussed with the Director and Head of the Institution to resolve the differences and avoid delay in clearance of bills.

The Finance officer needs to play a significant role in smooth management of a public utility and welfare oriented institutions like mental health centres ensuring timely release of funds. He being an integral part of mental health centres should play the role of a coordinator between these hospitals and Department of Medical Health of State Governments. He may be advised to go and discuss the matter relating to the grant-in-aid with State authorities for getting proposals cleared quickly and sorting out the objections raised by audit team.

There is an urgent need for making allocation under a new head IEC in the budget as it is crucial to design and spread awareness about importance of mental health.

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