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Antiquity – the antidote of progress
A review of the working of
Mental Health Hospital
Bareilly (U.P.)

By:

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Report of review of activities of Mental Health Hospital, Bareilly, Uttar Pradesh

Dates of review: 15th and 16th April, 2008:

I visited the Mental Health Hospital, Bareilly from 8.30 AM to 8 PM on 16.4.2008. Prior to this and immediately after my arrival at Bareilly by Sramjeevi Express from New Delhi at 6 PM on 15.4.2008 I spent over 2 hours with the Director – Dr. Raghav Ram, Medical Superintendent – Dr. A.K. Tiwari, Senior Psychiatrist – Dr. Sunil Srivastav, Senior Psychiatrist – Dr. S.K. Saxena and others and discussed with them about problems of mental health in general, increase in the incidence of mental illness, how by 2020 depression, according to a projection made by the WHO will be the single largest killer and not cardio vascular complications, how to educate and enlighten all sections of the society and in particular, the unlettered masses not to fall victims of depression despite trying circumstances and how to create a literate and learning environment in a large State like U.P. with a medium rate of literacy (57.4%) and a low level of awareness about the multifaceted dimensions of mental health vs. human rights so that people in all age groups in general (children, adolescents, adults and elderly) and the ignorant and non-literate masses in particular could be made more aware, more agile and more alert to ward off mental illness by timely and adequate preventive measures and to deal with mental illness when it comes by timely and effective corrective measures.

Overall infrastructure to deal with the problem of mental illness in U.P.:-

There are 3 mental health hospitals one each at Agra, Bareilly and Varanasi (Mental Health hospitals at Agra and Varanasi have been inspected earlier in January, 2008 and July, 2007 respectively and the review reports submitted to the Commission). There are 8 medical colleges located at Meerut, Aligarh, Agra, Kanpur, Lucknow, Gorakhpur, Allahabad and Varanasi each with a department of Psychiatry. King George Medical College Hospital, Lucknow has one of the biggest general

hospital psychiatric units in the country with a bed strength of 200. Incidentally Lucknow has also one of the oldest private Psychiatric hospitals called Noor Mazil hospital. Practising Psychiatrists (Private) are also available in most of the cities and towns.

Historical background of Mental Health Hospital, Bareilly:

Bareilly is a divisional and district headquarter in U.P., has a large army cantonment and a population of 1.2 million. The hospital was established by the colonial rulers in 1862, 3 years after the Agra mental asylum (now renamed as IMHH, Agra) as a mental asylum and the name was subsequently changed to Mental Hospital in 1925.

It is located 0.5 kms. away from the city centre and 3 kms from Bareilly (North) Railway Station. It is managed by the Health Department, Government of Uttar Pradesh. Antiquity could be a source of strength as well as liability. Old institutions over a period of time acquire maturity as also a standing and repute for the good work done and contribution made. Physical and academic infrastructure, human resource development and management related activities etc. tend to stabilize and the satiety of the clientele for whom the institution has come into being also tends to reach optimal levels. The weaknesses and liabilities, however, spring from the following:-

- rules and regulations governing the functioning of the institution become archaic and irrelevant in view of the sweeping changes which follow;

- State Government policy of recruitment, posting and transfer ordinarily tends to be largely mechanical, oriented to a rigid bureaucratic procedure; it does not normally aim at or end up putting the right man at the right place at the right time in the right manner. The policy neither promotes human resource development nor the genuine needs of a social service institution. Adhocism and contractual appointments with consolidated wages tend to be disincentives to attract talent to government institutions;

- Budgetary constraints and poor scales laid down for expenditure against food, dress, linen, sanitation and personal hygiene remain uncorrected for years;

- Policies flowing from traditionalism and conservatism are opposed to reforms and change and are often associated with negativism;

- Lack of right initiatives results in acute shortage of professionals (psychiatrists, clinical psychologists, psychiatric social workers, technicians etc.); such shortage does not get corrected over years as (a) number of seats in M.D. Psychiatry, Diploma in Psychological Medicine, Diploma in Psychiatric Nursing, M.Phil in Clinical Psychology, Ph.D. in Clinical Psychology and Ph.D. in Psychiatric Social Work remains limited and unchanged [this is reportedly largely on account of the rigid and bureaucratic approach and procedure followed by the Medical Council of India (MCI)] (b) scales of pay and allowances and various other incentives remain static for a long period (c) opportunities for exposure of professionals to seminars, symposia and workshops are not enlarged and facilitated and, therefore, avenues of human resource development remain limited (d) avenues for imparting psychiatric training to nurses so vital for promoting their professional expertise are not created and sustained (e) required number of staff quarters are not constructed making thereby professionals (MOs, Para medical staff) to commute long distances to come to the hospital for work at considerable personal discomfort, inconvenience and expense which is also time consuming (f) absence of a well equipped library with sufficiently large number of books, journals, periodicals and with the required number of large sized and well furnished reading rooms where professionals can have a window to the ever widening and ever enlarging frontiers of knowledge.

information and expertise in the field of psychiatry, clinical psychology and psychiatric social work.

- The Mental Health Hospital has been an unintended victim of some of these weaknesses and liabilities flowing from its antiquated structure and tradition such as:-

  - It has a jail type architecture;
  - This is a mental hospital; it is still being perceived to be a mental asylum;
  - There are closed wards (7) only; the family ward building has been constructed but is yet to be made operational;
  - There is a female ward with 112 beds but neither a lady psychiatrist nor a lady general duty medical officer is in position. Lady patients usually prefer to be examined by a lady medical officer and resent being examined by a male doctor;
  - Relatives staying with the patients hasten the pace and progress of recovery; at the Mental Health Hospital, Bareilly no family members are allowed to stay or even visit the patients freely;
  - Most of the admissions like Varanasi are involuntary (by reception orders of CJMs);
  - At the rate of one staff nurse for 10 patients atleast 41 staff nurses should have been in position; there are only attendants looking after the patients;
  - Bareilly is a large district and division but there are no satellite clinics like Agra and Ranchi; such a decentralized arrangement would facilitate the

outreach of the hospital and establish a better interface with the people and the community at the grass root level.

Physical infrastructure:

The hospital is functioning in its own premises. It has an extensive ground area of 56 acres and built up area of 39,168 sq. meters. There is a boundary wall all around but there are encroachments specially near the boundary around the agricultural farm. On the south side of the hospital there was an approach road for staff quarters and a Nala for drainage which has been included in and blocked by the premises of School Awanti Bai, Girls Degree College, Bareilly.

- The hospital has direct approach through main road running Gandhi Park to Shyamganj.

- There is no park inside the hospital where inmates can get together with family members for little relaxation and cheer as family wards (open wards) are not functional at present.

- The building blocks being old are likely to develop cracks (both horizontal and vertical), leakage and seepage unless grading plaster and chemical treatment of roof and measures for plinth protection are provided. In many blocks floors have been damaged and door and window shutters have been worn out while some of the blocks including residential units would need complete rewiring (as the old wires have been worn out leaving open the possibility of electrical hazards). The Departmental/Junior Engineer is yet to prepare and give estimates for carrying out repair to these damaged premises.

Human Resource Development:

Dr. Raghav Ram took charge as Director of the Mental Health Hospital w.e.f. 9.10.2008. The incumbency of the Directors during the last

7 years, dates of joining and discipline to which he/she belongs are contained in the Table-I below:-

Name of the incumbent	Discipline	Date of joining
1. Dr. P. Singh	M.B.B.S. (General)	21.6.01 to 23.9.04
2. Dr. (Mrs.) S. Sihota	M.D. (Psychiatry)	24.9.04 to 2.11.04
3. Dr. P. Singh	M.B.B.S. (General)	2.11.04 to 31.1.06
4. Dr. M.A. Haque	M.B.B.S. (General)	1.2.06 to 30.4.07
5. Dr. (Mrs.) S. Sihota	M.D. (Psychiatry)	1.5.07 to 9.1.08
6. Dr. Raghav Ram	M.B.B.S. (Paediatrics)	9.1.2008 till date

From the above it may be seen that Directors have been subjected to frequent transfers and postings and there has been no proper continuity of tenure. It is essential that once the selection of the incumbent is made the Director of the hospital should be given a fixed tenure of minimum 3 years so that he/she is able to devote sometime to think and plan the changes and improvements needed in the hospital and is also in a position to implement those changes and improvements.

Rule 20 (F) of State Mental Health Rules specifically provides:-

> 'The supervising officer-in-charge of such hospital or nursing home is a person duly qualified having a post graduate qualification in Psychiatry recognized by the Medical Council of India'.

It appears that no clear and conscious policy has been followed by the State Government in posting a suitable and qualified person as Director who would conform to this statutory requirement. To illustrate, Dr. (Mrs.) S. Sihota the only lady psychiatrist in the State of U.P. who was Director of the mental health hospital, twice has now been posted as Superintendent-in-chief, Women's Hospital, Varanasi which is a predominantly gynaecological and obstetrics institution. Her services

could have been better utilized as Director of MHH, Bareilly or even Superintendent, Mental Health Hospital, Varanasi.

Similarly, a senior Psychiatrist – Dr. S.K. Saxena, M.D. Psychiatrist has been posted as Superintendent, district headquarters hospital whereas his services could have been utilized as a psychiatrist in MHH, Bareilly against one of the three vacant posts. Dr. J.P. Narayan, another M.D. in Psychiatrist has been posted to the district headquarters hospital. On the request of Director, MHH, Bareilly his services are being utilized on all attachment basis from April, 2008. This, however, is purely a temporary arrangement. He could as well be posted to MHH, Bareilly where against 6 sanctioned posts of psychiatrists, 3 are still vacant.

As one enters the room of the Director one is surprised to find that there is no incumbency chart nor is there a single chart or poster to carry the following messages:-

- mental illness is like any other illness;
- it is partly genetic and partly acquired;
- it is largely related to the environment in which one works and lives;
- if the environment in which one works and lives is kind and compassionate and if the treatment of one human being by another is humane there will be limited scope or possibility of mental illness;
- mental illness is not a curse or a sin; it is fully preventable and correctable;
- if despite best efforts and precautions mental illness strikes, there should be no delay in bringing the patient to the hospital for check up, diagnosis and indoor admission, if necessary;

- there should be continuous compliance with the drugs and no scope on occasion for discontinuation which will entail irreversible consequences;

- kindness and compassion should pervade the environment in the hospital where the patient has been kept for treatment as at home where the patient is taken after being discharged from the hospital.

Dr. S.M. Channabasavanna who was the Principal Investigator of 'Quality Assurance in Mental Health Project' (1997-99) had after visiting Mental Health Hospital, Bareilly the following observation to make on the administrative infrastructure:-

> 'The Medical Superintendent is not a Psychiatrist. There are two Psychiatrists and four general medical officers. There are no posts of clinical psychologists, psychiatric social workers, psychiatric nurses or occupational therapists. Surprisingly there is not a single nurse posted in the hospital'.

There has not been much change in the position even 10 years after these observations were made (1998-2008).

<u>Administrative and financial powers of the Director:</u>

The post of Director was created vide GO No. 33505/Sec-2-5-05-07/367/04 dated 18.5.2005. The Director is the Chief Executive of the hospital and is responsible for its smooth management and day to day functioning. He has, however, been vested with extremely limited administrative and financial powers as would be evident from the following Table –II:-

Administrative Powers	• Filling up of Group 'D' employees against sanctioned and vacant posts only.

	• Power to take disciplinary action against Group 'D' employees only. • Power to sanction all kinds of leave to hospital staff. • Power of internal reforms and changes in hospital working for improvement.
Financial Powers	• Power to draw and disburse salary and provident fund of hospital staff. • Power to purchase medicines, raw materials for occupational therapy, food and other contingent items during normal times as well as in crisis within the allotted budget (within a limit of Rs. 1,00,000/-). • No power to raise the per capita expenditure on a patient (which is and should be a minimum of Rs. 500/- per day as at Agra and Ranchi).

The Director does not have the following powers:-

- power to create any post according to the exigencies of a situation;
- power to send any staff member for any specialized training to any institution;
- power to purchase books, journals, periodicals for the library;
- power to outsource certain activities according to exigencies of a situation even if such outsourcing is urgently required for proper functioning of the hospital.

- Power to raise the per capita expenditure on a patient (which is Rs. 500/- in Agra and Ranchi and should be in MHH, Bareilly too).

- Power to reallocate funds from one head of account to another according to exigencies of a situation.

- Even according to the established staffing pattern, there are a number of positions which are lying vacant as would be evident from the following Table-III:-

Name of the position	Sanctioned	In position
1. Director-cum-Supdt.-in-chief	01	01
2. Medical Supdt.	-	01
3. Psychiatrist	06	03
4. General Duty Medical Officers	Nil	Nil
5. Chief Pharmacist & Pharmacist	04	04
6. Attendants	Male – 50 Female – 21	Male - 49 Female - 18
7. Head Attendants	Male – 06 Female – 02	Male – 05 Female – 02
8. Sweepers	Male – 18 Female – 06	Male – 17 Female – 06
9. Ministerial staff	05	03

- No post of Administrative Officer or Accounts Officer has yet been sanctioned even though the hospital is operating a budget size of Rs. 3 Crore.

- The Director indicated that the following essential posts are required as per norm and they need to be sanctioned by the State Government:-

  - Clinical Psychologist;
  - Psychiatric Social Worker;
  - Nurses including psychiatric nurses;
  - Anaesthetist;
  - Radiologist;
  - Pathologist;
  - Tubewell operator

Proposal for creation of these posts and various other related miscellaneous matters has since been sent by the Director to the Director, Health and Medical Services. The references are all placed in Table-IV below:-

Table-IV:

List of Reference letter and proposal sent to Director General, Medical and Health Services, U.P., Lucknow and Medical Secretary, U.P. Government for creation of post/filling sanction post for improvement of the patient care with Mental Hospital, Bareilly (U.P.)

S.No.	Letter No.	To whom written	Subject/Matter	Outcome
1.	MH/E-12/04-05/dated 08.09.04	Director General	Posting of Psychiatrist Doctors	-
2.	MH/E-12/04-05/575/dated 20.10.04	- do -	Posting of Doctors	
3.	MH/FW/2005-06/413 08 dated 08.08.2005	DG, C.C. to Secretary Medical & Health, U.P. Government.	Posting of M.O., Staff Nurse, Para medical staff.	4 Staff Nurses posted in month of Feb.08.
4.	MH/E-12/2005-06/568 dated 05.11.2005	- do -	Posting of Doctors	

5.	MH/Estt./2006-07/35 dated 12.4.2006	DG, C.C. to Secretary, Medical and Health, U.P. Government.	Posting of Psychiatrist Doctors and Staff Nurse.	
6.	MH/Estt./2006-07/183 dated 2.6.2006	- do -	Demand of Nurses Staff.	
7.	MH/CHA/2006-07/341 dated 25.7.2006	Principal Secretary, C.C. Director General, Medical & Health, U.P. Lucknow.	Posting of Psychiatrists.	
8.	MH/CHA Welfare/2006-07/314 dated 26.7.2006	Principal Secretary, U.P. Govt. C.C. Director General, Medical & Health, U.P. Lucknow.	Sanction Staff Nurse and Para Medical Staff.	
9.	MH/CHA/2006-07/654 dated 16.11.2006	- do -	Posting of Psychiatrist.	
10.	MH/Estt./2006-07/219 dated 24.5.2007	- do -	Posting Male and Female Nurses Staff.	4 Staff Nurses posted in the month of Feb.08.
11.	MH/CHA/2007-08/333 dated 3.7.2007	- do -	Posting of Anesthesia.	
12.	MH/CHA/2006-07/302 dated 15.7.2007.	- do -	For posting Female Psychiatrist.	
13.	MH/CHA/2007-08/383 dated 22.7.2007	Director Administration	Posting of Psychiatrist.	

14.	MH/CHA/2007-08/388 dated 23.7.2007.	Director General	Posting of Psychiatrist.	
15.	MH/CHA/2007-08/420 dated 9.8.2007.	Director Administration Principal Secretary and D.G.	Posting of Psychiatrist.	
16.	MH/CHA/2007-08 dated 10.8.2007	Principal Secretary	Posting of Psychiatrist, Nurses, Anaethesia, Lab Staff, X-ray Technician.	
17.	MH/NHRC/2008-09/118/dated 24.5.2008	Director General	Psychiatrist Training to Nurses and Doctors.	
18.	MH/Inv./V.I./2007-08/;806/dated 22.7.006	- do -	Increase sanction post on contract basis.	

Visit to OPD:

Interaction with patients at the OPD and outcome thereof:-

I visited the OPD from 9.30 AM to 11.30 AM on 16.4.2008, met and interacted with the patients and their relatives. In all 31 patients have been registered by 11.30 AM. Of them 13 were examined by Dr. Sunil Srivastav, Psychiatrist and the rest by other doctors. The daily outturn of patients goes upto 100. While the OPD is open from 8 AM to 2 PM and patients with their relatives keep on coming and leaving (after examination) we need to provide a proper sitting arrangement along with toilet, provision of potable drinking water, a newspaper stand with daily newspapers (in Hindi) and periodicals (in Hindi) and a television for listening to news so that patients and relatives are not bored due to long

hours of waiting and have some relaxation. We need to simultaneously ensure the following:-

- for a hospital with a bed strength of 400+ patients and daily average outturn of OPD patients being 100+ we need a registration counter to be manned by atleast 5 to 6 persons with a staff nurse;

- we need a data entry operator to record and store in the computer the demographic data as also other data about the nature and character of ailment;

- we need a large size record room where all files (old and new) could be neatly arranged and kept in required number of steel racks of sufficient height;

- each file should be allotted one hospital serial number and kept year-wise.

  Each file should contain the following:-

  - personal data (name, age, sex, address and occupation etc.);

  - name of the informant;

  - chief complaint/illness;

  - history of the present illness;

  - past history of psychiatric illness and other associated illnesses (appendicitis, cardio vascular and cardio-respiratory diseases, communicable diseases);

  - personal history (marriage, divorce);

  - family history (was the form of mental disorder diagnosed as genetic);

  - premorbid personality (how was the personality before illness).

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The following guidelines should also be kept in mind while dealing with OPD patients:-

- close vigilance should be kept to ensure that in no case and on no account the waiting period should be more than 2 hours as long waiting period for patients and relatives who have come from far off places, often in empty stomach has its attendant complications; this should particularly be watched in case of elderly couples or elderly patients coming from far off places and being not in a stable physical or mental condition to wait for hours;

- close vigilance should be kept to ensure that no patient is brought tied by chains or ropes; in case any patient is found in that condition he/she should be immediately freed;

- if there are patients who are unusually aggressive and violent and are conducting themselves in a manner which may disturb peace and tranquility in the OPD they should be segregated and sedatives should be administered to such patients; they should be kept in a separate observation room which is close to the OPD and be examined as OPD patients only after they have become normal;

- the people at the registration counter should be trained to be civil, courteous and considerate towards the patients; they should be trained not to raise their voice but speak in a soft and sub dued tone;

- the patients should be clubbed under 2 categories namely BPL card and Antyoday Card where the treatment is free and green card (income between Rs. 10,000/- to Rs. 20,000/-) where 25 to 50% of the patients selectively are given free treatment;

- the dispensing unit should also be close to the OPD;

- it should be so managed that dispensing medicine in each case should not take more than 5 minutes;

- the medical officer/psychiatrist examining the patient should issue prescriptions for such medicines only which are available in the store only; issuing a prescription for a medicine which is not available in the store has its attendant complications;

- strict confidentiality should be maintained about each and every case;

- research scholars can study these cases but cannot and should not make use of them for publication in any newspaper, journal.

Table-V gives a breakup of patients registered in OPD during the last 8 years and upto March, 2008. The Director was requested to maintain separately figures of old and new patients who are being registered at the OPD as is being kept in all other mental health hospitals.

Table – V

Patients Attendance in OPD during last eight years

2000 (Jan-Dec)	Male Female	8112 3893	Total 12005
2001 (Jan-Dec)	Male Female	11152 5573	Total 16725
2002 (Jan-Dec)	Male Female	15930 9793	Total 25723
2003 (Jan-Dec)	Male Female	17861 9586	Total 27447
2004 (Jan-Dec)	Male Female	21939 11436	Total 33375

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2005 (Jan-Dec)	Male Female	21762 11256	Total 33018
2006 (Jan-Dec)	Male Female	23674 10278	Total 33952
2007 (Jan-Dec)	Male Female	25950 13840	Total 39790
2008 (Jan-March)	Male Female	6130 3164	Total 9294

Interaction with OPD patients and outcome thereof:

1. **Kaushalya (18):**

She has been brought by her father by a truck from Khamaria in Pilibhit district entailing an expenditure of Rs. 28/- (one way). This is the second time, the patient was visiting MHH, Bareilly, the first being on 2.4.2008. They belong to a low middle class family, the income being limited to barely Rs. 60/- per day. On account of ignorance, the patient was first taken to a private Psychiatrist at Bareilly entailing a high expenditure of Rs. 5000/- including consultation fee, tests and cost of medicines. The patient complains of indulging in loose and irrelevant talks and keeps on remembering Santosi Mata. The patient's father was also afflicted with mental illness and was admitted and treated for 3 months in MHH, Bareilly. He was administered modified ECT.

2. **Israr Ahmed (75 years):**

He is a resident of Gunnaur in the district of Badaun which is about 80 kms away from Bareilly. Coming by bus and rickshaw to the hospital has entailed an expenditure of Rs. 100/-. His wife who has accompanied him is suffering from arthritis. As far as the patient himself is concerned, he indulges in loose and irrelevant talks, has been wandering aimlessly and physically abusing others; he has been shivering too for 11 years. He has also been admitted 11 times in the hospital. His wife stated that there has been timely and continuous compliance with drugs. The patient

appears to be a victim of both neurological as well as mental illness. The slow response and recovery of the patient appears to be due to old age. The case requires multiple screening including CT scan for which minimum Rs. 1500/- is needed which the patient can ill afford.

3. **Anil Singh Sisodia (27 years):**

He has come from Badaun district, has come by bus entailing a one way fare of Rs. 28/-. He has come to the hospital for the 5th time with the complaint of heaviness in head. He has been admitted to the hospital twice and has undergone treatment and has substantially recovered too.

4. **Surjit Singh Katra (22 years):**

He has come from district Shahjahanpur. He appears to have fallen from a jamun tree and got treated by a private doctor. He is under treatment for the last two and half months and is now feeling much better. He indulges in loose, irrelevant and purposeless talks and also cries loudly all the time. He has normal sleep but reduced appetite. He has already spent Rs. 10,000/- to Rs. 12,000/- by undergoing treatment in a private clinic which is a very difficult proposition for a family leading a hand to mouth existence.

5. **Soni (18 years):**

She has also come from Shahajahanpur but has been brought by the police. The patient is suffering from delusional disorders 'such as bells are tolling in my ears, I am being bitten by snakes'. She has also been singing, dancing and weeping in a disorderly manner. Her treatment is going on for the last one year but in between the treatment was discontinued due to death of brother of the patient. Some improvement has come with the second visit. The patient is too poor economically to afford frequent travel to the hospital (which costs Rs. 160/- each time) as also the cost of treatment.

6. **Salim (22 years):**

He has come from Bareilly city, tears clothes, indulges in abuses, threatens physical violence and has reduced sleep and appetite. This is his first visit to the hospital. Even though the disease struck about 6 months back he has come late due to ignorance that such a hospital like MHH, Bareilly with facility for treatment of mental illness is available in the city where he resides. His father is no more, has 2 brothers who are married and living separately. The delay in coming to the hospital and also on account of the fact that he had gone for in treatment in the hands of the Maulana (the religious head of Islam) but did not receive the desired results has made matters difficult for him.

7. **Prema Devi (30 years):**

She has come from Bareilly town. Married about 15 years ago, she is suffering from epileptic fits one year after marriage. She was aware of the existence of the hospital and has come on her own. Her main complaint is her inability to hold anything tight in hand (due to epileptic fits).

8. **Akash (10 years):**

He has come from Village Parsone, District Bareilly after incurring an expenditure of Rs. 50/- (to and fro). He has been treated for epilepsy in the past. His mother who has accompanied him stated that they have a large family of 8 children and find it extremely difficult to make both ends meet with a total income of Rs. 2500/-.

9. **Kisan (6 years):**

He has come from Pilibhit district entailing an expenditure of Rs. 200/- for 2 persons (to and fro). He is diagnosed to be suffering from mental retardation with Psychosis. Prior to coming to Bareilly, the patient was treated in a private hospital for the last 2 years involving an expenditure of Rs. 70,000/- (including consultation fee, CT scan and cost of medicine). He has reduced appetite and sleep and indulges in loose, loud and irrelevant talks.

10. Shyam Prakash alias Sharwan (20 years):

He has come from Hardoi district. This is his 2nd visit to Bareilly. He was addicted to drugs earlier. He refuses to comply with medicines and injections and is quarrelsome. Since Lucknow is near Hardoi and King George Medical College has a full fledged department of Psychiatry with 200 beds he was advised to go to KGMC, Lucknow for treatment as well as follow up which will save him a lot of avoidable expenditure.

11. Somwati (a middle aged woman whose age cannot be ascertained):

She has come from Tehsil Baheri in Bareilly district. She has 2 unmarried daughters and is worried over the bleak prospects of their marriage. Since she is mentally ill she is seeing hallucinations of being killed every moment.

12. Hare Piary (25 years):

She has come from the district of Badaun by spending Rs. 120/- (to and fro). This is her first visit to the hospital. Earlier and during the last one and half yeas she was treated in a private hospital entailing an expenditure of Rs. 20,000/-. She comes from a large family of 7 members and has become a liability in a situation of unstable employment and low income.

13. Kallo Devi:

She is a widow and has been brought by her nephew. She has 4 unmarried daughters and one unmarried son who does not care much about his mother and sisters. The suffering of the patient on account of depression was compounded in the wake of death of her elder son. She has been undergoing treatment in a private clinic for the last 4 years entailing an expenditure of Rs. 10,000/- to Rs. 15,000/- on account of the fact that she or her children had no knowledge about the government mental hospital.

14. **Mahesh Prajapati (25 years):**

He is undergoing treatment as an OPD patient for the last 2 years. His memory is weak, he indulges in loose and irrelevant talks and shows too much of anger and peevishness. With regular treatment and compliance with drugs his condition is now much better.

Outcome of interaction with OPD patients:

- Ignorance of the location of the 150 year old hospital at Bareilly is pervasive.
- The patients come from an extremely poor socio-economic background. They are ignorant and illiterate. They have large families and low earnings. Mental illness has come as a terrible visitation to these families.
- They are going to faith healers or to private practitioners spending in the process huge amounts ranging between Rs. 10000/- to Rs. 15000/- on an average. There is no institutional mechanism which can exercise some control over such exorbitant amount being charged by the private practitioners.
- In the process of going to faith healers there is avoidable delay in bringing the patient to MHH, Bareilly. The condition of the patient takes a turn for the worse due to late coming to the hospital.
- People are coming from long distances and yet they do not know that there is a hospital nearby (like Hardoi and Lucknow where King George Medical College has a full fledged department of Psychiatry with 200 beds); this proves to them too costly later.
- Widows are being neglected by their own children and are brought to hospital by somebody other than the children.
- If mother is a victim of mental illness, the daughters cannot be given away in marriage.

- In case of acute schizophrenia where the patient tears away the prescription or refuses to be given injection admission to the IPD is the only alternative. Bareilly has a severe limitation of the family ward (open ward) not being functional; relatives cannot stay with the patient in the closed ward. In such a situation where the relatives cannot stay with the patient, the possibility of early recovery is remote. Besides, if the relatives simply leave the patient in the closed ward and do not turn up later release and rehabilitation of the patient will be fraught with problems.

Interaction with IPD patients and outcome of interaction:

It was stated that the average stay of a patient is 2 to 3 months in the hospital leaving apart some chronic patients and patients brought by the police. The difficulties in some of these cases where the patients have been effectively treated, have substantially recovered, are fit for discharge but cannot be discharged as nobody is coming forward to take them came out clearly in course of interaction with the patients as under:-

Female Ward:

I Kumari Mirdula is about 11-12 years old. She was admitted as an IPD patient since 8.6.2001. correspondence at the address given at the time of admission is taking place but its an infructuous exercise as nobody from the given address is coming forward to take the patient. The address seems to be wrong or insufficient.

II Munni is about 30 years old and was admitted on 17.4.2006. She was brought by the Police Address given at the time of admission was Haiderganj, Barabanki. The patient's bhabhi and bhaiya are supposed to be living there. Even though hospital authorities entered into correspondence at the said address, there has been no response.

III Smt. Lakshmi (30). Her date of admission is 22.10.99. The hospital authorities have entered into correspondence in the

address given at the time of admission but nobody has turned up so far.

IV In the following cases there is no response from the relatives in the address given at the time of admission:-

- Khillo Devi (30) DOA: 17.9.84;
- Km. Ramola (20) DOA: 25.7.90;
- Bimla Bihari (46) DOA: 1.9.90;
- Smt. Arti Das (35) DOA: 18.3.94 (from WB);
- Smt. Warisha (42) DOA: 2.11.94;
- Safia (45) DOA: 1.7.96;
- Bhusan Sethi (53) DOA: 5.2.2006

  (she is a patient of chronic schizophrenia and her brother is a Dy. CMO. She was sent with police escort but he refused to accept her.
- Usha Saxena (50) DOA: 4.12.98;
- Madhubala (35) DOA: 12.3.2004;
- Beena Kumari (40) DOA: 1.7.92;
- Kamla (unknown patient) DOA: 27.9.91;
- Alka Rastogi (50) DOA: 21.8.88.

<u>Male Ward:</u>

I Pradeep Kumar Mishra, a resident of Varanasi was admitted by the father on 17.4.97 at the age of 41. This is a case of schizophrenia but is currently in an improved state. The patient's sister is not willing to take back the patient due to dual responsibility of taking care of her family and her old father.

II Kamal Kumar Jaiswal, a resident of Nainital admitted by father on 28.6.88 at the age of 50 years. This is a case of Schizophrenia. Nobody from the family meets him and was not accepted by the brother when attendant staff escorted him to his home.

III Madan Lal Shah, a resident of Lucknow was admitted by his father on 17.9.79 at the age of 54 years. This is a case of Schizophrenia. During the last 6 years nobody from the family has visited him.

IV Sabir Hussain a resident of Uttaranchal was admitted by his wife on 22.12.2003 at the age of 64. He was treated for Schizophrenia and is in an improved state. Inspite of protracted correspondence none is coming to take him back.

V Sailendra Singh, a resident of Pilibhit was admitted by his father on 28.2.95 at the 48 years. He was treated for Schizophrenia and is now in an improved state. He was escorted to his home by escort staff of the hospital but his brother refused to accept him and, therefore, he had to be brought back to the hospital.

VI Prabhu Dutt Jha was admitted by his father on 1.2.93 at the age of 48 years. He was treated for Schizophrenia and is now in an improved state. His father never visited him after he was admitted. He was sent home by the escort staff but the house was found locked.

VII Bhagwan Prasad was admitted by his father on 28.4.1994 at the age of 59 years. He has been treated for Schizophrenia but condition has not registered any improvement. His father (who must be pretty old) has not come to meet him even once during the lat 14 years.

VIII Mahesh Vohra was admitted by his brother on 27.5.2006 at the age of 49 years. He was treated for Schizophrenia and is in an improved condition. His brother, however, who got him admitted does not acknowledge the correspondence sent to him by the hospital authorities.

IX Mukesh Joshi who was admitted by his mother on 29.6.2002 at the age of 49 years has been treated for Schizophrenia and is in an improved condition. He was discharged and escorted to his home when both his mother and brother refused to accept him.

X Brij Mohan who was admitted by his brother on 31.1.2004 at the age of 35 years has been treated as a case of Schizophrenia. He has since improved and is fit to be discharged. His brother, however, has not come to meet the patient even once after admission.

Non acceptance of a mentally ill person who has been admitted and treated and who has substantially recovered by the relatives and family members has led to their long stay and resultant incarceration inside the closed ward in the mental hospital. Some sincere efforts are being made by the hospital authorities to bring down incidence of such long stay even though they have not fully succeeded. The efforts are as under:-

- counselling of the family member/relative/guardian at the time of admission;
- involvement of NGOs;
- repeated correspondence for whatever its worth.

Further suggested course of action:

- A mentally ill person who has recovered but who is not acceptable to the family members and relations should be maintained at the cost of the state. Such a provision exists in Chapter VIII (Section 78) of Mental Health Act, 1987. To quote:-

  'Section 78 – cost of maintenance to be borne by Government in certain cases – the cost of maintenance of a mentally ill person detained as an inpatient in any Psychiatric hospital or psychiatric nursing home shall, unless otherwise provided for by

any law for the time being in force, be borne by the Government of the State wherein the authority which passed the order in relation to the mentally ill person is subordinate if (a) that authority which made the order has not taken an undertaking from any person to bear the cost of maintenance of such mentally ill person and (b) no provision for bearing the cost of maintenance of such a District Court under this chapter.

Section 79 deals with the procedure for submitting an application to District Court for payment of cost of maintenance out of the estate of the mentally ill person or from a person legally bound to maintain him.

Table-VI below gives a complete picture of admission and discharge over last 8 years which indicates that the pace of discharge has been quite slow for reasons already explained earlier.

Table – VI

Admission and Discharge over last eight years

Year	Admission			Discharge		
	Male	Female	Total	Male	Female	Total
2000 (Jan-Dec)	357	69	426	347	64	411
2001 (Jan-Dec)	351	73	424	350	42	392
2002 (Jan-Dec)	436	146	582	484	135	619
2003 (Jan-Dec)	535	162	697	359	101	460
2004 (Jan-Dec)	532	227	759	692	228	920
2005 (Jan-Dec)	405	109	514	393	117	510
2006 (Jan-Dec)	326	117	443	325	103	428

2007 (Jan-Dec)	391	96	487	354	96	460
2008 (Jan-March)	75	10	85	81	50	131

Right to Food:

Table-VII below indicates the timing of breakfast, lunch and dinner and the menu for each. The following deficiencies were observed in the kitchen and serving of food which need attention:-

Table - VII

Menu of breakfast, lunch and dinner for admitted patients:

Date	7.30 AM to 8 AM (Breakfast)	10 AM to 10.30 AM (Lunch)	6.30 PM to 7 PM (Dinner)
Monday	Tea, Daliya	Roti, Rice, Dal, Salad, Vegetable according to season.	Roti, Dal, Kichadi, Vegetable according to season, pickles.
Tuesday	Tea, Daliya	Roti, Rice, Dal, Salad, Vegetable according to season.	Roti, Dal, Kichadi, Vegetable according to season, pickles.
Wednesday	Tea, Daliya	Roti, Rice, Dal, Salad, Vegetable according to season.	Roti, Dal, Kichadi, Vegetable according to season, pickles.
Thursday	Tea, Daliya	Roti, Rice, Kadi, Salad, Vegetable according to season.	Roti, Raita Bundi, Dal, Kichadi, Vegetable according to season, pickles.

Friday	Tea, Daliya	Roti, Rice, Dal, Salad, Vegetable according to season.	Roti, Dal, Kichadi, Vegetable according to season, pickles.
Saturday	Tea, Daliya	Puri, Pulao, Chholey, Rajma, Raita Bundi, Salad, Vegetable according to season.	Roti, Dal, Kichadi, Vegetable according to season.
Sunday	Tea, Daliya	Roti, Rice, Dal, Salad and Vegetables according to season.	Roti, Dal, Kichadi, Vegetables according to season, pickles.

I The kitchen block is quite old and suffers from the following deficiencies:-

- there is no chimney to provide an outlet for smoke;
- sufficient number of barlights and exhaust fans have not been fixed to ensure adequate lighting and ventilation;
- there are no separate platforms for washing, cutting and storing of vegetables meant for cooking;
- there is no electric kneader and no chapatti making machine;
- there is no arrangement by which food after being cooked could be stored in a stainless steel container hot before being served.
- in the absence of dining shade and dining table food is being served in open space which is unclean, unhygienic and could be making the patients more vulnerable to infection;

- the timings for serving of food are odd; the gap between dinner and breakfast is 12 hours while the gap between lunch and dinner is about 8 hours. Such huge gaps are likely to cause gastric problems;

- there is no dietician to verify and attest that the food being served conforms to a minimum kilo calorie of 2500 for female patients and 3000 kilo calorie for male patients;

- there is need for supplementation in such cases where the patients are malnourished or underweight and are in need of high calorie diet. No such special attention appears to have been paid so far.

Suggestions:

- Food articles (including vegetables) should be issued from the central store according to an order of authorization and in each shift.

- Three to four patients should draw ration from the central store as per entitlement per day.

- Food articles drawn from the store should be cooked in front of the supervisory staff as well as patients who draw the ration so that pilferage, if any, is prevented and there is complete accountability and quality control in storage of food articles and preparation of food.

- Monthly medical check up of food handlers/cooks should be conducted.

- Testing of food by supervisory officers should be done before it is served.

- Food which is highly unclean and unhygienic should not be served in open space. Dining shades should be constructed without further delay and dining tables should be installed at the earliest.

- Trolleys should be ordered on priority for transportation of food from the kitchen to the wards.

- The Indian Council of Medical Research (ICMR) has prescribed certain nutrient requirements and recommended dietary allowance for able bodied adults (women and men). These are contained in a table given below:-

Group	Particulars	Body Weight (kg)	Net Energy	Protein (gm)	Fat (gm)	Calcium (gm)	Iron (mg)	Iron (retinal)	Bita Vitamin
Man		60	2425	60	20	400	28	600	2400
Man		-	2875	60	20	400	28	600	2400
Man		-	3800	60	20	400	28	600	2400
Woman		50	1875	50	20	400	30	600	2400
Woman		-	2225	50	20	400	30	600	2400
Woman		-	2925	50	20	400	30	600	2400
Woman		50	+300	+15	30	1000	30	600	2400
Woman		-	+550	+25	30	1000	30	950	3800
Woman		-	+400	+18	45	1000	30	950	3800

- The concept of balanced diet (a balanced combination of carbohydrates, protein, fat, calcium, iron, Vitamin A, Thiamin, Riboflavin, Nicotinic acid, Pyridoxin Ascorbic acid, Folic acid, Vitamin B-12 is not a search for the moon which is utopian but possible, feasible and achievable. Such a package can be designed by making use of locally available cereals, pulses, fruits and vegetables.

- To illustrate, the fruits and vegetables which are available in Bareilly and surrounding areas and which contain Carotene

(Vitamin A), Vitamin 'C', Vitamin B-12, Iron, Calcium, Folic Acid, Zinc selectively are:-

Carotene (Vitamin A) rich foods:
Vegetables:

1. Bathua – 1740;
2. Carrot – 8840;
3. Carrot leaves – 5700;
4. Coriander leaves – 6918;
5. Raddish leaves – 13000;
6. Spinach – 9440;
7. Turnip green – 9336;
8. Curry leaves – 21000;
9. Beet green - 5862

Fruits:

1. Raspberry – 1248;
2. Jackfruit – 175;
3. Mango ripe – 2210;
4. Orange – 2240;
5. Papaya – 2740;
6. Green chillies – 2430;
7. Tomato ripe – 3010;
8. Pumpkin – 2100

Vitamin 'C' rich foods
Vegetables

1. Drumstick leaves – 220;
2. Coriander leaves – 135;
3. Lemon – 59;
4. Lemon sweet – 45;
5. Lime – 63;
6. Tomato ripe – 57;
7. Cauliflower – 56;
8. Drumstick – 120;

9. Chillies green – 110;
10. Turnip greens – 180

Fruits:

1. Amla – 600;
2. Guava – 212;
3. Orange – 30;
4. Orange juice – 64;
5. Papaya ripe – 57;
6. Strawberry – 52;
7. Pineapple – 39;
8. Lime sweet malta – 54.

Iron rich foods:
Vegetables:

1. Lotus stem dry – 60.6 (kamal ki kakdi)
2. Turmeric – 67.8;
3. Niger seeds – 56.7;
4. Cauliflower greens – 40.00;
5. Turnip greens – 28.4;
6. Bengal gram leaves – 23.8;
7. Cowpea leaves – 20.1

Fruits:

1. Coconut dry – 69.4;
2. Mango powder – 45.2

Calcium rich foods:

1. Ragi – 344;
2. Wheat flour – 48 (whole)
3. Bengal gram – 202 (whole)

4. Bengal gram dal – 154;
5. Rajma – 260;
6. Soyabean – 240;
7. Bathua leaves – 150;
8. Bengal gram leaves – 340;
9. Carrot leave – 340;
10. Cauliflower greens – 696;
11. Curry leaves – 830;
12. Radish leaves – 310;
13. Turnip green – 710;
14. Coriander leaves – 184.

Milk/fruits:

1. Coconut dry – 400;
2. Dates dried – 120;
3. Buffalo milk – 210;
4. Cow milk – 120;
5. Goat milk – 170;
6. Curd (cow milk) – 149;
7. Channa (cow milk) – 208;
8. Channa (buffalo milk) – 480;
9. Cheese -790;
10. Skimmed milk powder – 1370; (cow milk)
11. Whole milk powder – 950 (cow milk)

Vitamin B-12 rich food:

1. Buffalo milk – 0.14
2. Cow milk – 0.14
3. Curd (buffalo milk) – 0.10

4. Curd (cow milk) – 0.13
5. Skimmed milk powder – 0.83

Folic Acid Rich Foods:

1. Bengal gram – 186;
2. Green gram – 140;
3. Cow pea – 133;
4. Black gram dal – 132;
5. Lady's finger – 105;
6. Spinach – 123;
7. Soyabean – 100;
8. French beans – 45;
9. Wheat whole – 36;
10. Tomato ripe – 30;
11. Carrot – 15;
12. Skimmed milk – 12.5;
13. Cow milk – 8.5

This may not be treated as something exhaustive but only illustrative. The purpose of this elaborate exercise is twofold: (a) Mental Health hospital has a large agricultural form (b) the hospital authorities should be in a position to switch over by way of diversification to such fruits and vegetables which have the above nutrients (beta carotene, vitamin C, Iron, calcium, Vitamin B-12 and Folic Acid. The Agriculture Supervisor who is planning the year long production process should be given a short term orientation and training in nutrition and nutritive value of food so that the entire planning process can be shaped accordingly.

Right to potable water:

In dealing with right to potable water the following questions need to be addressed:-

- whether arrangement for storing sufficient water for cooking, cleaning, bathing, drinking etc. @ 135 litres per head in the overhead storage tanks had been made;

- whether arrangement for distribution of water to all wards (both male and female) for the purpose of cleaning, washing, cooking, bathing, flushing (the cistern in the toilet) and drinking has been made;
- whether care has been taken to ensure that the pipelines meant for distribution of water do not get intermingled with sewerage lines;
- whether care has been taken to ensure that the over head tanks are being cleaned by using the state-of-art-technology with mechanized dewatering sludge removal, high pressure cleaning, vaccum cleaning, antibacterial spray and ultra violet radiation;
- whether samples of water are being collected and sent to approved PH Laboratories to ensure the following:-
    - o water is free from chemical and bacteriological impurities;
    - o water is free from excess of iron, calcium, sodium, sulphur, magnesium and floride;
    - o it has no colour, no hardness and no alkalinity;

• The management of Mental Health Hospital have not been able to respond to all these points clearly and convincingly. For example, they have acknowledged that water supply is sufficient without doing an arithmetical calculation in the following manner:-
    - sanctioned accommodation – 408 (male -296, female – 112);
    - functioning accommodation – 280 (male -168, female – 112);
    - we have to provide for water storage capacity for the sanctioned accommodation i.e. 408.

- we need to ensure provision of water @ 135 litres per head (which should include both patients as well as supporting staff who stay and work inside);
- the total requirement of water should, therefore, be (408x500) litres or 2.04 lakh litres in the minimum.

- Any storage capacity less than this would be a violation of right to water.
- Similarly, it is neither clear nor convincing when hospital authorities say that water testing is not being done and water sample is not being drawn and sent to any laboratory.
- This is clearly a violation of the democratic right of all the inmates to potable water.
- Very often intermingling of water supply lines does take place with sewerage lines and water gets contaminated. Sometimes cracks appear in the pipelines (when such pipelines outlive their utility due to sheer and efflux of time) making water meant for drinking water purpose open to pollution and contamination. The pipelines need replacement in such a situation. We need to be vigilant and surveillant about all these possibilities. Instead of being vigilant and adopting precautions the hospital authorities have simply taken a stand 'Drinking water is supplied through large tube well and submersible water pumps. Water supply is sufficient which is about 40 litres per head'. They have clearly lost sight of the need of water for bathing, cleaning, cooking, washing, flushing etc.

Right to Sanitation:

Right to sanitation implies:-

- every ward should have attached toilet facilities;
- the toilet should have an enclosure, Indian commode (IC), Western Commode (WC) and cistern;

- the flushing arrangement and availability of water for the toilets should be adequate;

- all old service latrines should be converted to sanitary latrines with glazed tiles to cover upto 1 metre height;

- the toilets should be kept neat and dry;

- the toilet patient ratio should be 1:4 in the minimum.

The Hospital authorities have not taken care to respond to any of these points except stating that patient toilet ratio is 5:1.

Right to personal hygiene:

In dealing right to personal hygiene it is important to address the following questions:-

- personal hygiene starts with the kitchen and goes to the wards, dining table, OT, toilet, library, reading room and assembly places;

- at the kitchen cooks should be provided with apron, cap and nasal mask in 2 sets;

- separate toilets for male and female kitchen staff should be provided;

- there should be provision for supply of hot water in the kitchen;

- the utensils should be made of stainless steel (not aluminum) (they do not absorb dust);

- utensils should be thoroughly cleaned in each shift after cooking;

- laundry services should be mechanized as manual laundering operations lead to accumulation of water at a point and an unclean and unhygienic environment;

- the mechanized laundry should have the following components:-
  - collection of clothes;
  - washing;
  - drying;
  - pressing;
  - delivery.

- for 408 beds as in MMH, Bareilly we may go in for a 200 kg capacity mechanized laundry with a washer, extractor and drier;

- bedsheets, linen, pillow covers and clothings of patients should be collected, washed, dried up, pressed and delivered within 48 hours;

- the clothings of inmates should be changed once in 3 days, linen twice a week and bedsheets also twice a week;

- adequate quantity of soap, detergents etc. to the inmates should be issued in case there is no mechanized laundry and some of the inmates may like to wash their own clothings;

- adequate quantity of oil (preferably coconut and not mustard) and lifebuoy soap should be issued to the inmates to use them while taking bath and to keep themselves clean;

- the preference of the inmates for a particular oil may be ascertained before supplying the oil; if they prefer shampoo, the same should also be made available;

- the toilets should be regularly cleaned with detergents and chemicals to present a tidy and hygienic look.

(13)

- There is no response to any of these issues relating to personal hygiene from the side of the hospital.

Supportive services:

- It was acknowledged by the hospital authorities that the following supportive services are conspicuous by their absence or inadequate:-
  - internal communication facilities are inadequate; there is just one telephone and fax installed in the Director's room;
  - there is no arrangement by which a patient's relative can ring up to have access to some basic information about admission, about the condition of the patient, how he/she is responding to the treatment etc.;
  - there is no emergency ward and emergency beds for male and female patients;
  - due to paucity of funds no journal and periodical for professional use is being subscribed;
  - there is no e-connectivity between the library and various departments/divisions/sections of the hospital;
  - even for the patients except 2 newspapers no other journal or periodical is being subscribed;
  - there are no other avenues of recreation for the inmates; no TV sets have been supplied to the wards;
  - no other cultural activities are being organized with the initiative of hospital administration in which the inmates can participate;

- no yoga or pranayam or meditation activity is being organized by the hospital administration for the benefit of the participants.

Occupational Therapy:

- It is important that the hospital authorities bear the following distinct advantages of right to work and acquisition of skills through occupational therapy for a mentally ill person who is being treated in a mental health hospital;
    - they impart work culture, work ethics and work skills;
    - they impart discipline;
    - they help to develop the right attitude towards work;
    - they promote respect for dignity of labour;
    - they promote constructive development of human mind;
    - they promote physical and mental well being of inmates;
    - they ensure productive utilization of time;
    - they promote dialogue, companionship, a spirit of fellowship or partnership and a cooperative way of living;
    - they promote group adjustment and solidarity;
    - they help to build habits of concentration, steadiness, regularity and precision in work;
    - they promote and develop capacity for sustained hard work;
    - they help to awaken the self confidence, self efficacy and self development of inmates.

- It is, however, not clear if, while selecting the inmates for imparting training in a particular skill, their aptitude, preference and interest have been taken into account.

- It is also not clear if, while selecting the inmates for imparting training in a particular skill only those patients who have been effectively treated, who have substantially recovered or those who are fast on the way to recovery and who are otherwise physically and mentally fit have been selected.

- What is most important in skill training is that it leads to a phase of productive and meaningful rehabilitation in later life. Since the average duration of stay of a mentally ill person as an IPD patient in the mental health hospital is 8 to 12 weeks (2 to 3 months) it is necessary and desirable that the skills which are acquired in the OT unit of the hospital are continued, refined and sharpened and the State Government takes a direct responsibility in this regard.

- There does not appear any evidence as to whether the State Government have ever evaluated the content, quality and impact of skill training as a tool of rehabilitation of mentally ill persons and whether they have taken care to remove the deficiencies to impart strength and resilience to the programme.

Psychiatric Services:

- Since there is no clinical psychologist the following professional services which could have been rendered are conspicuous by their absence:-
    - psycho-diagnostic assessment; IQ assessment, neuro-psychological assessment, personality assessment;
    - psychotherapeutic management, supportive psychotherapy, cognitive behaviour therapy, counselling and guidance, group psychotherapy.

- Similarly, since there are no psychiatric social workers there is no home visit or contact of family members/relatives of IPD patients. In other words, no initiative could be taken in the direction of

reintegration of mentally ill persons who have been effectively treated into the mainstream family, community or society.

- There is no community outreach mental health programme on any day in a week when the faculty members could participate in a community outreach programme as in Agra and Ranchi.

- As far as Psychiatric services are concerned the following principles/issues should be kept uppermost in mind so that with all the limitations around maximum relief could be provided to the IPD patients:-

  I All patients are not required to be admitted. The decision to admit a person should largely depend on the nature and character of illness and has to be taken by the treating physician entirely on the basis of his/her own assessment and not under any duress. Associated management problem is one of the other factors which should be kept in view while deciding in favour of admission.

  II Once a patient is admitted he/she should be subjected to a regular check up of BP, weight, all other parameters and blood profiles atleast once a month. The findings of such examination should be neatly and systematically documented in a register called, 'Medical examination of IPD patients'.

  III Counselling (both drug related and behaviour related) at the time of admission as also at the time of discharge is very important. Counselling promotes awareness among the patients and relatives about the importance of taking the drugs according to prescribed dosages and duration. It instils a lot of hope in their minds that all is not lost. It imparts a new sense of urgency and seriousness among the patients and relatives that correct drug and diet schedule would be beneficial in the long run to the mentally ill persons.

IV Engaging a schizophrenic patient in a warm and yet informal conversation will make him/her feel better. While the psychiatrist should do it while taking the rounds, the frequency of such interaction may be limited. Instead of putting 2 schizophrenic patients together, it may be useful if a patient who has already been treated and who is fast on the way to recovery is put near the bed of a schizophrenic patient who has been admitted and where the full course of treatment is yet to gather momentum or take effect so that he could keep the latter engaged in good conversation and prevent him from withdrawing into a stupor (Schizophrenic patients tend to be withdrawn).

V It is quite possible that a mentally ill person may have other associated complications (related to kidney, liver, lungs, cardio-vascular and cardio-respiratory) for which the mental health hospital in question may not have the expertise or personnel or equipments. In all such cases reference of the patient to a Medical College Hospital (either State run/managed or private) becomes necessary and desirable. The principles which should govern such referral cases are:-

- all such cases should be entertained and admitted; they should never be returned;
- the Medical College hospital should not lay down such conditions as the referring mental health hospital will find it difficult to comply;
- the patient should not be discharged before the full course of treatment has been completed.

In all such cases it should be borne in mind that a patient is a patient regardless of whether he/she has been admitted in a mental health hospital or in a Medical College Hospital. Each and every such case deserves to be treated with kindness and compassion, urgency and

seriousness of concern regardless of artificial differences in the source or origin. Through such an intensely humane approach, the Director, the Medical Superintendent, other psychiatrists and General Duty Medical Officers, para medical staff should be able to generate trust and confidence in the mind of the patients and their relatives. It is with adoption of such an approach that the impact of treatment on the overall health and psyche of the patient would be perceptible. This is the single most important attribute of success in the functioning of a mental health hospital.

- As observed earlier we need a complete team comprising of psychiatrists, clinical psychologists and psychiatric social workers to do justice to psychiatric services.

- To elaborate, a clinical psychologist validates the clinical diagnosis by a Psychiatrist by undertaking a series of psychological tests such as:-
  - Projective test;
  - Thematic perception test;
  - Rosac inkblot.

- Such tests are undertaken after the case history has been referred by the psychiatrist along with the patient and the relatives to the clinical psychologist.

- Reference can be made both at the time of diagnosis and before admission.

- Tests are difficult if the patient is mute and not opening up.

- In such situations relatives have to be interrogated; their cooperation in carrying the psychological tests to a logical conclusion is absolutely essential.

- In normal cases the psychological tests may take about an hour while in more difficult cases the tests may take 2 to 3 days.

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- There are a few positive outcomes of these tests. These are:-
  - validation;
  - counselling;
  - psychotherapy (the way we talk, the manner in which we exercise our options, the way we develop an insight, the way we acquire the strength and resilience to cope with stresses and strains of life);
  - behavioural therapy (how to expose ourselves to stress in a graded manner);
  - assessment of the status of mentally retarded children;
  - motivational studies (studying and assessing factors of strength and resilience as well as risk factors).
- In MHH, Bareilly, in the absence of a clinical psychologist it is not possible to have a composite and consultative assessment of the status of a mentally ill person.

Similarly after the patient has been treated and discharged it is not possible, in the absence of home visits and contact by a psychiatric social worker, to get any feedback about the status of a patient who is receiving domicilliary treatment. Such feedback and its proper documentation is essential to do a correct assessment of the status of the patient when he/she comes for a follow up.

Other significant omissions:

Every Mental Health Hospital should be self sufficient to the best extent possible even though a dependency status cannot altogether be dispensed with. This self sufficiency is extremely important in regard to investigation and treatment facilities. Expressing unhappiness over the sorry state of affairs obtaining in many mental health hospitals, Dr. S.M. Channabasavanna Committee had observed:-

'It is rather upsetting to note that even routine blood and urine tests are not available in more than 20% of the hospitals, even for inpatients. Other investigations such as VDRL, serum lithium estimation, X-ray, EEG, HIV screening, Hepatitis B screenings are available in different hospitals depending on their resources and sophistication. They are present in less than 30% of the hospitals. Even then the routine tests are not available through 24 hours. These tests are no longer considered specialized but are needed to make crucial decisions in treatment.'

In MHH, Bareillly there is no pathology lab. A pathological laboratory building has been constructed but it is yet to be functional as there is no pathologist/laboratory technician. All the pathological tests are being carried out from the district headquarters hospital or private hospitals. In other words, the investment made in the building meant to be used as a pathological laboratory has remained infructuous.

Modified ECT:

- Every such process has 2 components namely (a) administering ECT and (b) recovery. For administering ECT services of a qualified, trained and experienced anaesthetist are needed and the same is being obtained on part time basis from the district headquarters Women's hospital. By the very nature of the operation we need to have both the main ECT room as well as the recovery room air-conditioned. This is not so in MHH, Bareilly. On an average 9 to 10 patients are being administered ECT every alternate day. Dr. Rakesh Dubey, M.D. in Anaesthesia from the Women's Hospital, Bareilly who is administering the ECT stated that during the last 4 months since he is looking after this work there has not been a single casualty. On an average a patient takes about half an hour to recover after modified ECT has been

administered. There should be 2 proper beds with a cot in the recovery room. At present only 2 mattresses have been kept.

- In a B class city like Bareilly with 1.2 million city population it was painful to note that supply of electrical energy is only for 16 hours a day and for the remaining 8 hours either there is total load shedding or erratic supply with frequent interruptions. Since uninterrupted supply of electricity is a must while modified ECT is being administered, there is urgent and imperative need for a dedicated generator set or high power inverter. This should be procured and installed at the earliest.

- The Director has prepared a list of machines and equipments with adequate justification for the same. The list is contained in Table-VIII below. I have scrutinized the same and feel that the machines and equipment proposed in the list are related to the genuine needs of the hospital and the same should receive urgent priority consideration of the State Government.

Table – VIII

Machine and Equipment which are needed for Office and Hospital

S.No.	Name	Quantity	Estimated Cost in Lakh	Justification
1.	Tractor 35 HP with accessories	01	5.00	Existing 9 acre farm and additional land which can be better utilized as farm.
2.	Computers	02	1.00	One for OPD and One for Store.
3.	Colour Photocopier Machine	01	1.50	At present no photocopies machine exists in hospital.

4.	Laser and Inkjet Printer	1+1	0.35	Needed with computer.
5.	Scanner	01	0.07	Needed with computer.
6.	Deep Freezer 200 Lt.	01	0.50	Required for kitchen to store vegetables etc.
7.	CT Scan machine	01	150.00	For Hospital.
8.	Boyles apparatus	01	1.00	Only one old machine is available one new boyles machine for giving ECT under Genuine anaethesia is needed.
9.	Defibrillator	01	1.50	Mandatory for ECT room.
10.	Cardiac Monitor	01	1.50	Required for ECT room.
11.	Semi-Auto analyser	01	3.00	For Pathology Lab.
12.	X-ray machine 300 MA	01	5.00	The old X-ray machine is condemned.
13.	Necessary equipment for pathology lab.		5.00	Necessary for Pathology Lab.
14.	Psychological Testing batteries.		1.00	Extremely urgent for psychological testing of psychiatric patients.

Drug Management:

- The annual budget of MHH, Bareilly towards purchase of drugs is around Rs. 75 to Rs. 80 lakhs.

- It was stated that the Director, MHH has complete freedom to purchase drugs within the amount but subject to a limit of Rs. 1 lakh at the time of each purchase. Most of the medicines are under rate contract.
- Dispensing Unit is an integral part of OPD itself.
- On an average about 15 minutes are taken to dispense the medicine; this is much longer than what is required and should be brought down.
- Medicines at the OPD are supplied for 15 days but in cases of long term maintenance therapy or patients coming from long distances the supply of medicines could be for one month.
- No artificial scarcity has ever been created so far.
- No patient at the OPD has been turned away on account of such scarcity.

Canteen Facility:

- Patients coming from far off places with their relatives leave in the late hours of the evening/night to reach OPD in MHH, Bareilly in the early hours of the morning.
- The MHH is located 3 km from the Railway Station and bus stand.
- The patients with their relatives have to wait for atleast 2 hours to get the examination completed and to collect medicines before leaving. A slightly longer time would be needed where blood and urine samples will have to be collected for pathological tests.
- The patients along with relatives cannot leave till OPD examination, collection of medicines and all other formalities have been completed. At the same time, it will be inhuman to keep them in a hungry stomach since no other alternative to a canteen is available.

- The city and restaurant services in the city being away it will be expensive and time consuming for them to go to the city to have some food.

- The best course of action would, therefore, be to open canteen services for the patients and their relatives within the premises of MHH, Bareilly.

- For construction of a canteen building with adequate sitting arrangement for atleast 100 persons at a time plan and estimates should be prepared and sent to the State Government by the hospital authorities during 2008-09 itself.

- Since Gwalior Manasik Arogyashala (GMA) has recently commissioned a full fledged canteen building for use of patients and their relatives, it may be useful to depute an officer to have a look at the same and to prepare plan and estimates for construction of a similar canteen building for use of patients and their relatives.

Executive Summary of impressions, observations, conclusions and recommendations:-

- Building up of every institution is fraught with problems, constraints and challenges.

- Mental Health Hospital is an important service institution but has certain peculiarities and complexities which distinguish it from other social and service institutions.

- It is also different as in addition to providing dedicated service it is meant to promote, protect and preserve human rights of every patient and persons accompanying them.

- For success of every institution a composite planning is required at the inception of the institution itself.

- This important principle is applicable to MHHs as well.

- Composite planning would mean:-
  - planning the physical infrastructure;
  - planning support services, facilities and amenities;
  - planning Human Resource Development;
  - planning for procurement and installation of all important and essential machines and equipments;
  - planning certain measures which will mitigate/offset occupational risks and hazards of employees.
  - while the 5 components mentioned above are broad heads, each one has got a subset of components/activities.
  - Physical infrastructure would cover the following subsets:-
    - construction of boundary wall; office building and staff quarters;
    - construction of OPD, waiting hall near the OPD for patients and relatives, registration counter, dispensing room, record room, computer room, room for the psychiatrists, clinical psychologists, psychiatric social workers, library with a reading room separately for officers and patients, pathological laboratory, laboratory for psychological tests, x-ray clinic, ECG, EEG, ECT room and recovery room (both to be air-conditioned), central drug store, open wards (family wards) for male and female patients, OT for male and female patients, jail ward (for involuntary admissions), day care centre, half way home, drug de-addiction centre, community outreach programme/satellite clinics etc.

- Support services, facilities and amenities would cover the following subsets:-
  - kitchen;
  - dining hall;
  - canteen;
  - bakery unit;
  - RO plant for potable water; pipelines for distribution;
  - Water storage tanks for storing water for other purposes (cooking, cleaning, washing, bathing, flushing latrines etc.);
  - Conservancy facilities (Indian commode, Western commode, septic tank, sewerage lines etc.);
  - Lighting and ventilation;
  - Emergency services;
  - Telephone/fax;
  - Incinerator for biomedical waste management;
  - Library for officers;
  - Patient's library;
  - Diagnostic centre;
  - Occupational therapy and rehabilitation units;
  - Yoga, pranayam and meditation hall;
  - A hall for get together of patients with parents/family members/relatives.
- Human Resource Development will have the following subsets:
  - selection of personnel to various categories;
  - orientation and training of medical officers and para medics;
  - research;

- participation in conferences (both regional, national and international); presentation of papers; chairing technical sessions;
- teaching;
- publication of papers;
- awarding of M.Phil and Ph.D.;
- evaluation of the content, quality and impact of various academic programmes including teaching and research.

- Procurement and installation of essential machines and equipments would have the following subsets:-
  - preparation of list, placement of orders, acquisition etc.;
  - entering into rate contracts for procurement, installation, repair and maintenance;
  - installation of one dedicated DG set to take care of interruptions and trippings in supply of electrical energy;
  - inventory planning.

- Mitigating/compensating occupational risks and hazards would cover the following subsets:-
  - identifying occupational risks and hazards in each category of personnel;
  - providing for risk allowance and other incentives to sustain employees' morale and motivation;

- MHH, Bareilly was originally intended to be a lunatic asylum in 1862.

- Obviously the type of composite planning with all the components and sub sets as highlighted in the earlier paras would not have been possible then.

- All the 3 structures at Agra, Bareilly and Varanasi are about 150 years old.

- Many of the barracks/buildings which were built with lime and mortar without any DPC and without plinth protection (as RCC structures are a recent phenomenon only) have outlived their life; they are unsafe and may collapse at any point of time.

- Regretfully the whole approach to the issue of repair and maintenance as of now has been adhoc, piecemeal and unscientific. Funds are being allotted on a piecemeal basis for repair and maintenance which are grossly inadequate; in the process many important items of repair swork are being left out.

- The correct way to go about the whole issue is to make a reference to National Building Research Institute (NBRI) at Roorkie about the safety, stability and durability of the structures.

- If the NBRI team, after inspection of the structures and testing of safety of foundational structure opine that the building is unsafe for human habitation a bold and timely decision in favour of dismantling the existing structures would be necessary.

- No adhocism or postponement of a decision would do as safety and security of human life and limb are involved.

- Equally important and urgent is the task of urgent inspection of drainage, sewerage and drinking water pipes (they are most likely to be worn out after 150 years of existence) with a view to replacing them by new and better pipes.

- This action does not brook any delay in the interest of safety, security and personal hygiene.
- Water storage tanks (RCC structures) at IMHH, Agra which had developed cracks are being replaced at a cost of Rs. 1.01 Crore.
- Similar action is required to be taken in regard to water storage tank at MHH, Bareilly as well.
- Regardless of when a decision is taken to dismantle the existing structures on the ground of safety and durability certain decisions are required to be taken on priority basis; these decisions by no stretch of imagination can be postponed:-
  - Family Ward building (comprising of 4 family blocks) is lying ready since April, 2007 and could not be operational as yet due to want of staff, furniture, equipments;
  - These have a total bed strength of 40 and the charges are Rs. 34/- per day per bed.
  - Government of U.P. has been addressed since 10th August, 2007 for sanction of the following posts to make the family ward operational:-
    - staff nurse – 41;
    - psychiatrist – 05;
    - clinical psychologist – 05;
    - attendant 4 over and above 78 who are already there.
    - Anaesthetist;
    - Radiologist;
    - Matron;
    - DG set operator;
    - Tubewell operator;
    - X-ray technician.

- These are yet to be sanctioned.
- Time is the essence in the entire decision making process involving such vital issues.
- If the corresponding supporting staff are not sanctioned the investment made in the family ward building will be infructuous.
- The Divisional Commissioner is the representative of the State Government at the divisional level. He was good enough to spare about an hour (from 6 PM to 7 PM on 16.4.2007) for bringing to his notice a number of inadequacies and deficiencies inhibiting the functioning of the hospital. In particular, the following outstanding issues were discussed with the Divisional Commissioner in his chamber:-

I **Physical infrastructure:-**

The subsets under this main component are:-

- removal of encroachment;
- drainage and sewerage;
- new blocks for the canteen;
- construction of addl. Staff quarters;
- ECG;
- EEG.

II Human Resource Development and Management

III Information, Education and Communication (IEC)

IV Matters pertaining to Police

V Day Care Centre }
Half Way Home } - for rehabilitation of cured patients.

VI Matters pertaining to judiciary

VII Day care centre, Half Way Home, Quarter Way Home

VIII How to break the mindsets of a stigmatized society?

- In course of discussion the following ground level issues were specifically brought to his notice with a request to take them up with Principal Secretary, Health Deptt., Government of U.P.:-

  - sanction of new posts as proposed by the Director, MHH, Bareilly since 10th August, 2007;

  - imbalances in the human resource management due to the faulty HRD Policy of the State Government such as:-

    - there are 3 psychiatrists at district headquarters hospital (including Dr. S.K. Saxena, a senior psychiatrist whose case has been dealt at page 7) Bareilly where there are no beds for admitting mentally ill persons;

    - even psychiatrists are being posted to PHC without any work;

    - all this is a reality at a time when against 6 sanctioned posts of psychiatrists only 3 are in position;

    - even a 400+ bed MHH, Bareilly is going without a clinical psychologist.

    - There are also disparities in scales of pay of attendants in jail, mental hospitals and police (constables) while there is not much of a difference in their duties and responsibilities.

    - There should be a human dimension to every order of transfer and posting. Sometimes orders of posting of a psychiatrist are cancelled without assigning any reason (even though State

Government have the inherent power to do so) even after the orders have been in force for some time. This gives rise to dislocation in home and family life of an incalculable magnitude. The transferred officer becomes the worst victim of such a situation. The order has been cancelled before he could join. He goes back to the old station but is not allowed to join.

- There are several administrative difficulties which could be resolved if a little attention is paid to streamline the procedure. To illustrate, the budgetary allocations are released in June even though the Appropriation Bill is passed by the Assembly in March itself. How do the hospital authorities incur expenditure (both recurring and non-recurring) in April and May without allocations? How do they run and manage the hospital without funds?

- Attendants (80) do become a source of indiscipline in the management of the hospital. Most of them are from Bareilly city and being low paid employees remain at one point for a long time and in the process acquire vested interests. If their salary could be at par with warders in jails the warders and attendants could be made transferable as and when administrative exigencies for such transfer arise.

- Long stay of patients is posing a serious problem. The duration of long stay is ranging between 10 years to 44 years. After the patients have been effectively treated and have been declared fit for discharge, they cannot be discharged on account of the following reasons:-

(3)

- addresses furnished by the relatives at the time of admission have undergone change;

- sometimes the addresses are found to be fictitious;

- protracted correspondence does take place in the given addresses but the entire exercise turns out to be infructuous as there is no response;

- wherever there is a response (these are few and far between) it is negative in as much as there is no willingness to take back the mentally ill persons who have been treated and cured into the fold of the family for more reasons than one;

- there is a variety of situations involving widows, widowers, sons and daughters placed in a widely varying socio-cultural context where mental illness is seen as a taboo or stigma and a mentally ill person is perceived as an untouchable. The grounds on which a mentally ill person is unacceptable to a family and the society are:-

    - old age of parents and their inability due to physical and economic infirmities to look after a young person who was mentally ill and who, even though treated and recovered has substantially lost the capacity to earn;

    - the sister of the patient has been married and has gone into the fold of another family where her husband is not willing to entertain the patient who even though treated and cured will continue to be a liability and cause of social stigma;

    - the husband has remarried and is unwilling to take back the wife into the fold of the family;

- the wife who voluntarily brought the husband and got him admitted into the mental health hospital is unwilling to accept the husband; she is writing to the district authorities against the husband.

- The above are symptomatic of a deep malaise afflicting a sick society. What could be the contributory factors? There is not one but many such as;-

  - unplanned urbanization;
  - unbridled migration in search of the 'golden archipelago';
  - vulgar consumerism;
  - break down of joint family system;
  - atomized family structure;
  - neglect of children and childhood;
  - marital discord, much of it flowing from mutual distrust and suspicion;
  - break down of love relationship;
  - collective social resistance to inter-caste and inter religious marriages, even if the same are based on genuine love;
  - intense discrimination between siblings by parents at home;
  - emergence of too much of adversarial relationship amongst castes, classes, sects and faiths giving rise to mindless violence, hatred and intolerance in a highly stratified society;
  - too much of fads, taboos, obscurantist ideas and practices (witchcraft);
  - too much of parental expectation and pressure on school and college going children to prove themselves and rise to heights which drives the children to desperation and sometimes make them commit suicides;

- neglect of the old by the young;
- a callous and insensitive society and state;
- foot loose governance without transparency and accountability.

* What is the way out?

* The way out is twofold: one is attitudinal and behavioural change which can be brought about by advocacy or a powerful communication strategy. The second is statutory intervention with a positive and proactive District Judge who is the Chairman of the District Legal Aid Society and who can facilitate implementation of Section 78 and Section 79 of Mental Health Act, 1987.

* Under the first we need to design powerful IEC packages containing socially relevant and powerful messages as have been illustrated at page 7 through charters, posters, pamphlets and widely disseminate them through the reception centre/OPD of the hospital, public places, print and electronic media. The messages relevant for rehabilitation and reintegration of a mentally ill person into the mainstream of the society:-

  - mental illness is not a fatality, not a curse, not a sin related to the misdeed of the previous birth (as they believe in Thailand);
  - it is a disadvantage or disability related phenomenon and if detected and treated in time is fully correctable;
  - a mentally ill person is not a non-person but a human being entitled to be treated with the dignity, decency, equality and freedom as any other human being;

* Reference has already been made to the role of the State regarding cost of maintenance of a mentally ill person detained as an inpatient in any Psychiatric hospital or psychiatric nursing home u/s

78 of Mental Health Act, 1987. This role has to be performed by the District Court to whom an application has to be made for payment towards the cost of maintenance u/s 79 of Mental Health Act, 1987. Since District Judge happens to be the Chairman of the District Legal Aid Society he has to make available the services of an Advocate from the said society so that such applications (which will have to be filed by the Director of the Mental Health Hospital) are disposed of as expeditiously as possible and in a manner which are beneficial to the interests of the aggrieved (the mentally ill person).

- To conclude, U.P. has a population of 16.60 Crores with a very high density of population (689) and an estimated load of 16,60,528 cases (major) and 83,02,640 (minor) of mental illness/disorders. To cope with this heavy load of cases it has only 1750 beds in government sector and 275 beds in private sector. The number of professionals to treat these cases required and available are:-

  - Psychiatrists required - 1660 }
  - Psychiatrists available - 115 } - Deficit 1545

  - Clinical Psychologists required – 2490 }
  - Clinical Psychologists available - 20 } – Deficit 2470

  - Psychiatric Social Workers required – 3320 }
  - Psychiatric Social Workers available – 35 } – Deficit 3285

  - Psychiatric Nurses required – 202 }
  - Psychiatric Nurses available – 0 } - Deficit 202

- The above requirement has been calculated according to the following norm:-

  Psychiatrists - 1:0 per 1,00,000 population
  Clinical Psychologists – 1.5 per 1,00,000 population

Psychiatric social workers – 2.0 per 1,00,000 population

Psychiatric Nurses – 1.0 per 10 Psychiatric beds.

- A balanced combination of the above four categories of professionals makes composite planning for a MHH a reality.
- In U.P. in general and MHH, Bareilly in particular that combination or composite planning are sadly missing.
- It is time that we wake up and strive hard to have this combination or composite planning in place without which the entire investment already made will be a big waste or infructuous.
- The planning process to achieve the desired results should involve:-
    - a sustained dialogue with MCI and NCI;
    - substantial improvement in terms and conditions of service of medical officers and paramedics;
    - substantial delegation of administrative and financial powers;
    - sagacious use of such powers;
    - creation of a healthy, congenial, interference free and stress free working environment.

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