Report on the visit of Dr. Justice Shivaraj V. Patil, Member NHRC to Government Hospital for Mental Care Visakhapatnam on November 19, 2005

Dr. Justice Shivaraj V. Patil, Member NHRC visited the Government Hospital for Mental Care Visakhapatnam on November 19, 2005 to examine the living conditions of the inmates as part of the Commission's obligations u/s 12(3) of the Protection of Human Rights Act 1993. He was accompanied by Shri Chaman Lal, Special Rapporteur, NHRC who made a detailed study of the infrastructure and services of the Institution on 17-18 November and identified issues for the Member's consideration. Prof. Dr. G. Bhagya Rao, Supdt. of the Institution gave a detailed briefing on its functioning including its current problems and new challenges. The briefing was followed by a round of the campus which covered both the old and new buildings and included visit to OPD, Patients Ward (Male and Female), Family Ward, Kitchen, Occupational Therapy Ward and Forensic Ward. The visit concluded with an interaction of the Member with the hospital staff.

The Government Hospital for Mental Care Visakhapatnam was visited by Dr. Channabasavanna Committee constituted by the NHRC in 1998 to review the state of Mental Health Care facilities in the Government Mental Hospitals in the country. The report of the

facilities, admission and discharge procedure and the living conditions of inmates. The Committee had adversely commented on the jail like structure and functioning of the Centre with preponderance of closed wards and limited capacity for family wards. It also found the standard of water supply, electricity, sanitation and hygiene as poor. Internal roads were in bad condition and the whole area was found poorly lit. Food was of poor quality with per head expenditure of Rs. 14 per patient per day. The kitchen needed renovation. Shortage of cots, sheets and blankets was specifically mentioned. Facilities for psychological testing were not available and only direct ECT facilities were in use with no psycho social and behavioral interventions. Recreational facilities were lacking. The staffing pattern did not include the essential posts of Clinical Psychologist and Psychiatric Social Worker. A number of sanctioned posts were lying vacant. Pointing out some cases of admission under the Indian Lunacy Act, 1912 even after its repeal and replacement by the Mental Health Act, 1987 the Committee recommended sensitization programme for the members of legal profession.

Following its observations, the Committee had advised the authorities concerned to:

a) Abolish Cell admission;

b) Construct new Wards of shorter capacity (not more than 20) in ward;

e) Improve supply of water and electricity;

f) Ensure supply of nutritive food of 3000 calories per day to each patient; and

g) Develop occupational therapy facilities

The Member's visit preceded by a detailed study by the Special Rapporteur shows that while remedial action has been taken on some of the recommendations of the Committee, the Institution is still lacking in many respects. This will be clear from the observations/suggestions of the NHRC Team given below:

HOSPITAL INFRASTRUCTURE

The Government Hospital for Mental Care Visakhapatnam is one of the oldest Mental Hospitals in India. It was set up as a Lunatic Asylum in 1871 with a capacity of 94 patients. Its capacity was increased in a phased manner over the years to the current level of 300 – 225 male and 75 female. A De-addiction ward started in 1994 was closed down after functioning for about a year. A Family Ward with bed strength of 12 was started in 1992. In 1996, Emergency Psychiatric Services were set up. This has been a teaching hospital since 1970 attached to the Andhra Medical College, Visakhapatnam under the Academic Control of NTR University of Health Sciences Vijayawada. Post Graduate Diploma in Psychiatric Medicine (DPM) was started in 1978 with intake of two students per year and PG Degree in Psychiatric Medicine was started in 1984 with intake of one student per year.

As all the buildings had become dilapidated ruling out the possibility of economic repairs, the Government sanctioned construction of a new building at a cost of Rs. 12.00 crores. For this, the Institution had to part with a major chunk of its original land measuring 50 Acres. In the new distribution, 15 acres of land was allotted to the Institution and the rest was to be utilized for constructing at this site a TB Hospital, ENT Hospital, Infectious Diseases Hospital, Super Specialty Hospital and the Regional Public Health Lab. While TB Hospital, ENT Hospital, ID Hospital and Regional Lab. building have come up and these institutions have started functioning the proposal for setting up of the Super Specialty Hospital was later dropped. The Institution is now holding 15 Acre of area where the new building has come up and 13 Acres in the adjacent area. A Mental Health Institution needs a lot of open space to develop recreational facilities for exercises, games, gardening and horticulture. The new building is too cramped to meet this essential requirement. The Member felt that the least that could be done now is to make sure that the adjacent land measuring 13 acres as per the information given by the Supdt. is not taken away from the Institution for any other purpose. The Member also pointed out the need for protecting the new building from being inundated in rainy season as it is seen to be situated in a low lying area without a proper drainage system.

The new building has been constructed to accommodate 400 patients. The design gives it the same jail like appearance which Dr. Channabasavanna Committee had decried. The construction indicates

cent percent closed admissions except in the Family Ward which will accommodate 82 patients. The Member objected to the iron gates of the wards and suggested that these could be replaced by wooden doors having transparent windows of appropriate size.

The hospital is presently having 14 wards including one Criminal ward. In addition, 17 single patient cells are also being used for cell admissions. The new building designed for 400 beds will have a total of 21 wards – 7 Male wards, 7 Female wards, 5 Family Wards and two Criminal Wards. Three out of a total of 21 wards will be Paying wards. It is worth noting the capacity of Family ward will be increased from the existing 45 to 82.

On the day of the visit (19th Nov), the Hospital was holding 224 patients against the capacity of 300. The Supdt. informed that the normal occupancy fluctuates from 200 to 250. As such the existing capacity is being utilized up to 80% only. 185 out of a total of 224 patients were shown as voluntary patients. 168 out of a total of 224 patients were found lodged in Closed wards, 17 of them in single Cells. Even after excluding the criminal patients numbering 10, this gives a high percentage of 70.5% closed ward admissions.

The Supdt. informed that the original sanction of Rs. 12.00 crores for the construction of the New Hospital Building was revised to Rs. 10.10crores to provide additional funds for other hospitals which have come up at this site. This has affected the construction of Auditorium and staff quarters (numbering 52). It has also affected the

work on landscaping. Shri G. Kanthu, E.E. and Shri T. Taviti Naidu, DEE, APMHIDC informed that the new building would be ready in all aspects including landscaping by the end of December 2005.

Like all other Government Mental Hospitals, this hospital is also entitled to receive a special central assistance of Rs. 3 crore from the Government of India under the Tenth Five Year Plan. However, the Institution seems to have been very late in submitting its proposal. While most other Government Mental Hospitals had forwarded their proposals in 2003, the proposal in respect of this hospital has been forwarded by the State Government to the University of Health on 18.6.05.

The Member pointed out the need for the Institution to have a Master Plan for future additions and expansion.

STAFFING PATTERN

The staffing pattern includes six posts of Psychiatrists and 10 of non-Psychiatry Medical Officers. Presently, there are no vacancies. In addition, 10 Psychiatrists and 3 non-Psychiatrists have been provided on attachment from Andhra Medical College Visakhapatnam which includes two Professors, 4 Associated Professors and 4 Tutors in Psychiatry. While the availability of Psychiatrists (15) is well in excess of actual requirements, the staffing pattern includes only one post of Clinical Psychologist which has been filled by contract appointment.

The following vacancies need to be filled at the earliest:

1. Occupational Therapist – Vacancy continuing since beginning. It explains the deficiency of occupational therapy pointed out by Dr. Channabasavanna Committee.
2. Social Worker.
3. Bio-chemist
4. E.E.G. Technician
5. Deputy Overseer – he is to supervise the Class IV employees.
6. Carpenter Instructor
7. Plumber
8. Electrician (only one post sanctioned and lying vacant)
9. Bore-well Driver
10. Librarian.

The staffing pattern does not include any post of psychiatric social worker. It also requires at least two posts of Gardener to develop the new areas and also provide occupational therapy facilities. The Supdt. informed that the key posts, which are lying vacant, can be filled through direct recruitment only for which Government relaxation is required.

For the new Hospital with 400 bed capacity, at least 5 posts of Clinical Psychologist and 5 of Psychiatric Social Worker would be a minimum requirement. Another major deficiency of the staffing pattern is that none of the 54 authorised Nurses (12 Head Nurses and 42 Staff Nurses) is trained in Psychiatry. Although, they have been

given orientation course of one week duration, it can not be considered a substitute for their regular training in psychiatry.

ADMISSION AND DISCHARGE

Admission and Discharge procedure has been streamlined and brought in tune with the provisions of the Mental Health Act, 1987. Year-wise statistics since 2002 are given below:

Year	Admission	Discharge	Voluntary	Non-voluntary	
				Civil Certified	Criminal
2002	2467	2316	2409	26	32
2003	2655	2515	2528	62	65
2004	2705	2583	2612	37	56
2005(upto 30 Sept.)	1988	1890	1942	22	24

All the voluntary admissions are u/s 19 of the Mental Health Act which provides for admission under certain special circumstances on request by a relative or friend of the Mentally ill person. The Supdt. and his senior colleagues told that the patients are convincingly explained the benefit of admission and are, therefore, admitted as voluntary patients. The Special Rapporteur explained to the Supdt. and his colleagues that hospitalization u/s 19 can not exceed 90 days without obtaining reception orders from the competent court. While they stated that all such persons are actually released before completion of 90 days, the Special Rapporteur could detect 3 cases where this limit has exceeded. The legal necessity of obtaining the authority of the court concerned was explained to the Superintendent.

ADMISSION

Dr. S.M.Channabasavanna Committee report makes a specific mention of "need to orient the legal profession regarding the new development in Mental Health Jurisprudence". This need remains unaddressed. The team was shocked to notice a reception order dated 28 July, 2005 issued by Additional Judicial Magistrate, Ist Class Gudivada ordering admission of a patient Sarada Kumari d/o Madhav Ready Veeraswamy for closed ward treatment under the provisions of Sections 10 and 14 of Indian Lunancy Act, 1912 which is not on the statute book since the enactment of the Mental Health Act in 1987.

Although the sanctioned strength for admissions is 300, only 250 beds are effectively used as some buildings have become unusable. The daily average bed occupancy and average length of stay are shown below:-

Year	Daily average Bed occupancy	Average length of stay
2002	237	37
2003	259	37
2004	259	38
2005	260	35

Average length of stay in the Family Ward is found to be around 21 days which is fairly satisfactory.

LONG STAY PATIENTS

The number of LSPs has always been manageable in this hospital which is commendable. Only 17 Long Stay patients (2 years or above) were found in this hospital on the day of the visit. The Special Rapporteur examined all the cases. The Member also interacted with some of them. 8 patients out of a total of 17 are fit for discharge but their families are not traceable. The following observations were made:

K. Swara Singh – He was admitted on 10.4.01 as a CC case and treated for chronic schizophrenia. He was recommended for discharge on 17.7.01. As per the Psychiatrist, he is fully recovered and fit for reintegration in family/society. However, there has been no response to the letters sent to his family. He told the Special Rapporteur that after the death of his mother and father, there is no body in his family who would be willing to take him back. He categorically expressed his wish to stay in the hospital for good. The Supdt. was advised to find some job for him on nominal remuneration within the hospital. It is not only unnecessary but cruel to keep this man locked all the time when he can provide useful assistance in some branch. This would also mean rehabilitation of a cured patient. Such measures have been tried successfully in many mental hospitals.

Anusha – She was admitted on 5.3.02 under a court order which indicated her age as 30. She was treated for mental retardation with psychosis and recommended for discharge on 27.8.02. She is

still here because her family could not be traced. An effort was made to trace her family by taking her in an Ambulance to the area where she said she was living. She could not indicate her house. The Member interacted with her and she expressed her desire to stay in the hospital because of the shelter and safety it provides. Obviously, she would be willing to go out provided safety and security are arranged for her. She is regularly attending the occupational class in candle making as per the statement of the Supdt. She should be paid nominal incentive money which would enhance her self-esteem.

K. Eswamma –She was admitted as a CC case on 6.9.03 at the age of 40. She was treated for Psychosis NOS and recommended for discharge on 28.1.04. There has been no response to the letters sent at the address given by the patient. She told the Special Rapporteur that she can locate her house in Vijayanagar if she is taken there. The team felt that this effort is worth making.

P. Nagmani – She was admitted on request of her mother on 3.4.03 at the age of 22. She is fit to be discharged but her mother has since become untraceable. Efforts made by the Police to trace her mother at the given address also proved futile.

Suvvi – She was admitted on 13.9.03 at the age of 45 as a CC case. She was recommended for discharge on 28.1.04. No one has come from her family to take her back. She is languishing since no escort could be arranged to take her to her family.

Seetharama –She was admitted on 18.9.03 at the age of 37. She was treated for Psychosis and recommended for discharge on 26.12.03. There has been no response from her family and she could not be sent because of escort could not be arranged.

Mithila –She belongs to Orissa and was admitted on 14.2.96 and treated for chronic schizophrenia. She was recommended for discharge as long back as 22.6.96. Letters sent on her address in Sambalpur have brought no response.

DISCHARGE PROCEDURE

Although discharge procedure has been streamlined and brought in conformity with the provisions of Mental Health Act, 1987, a number of patients continue to languish even after being declared fit for discharge. This happens very rarely in case of voluntary patients although such situations do arise occasionally. One of the voluntary patients (P. Nagamani) was abandoned by her mother after getting her admitted. The discharge of patients admitted under court orders are ordered u/s 40 of the Mental Health Act, 1987 on the recommendations of the Discharge Committee which reviews these cases every month. Intimation is sent to the family and simultaneously to the court with the request for arranging escort. In cases where families do not turn up, the court is being approached for arranging escort. The statement of long stay patients submitted by the Superintendent mentions 11 cases where response from the court is awaited. The NHRC team felt that this is not the correct procedure. The request for providing escort to take a prisoner to his family should

be addressed to and met by the District Magistrate and Supdt. of Police. The Act lays down that the court concerned is to be informed of the discharge of the patient received under a reception order. It is not required to approach the court for arranging the police escort in every case. The State Govt. (Home Department) should instruct all the District Magistrates by a circular order to entertain request for escort to take the cured patients to their families in cases where the patient's family does not come forward to take his/her custody. The matter was discussed with the acting D.M., Sanjeev Sultania and IGP,Visakhapatnam by the team at the official dinner hosted by the District Administration and both responded positively. It is in the interest of the hospital and the State Govt. that all such patients, who are cured and have functional families to return to, are discharged and the vacated beds utilised efficiently.

The Superintendent cited a number of cases where difficulties are encountered in getting favourable response from the family at the time of discharge. Either the addresses are found to be false or the communications received by the families are ignored. The Member suggested that while admitting patients, full particulars should be recorded of not only the immediate family members as is being done at present but also the near relatives and one or two prominent members of the community. They can be approached in case the family does not response. This will help in putting some justified moral pressure on the family of the patient to accept their obligation of taking the patient back after he is cured of mental illness.

SERVICES

Casualty and Emergency Services – Round the clock, casualty and emergency services are available. The number of beds in the Emergency Ward can be increased from 8 to 12 in the new building. In the new building a Short Stay Ward can also be established.

Out-patient Services –The OPD functioning in the old building has retained all the deficiencies pointed out by Dr. Channabasavanna Committee. Seating capacity for the waiting patients is inadequate as before. Basic amenity of drinking water has not been provided. The number of Consultation rooms (3) does little justice to the increasing number of OPD cases. The available figures of daily average of OPD cases since 1.1.2001 show the increasing accessibility of the Hospital and utilization of its services:

Year	New Cases	Daily average of new cases	Old cases	Daily average of old cases	Total OPD	Total average
2001	3013	10	31420	100	34433	110
2002	3278	10	32374	103	35652	113
2003	3615	12	38182	122	41797	134
2004	3934	13	42939	137	46873	150
2005(up to Sept.05)	3298	14	37033	162	40331	176

The statement received from the Supdt. gives the waiting time at the OPD for each patient as one hour for the old and two hours for the new case and three hours for admission. However, on interaction with the waiting patients and family members, the Special Rapporteur found that the average waiting time is two hours for old and 4-5 hours for new cases. With the availability of as many as 15 Psychiatrists, the situation can be certainly improved.

In-patient Services – The overall condition of the Wards in the old building remains unsatisfactory as before. Sanitary conditions are still poor. Although a statement received from the Supdt. shows availability of 228 cots for 224 patients, the Special Rapporteur saw quite a few patients without beds in the Wards that he visited. Most of the patients were found using their own bed-sheets and blankets raising doubts about the claim that these items are being supplied by the Institution to all patients. Pillow is not an item of issue. There are no arrangements for keeping the patients' belonging. These are proposed to be made once the Hospital starts functioning from the new building. However, the Female wards functioning from the new building are also without these facilities.

Each ward meant for 16 patients is having four toilets and three bathrooms attached to the wards. After all the patients are shifted to the new building, there will be no shortage of toilets and Bathrooms.

The state of water supply has certainly been improved since the visit of Dr. Channabasavanna Committee. Round the clock, water supply is being ensured by two Bore-wellswith an overhead tank of 20000 Ltr. capacity and 40,000 Ltr. sump. The sump in the new building has a capacity of 2.5 lakh Ltr. and there are 21 tanks of 2000 Ltr capacity each. 125 K.V. Generator has also been installed in the new building to ensure uninterrupted supply of electricity.

PROCUREMENT OF MEDICINES

The Supdt. confirmed adequate budget allotment for purchase of medicines which accounts for10 to 14% of the total annual expenditure. However, 80% of the allotted funds are utilised for centralised procurement arranged by the Andhra Pradesh Medical Health Infrastructure Development Corporation (APMHIDC). Only 20% budget is available to the Supdt for meeting day-to-day emergent needs and procuring those medicines, which are not supplied by the APMHIDC. The NHRC team was informed that out of a total of 20 common drugs, 15 are approved for centralised procurement but supplies are to the extent of not more than 50%. The following drugs are approved but not being supplied by the Central Drug Stores of A.P.MHIDC:

Sl. No.	Name of the Drug
1.	Tab. Carbamazepine 200mg
2.	Tab. Chlorpromazine 100mg
3.	Tab. Fluoxetine 20mg
4.	Inj. Fluphenazine Decancate 25mg

5. Tab. Haloperidol 5 mg
6. Inj. Haloperidol 5mg
7. Tab. Lithium Carbonate 300mg
8. Tab. Nitrazepam 10mg
9. Tab. Olanzepine 5mg/10mg
10. Inj. Promethazine Hcl. 50 mg
11. Tab. Resperidone 2mg/4mg
12. Tab. Sodium Valproate 200mg/500mg
13. Tab. Trihexyphenidyl Hcl. 2mg

The following drugs are considered essential but are not approved for supply by the APMHIDC. The patients are required to purchase these on their own:

1. Tab. Amitriptyline 25/75mg
2. Tab. Chlordiazepoxide 25mg
3. Tab. Clozapine 25/100mg
4. Tab . Disuifiran 250mg

The following ECT drugs are also approved but not being supplied:

1. Inj. Thiopental Sodium 500mg/1g
2. Inj. Succinyl choline chloride 500 mg

The matter needs immediate attention from the Department of Health and Family Welfare.

RECREATION

Recreation facilities are utterly inadequate, if not non-existent. Patients do not have access to any reading material Newspapers or Magazines. The elementary facility of TV is available in 4 out of a total of 13 wards now in use. There are no facilities of indoor games. Patients are not taken out regularly for exercise/walk. There is very

little concern and appreciation of these basic needs of inmates. The Supdt. stated that these deficiencies will be removed once the hospital starts functioning from the new building in two months time.

FOOD

Dr. Channabasavanna Committee had commented on the poor quality of food by a private contractor. The same arrangement continues although under the supervision of a qualified Dietician of the hospital. The Committee had recommended a diet scale ensuring daily supply of 3000 calories to each patient. The current food scale introduced on 13.10.99 for patients in TB and Mental Hospital is based on the following average nutritive value:

K. Calories	- 2400
Protein	- 80 gm
Fats	- 30 gm

The patients are provided breakfast, lunch and dinner with no provision of tea in the morning or in the evening. Diet is vegetarian except for boiled egg supplied at lunch and dinner. The monetary value of the diet scale calculated in 1999 as Rs. 20 per patient has continued as a ceiling on expenditure on food per patient per day. The Dietician was asked to calculate the current cost of the scale which was shown to the Member. It comes to Rs. 26.40. It is worth considering how a private contractor getting Rs. 20 per patient per day can supply food worth Rs. 26.40 per patient per day and remain in business by earning some profit. Obviously the scale is diluted and actual calorie intake cannot be more than 1800. The team felt that the diet scale worked out on the calorie requirement has to be prescribed

in kind and not in monetary terms as is being done at most other places. If it is not possible to increase the calorie to 3000 as suggested by Dr. Channabasavanna Committee, the existing scale of 2400 calorie may continue but the scale worked out in terms of various items of diet must be enforced regardless of the total cost without imposing any ceiling on the cost. The team felt thoroughly unsatisfied with the arrangements for the supply of food which is the most basic human right of the patients.

The family members staying with the patients in the Family Ward have to make their own arrangements for food. Some of them must be managing with food supplied to the patients with further reduction of patients' intake. The Supdt. informed that a canteen will be started in the new building to meet this requirement. The Government of Kerala has recently sanctioned free supply of food to the patient's attendant as an incentive to have more patients in Family wards. This is a commendable welfare measure which the Government of Andhra Pradesh may also adopt.

DIAGNOSTIC AND THERAPEUTIC FACILITIES

With the installation of a Semi-auto Analyser in May 2001, the hospital has become self-reliant to conduct most of the routine tests instead of referring them to King George Hospital Visakhapatnam as was the case when Dr. Channabasavanna Committee had visited. The following tests are now being conducted at the Hospital:

Clinical Pathology:

TC	*DC*	*ESR*	*Platelet count*
HB	PCV	RBC	AEC
BT(Bleeding time)	CT (clotting Time)	M.C.U.	M.C.H
MCHC	Smear for MP	Smear for MF	

Bio-Chemistry:

Blood Urea	Creatinine	Blood Sugar	Billirubin
SGPT	SGOT	Serum Cholesterol	
Ag.ratio	1)Proteins	2)Albumin	

Urine

Albumin	Sugar	Bile salts	Bile *pigments*
Microscopic			

Motion

Ova	Cysts.

The vital facility of Serum Lithium Estimation which was there at the time of the Committee's visit is no longer available. The following table shows progressive utilization of Pathology and Bio-Chemistry and other diagnostic facilities:

YEAR	CLINICAL PATHOLOGY	BIO-CHEMISTRY	TOTAL
2001	10871	717	11588
2002	14605	807	15412
2003	14695	345	15040
2004	15291	6082	21373
2005 Up to10/05	11922	5393	17315

YEAR	X-RAY	E.C.G.
2002	87	79
2003	108	149
2004	187	86
2005 (Till Nov.)	167	130

Year	E.C.T.(Direct)	Modified	Total
2003	259	2952	3211
2004	526	3145	3671
2005 **(Up to Oct.)**	346	3331	3677

Clinical Psychologist Dr. Mitra informed that 5.6% of the OPD and 17.8% of the indoor patients are being referred to her. Considering that she is the only Clinical Psychologist the Institution has, the work load is appreciable.

The following table will be found useful in assessing the workload of the clinical psychologist:

Period	Assessment	Counselling	Total
8 Aug.01 to December 01	60	8	68
Jan. to Dec.02	236	109	345
Jan.03 to Dec.03	304	296	600
Jan.04 to Dec.04	367	410	777
Jan.05 to Nov.05	301	454	755

Bio-Chemist of the Hospital retired from the service on 31.7.05. The post is yet to be filled up.

The following facilities are being provided in the Clinical Psychology Department at Government Hospital for mental care:

1. IQ Assessment
2. Personality Assessment
3. Diagnostic Psychometry
4. Tests to rule out Organicity
5. Cognitive Behaviour Therapy to
   a) Alcoholic Patients
   b) OCD patients
   c) Depressive patients
   d) Patients with Adjustment and Conduct Disorders
   e) Patients with Marital problems
   f) Patients with Anxiety Disorders.

The following additional Test material is required:

1. Child Apperception Test
2. Memory for design Test Av
3. Benton's Visual Motor retention Test Av
4. Trail making Test
5. Weschler's Memory Scale Av.
6. NIMHANS Neuro Psychological Test Battery Av
7. Luria Nebraska Neuropsychological Test Battery Av
8. Millon Clinical Multiaxial Inventory
9. Wisconsin's Card Sorting Test Av.
10. Halstead Reitan Battery
11. Rating Scales for measurement of personality disorders, pain, psychosis, suicidal intention, quality of life and child-behaviour check list.

OCCUPATIONAL THERAPY

It is claimed that the following units have been set up and are functioning in the Occupational Therapy Unit of the Hospital in the new building:

1. Dress making
2. Tailoring
3. Candle making
4. Paper Cover making
5. Gardening.

The Special Rapporteur examined the matter in detail. Dress making unit is being operated by the Hospital's Tailor with no patients attached at present. He informed the Special Rapporteur that two patients used to come about a month back and were discharged after working for about a month. The Unit is having three sewing machines in serviceable condition. The Weaving Master is looking after the Paper cover making unit where three patients are currently working. The candle making unit is engaging four female patients. This was sponsored by the Rotary Club Vizag Midtown. Two personnel of the Hospital were given basic training in Candle making by Jan Shikshan Sansthan Visakhapatnam. Gardening work is presently stopped and will be resumed after the completion of construction.

The occupational therapy a vital component of Mental Health Care is not receiving any serious attention despite availability of some staff and interest shown by private parties like Rotary Club. The post of Occupational Therapist is lying vacant ever since it was sanctioned in August 1995. The Member explained to the Supdt. the importance

of Occupational Therapy and wanted him to emulate the example of Thiruvananthapuram where a Bakery Unit has been started which is also providing employment to the cured patients of the Mental Hospital.

DEATH OF PATIENTS

The following table gives information about the number of deaths and suicides since 1999:

Year	Deaths	Suicides	Whether post-mortem done or not
1999	2	-	Not done
2000	4	-	Not done
2001	4	1	Done
2002	7	1	Done
2003	3	2	Done
2004	8	2	Done
2005	5	-	Not done

7 deaths in 2002, 8 in 2004 and 5 in the current year certainly show a high mortality rate. The incidence of suicide which was a regular feature in the years 2001 to 2004 is also a cause for concern. The Special Rapporteur examined in detail the latest case of suicide that occurred on 24.12.04. Deceased J. Kakeswar Rao, 26 years was admitted on 18.12.04 as a case of Paranoid Schizophrenia. He was lodged in a single cell. He committed suicide on 24.12.04. The inquest was held and body was sent for post-mortem examination but the report was not available in file. His file gives no details of the incident and circumstances leading to it. There is a brief unsigned

note saying that he committed suicide by hanging at 4.05 hrs on 24.12.04. An attitude of casualness and insensitivity towards human life is clearly evident.

ESCAPE OF PATIENTS

The incidence of escape had recorded a spurt in 1999 when 130 patients – 127 male and 3 female, escaped from the hospital. Although the following figures show a marked decline, the problem is still serious enough to engage attention of the authorities.

Calendar Year	Escape		Total
	Male	Female	
2000	36	2	38
2001	27	2	29
2002	34	1	35
2003	24	4	28
2004	15	3	18
2005	26	nil	26

It may, however, be clarified that there has been only one escape of criminal patient (in the current year). This seems to have made the Police guard posted for guarding the criminal patients unduly over cautious. The forensic ward was found having double locks during day time while a sentry was standing on duty outside the ward. The hospital staff should develop confidence to take care of the forensic patients without imposing unnecessary restraints on their freedom within the hospital complex.

FORENSIC WARD

3 convicts and 7 under trials, all male patients, were found held in the forensic ward established in the new building. The Special Rapporteur spoke to all of them individually. The particulars of P. Venkataraman admitted as an undertrial patient on 30.8.05 need correction. He is shown as an undertrial prisoner u/s 304 IPC whereas his file mentions the offence as 304A IPC. He was in the hospital twice before – in October, 2004 and January, 2005 and was released on 14.2.05. He caused death by rash and negligent driving and got involved in a case whose full particulars are not available in the file. He has been recommended for discharge on 23.9.05 but escort could not be arranged. The status of his driving licence, if any, needs to be checked. His trial remains suspended even after he is medically certified fit to defend himself. Monthly reports on the condition of patients are being sent to the court concerned regularly.

TRAINING FACILITIES

Government Hospital For Mental Care, Visakhapatnam is a teaching hospital attached to Andhra Pradesh Medical College, Visakhapatnam under the academic control of NTR University of Health Sciences, Vijayawada, Andhra Pradesh. Post Graduate Diploma in Psychiatric Medicines was started in 1978 with intake of 2 students per year. Post Graduate Degree in Psychiatric Medicines was started in 1984 with an intake of one student per year. A total of 40 Diploma and 15 Post-graduate Degree students have successfully

passed out since these facilities were developed. The NHRC team met 4 MD and 5 DPM students currently undergoing these courses. It is interesting to note that there has been no increase in the number of seats fixed initially although a teaching staff numbering 13, including 10 Psychiatrists – 2 Professors, 3 Associate Professors, one Assistant Professor, 4 Tutors and 3 non-Psychiatrists has been provided over the years. From a detailed discussion with the Supdt. and his senior colleagues, the Team learnt that as per the MCI norms, the number of seats in Diploma and Post-graduate Degree course can be increased to 12 and 6, respectively. It was interesting to find that the Andhra Pradesh Govt. had vide its G.O.Ms. No.14 dated 21.1.02 increased the seats in PG Psychiatry from one to six in this hospital as part of a total increase of PG seats of Psychiatry in the State by 14. This was in response to a strike called by junior doctors in January, 2000 demanding increase in PG seats in various Govt. Medical Colleges in the State. The junior doctors' association had also launched a strike in November, 2001 with the same demand. It is interesting to note that the decision of the Govt. announced in January, 2002 has not yet been given effect and the Govt. Medical Colleges in the State numbering 9 are still continuing with the earlier capacity although PG seats were required to be increased by 474 – 311 clinical and 163 non-clinical. The Team pointed out the absurdity of the situation in the light of the increasing demand for Psychiatrists and availability of infrastructure and teaching faculty at this place. The State Govt. should take immediate action to implement the decision of January, 2002 and make full use of the existing potential in the medical colleges.

This Hospital is also imparting Training in basic Psychiatry to MBBS students. Students of 6 & 7 semester are posted to this hospital regularly by the AMC, Visakhapatnam in batches of 20. Besides 12, theory classes are arranged for the 9th semester students in batches of 15. Till date a total of 376 MBBS students have received this training.

572 nursing students and 80 students in social work have also been provided training from 2001 onwards. In the year 2005-06, 119 under-graduate, 136 nursing, 8 social work and 15 psychology students have undergone training in this hospital.

IN-SERVICE TRAINING

In-Service Training is not receiving much attention. As observed by the team, none of the nurses of this Hospital is trained in psychiatry. They were imparted only a one-week orientation training about one and a half year back. Although this cannot be obviate the need for their regular training in psychiatry, orientation course should be run more regularly in order to sensitise the nursing staff and also attendants about treatment and care of mental patients. The non-Psychiatry Medical Officers are also required to be put through such orientation programmes.

NGOs INVOLVEMENT

4 organisations, namely Shri Satya Sewa Samithi, Rotary Innerwheel, Rotary Vizag Mid Town, Free Masos and a number of churches are involved in the activities of this Hospital such as conducting celebrations on Republic Day, Independence Day, Mental Health Week and other religious festivals. Occasionally, they distribute clothes, fruits, bread etc. to the inmates besides arranging sports and extra cultural activities. Rotary Club Vizag Mid Town has come forward to adopt the Central yard of the newly constructed hospital to develop landscaping and greenery. They have also offered to donate a paper plate making machine to the occupational therapy unit of the Hospital. The team felt that there is a good scope for increasing the involvement of NGOs in education and entertainment of the inmates. NGOs can also help in establishing a Half-Way-Home for the patients an essential need of the Institution that has not received any attention till now.

BOARD OF VISITORS

The mandatory Visitors Board provided u/s 37 of the Mental Health Act, 1987 has not been constituted by the State Govt. However, the Hospital Development Society of Govt. Hospital for Mental Care, Visakhapatnam was constituted by the Govt. vide GOMs No. 403/HM&FW(MI)Department dated 7.9.98. The Superintendent informed that the same Society is also performing the functions of the Visitors Board and visiting the Hospital and

participating in the decision making for developmental activities. The Committee is headed by the District Collector and has both official and non-official Members. The Supdt. is the Convener of the Committee. The Team felt that the Hospital Development Society comprising one Chairman, 11 Members and 2 special invitees including the local MP, 3 MLAs and Zila Parishad Chairman cannot really ensure compliance with the provisions of the Act relating to a monthly joint inspection by not less than 3 visitors to examine the state of administration, admission and discharge matters and living conditions. The matter needs immediate attention from the Department of Health and Family Welfare, Govt. of A.P.

COMMUNITY SERVICE

The Hospital is running Community Psychiatrist Services at Mother Theresa Home and Prema Samajam and the Central Prison, Visakhapatnam besides holding identification camps of Disable Welfare Department. Mother Theresa Home and Prema Samajam are the Homes for destitutes. One Psychiatrist of this hospital visits these Homes every month to render medical services and distribute medicines free of cost. Monthly visits are also made to Central Prison, Visakhapatnam to provide necessary follow up treatment to the inmates and distribute free drugs. However, no records of this work are being kept and no data could be shown to the Special Rapporteur for his satisfaction.

This hospital has been made the Nodal Institution for the District Mental Health Programme extended to District Vizianagaram. Although, Govt. of India had sanctioned the Project in 1999 as a centrally funded scheme for five years, it was actually commissioned in April, 2005 on receipt of Govt. permission issued by GOMs No. 42, HM/FW(M2) Department dated 22.2.2005. Staff numbering 11 including one Psychiatrist, one Clinical Psychiatrist and one Social Worker has been appointed on contract basis. Six Centres have been selected and Weekly visits started just a week before the visit of the NHRC. No data could be furnished to the Special Rapporteur on the work done so far. It can be safely stated that the State Govt. has been extremely late in launching this programme which was started in most other States much earlier. The programme is to be taken over by the State Govt. after 5 years. Key activities like orientation training of Doctors/Medical Officers, para-medical personnel and non-medical personnel are yet to be started.

CONCLUDING REMARKS

Most of the observations of Dr. Channabasavanna Committee are still valid as a number of its recommendations are yet to be implemented. The only positive development since the visit of the Committee has been the construction of a new hospital building, which will accommodate 400 patients and have almost all the facilities of a teaching hospital. The much needed enhancement of staff by creating posts of clinical psychologists and Psychiatric Social Workers is nowhere in sight. Cell admissions still continue. There has

been hardly any progress in conversion of closed wards into open wards. Average Length of Stay (ALS) has, however, come down. While Diagnostic and Therapeutic facilities have been upgraded, very little has been done to develop occupational therapy facilities. The food scale prescribed in 1999 is actually not being implemented and in fact cannot be implemented because of the monetary ceiling (Rs.20 per patient per day) imposed on expenditure under this head. Recreation facilities remain poor as before. Rehabilitation services are totally missing. The death rate and incidence of suicide are a serious cause for concern. While admission procedure has been streamlined and brought in conformity with the Mental Health Act 1987, a number of patients continue to languish even after acquiring fitness for discharge because of difficulties in arranging police escort to take them to their homes. The reach and range of Community Services need to be expanded. Government Hospital For Mental Care, Visakhapatnam has a lot of untapped potential to become a major Centre of Education in Mental Health. Dr. Bhaya Rao, Supdt. is ably leading a team of competent and dedicated professionals. The Govt. of A.P. should remove the organisational inadequacies and help the Institution realise its full potential.

(Chaman Lal)
Special Rapporteur
8.12.05