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Report on visit to NIMHANS, Bangalore and Karnataka Institute of Mental Health, Dharwad from 18.4.2007 to 20.4.2007 by Dr. Lakshmidhar Mishra, IAS (Retd.), Special Rapporteur, NHRC.

Immediately after my arrival at Bangalore on 18th around 1300 hrs. I proceeded to the National Institute of Mental Health and Neuro Sciences or NIMHANS, which is a deemed University and country's premier mental and neuro sciences health institution. Prior to my visit I had written to the Director and Vice Chancellor – Dr. D. Nagaraja. The purpose of visit was threefold namely (a) familiarize myself with the facilities available in NIMHANS as a premier mental health centre in the area of teaching, training, treatment, care and attention and research in mental health (b) familiarize myself with the latest status of Project 'Quality Assurance in Mental Health' launched by NHRC in June, 99 with Dr. S.M. Channavasavanna of NIMHANS playing a key role and (c) having the collective advice and wisdom of Director and other Senior Faculty members of NIMHANS on what should be the best strategy to monitor the functioning of different Institutes of Mental Health in different parts of the country in the light of the directions of the Supreme Court on 11.11.97 entrusting this responsibility to NHRC.

With a modest beginning as a mental hospital with 3 departments, 7 faculty members and 300 beds in 1925 by the erstwhile Government of Mysore the Institution has grown rapidly in stature and strength, first to an All India Institute of Mental Health in 1954 and later to the present autonomous National Institute of Mental Health and Neuro Sciences

(NIMHANS). Today its status can be described by the following:-

- a deemed University;
- a premier hospital with a total inpatient bed strength of 925 and 1626 support staff;
- a post graduate training Centre with 21 departments, 146 sanctioned faculty members and 280 post graduate trainees;
- a leading centre of research in mental health, neuro sciences, biophysics, bio-statistics, epidemiology, health education, human genetics, social psychology, neuroanaesthesia, neurochemistry, neuroimaging and interventional radiology, neurology, neuromicro-biology, neuropathology, neurophysiology, neuro-surgery, nerurovirology, psychiatry and neurological rehabilitation, psychiatric social work etc.

The Institute is linked to the memory of Stalwarts in the field of mental health like Prof. M.V. Govindaswamy, Dr. N.C. Surya, Dr. K. Bhaskaran, Prof. R.M. Varma, Dr. R.N. Moorthy, Dr. D.L.N. Murthy Rao, Dr. G.N. Narayan Reddy, Dr. Channabasavanna, Dr. (Mrs.)M. Gourie Devi and so on. They assiduously built up stage by stage this great centre of learning, treatment, research and excellence in both mental health and neuro sciences and succeeded in elevating it to the lofty position where it rests today. As a matter of fact, Dr. M.V. Govindaswamy, the founder-Director, NIMHANS (1954-

59) had spelt out the vision for the Institute in 1955 to include services for psychiatry, neurology and neurosurgery with a multi-disciplinary approach encompassing pathology, biochemistry, drama, literature, social psychiatry and appropriate portions of Indian Philosophy and Ayurveda. As the found director of All India Institute of Mental Health he had clearly envisioned the objectives of the Institute as under:-

I to train integrated teams of psychiatrists, neuroglogists, neurosurgeons, clinical psychologists, psychiatric social workers, nurses and other personnel required to staff mental hospitals, medical college hospitals and district hospitals in India.

II to impart knowledge regarding integrated mental health and neuro sciences to specialists and general practitioners.

III to train clinical psychologists and psychiatric social workers through this integrated approach.

IV to plan and conduct research in problems related to mental health and neuro sciences.

Forty years from the date the Institute came into being i.e. on 14.11.94 and in recognition of its preeminent academic position NIMHANS has been declared a deemed University with complete academic autonomy. I spent about 3 hours (1330 hrs to 1630 hrs) with the Director, faculty, supporting para medical staff as also the inpatients (both

children and adults). It is difficult to count and recount the achievements of an institution which has successfully completed 50 years of its existence [NIMHANS has celebrated its golden jubilee {1954-2004)]. The growth and expansion have been phenomenal and track record of performance – registration, screening, casualty, admission, follow up and extension services all impressive. However, in course of my very brief sojourn on the corridors of this great institution the following struck me deeply:-

- Sylvan surrounding and greenery which always have a conducive impact on human mind, making it serene and tranquil;

- Elegant architecture of structures within the campus;

- Safety and stability of structures (not a single crack anywhere);

- The blocks have been planned according to functional convenience characterized by adequacy of space, no evidence of congestion or overcrowding, adequacy of lighting and ventilation etc.;

- The physical environment is immaculately neat and tidy maintained and reinforced by clean and hygienic habits of people – patients, relatives, visitors etc.;

- Civil, courteous and kind treatment (in the words of HE – the President of India – Shri A.P.J. Abdul

Kalam 'ignited minds tinged with compassionate hearts');

- Fair and reasonable rates both in the paying wards, in the canteen, for various items of pathological tests and making it possible for large number of low income patients from different parts of the country to avail of the facilities in NIMHANS;

- Physically, orthopaedically and visually challenged and mentally retarded children (victims of autism and cerebral palsy) receiving special attention in the Child Psychiatry Centre;

- A very high standard of care and attention to deal with disorders of both mind and the brain with a special focus on service, training and research, state-of-the-art diagnostic and therapeutic techniques, emphasis on both prevention and correction through community service and public education programmes, training and continuing professional education and applied research going together, a very large number of papers of excellent quality which are outcomes of scintillating action research being published year after year in national and international journals adding to intellectual animation and pursuit of excellence.

- The autonomous character of the Institute being evident from the smooth decision making process

and the latter being possible through (a) an Institute society (b) Board of Management (c) Academic Council (d) Board of Studies and Series of Committees such as Finance Committee, Building and Works Committee, Hospital Management Committee, Rehabilitation Committee, Human/ Animal Ethics Committee, PHO Committee etc.

In course of my meeting with the Director and faculty I shared a gist of my observations and impressions emanating from visit to mental health hospitals/institutes at Gwalior, Jaipur, Agra, Ranchi and Cuttack and sought the benefit of the collective advice and wisdom in the following areas of concern:-

- relapse – why and when;

- domiciliary vs. hospital treatment;

- how to ensure timely compliance in a scenario of endemic poverty, ignorance, illiteracy and social backwardness;

- creation and management of halfway homes – why, when and by whom;

- geriatrics related problems which prolong stay of patients;

- referral service and heavy dependence of mental health hospitals on general hospitals for pathological tests, diagnosis and treatment of associated ailments;

- absence of a well equipped drug deaddiction ward;

- absence of a well equipped child psychiatry ward;

- absence of a well equipped geriatric ward;

- absence of a proper personnel and human resource development policy causing shortage of personnel in various grades;

- absence of adequate delegation of administrative and financial powers in favour of Director, Mental Health Hospitals resulting in excessive dependence of the latter on the State Governments (wherever the same are under the administrative control of State Governments) and causing in the process dilution of the autonomy in management of hospitals.

- Special problems related to repair and maintenance arising out of antiquated character of buildings (100 to 150 years) vis-à-vis remote possibility of total replacement due to heavy costs.

At the end of the one and half hour discussion there was consensus on the following issues:-

- Long stay of patients should be minimized;

- Stay of inpatients should not exceed 4 weeks;

- Domicilliary treatment should be encouraged backed by post admission and pre discharge councelling, home visits, contacts, continuous vigilance and surveillance on the part of relatives and monitoring by psychiatric social workers;

- Closed wards should be reduced in number and more and more open wards (where relatives can stay with patients) should be encouraged.

- Special care should be taken to ensure easier availability of psychotic drugs in the periphery i.e. in government hospitals which usually do not store psychotic drugs.

- There should be a progressive policy of making psychotic drugs available free in view of endemic poverty and deprivation in the countryside.

- The border line between mental disorder and mental retardation is thin. Both should go together.

- There should be a clear state policy to promote, design and disseminate the central message associated with various forms of mental disorders. This is known as IEC (Information, Education and Communication).

- Prognosis (recovery) is different in diverse situations. With children and elderly it is most

difficult while in cases of middle aged adults (18-35) it is somewhat manageable and better.

- Chronic cases which require prolonged treatment should be handled with a lot of kindness, compassion and special care.

- Correct diagnosis at the hospital followed by timely decision to admit and provide proper treatment should be the starting point in dealing with mentally ill persons followed by timely discharge, pre discharge counseling, domiciliary treatment and a strong culture of compliance.

- Drug Deaddiction Centre, occupational therapy and halfway homes should be an integral part of the entire process of treatment, care and attention in a mental health hospital.

- Halfway homes and their management should be entrusted to good, reliable, willing, committed and experienced NGOs.

- The suggestion about having more and more day care centers – a suggestion which was made in course of my visit and interaction with medical officers, psychiatrists and clinical psychologists at GMA, Gwalior in January, 2007 was reiterated by the faculty of NIMHANS.

A brief presentation was made by one of the senior faculty members on the monitoring of impact of 'Quality Assurance in Mental Health Care' which was conducted as a Project by NHRC in 1997-99 and executed by a 10 member multi disciplinary team of NIMHANS. The following progress of the project was surveyed in 2005. Regretfully, only 13 of 37 hospitals have sent follow up report so far. The follow up report covers infrastructure, staffing pattern, maintenance of records, rehabilitation, level of various support services, facilities and amenities, suggestions and recommendations made by the hospitals etc. A gist of the status of compliance by various hospitals with the recommendations/expectations of the Project is indicates as under:-

I **Infrastructure:**

- Goa has shifted to new premises;

- Jammu, Kozhikode, Vizag, Trissur and Jamnagar have reported that new construction work being in progress;

- Thane, Cuttack and Ratnagiri have reported renovation work has been taken up;

- Bareilly, Nagpur and Kolkata have not reported any new construction work.

II **Staffing Pattern:**

- Thane, Kozhikode, Bareilly, Nagpur and Kolkata have reported serious problems being faced by their hospitals due to paucity of personnel.

- The vacancy of posts in all categories (Psychiatrists, Clinical Psychologists, social workers, trained psychiatric nurses and Group D) persists.

III **Maintenance of medical records:**

- Kozhikode, Bareilly, Vizag and Tezpur have reported computerization of medical records in their hospitals.

- Jammu, Goa, Cuttack, Trissur and Kolkata have reported some improvement in medical records without specifying the nature of improvement.

IV **Support Services:**

- Jammu, Kozhikode, Goa and Tezpur have reported improvement in power supply.

- Vizag and Bareilly have reported erratic power supply.

- Kozhikode, Goa, Cuttack, Trissur and Tezpur have reported that canteen facility is available without specifying whether relatives of patients can avail of the same and at what rate.

- Goa and Tezpur have reported about library facility without specifying number of books and journals in the library, computerization of books and journals and reading books facilities.

- Goa, Bareilly, Trissur and Tezpur have reported about intercom facility.

V Medication and Diet:

- All except Nagpur have reported that they make available drugs to the patients.

- There is no indication in the reports if drugs are sold or made available free of cost and if so, to which category of patients, whether similar facilities are available at district headquarters hospitals and other peripheral centers.

- Thane, Kozhikode, Bareilly, Goa and Vizag have reported improvement of diet in their hospitals without specifying the following:-

    - menu for breakfast, lunch, afternoon tea and dinner;

    - whether food is served centrally in the kitchen or sent through trolleys to respective wards;

    - whether dining tables exist or patients take food in their respective floors sitting.

VI Rehabilitation and recreation:

- Except the Institutes of Mental Health at Jammu, Cuttack, Visakhapatnam, Ratnagiri and Nagpur most have started rehabilitation and recreation facilities for mentally ill persons in the hospital.

VII Canteen and Library facilities:

- Kozhikode, Bambolim, Cuttack, Trissur and Tezpur have reported that canteen facilities are available.
- Bambolim and Tezpur have reported that library facilities are available.
- There is no proper response from the rest.

VIII Power Supply:

- Jammu, Kozhikode, Bombolim and Tezpur have reported improvement in power supply infrastructure.
- Visakhapatnam and Bareilly have reported erratic power supply.
- There is no proper response from the rest.

IX Telephone services:

- Bambolim, Bareilly, Trissur and Tezpur have reported availability of intercom facility.
- Rest of the hospitals (except Ratnagiri and Kozhikode) have reported about minimal telephone facility.
- Ratnagiri and Kozhikode have not commented anything about adequacy and effectiveness of telephone connectivity and services.

X Finances:

- Jammu, Kozhikode, Bareilly, Thrissur, Jamnagar, Tezpur, Ratnagiri and Nagpur have reported enhancement of budgetary allocations for their hospitals.

- Thane and Kolkata have reported that there is no change in budgetary allocations in respect of their hospitals.

From the reports monitored by NIMHANS a number of suggestions and recommendations have been received. These are:-

- All vacant posts should be filled up;

- All officers and staff medical and para medical should be trained;

- Rehabilitation services should be strengthened;

- New equipments necessary for psychiatric and psychological tests should be sanctioned and installed;

- Observations emanating from current visits of NHRC to mental health hospitals at Jaipur, Agra, Gwalior and Ranchi should be shared.

Visit to Karnataka Institute of Mental Health, Dharwad (19.4.2007)

The visit coincided with the eve of Basaveswar Birthday (Basaveswar Jayanti) which is celebrated all over Karnataka with a lot of excitement, joy and fervour. Since this is a great historical event, it may be appropriate to say a few words about Basaveswar and his philosophy (which continues to be relevant even today) before covering Karnataka Institute of Mental Health. Born in 1132 AD, Basava adumbrated his philosophy of life and religion in the language of the people. He spearheaded a massive revolutionary movement to change a highly inequitable social order based on the pernicious caste system. Through a literacy genre called 'Vachanas', acclaimed by scholars for their inimitable beauty, brevity, profoundity of thought he boldly proclaimed that religion was meant to bring dignity and light to a man/woman's life. To liberate the oppressed, deprived and disadvantaged from the vicious spell of traditional and conservative fads, vasava created a new religious order with such vital principles as self respect, spiritual equality, fraternity, liberty of worship and monotheism animating it. It is somewhat inconceivable that 9 centuries ago he fought against casteism, idol worship amounting to bigotry in the name of so called religion, fought for inter caste marriages and like Baba Saheb Bhimrao Ambedkar fought for restoration of complete equality between man and man, man and woman and all sections of a stratified society divided on the basis of caste, creed, colour, gender, faith, social origin and so on. No two socio religious leaders in Indian social

history come to such a wonderful meeting point as Basava of 12th Century Karnataka and Babasaheb B.R. Ambedkar of 20th Century, India.

Historical background of Karnataka Institute of Mental Health:

One of the oldest mental health hospitals in the State, it started as a 'Lunatic Asylum' in 1845. There were five such asylums at the relevant point of time namely Bombay Presidency (Southern part), Yerawad (Pune), Colaba, Ratnagiri and Thane. The retributive system of justice being the dominant one in vogue at the relevant point of time, a portion of the jail was converted as wards to accommodate the lunatics, the concept of kind and compassionate care and attention towards lunatics (a term which is now expressly forbidden in the Mental Health Act, 1987) being conspicuous by its absence then.

In 1909 the asylum was separated from jail and a dividing wall around the asylum was constructed. In 1922 the asylum was renamed as Government Mental Hospital although the precise extent of facilities for care and attention of mentally ill persons available at the relevant time is not known.

Till 1960, the hospital was under the additional charge of District Civil Surgeon (a nomenclature now changed to Chief District Medical Officer), Dharwad. The period between 1960-63 was a golden one in the history of the hospital when Dr. S.M. Channabasavanna, the noted Psychiatrist was the

Superintendent. A series of innovative changes were introduced during this period such as (a) using psychotropics (b) ECT (c) outpatient's Deptt. (OPD). The overwhelming thrust was on improving the quality of services in the mental health hospitals so that more and more voluntary admissions would take place. Yet another significant change was recognition of the hospital as a teaching institute by the Karnataka University. The hospital went through the following phases of evolution and growth from 1971 onwards:

- The OPD services were encouraged and maintained between 1971 and 1974;

- Occupational therapy had a modest beginning between 1975 and 1977 and about ½ an acre out of 1 acre of vacant land in the hospital was utilized for this purpose;

- Diploma in Psychiatric Medicine (DPM) was started in collaboration with the department of Psychology of Karnataka University in 1979. Between 1980 and 1989, 17 DPM students were trained.

Regretfully due to problems of shortage of trained manpower in the hospital there was a setback and the PG course was closed down. In 1990 a group of retired persons based in Dharwad city came forward to register a society and start a centre for rehabilitation of mentally ill persons with the Dy. Commissioner, Dharwad as the Chairperson. The latter was good enough to allot 1 acre of land. The Centre is functioning in the same space which is a part of that one acre

of land though in terms of number of trades/skills and number of participants it is on a miniscule scale.

In 1993 the name of the hospital was changed from 'Mental hospital' to Karnataka Institute of Mental Health, the name by which it continues till date.

In the wake of filing of the Public Interest Litigation (PIL) being entertained as Writ Petition No. 18741/1996 and in the wake of series of directions being issued by the apex Court and subsequently by the High Court of Karnataka the tides of fortune turned in favour of the Institute which had started languishing since 1989. The winds of change which positively affected the fortunes of the Institute since the last part of 90s are:-

- The Institute was attached to Karnataka Institute of Medical Sciences (KIMH), Hubli for developmental purposes as per GO No. AKUK/68/MSF 99 dated 8.7.1999 of the Government of Karnataka.

- The entire administrative and financial control of KIMH, Dharwad was subsequently handed over to Director, KIMS, Hubli on 16.12.1999.

- A team headed by Dr. (Mrs.) M. Gourie Devi, Vice Chancellor, NIMHANS, Bangalore visited the hospital and submitted its recommendations to Government of Karnataka in January, 2000.

- On the direction of the High Court of Karnataka and recommendations of NIMHANS, Bangalore and with liberal receipt of grant in aid from Government of India a new hospital building consisting of a new OPD block, emergency ward, casualty services, ECT room for administering modified ECT, store room, pathological laboratory and 8 open wards of 20 beds each (200 beds in all), 8 special wards, dharmashala (waiting and resting place for patients) was built. The new building started functioning with 8 open wards of 20 beds each from May, 2005. Following the recommendations of the High Court of Karnataka, 65 new posts were created. It was very heartening to note that Dr. V.S. Acharya, Minister for Medical Education made an announcement while inaugurating the new building that KIMH should become an autonomous P.G. Teaching Centre of North Karnataka.

Physical Infrastructure:

The new building is being constructed in 3 phases. The first phase has been completed in all respects at an estimated cost of Rs. 7.5 Crores by RITES, a public sector enterprise under the Ministry of Railways and physical possession of the newly constructed Blocks has been handed over to KIMH authorities.

The second phase of construction work comprises of a nursing school, construction of Type-IV staff quarters and Administrative building at an estimated cost of Rs. 4 Crores (these are the revised estimates as against the original

estimates of Rs. 2.5 Crores). The proposal is pending with the Estate wing of KIMH, Hubli for finalization of tenders. For the first time when tenders were invited and bids (both technical and financial) were received, the lowest bidder at the time of bid demanded an extra amount of Rs. 40 lakhs which was not acceded to resulting in cancellation of tender. The entire process was initiated during the last financial year (2006-2007). In the new financial year a fresh proposal for release of funds will have to be submitted through KIMH to the Health Department of State Government. This has not yet been initiated.

The third phase comprises of construction of all other staff quarters, construction of a compound wall, execution of a full fledged water supply system comprising of filtration chamber, storage tank, laying of pipelines etc. This is estimated to cost Rs. 11 Crores and has not been processed at all.

The total geographical area of KIMH is 19 acres while the built up space is 78,325 sq.ft. in the new building and 57,115 sq.ft. in the old building. The old building which comprises of the chronic patient's ward, female open ward, lunatic ward and jail ward is in a bad shape. All of them need to be dismantled in the interest of safety and rebuilt.

There are 2 built in staff quarters one meant for the Superintendent and another meant for the nursing Superintendent. Both are as old as the original hospital building (162 years). While the Superintendent's quarter is

being used, the one meant for the nursing Superintendent has been abandoned. The staff quarters will have to be built afresh. This has already been included in the third phase of the proposals for modernization of the Institute.

The condition of 20 staff quarters (for Class IV) which were built years ago appears to have deteriorated over the years and are now unfit for human habitation. New Type-IV quarters have become a necessity and their construction has been included in the 2nd phase of modernization proposals.

To sum up, adequate space is available for present and future development which should take care of (a) redesign of the room of the Superintendent of the Institute which is too small and congested, does not have a small conference table and a few chairs for case conferences and other internal meetings from time to time (b) redesigning the library to provide for a reading room and proper arrangement for stacking of books and journals in steel racks with complete computerization facilities for receipt and issue of books, journals and periodicals (c) setting up a new lunch-cum-rest room for faculty members (d) redesigning the existing canteen on construction of a new canteen building (the available space in the existing canteen building is too small and the arrangements for sitting, serving meals/snacks too cramped) where atleast 100 people should be able to sit and eat inside with construction of a fruit stall close to the canteen so that patients and relatives can buy fruits which are available in plenty in Dharwad (e) reconstruction of class IV quarters which are in a bad shape and (f) construction of staff

quarters (g) construction and operationalization of a new geriatric ward and child psychiatric ward and (b) construction of a full fledged occupational therapy-cum-yoga and mediatation centre.

Administrative infrastructure:

The Institute which is under the overall contral and management of the Department of Medical Education is not an independent and autonomous body but an outfit of Karnataka Institute of Medical Sciences. The implication of this statement would be clear from the following:-

- KIMS, Hubli has overall administrative control as also control over budgetary and financial matters;

- The entire staff of KIMH are working under the control of Director, KIMS, Hubli on deputation as per GO No. AKUK/35/MSF/2001 dated 25.7.2002.

- The salary, allowances and all other financial benefits of the entire staff of KIMH are paid by the Director, KIMS, Hubli out of lumpsum grants released by Government of Karnataka, Medical Education Department. It has a plan and non plan budget of Rs. 40,00,000/- (Forty Lakh) and Rs. 2,57,14,000/- (Two Hundred Fifty Seven Lakh and Fourteen Thousand) respectively.

The Institute is headed by Director, KIMS, Hubli since 1997. Dr. M.G. Hiremoth who is Director of KIMS is also Director, KIMH, Hubli since 22.6.2006. Dr. Shivashankar Bhimrao Pol (Dr. S.B. Pol in short) is the Superintendent of KIMH since 28.5.2005.

Unlike Agra and Ranchi where the Institute have a Managing Committee and a number of functional sub committees there is no such managing committee for KIMH, Dharwad. Instead, there is a Governing Council for KIMS, Hubli which is the highest decision making authority for KIMH group of hospitals including KIMH, Dharwad. The composition of the Governing Council is as under:-

- Minister, Medical Education - Chairperson
- Principal Secretary, Finance Deptt. - Member
- Vice Chancellor, Rajiv Gandhi University For Health Sciences, Bangalore - Member
- Secretary, Health & Family Welfare Department - Member
- Secretary, Social Welfare - Member
- Director, Medical Education - Member
- Director, Health & Family Welfare Services, Bangalore - Member
- Director, KIMS, Hubli - Member
- Two faculty members of KIMH (currently Dr. Abdul Karim and Dr. Sanjay Dangre are members) - Member

- One or two environment Professional in the field of medicine - Member

  (usually an NGO of repute and standing with experience and expertise in environment

  is nominated).

- Medical Supdt., KIMH, Dharwad - Member

I was given to understand that there are a number of Committees such as Finance Committee, Purchase Committee, Academic Committee etc. to oversee and coordinate the management problems of KIMH group of hospitals including KIMH, Dharwad. In all there are 5 number of hospitals under KIMH such as:-

- Medical College Hospital, Hubli;
- KIMS, Hubli;
- Infectious Diseases Hospital;
- Primary Health Centres under supervision of KIMS, Hubli;
- KIMH, Dharwad.

It is, therefore, not a very healthy or happy arrangement that the day to day management problems of KIMH should be overseen by a Governing Council and Committees functioning outside the ambit of KIMH. For a smooth, timely and efficient decision making process KIMH should have its own managing committee and sub committees vested with discharge of specific mandates such as works programmes, purchase of store items, personnel management, discipline

and academic matters. The managing committee and sub committees should function within an ambit of delegated administrative and financial powers. This will help in (a) accelerated decision making process (b) accelerated control over expenditure (c) ensuring that funds are utilized for the purpose for which they are sanctioned.

There are 3 sanctioned posts of Psychiatrists, 3 sanctioned posts of general duty medical officers, 4 sanctioned posts of Clinical Psychologists and 6 sanctioned posts of Psychological social workers. Incumbents against all these posts are in position except Psychiatrists where there is one vacancy.

A complete statement indicating the posts sanctioned and posts against which incumbents are in position or posts which are vacant is given in Annexure-I.

There are certain posts (49) which are proposed to be filled up on outsourcing basis according to G.O. No. HFW/29/KVM/2004 dated 19.8.2004. These are as under:-

Staff nurse	-	12
Dietician	-	01
Pharmacist	-	01
Driver	-	02
Medical Record Officer	-	01
Occupational Therapist	-	03
Occupational Instructor	-	05
Data Entry Operator	-	02
EEG/ECG Technician	-	02
Group D Staff	-	20

The rationale of such a decision is not clear. Every post is linked to a particular job. A job can be perennial or casual, sporadic and intermittent. If a job is perennial or uninterrupted, it has to be performed on a regular basis by an incumbent who should be recruited on a permanent basis. It is altogether a different matter that a job may be withdrawn necessitating abolition of the post but as long as the job remains and the job is regular or permanent in character the post has to be filled up on a regular basis. The other danger in outsourcing is that the outsourced jobs are of low wage, insecure and may not be performed by the incumbents with the same motivation or dedication. It may be performed for sometime out of fear or insecurity but the arrangement will be counter productive in the long run. In any case, the Superintendent of KIMH being the man incharge on the spot and being aware of various ramifications of such an arrangement (as to whether the post should be filled up on a regular or contract basis) such matters should ideally be left to his discretion and wisdom.

In dealing with administrative infrastructure and manpower planning three important aspects will have to be kept in view. These are (a) there should be a proper correlation between the scale of pay, nature of work, stresses and strains associated with the work, incentives which can be thought of to ease/compensate such stresses and strains; (b) a work study should be conducted to identify correct manpower needs in advance and (c) the recruitment policy should be such that the recruitment process is conducted

with total transparency and objectivity, justice and fair play so that the right person (whose heart is in the right place) is picked up and put at the right place in right manner and in right time.

In KIMH, Dharwad there is no evidence if (a) such a manpower study has been conducted and the correct size of personnel to man various positions has been determined in advance and (b) if there is a proper correlation between the requirements of a job and the aptitude and endowment of an individual. The work, conduct and performance of individuals against various positions should be subjected to an objective and dispassionate review with proper checks and safeguards and timely correctives applied so that performance levels are kept at optimal levels. This is how human resource development and human resource management should go together and not be viewed as two separate compartments.

It was encouraging to note that recently a decision has been taken by KIMS that services of the faculty of the Institute should be used for teaching the students who will come from KIMS. The faculty of KIMH has no objection to this arrangement as this will improve their exposure to teaching, sharpen and refine their teaching skills and update their knowledge and information but at the same time they feel that it will be a significant addition to their current duties and they may be suitably compensated for this extra responsibility. The faculty has a point which deserves consideration.

OPD and its management

I spent about 2 hours in interacting with 14 patients who had assembled around 8 AM in the OPD. A gist of these cases which represent a wide variety of situations and diversity of human characters is reproduced below purely from the point of being stories of deep human interest:-

1. Kashibai (56)

She has been brought from Bijapur by bus by her son-in-law and husband. She has no male issues and all her 4 daughters have been married. She has been diagnosed as a case of psychosis; additionally she has multiple somatic complaints. She was reported to be continuously crying for 2 months. She sits dull and withdrawn, has decreased sleep and reduced intake of food and often expresses a death wish. She has come to KIMH only after being examined by the Psychiatrist at the district headquarters hospital, Bijapur. She discontinued after taking psychotic drugs for 5 days and hence there has been no improvement in her condition. Her husband and son-in-law were advised that compliance with the line of treatment prescribed is a must as non-compliance will result in relapse.

2. Vasavraj (13)

The boy has been brought to KIMH by his father from Sindanur (Raichur district) and has been diagnosed as a case of mania. He absconded from home since 18th April, 2007, ran 20 kms. in 3 hours before he was caught. He had no sleep whatsoever for 4 days. He alternates between

laughter and tears. He should have been put in a Child Psychiatric Ward but since no such ward is in existence he has to be kept with adults with a number of undesirable consequences. Prognosis (recovery) in such cases is difficult but recovery also gets delayed and compounded without proper care and attention which is possible in an exclusive Children's Psychiatric Ward.

3. **Mallamaa (25)**

She has been brought to KIMH by her husband (who is a small/marginal farmer) at considerable expense by bus from Harappanhalli in Devengere district. Diagnosed as a case of mania she is under psychiatric treatment for the last 3 years with the following symptoms:-

- she sits often in a vacant and pensive mood;
- he starts crying all of a sudden;
- she has reduced appetite and sleep and feels like vomiting all the time as soon as she has finished eating;
- she has been continuously under depression;
- there are rapid and slow cycles of depression (it gets reduced in winter but increases in summer).

4. **Durgamma (16)**

She has been suffering for 8 to 9 months but has been brought for the first time by her father and brother in law from

Sindanur in Raichur district at considerable expense after the suffering was found unbearable. She sits alone, alternates between laughter and tears, has reduced sleep and appetite and wants to run away. Her ailment is yet to be diagnosed.

5. Bimanna (28)

He has been brought from Raichur by father and brother for the first time with considerable expense after months of complaints such as muttering to self and with total loss of faith in the efficacy of the treatment at district headquarters hospital at Raichur.

6. Govindramma (55)

He has been brought by son and friend (neighbour) from Belgaum. He has been a victim of addiction to alcohol (country liquor) and the psychiatric problems are the direct offshoot of this addiction. He has been showing multiple symptoms of psychiatric disorders for about a week such as wandering aimlessly to somebody else's house, no sleep and appetite.

7. Netravati (13)

She has been brought by her mother and brother for the second time for follow up to KIMH. She has been suffering from neurotic symptoms such as anxiety, hysteria, too much of grief reaction (beyond 2 to 3 days), adjustment disorder, learning disorder, hallucination etc. For these reasons she left school and has been working as a domestic help (even though employment of children as domestic help

stands prohibited by law since 10.10.2006). Because of the care and attention bestowed by her mother and on account of compliance with drugs prescribed last time her prognosis is reported to be good.

8. Nagappa (30)

He has been diagnosed as a case of mental retardation with psychosis which has practically no cure. He has come to KIMH for a disability certificate under the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. Such certificates are issued after a thorough medical examination by a Board comprising of the Superintendent of KIMH as the Chairman, the Psychiatrist of KIMH and a general physician as members.

9. Hemlata (39)

This is a case of post menopausal depression which has increased of late. The depression is associated with a desire for more children. She has been suffering from 1999 with reduced appetite and sleep and multiple somatic complications. She has been brought by her husband from Bellary (a distance of 250 kms.) by bus at considerable expense.

10. Jagdish Rathod (39)

He has been brought by his wife and a relative from Bijapur and has been diagnosed as a case of mania with symptoms such as soaring ambition, decreased sleep, reduced appetite.

11. Ballappa (59)

He is an agriculturist from Bagalkote and has been brought to KIMH by his wife. He has the history of a sustained head injury which damaged his right temporal lobe. He has already undergone neuro surgery at Bagalkote district headquarters hospital and since then has been showing symptoms of restlessness, irritability and aggressiveness.

This is the pathetic case of a person who was hit by a bus while traveling by an auto. He has no source of income and his will be the case of a lifelong treatment. He does not want to go to NIMHANS Bangalore as he feels he will be lost in the sick, hurry and divided aims' of an urban metropolis.

12. Kasturi (30)

This is a case of depression arising out of domestic violence. Her husband is alcoholic, beats her black and blue and has virtually driven her to a stage of desperation and 'point of no return'. Her husband's extramarital relationship has made matters worse for her. Despite this worst form of abuse, violence and humiliation she is not inclined to leave her husband and prefers to suffer in silence. Her mother who has brought her to KIMH is also in agreement with her.

13. B. Kotrappa (32)

He has come from Bellay district. It's a case of follow up for 4 years. Even though there has been 75% improvement due to proper counselling and drug compliance

earlier symptoms of giddiness, dullness/weakness, palpitation, decreased appetite and sleep continue to persist.

14. Khatrash (28)

He has been receiving treatment as an OPD patient for the last 3 years after being admitted twice. Even though there has been 75% improvement and his somatic and biological conditions are normal his irritability (characterized by loss of temper or cool) persists and he does not want to work out of aversion for work.

The following are some of my observations and impressions at the end of going round the OPD and interaction with the patients and their relatives accompanying them:-

- the daily average outturn of patients (both old and new) is 255; the outturn going up sometimes to 300.
- On an average one to two relatives are accompanying the patients.
- The waiting period for old cases is about 3 hours while the same for new cases is about an hour.
- On 19.4.2007, the day of my visit between 8 AM to 10.30 AM about 72 patients have been registered and 15 were still waiting. Since OPD timings are upto 4 PM, the number of case was likely to touch 300.

- The waiting hall has about 100 chairs evenly spread out. Since patients come and go the sitting arrangement appears to be adequate.

- Most of the male patients interrogated are agriculturists (small and marginal farmers).

- When a tragedy (in the shape of mental disorder) strikes any member of the family they are driven to a lot of financial distress. They first go to the district headquarters hospital or to a private clinic. They come to KIMH, Dharwad only after trying out various other alternatives. Travel of self and relatives over long distances by bus or rail is a very expensive proposition. Those who come for follow up through the OPD have to make arrangements for stay at Dharwad as they may not be able to leave on the same day. Every such stay with food and other incidental charges turns out to be an expensive proposition.

- Many of the patients and relatives have to incur loans/advances to avail of the hospital treatment.

- Many of them lose confidence in the efficacy of treatment at the district headquarters hospital and come to KIMH, Dharwad after hearing about the reputation and standing of the latter from others.

- Their hopes and expectations are not belied even though traveling all the way from Bijapur, Raichur,

Bellary and Bagalkote to Dharwad is quite an expensive proposition.

- Sometimes the plight and predicament of patients and the relatives accompanying them baffle description. To illustrate, I met one elderly couple around 11 AM desperately waiting in the OPD waiting hall for their chance. Nobody noticed them till I took the Superintendent near them and requested him to allow the couple to jump the queue, get expeditiously registered and examined by the Psychiatrist. The couple were in their 70s. The old man had met with an accident, had undergone brain surgery, was suffering from dementia and was totally mute and expressionless. The old lady truly devoted to her husband was completely bewildered not knowing what to do. Her helplessness was evident. I requested the Director to do the needful on priority without any loss of time. The best course of action to deal with all such cases is to go in for a geriatric ward so that cases of such elderly persons can be straightaway entertained there instead of they being called upon to come to general OPD and being made to wait for hours. Till the geriatric ward has been made fully operational, the Superintendent should pay personal and priority attention to all such cases and issue instructions to all concerned to treat all such cases with kindness and compassion that they deserve.

- For poor patients who have to commute long distances from their native place to reach KIMH, Dharwad by bus and incur considerable expenditure in that process something needs to be urgently done to move Karnataka State Road Transport Corporation (KSRTC) to provide concessional tickets to all such patients and their relatives accompanying them.

- The Superintendent on the basis of an informal census of the poor status of patients coming to OPD for treatment/follow up/admission should formulate a proposal and send it to Secretary, Medical Education Department through Director, KIMS with a request that the proposal may be sent to Secretary, Transport Department for a final decision.

- All patients are not illiterate nor are the relatives accompanying them. In addition to extending a humane and compassionate treatment to all patients, it is necessary and desirable to design series of IEC packages (Information, Education and Communication) in simple and colloquial Kannad, well visualized and well illustrated by a team of creative and imaginative designers/artists and display them on the walls and all other conspicuous points. The package should contain basic information about various forms of mental disorders, their symptoms, preventive and corrective measures, dos and do nots etc. As the relatives who are literate in Kannad and who understand the implications of such messages look at these charts,

posters on the walls and other conspicuous points, they will start internalizing the implications of these messages and would be careful enough not to repeat the mistakes of the past and enable and facilitate the patients to adhere to a culture of compliance. This will have tremendous spin off effect which is more powerful than formal counselling by the psychiatrists, clinical psychologists and social workers. More than anything else it will assure and reassure the patients and their relatives that all is not lost and there is always hope for correction and improvement.

Registration and record room:

The registration counter is manned by 8 persons (all matriculates) and one staff nurse. Between January, 2007 till date 2094 cases have been registered so far making it over 600 registrations every month. In all 99561 cases have been registered so far. All the new cases are being computerized by the data entry operator. For every patient one file is being opened. The names of patients are being alphabetically catalogued (indexed). For 99,561 cases registered 99,561 files have been opened. All the files have been neatly arranged in 32 racks of 15' height and 3' width (six racks of the same size have been recently ordered which when received would make the total number of racks as 38). Each file is being allotted one hospital serial number and kept year-wise. It takes less than 1 minute to trace a file.

Each file contains in brief the following:-

- personal data (name, age, sex, address, occupation etc.)
- name of the informant;
- chief complaint/illness;
- history of present illness;
- past history of psychiatric illness and other associated illnesses (appendicitis, cardio vascular and cardio respiratory diseases, communicable diseases etc.);
- personal history (marriage, divorce);
- family history (was the form of mental disorder diagnosed as genetic);
- premorbid personality (how was the personality before illness);

The following are some of the additional redeeming features in the system of registration and filing:-

- strict confidentiality is being maintained about each and every case;
- research scholars can study these cases but cannot make use of them for publication in any newspaper, journal etc.;

- the people at the registration counter have been trained to be civil, courteous and considerate towards the patients;

- They have been trained not to raise their voice but speak in a soft and subdued tone;

- The patients have been clubbed under 2 categories namely antyoday card (income upto Rs. 10000/- per annum) where the treatment is totally free and green card (income between Rs. 10,000/- to Rs. 20,000/-) where 25 to 50% of the patients are given free treatment. Such decisions about free treatment are taken by the Superintendent on the basis of interaction with patients.

Table – I gives a breakup of old and new patients registered in OPD.

Year	New Cases				Old Cases				Grand Total
	M	F	C	T	M	F	C	T	
1997	2607	1481	282	4370	23658	13810	3664	41132	45502
1998	2438	1376	284	4098	23389	14418	3148	40955	45053
1999	2762	1504	356	4622	24295	14199	3272	41766	46388
2000	2901	1628	459	4988	24855	15346	2832	43033	48021
2001	3223	1830	492	5545	31258	17992	3700	52950	58495
2002	3650	1984	575	6209	35102	19485	4294	58881	65090
2003	3522	2101	543	6166	38814	22899	5447	67160	73326
2004	3563	2243	468	6274	46806	27510	5568	79884	86158
2005	3605	2298	549	6452	50630	29312	5136	85078	91530
2006	3725	2388	641	6754	50353	30155	5407	85915	92669

Table – II gives the yearwise breakup of number of patients registered from 2000 to 2007 (March, 2007).

Sl. No.	Year	No. of patients registered
1.	2000	4988
2.	2001	5545
3.	2002	6209
4.	2003	6166
5.	2004	6274
6.	2005	6452
7.	2006	6754
8.	2007 upto March	1728
	Total	**44116**

Post registration, examination and diagnosis:

Role of Clinical Psychologist:

- All cases are first seen by the clinical psychologist and then by the psychiatrist.

- In course of examination, the clinical psychologist looks at the following parameters:-
  - general appearance;
  - talk;
  - thought;
  - perception (delusion, hallucination etc.);
  - affect (mood);
  - cognitive functions (awareness of the reality);
  - consciousness;
  - memory;
  - orientation;

- intelligence;
- insight;
- judgement;
- intelligence quotient (iq).

- The clinical psychologists are MAs in Psychology with M.Phil or Ph.D. as additional qualifications.

- The staff attached to them are multilingual (Marathi, Kannad, Telugu keeping in view the fact that Karnataka is a multilingual State and these are the languages which are spoken by the people).

- The duration of the examination is half an hour for new cases.

- Counselling in old cases where patients come for follow up is about an hour.

- If in course of examination, it is found that the patient is too aggressive or violent he/she will be taken to an observation home and administered sedatives, psychotic drugs and modified ECT in emergency, if warranted.

- From the clinical psychologist the case file goes to the psychiatrist.

- However, before the case file is sent to the Psychiatrist, the clinical psychologist may take a view on the need for admission of the patient provisionally and may record his/her views accordingly in the case file.

Role of Psychiatrist:

The case file is received, the patient is once again examined, findings of the Psychiatrist are recorded and a final decision is taken on admission of the patient as IPD. In course of examination if the patient is not in a position to respond the psychiatrist turns to the relatives. Of the 9 new cases examined on 19.4.2007 (between 8.30 AM to 11 AM) the psychiatrist took a decision for admission of 2 patients as IPD. This is entered in the admission register and the patient is sent indoors.

Role of Social Workers (6):

Social workers are MAs in Social Work (MSW) entrusted with certain specific functions both at the pre and post admission stage such as:-

Before admission:

- They ascertain the name, correct home address and phone number of patient's relatives who have accompanied the patients.

- They counsel the relatives about their (social workers) home visits as also about the importance of drug compliance (each social worker has on an average undertaken 3 home visits every year).

- They counsel the relatives about the importance of keeping HS card, prescription and drugs supplied by

the dispensing unit to be kept safely in a plastic container.

- They issue cards for the mentally retarded as well as disability cards on the basis of hospital records. So far 6400 such cards have been issued between 1.4.2006 till date in the wake of implementation of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. The card would entitle a physically, orthopaedically and visually challenged person in Karnataka to receive disability pension of Rs. 400/- per month w.e.f. 1.4.2007.

After admission and before discharge:

- The social workers make local enquiries when whereabouts/addresses of patients are not available.

- They seek to find out the correct address whenever the address provided by relatives is found to be wrong – willingly or inadvertently.

- They counsel the family members about the need for and urgency of social acceptance when a patient is not found socially acceptable by family and relations after his/her discharge.

Role of general duty medical officers (GDMO) (6):

- Of the 6 sanctioned posts only 4 are in position.
- They have been trained in psychiatry.

- They issue prescription for both general as well as psychotic drugs for all follow up cases. Such prescriptions are generally issued for one month.

- The relative of the patient goes with the prescription to the drug dispensing unit to collect the medicines.

Open ward:

The open ward which started functioning from 2nd May, 2005 comprises of an emergency ward with 20 bed capacity separately (10 for male and 10 for female patients), 8 wards of 20 bedded capacity and 12 Special wards with attached bath room (separate for male and females).

Emergency ward (Male):

At the time of my visit there were 6 patients of whom 3 were cases of addiction, 1 each of bipolar affective disorder and mania and one case under observation. The relatives of the patients who have been victims of addiction were counselled to exercise strictest possible vigilance and surveillance so that such addiction is not repeated in future.

Female Emergency ward:

At the time of my visit there were only 4 patients of whom one is a victim of depression, two of paranoid schizophrenia and one of psychosis. Two have undergone ECT.

Both the male and female victims belong to lower middle class homes where such disorders have come as terrible visitations destroying the peace and stability of home. As a matter of fact, the home stands economically and financially ruined (as no able bodied earning member in the family is left to provide alternative avenues of livelihood) and there are serious questions about survival of the joint family system.

Main Male Ward No. I:

- Of the 8 male wards I could visit only one due to severe constraints of time. As against strength of 20 beds, 16 were found to have been occupied. The nature of ailment ranged from addiction to depression, mania to psychosis NOS and paranoid psychosis, bipolar affective disorder to schizophrenia and chronic schizophrenia.

Main Female Ward No. V:

- The bed strength is 20 and all of them were full. The nature of ailments diagnosed is: Psychosis (11), Schizophrenia (6), Paranoid Schizophrenia (1) and depression (2). In course of interaction with the patients and their relatives, a few sad cases came to light. These are:-
    - A bright and intelligent student developed psychosis as she was denied higher education

after Class X even though she secured 70% in SSLC.

- In 2 other cases of women, it was observed that there has been a relapse of the original ailment as (a) there was no proper and systematic compliance with drugs and (b) the ailment has acquired a chronic form and is untreatable. Both the women have come to the hospital for the 9th time and after an interregnum of 5 years respectively without realizing that very little can be done in such cases.

The following are some of the other significant features in regard to patients in the open wards:

- Average duration of patients is 12-15 days.
- Two deaths took place in open wards in 2006-2007 due to acute mayo cardiac infraction.
- Open wards are intended to facilitate stay of relatives with the patients which in turn has a sobering influence on the patients and helps their recovery. The experience with some of the relatives has, however, been to the contrary. Some relatives have absconded leaving the patients alone. Herculean efforts are involved to trace these relatives when the patient is to be discharged so that the patient can be sent home in the care of the relative concerned.

Table – III gives detailed information about admission and discharge of patients in the open ward from 2000 to 2006.

Sl. No.	Year	Admissions			Discharges		
		M	F	T	M	F	T
1	2000	1968	702	2670	1982	737	2719
2	2001	2257	705	2962	2223	690	2913
3	2002	2423	823	3246	2410	824	3234
4	2003	2273	807	3080	2305	824	3129
5	2004	1942	630	2572	1951	649	2600
6	2005	1703	667	2370	1783	659	2442
7	2006	1656	760	2416	1654	762	2416
Grand Total		**14222**	**5094**	**19316**	**14308**	**5145**	**19453**

Table – IV gives year-wise breakup of death of patients (1998-2006).

Sl. No.	Year	Deaths			No. of Absconded Patients		
		M	F	T	M	F	T
1.	1998	1	5	6			
2.	1999	5	6	11			
3.	2000	6	3	9			
4.	2001	8	2	10			
5.	2002	6	0	6			
6.	2003	8	6	14			
7.	2004	2	2	4			
8.	2005	2	3	5			
9.	2006	1	1	2			
	Total	**39**	**28**	**67**			

Annexure - II gives a detailed analysis of the causes and factors which contributed to the death of 67 patients between 1998-2006.

However, later in course of discussion with the Superintendent it transpired that there are some factual and scientific errors in these findings which are further clarified as under:-

- Cardio respiratory failure is a mode and not a cause of death.

- Similarly psychosis cannot be a cause of death alone.

- There are certain biological factors/indicators which are associated with Schizophrenia and which could cause death, not Schizophrenia perse such as:-

    - Schizophrenic patients cannot sneeze;

    - While eating there is a possibility that they may be choked to death as the vegal nerves of the suffering Schizophrenic patient have been weakened;

- Similarly mania with psychotic symptoms cannot be a cause of death.

Closed ward:

- Two wards of 20 bed each are available for regular patients, two wards for chronic patients and one ward

for convicts/undertrial prisoners sent by the Judicial Magistrate, 1st Class in place.

- Two female closed wards are also in place.

- Number of patients in closed wards as on 15.4.2007 is:

Male	–	33
Female	–	24

- The closed wards are 162 years old and is in very a bad shape in all respects (physical safety and stability, lighting and ventilation). They remind what Nobel Laureate Viswakabi Rabindranath Tagore wrote about 100 years ago. I quote:

> "I look before me a deep dark world,
> A world caged and cabined,
> By narrow, dark and empty cells"

- There are in all 18 chronically ill patients.

- Most of them have been received under orders of Judicial Magistrate, 1st Class.

- Their original names were not known or could not be ascertained and therefore, new names have been given to them.

- Amongst the chronically ill female patients, there is one who is educationally highly qualified. She is an M.A. (Psychology), is 42 years of age and has none else in

the world except a 92 year old father and son who is away in Australia. She came to the female ward about 12 years ago and does not remember anything.

- Regretfully there are no rehabilitation centers for such patients who are unsure about their destination even after they have been effectively treated. Such centers should be started by Government of Karnataka without further delay.

- Of the chronically ill 18 patients, 13 are victims of chronic schizophrenia, 2 are victims of mental retardation with epilepsy, 2 are victims of mental retardation with psychosis and one is a victim of mental retardation.

- These patients cannot withstand the strain of modified ECT. There are being mostly administered psychotic drugs which are in the nature of maintenance doses.

- Two of them are gifted singers. Their genius for singing has not withered away despite the fact that their lives have been consigned into 'narrow, dark and empty cells' from which there is limited scope for any deliverance.

Male Chronic Ward:

There are in all 21 beds and all of them have been occupied. The have been diagnosed as suffering from mental retardation with epilepsy (3), chronic schizophrenia

(10), mental retardation with psychosis (7) and mental retardation with psychosis (abnormal behaviour) (1).

Ward for Wandering lunatics:

There are in all 14 beds and all of them have been occupied. Out of 14, 8 are schizophrenic, 2 are maniac and 2 are cases of mental retardation with epilepsy.

Ward for undertrial prisoners and convicts:

There are in all 8 beds of which 3 have been occupied. Of the 3, 2 are victims of chronic schizophrenia and 1 with mental retardation and epilepsy. Of the 3, 2 have spent more than 14 years in the ward which may be more than the maximum period of imprisonment. The chronic ward, the wandering lunatic ward and jail ward present indeed a pathetically distressing picture. Most of the inmates are beyond treatment, beyond correction. Most of them are mentally retarded and are mute and expressionless. They will not easily open up even when being prodded to do so though there are a few amongst them who have a flair for writing and singing. The only way by which they can be productively engaged is by imparting vocational skills to them by qualified teachers who are also empathetic and sensitive towards them, their needs, their hopes and aspirations.

Details of jail ward convicts and undertrial prisoners between 2000 to 2006 are given in Table – V.

S. No.	Year	JMFC Cases			
		UTP	Reg	Convicted	Total
1.	1998	27	24	1	52
2.	1999	33	28	1	62
3.	2000	45	29	1	75
4.	2001	58	40	3	101
5.	2002	26	33	0	59
6.	2003	24	50	0	39
7.	2004	17	18	1	36
8.	2005	25	31	2	58
9.	2006	20	35	0	55
	Grand Total	**275**	**253**	**9**	**537**

Adequacy of facilities and amenities for patients:

- Diet Scale:

Sl. No.	Diet Articles Particulars	Every patient Qty. (gram)
1.	Wheat Floor	265
2.	Tor Dal	70
3.	Vegetable	160
4.	Plantains	113
5.	Pulses	85
6.	Sweet Oil	40
7.	Tea powder	7

8.	Curry powder	7
9.	Tamarind	14
10.	Onion	26
11.	Salt	20
12.	Eggs – Monday & Thursday	1
13.	Awalakki – Monday & Thursday	90
14.	Sira rawa – Sunday	45
15.	Vanaspati	5
16.	Sugar	30
17.	Green Chilli	7
18.	Tomato	14
19.	Upama rawa – Tuesday & Friday	90
20.	Rice	113
21.	Milk	327
22.	Palav rice – Wednesday & Saturday	90

- **State of Kitchen:** Kitchen is managed manually. Vegetables are supplied every day by consumer co-operative society. Rice, wheat, floor, sugar etc. are stored in a separate kitchen store-room hygienically.

Dining Arrangements:

- Patients take their food by sitting on the floor.
- Food is served in respective wards.
- **Timings**

Morning Tea	-	6.00 am
Tiffin	-	7.30 am
Milk & Banana	-	9.00 am
Meals	-	12.00 pm
Tea	-	2.00 pm
Dinner	-	7.00 pm

- Food is served by Class - D employees of respective wards under the supervision of nursing personnel.
- The Superintendent, KIMH, Assistant Administrative Officer, Nursing Superintendent Grade-I and Staff Nurses and sometimes Director, KIMS, Hubli oversee the management of Kitchen and serving food.
- The Superintendent, KIMH was requested to work out the calorie value of the total quantities of food served (breakfast, lunch and dinner). He should satisfy himself that the total calorie value of food served does not fall below 3000 for adult male and female inmates.

Electricity:

The total electric load planned and built in capacity of KIMP is 150 KVA. As against this KIMH is using 40 KV electric load. After completion of 2nd and 3rd phase of construction (details of which have earlier been indicated at page 19-20) the electrical load will be increased. For power backup, tenders have been invited for a 100 KVA generator set. Bido (both technical and financial) have been received. They will be opened and finalized soon.

Telephone:

The PABX is for 200 lines while only 20 lines are currently being utilized. Every ward has been provided with intercom facilities. The office of the Superintendent has one landline and one for fax. A PCO has been installed in the campus for convenience of relatives of the patients.

Potable Water:

A 5 lakh litres storage capacity has been created. One overhead tank with 10,000 litres capacity and 8 syntax tans of 500 litres capacity each have been installed. As of now there is no scarcity of potable water for the office, open and closed wards, kitchen, toilets used by the patients etc.

Canteen:

In view of the very large outturn of patients everyday it is necessary to provide canteen facility within the precincts of KIMH for use of patients and relatives accompanying them.

The existing canteen building was a laboratory building and the space available inside is grossly inadequate both for preparation of snacks and other food items as also for service. Since there is no scope for expansion of the existing building a new canteen building with space for atleast 50 persons to sit and take food/snacks/tea/coffee should be planned. The Superintendent should formulate a proposal for construction of a new canteen and send it to the State Government (Department of Medical Education) through Director, KIMS.

Conservancy facility:

Every new ward has 4 bath rooms, 4 lavatories, one geyser room and one wash basin for every 20 patients. At the ratio of 4:1 this facility appears to be adequate. Similarly in the old wards there are 3 lavatories in each ward and 2 common bath rooms for 21 patients. At the ratio of 7:1 this appears to be a bit inadequate. The correct ratio i.e. 4:1 should be kept in view at the time of renovation of these wards which are 162 years old care should be taken to provide conservancy facilities in the correct ratio of 4:1.

Yoga and meditation:

A newly constructed building with a large floor has been earmarked for yoga and meditation. Earlier one yoga teacher was coming and imparting regular instructions on yoga free of cost. This arrangement has since been discontinued on account of lack of interest. It should be possible to revive the interest by explaining to the patients and their relatives

the immense benefits of all yogic exercises. The Superintendent was requested to take a lead in this matter.

Procurement and dispensation of drugs:

- Drugs are procured from Drugs and Logistic Society of Karnataka. The annual budget for drugs and dressings (both psychiatric and general) is of the order of Rs. 56 lakhs.

- The Medical Superintendent confirmed that allocations on account of drugs and dressings are adequate and there is no gap.

- In case drugs are not available in the society they are purchased directly from the firms as per the tender (rate contract) of Drug Logistic Society.

- I was given to understand that there is adequate stock of essential psychiatric drugs and other emergency drugs.

- There was a temporary crisis in August, 2006 as there was delay in finalization of the tender/rate contract of the Drugs and Logistic Society. With a view to tiding over such crises in future, Government in Medical Education Department have accorded permission to KIMH to purchase drugs from NIMHANS Cooperative Society in case the desired drugs are not available in the Drugs and Logistic Society. There is no crisis as of now.

Pathological tests:

Pathological tests like HB, TC, DC, Malaria, ESR, vidal test, VDRL, Blood lithium estimation, sputum etc. are being conducted at the Pathological Laboratory of KIMH. The laboratory comprises of Pathologist – 1 and Laboratory Technician – 2. The following equipments have been installed in the laboratory:-

- microscope;
- centrefuse;
- calorimeter;
- auto analyzer;
- ESR measuring equipment;

In all 24 items are available for test. Samples are collected in the morning. On an average 5 to 10 samples are received every day. The duration of the test is approximately one hour. The test results are transmitted without any delay.

In course of my visit to the laboratory I was impressed with (a) immaculately neat and clean environment inside the laboratory (b) the neat and orderly manner in which the samples are being received, tests conducted and test results sent to concerned quarters in time.

What, however, was a cause for worry was that (a) they are not permanent employees (b) they are on a minimum wage of Rs. 3750/- per month.

As clearly explained earlier, the status of an employee should be clearly related to the nature of the job. If the job is of a regular nature, the incumbent should also be appointed on a regular basis. Regretfully the Government decision has been contrary to this principle. Consequently, the pathologist and the laboratory technician are continuing on an adhoc or casual basis with a consolidated wage of Rs. 3750/- per month which is even below the subsistence level wage and which is a violation of human rights of these employees.

Modified ECT:

The Unit comprises of the following tools and equipments:-

- Pulse oxygen metre;
- ECT machine;
- Boils Apparatus;
- Suction Apparatus;
- Oxygen Cylinder;
- Refrigerator.

This is a recovery room for patients who are administered modified ECT. Both the ECT and recovery rooms are air conditioned and on an average 260 to 300 cases of ECT per month. The recovery has generally been smooth except one case where there was death 3 years back following certain complications.

Library:

KIMH has got its own library for doctors and para medical staff located in a small room without any reading room. A senior clinical psychologist is in overall incharge of the library. There is, however, no librarian even though there is no dearth of people with Master's degree in Library Science. It's a pity that the administration has stopped purchasing books/journals for nearly 10 years for their use. All books and journals (both Indian and foreign) need to be computerized and the library electronically connected to all departments so that reference materials are available in less time. A congenial environment needs to be created so that faculty members and research scholars can sit, browse through reference materials and also discuss among themselves. The existing library space being inadequate for this purpose, a new space which can meet all the requirements of a modern library with micro filming, facilities will have to be located so that the library can be shifted at the earliest.

Patient's Library and recreation:

About 300 books for patients have been donated by officers and staff. Two newspapers namely Samjukta Karnataka in Kannad and Deccan Herald in English are being subscribed for patients. The following journals all of which are in Kannad are also being subscribed:-

- Sudha;
- Kasturi;
- Karma Veera:

- Tushara;
- Femina.

Occupational Therapy:

This is at a very rudimentary stage both in terms of the number of skills/trades as also the number of patients who are receiving the skill training. The skills are:-

- Embroidery;
- Screen printing;
- Envelope making;
- Candle and chalk making;
- Paper plates made out of areca nuts leaves.

Seven senior and service minded retired officers have taken the initiative to form a Centre for Rehabilitation of Mental Patients (CROMP) within the premises of KIMH. Government of Karnataka has made one acre (out of 19 acres allotted to KIMH) of land available to CROMP for the purpose of (a) procuring and installing the tools and machinery for imparting training in the above skills/trades. CROMP does not receive any grant either from the Central or State Government. It is running purely on the sale of finished products made by the patients.

The office bearers of CROMP approached me for some financial assistance for (a) appointment of a qualified therapist (b) introduction of more skills/trades conforming to aptitude, preference and interests of the mentally ill persons

so that CROMP could grow in size and volume of operations and be financially self reliant over a period of time.

My advice to the office bearers of CROMP were:-

- a market survey should be undertaken to ascertain (a) what raw materials are available (b) what finished products can be made out of these raw materials and (c) what is the market available for sale of the products;

- a similar survey should be undertaken to ascertain the type of skills/trades in which the mentally ill persons in KIMH would show some genuine interest;

- the two should be fused together and an action plan should be prepared with full financial and administrative components of cost;

- the plan/project proposal may be sent to Ministry of social Justice and Empowerment for formal approval and sanction of grant-in-aid (in favour of CROMP).

Before leaving KIMH I had a very interesting meeting with the Clinical Psychologists, Psychiatrists, Social Workers, Para medical staff, administrative staff, Group D staff etc. I had yet another round of visits and interactions with Director, KIMS – Dr. M.G. Hiremath and his colleagues at KIMS premises, Hubli. The following points were raised by the people who were invited to these meetings:

Clinical Psychologists:

- They suggested that the following equipments were urgently needed in the domain of behavioural therapy
  - GSR;
  - EMG;
  - Alpha feedback.

The estimated cost of these equipments will be Rs. 1 lakh (approximately) and once they have been procured and installed relaxation and other exercises can be given.

M.D. Psychiatrists:

- For Prophylactic treatment in maniac cases a litchieum machine costing Rs. 4 lakhs would be needed.

- The EEG machine has already been installed but is non operational as there is no technician. The approved scale for a technician is Rs. 6000 but at this scale it has been an uphill task to get any technician. The scale needs to be enhanced so that a technician could be selected at the earliest.

General Duty Medical Officer:

- They urged that in view of frequent interruptions and trippings a power back up was absolutely necessary and urgent. For this tenders have been invited. The entire purchase process should be brought to a logical

conclusion and the diesel generator set should be installed at the earliest.

DPM Psychiatrists:

- At the rate of one psychiatrist for 10 beds atleast 15 psychiatrists were needed (150 beds in KIMH were operational) as against which there are only 4 psychiatrists.

- Besides, about 1 lakh patients are turning up at the OPD annually. This number is likely to increase further. More psychiatrists are needed to deal with the increased strength.

- At present there are unmanageable problems if one Psychiatrist goes on leave. There is no leave reserve psychiatrist whose presence could be handy to deal with such situations.

- A psychiatrist has no fixed working hours. His/her presence is required round the clock. He/she has no family life. The entire working environment is fraught with occupational risks and challenges. There is hardly any incentive to compensate against the stresses and strains.

- The Mental Health Act, 1987 is already 20 years old. There are a number of gaps, omissions and lacunae in the Act such as:-
    - MHA speaks of beds only;

- Beds come into the picture only after diagnosis through the OPD; beds have, therefore, to be seen against number of doctors, para medical staff etc. who man them;

- MHA has not prescribed any norm with regard to number of general duty medical officers;

- Minimum 2 doctors have to attend during OPD hours from 9 AM to 2 PM and 3 PM to 4 PM.

Psychiatric Social Workers:

- They perform a multiplicity of functions (home visits, issuing disability cards, making a patient socially acceptable against social pressures etc.). They have, however, no exposure to various mental health hospitals located elsewhere in the country. Such exposure should be provided.

- This will give them an opportunity to share ideas and experiences and enable them to acquire new skills/competencies.

- Through such exposure they can prepare a number of charts, posters, pamphlets, booklets in Kannad for use of patients and their relatives.

- A computer PC with one data entry operator should be installed in the room where the psychiatric social workers sit.

- The management should provide e-connection with all books and journals kept in the library.

- A vehicle is also needed for home visits by psychiatric social workers.

- There are no avenues of recreation such as lunch/rest room or a carom room. Since all the 6 social workers are over burdened these barest minimum facilities and amenities should be provided.

Staff Nurses:

- Intercom facility/landline facility should be provided in casualty/emergency room. In the absence of these, the staff nurses have to come to the room of the Superintendent with a view to making and receiving calls.

- In the absence of staff quarters the staff nurses have to commute a long distance of 18 km. every day. Besides, they have to changes buses too. Care and attention to mentally ill persons is required to be provided round the clock. The problem is compounded in KIMH as against 54 numbers of staff nurses only 32 staff nurses are in position and are overburdened. Accommodation should, therefore, be provided to all the staff nurses within the campus of KIMH.

- Currently out of 32, nine staff nurses are working as trainees. They are on adhoc basis and their salary is

low. Besides, there is inordinate delay in disbursement of their stipend. They have completed 3 years but are yet to be regularized.

- It was further represented that the staff nurses are not getting the retiral benefits (pension, gratuity etc.) in time. The delay is of the order of 1 year.

- The staff nurses do not get any deputation allowance even though they have come from the State Government on deputation.

- Since KIMH, Dharwad is attached to KIMS, Hubli all applications for withdrawal from GPF have to be sent to KIMS. Processing of these applications takes in-ordinates long time.

- It was represented that either KIMH should provide the prescribed uniform to all staff nurses or alternatively should pay uniform allowance. Instead, KIMH is only paying @ Rs. 160/- per month towards washing allowance.

- It was represented that in view of the arduous nature of work which has a component of high risk (on account of being called upon to deal with patients many of whom are either irritable or violent or aggressive) a night duty allowance @ 8% of the basic wages towards a sort of risk allowance may be considered.

- Since age of retirement of Central and many State Government employees has been raised to 60 years it should be done so in case of staff nurses.

- Passing the local language test entitles the staff nurses to get an additional increment. It was represented that all 32 staff nurses have passed the local language test. In all fairness, they should be paid their arrears of increment right from the day they passed the test.

Group 'D' Staff:

- While staff nurses work for 6 hours shift, Class IV staff are put to 8 hour duty but in effect it amounts to round the clock working. The nature of duty is full of occupational risks and hazards. In the past there have been assaults from violent patients resulting in death and serous injury to some Class IV staff. As in the case of staff nurses risk allowance should be considered for them as well.

- Salary of Class IV staff is released through KIMS and there is avoidable delay. Such delay should be minimized.

- The number of posts in operation are much less than the number of posts sanctioned. Besides, retirement after attaining the age of superannuation is not accompanied by filling up of posts.

- Staff quarters for Class IV should be constructed.

There were certain other concerns of general interest which were shared by the Superintendent with me before I wound up my review :-

- According to projections made by WHO cardiac arrest may be killer No. I as of now but by 2020 depression will be the main cause of worry. Psychiatric treatment should, therefore, be accorded a very high order of priority both in terms of physical and administrative infrastructure as also in terms of quality of care and attention to psychiatric patients.

- Projects which are sanctioned either by Government of India or State Government or any other international agency take care of the physical infrastructure but do not take care of
    - man power;
    - its orientation and training;
    - equipments;
    - their repair and maintenance.

- This makes planning for mental health lopsided.

- No proper work study is ever conducted to identify the correct manpower needs in advance nor any serious effort is made to put the right man at the right place.

There is no correlation between the scale of pay, nature of work, stress and strain associated with work nor any incentives are thought of to ease/minimize/compensate the stress and strain. This leaves a gap between expected outcome and actual outcome and the desired results are not achieved. The morale and motivation of employees are also adversely affected.

- When the layers of decision making are too many, there is avoidable delay, a number of gaps are left in the decision making process and optimal results are not achieved.

- Adhocism is the worst form of demoralization and demotivation. No specific purpose is fulfilled by adhocism.

- Step by step approach is always useful in finding solution to problems. To illustrate different stages in the process involved in dealing with the case of a mentally ill person are:-
    - OPD;
    - Registration;
    - Diagnosis;
    - Preadmission Counsellig;
    - Admission;
    - Care and attention – timely administration of drugs;

- Predischarge Counselling;
- Discharge;
- Domicilliary treatment;
- Ensuring continuous compliance and continuous follow up.

Treatment of a mentally ill person becomes meaningful and effective when these steps are followed one after the other.

- Secrecy and confidentiality in dealing with cases of mentally ill persons will have to be fully respected. They should not be photographed nor should their photographs be released to the press for publication. Contrary to this elementary principle of respecting privacy of the mentally ill persons occupying high positions in society have violated this basic norm causing a lot of embarrassment to the victim and their family members. This principle should be followed in letter and spirit.

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Annexure –I

Staff Position of Medical Superintendent and Staff as on 18.4.2007

Karnataka Institute of Mental Health, Dharwad

Sl. No.	Name of the Cadre	Sanctioned	Working	Vacant
1.	Medical Superintendent	1	1	-
2.	Medical Officer	6	5	1
3.	Lay Secretary	1	1	-
4.	C.A.O.	1	-	1
5.	Office Superintendent	2	1	1
6.	FDA	3	2	1
7.	SDA	4	4	-
8.	Typist	1	-	1
9.	Psychologist	3	1	2
10.	Pharmacist	1	1	-
11.	Social Worker	1	-	1
12.	Nursing Supdt., Gr-I	1	1	-
13.	Nursing Supdt., Gr-II	1	1	-
14.	Nursing Tutor	2	1	1
15.	Sr. Staff Nurse	9	5	4
16.	Staff Nurse	31	31	-
17.	Lab. Technician	1	-	1
18.	X-Ray Technician	1	1	-
19.	Electrician	1	1	-
20.	Driver	1	1	-
21.	Group D	97	64	33
	Total	**169**	**122**	**47**

Annexure – II

Karnataka Institute of Mental Health, Dharwad

Patient Death Report from the year 1998-2006

Sl. No.	Date	Name	Cause of Death
1.	25.1.1998	Basavaraj Nagappa Hadimani	Cardiac arrest.
2.	31.1.1998	Gyanamma S. Devarmani	Respiratory failure.
3.	12.4.1998	Ningappa Channappa Kamatar	Post complication of pepticulcer.
4.	16.7.1998	Vilas Venkatesh Reni	Cardiac arrest.
5.	3.10.1998	Vishnu Ramachandra Raiker	Cardiac arrest.
6.	9.10.1998	Premasudha Kotreppa Bellolli Babu	Chr. Malnutrition with cardiac respiratory.
7.	14.1.1999	Muttappa Y. Bomannavar	Cardiac arrest.
8.	17.2.1999	Ravi Kadappa Hugar	Cardiac arrest.
9.	15.3.1999	T.R. Velayudhan	Respiratory failure.
10.	7.4.1999	Savitri Gangadhar Korphade	Cardio respiratory failure.
11.	19.6.1999	Mallikarjun Gangappa Katagi	Heart Attack.
12.	7.7.1999	M.T. Chandramma	Chronic Malnutrition.
13.	27.7.1999	Chandabee Davalsab Shivalli	Cardiac arrest.
14.	4.8.1999	Ramzaanbee Khazasab Hiremani	Cardio respiratory failure
15.	5.8.1999	Sheela Dattraya Patil	Cardiac arrest.
16.	8.8.1999	Girija Mundas	Cardiac arrest.
17.	1.9.1999	Shivaputrappa Bhimappa Kadadavar	Respiratory failure.
18.	16.4.2000	Maruti Dondiba	Mayo cardiac infection.

19.	20.4.2000	Jairabhee Devagiri	Cardiac arrest.
20.	1.5.2000	Khadarsab Makbulsab Kigaralli	Cardiac arrest.
21.	18.6.2000	Soubhagya Basappa Bhovi	Malnutrition with chronic anaemia.
22.	7.7.2000	Channabasaveshwar Shankaragouda Patil	Hyper tension.
23.	11.7.2000	Rukma Mangesh Kurdikar	Chronic Schizophrenia.
24.	22.7.2000	Sharanappagouda Holegouda Goudar	Schizophrenia – hanging.
25.	18.7.2000	Motilal Danappa Lamani	Chronic Schizophrenia.
26.	8.12.2000	Ramesh Vishwanath Naik	Toxic peritonitis.
27.	1.1.2001	Mallesh Danappa Doni	
28.	19.1.2001	Hanumanth Narayan Padati	Cardiac respiratory arrest.
29.	7.2.2001	C. Lingaraj L. Chendaya Nayak	Respiratory arrest – suicide.
30.	21.6.2001	Maruti Jotiba Badiger	Cardiac arrest.
31.	13.9.2001	Shivanand Siddappa Babladi	Sudden heart attack.
32.	20.9.2001	Siddayya Durgamani	Sudden cardiac arrest.
33.	22.9.2001	Parawwa Amrutappa Annigeri	Severe anaemic with psychosis.
34.	14.10.2001	Hanumanthappa Mahadevappa Medar	
35.	19.10.2001	Meharunigar Abdulkhadar Mulla	Psychosis.
36.	5.12.2001	Goura Mohammad Surban	Acute Psychosis.
37.	15.1.2002	Vaitala Venkatarao	Psychosis Nos.
38.	31.1.2002	Girimallayya Somayya Matapathi	Paranoid Schizophrenia.
39.	26.2.2002	Bharamappa Parappa Kurbar	Epilepsy Psychosis.

40.	11.5.2002	Shivappa Bharamma Ramanal	Alcohol withdrawal features – psychosis.
41.	14.6.2002	Unknown (Saleema) Bijapur	MRI Behavioural problem.
42.	3.9.2002	Ramappa Harinshikari	Heart disease.
43.	22.1.2003	Ganapati Amminabhavi	Chronic Schizophrenia.
44.	28.3.2003	Basappa Maningappa Uppin	Schizophrenia Old age.
45.	12.4.2003	Anjaneya Mallayya Kurbar	Cardiac arrest.
46.	12.6.2003	Muttappa Fakkirappa Ganti	T.B. with respiratory problem.
47.	30.7.2003	Rabinabi C/o Chandasab	Chronic Schizophrenia.
48.	30.7.2003	Laxmibai Govinda Sirgikar	Schizophrenia.
49.	28.8.2003	Firma Madarsab Babarachi	Schizophrenia.
50.	1.9.2003	Anand Shivappa Jakli	Paranoid Schizophrenia.
51.	1.9.2003	Rajappa Hosagiriyappa Hubli	Psychosis Nos.
52.	11.10.2003	Gurubai Desai	Mania.
53.	13.11.2003	Netravati D. Tondekar	Heart attach – Mayo cardiac arrest.
54.	27.11.2003	Gangawwa Nagappa Byageri	Heart attack.
55.	28.11.2003	Shaila Paramesh Hegde	Cardiac respiratory failure.
56.	17.12.2003	Mallikarjun Rachappa Ghevari	BPAD Mania.
57.	11.2.2004	Suresh Parameshwar Bhatt	Mayo cardiac infection.
58.	29.5.2004	Manjula Suryakanth Dhooti	Cardiac arrest.

59.	28.8.2004	Basayya Sangayya Kotabalmath	Mania with psychotic symptoms.
60.	19.10.2004	Girija Veerabasappa Vibhuti	Cardiac arrest.
61.	26.4.2005	Mahadevi Shivalingayya Hiremath	Cardiac arrest.
62.	24.5.2005	Jannat Jayad Hussain Patan	Cardiac arrest.
63.	1.9.2005	Rayppa Devappa Kurbar	Cardiac respiratory arrest.
64.	24.9.2005	Basalingappa Tirakappa Keri	Massive Mayo cardiac infection.
65.	12.12.2005	Iramma Bhimanagouda Nagarbench	Acute Mayo cardiac infection.
66.	25.7.2006	Smt. Shantamma Rangappa	Acute Mayo cardiac infection.
67.	22.9.2006	Devu Bedigeri	Acute Mayo cardiac infection.