A report on the review of the activities/performance of the Institute of Mental Health, Hyderabad by Dr. Lakshmidhar Mishra, IAS (Retd.), Special Rapporteur, NHRC

Date of review: 19.7.2010 and 20.7.2010

A team constituted by NHRC under 'Quality Assurance in Mental Health' and the leadership of Prof. Channabasavanna, former Director and Dean of NIMHANS had visited the Institute in 1998-99 (exact date is not known). This had been preceded by the visit of a team from NHRC under leadership of Justice Shri Ranganath Mishra, ex-Chairperson of the Commission in 1996 (exact date is not known). A gist of the impressions, observations and recommendations of both the teams finds place in 2 publications brought out by the Commission such as:-

I. Quality Assurance in Mental Health, NHRC (1999) (page 141-145)

II. Mental Health Care and Human Rights, NHRC (2008) (page 292-296)

Since no other visit and review by the Commission had taken place during the long interregnum (1998-2010), this was included in my work plan for the year 2010-11, got duly approved by the Hon'ble Chairperson and the visit/review took place between 19-21st July, 2010. The dates were fixed in consultation with the Hospital Superintendent – Dr. Pramod Kumar and Dy. Superintendent – Dr. Anand in advance and a questionnaire designed by me was sent to them with a request to keep the responses ready for discussion at the

time of review. At the end of the review a wrap up meeting took place with Shri J. Satyanarayana, Principal Secretary, Health on 20.7.2010 between 3 PM to 4 PM (since elevated to the rank of Special Chief Secretary, Government of A.P.).

Historical background of the Institute

The Institute of Mental Health, Hyderabad earlier known as Government Hospital for Mental Health Care, was established in the year 1907 and situated at Jalna which was a part of Nizam's Government (presently Jalna is a district in Maharashtra). It was subsequently shifted to Erragadda, Hyderabad in 1908. It is spread over an area of 48 acres which was initially leased from the Royal Air force of Nizam at the rate of Rs. 200/- per acre but subsequently handed over to the Nizam's Government. It is an irony that even more than 50 years after the State of A.P. was born and the land and buildings were transferred to Government of A.P., they have not been formally alienated in favour of the hospital. The original land owners are even today demanding restoration of land to their possession and have filed restoration suits in the Civil Court. The Superintendent who is saddled with the responsibility of managing a 600 bedded hospital is also required to simultaneously attend to these Court cases which consumes a heavy toll of his time. There is a lot of uncertainty associated with the current litigation centering round the land issue and the shape of things to come is not known.

Physical infrastructure:

Of the total land area (48 acres) 2.4 acres have been taken over by the Municipal Corporation of Hyderabad and 1.5 acres have been

taken over by the Hyderabad Urban Development Authority (HUDA) for developing a nursery. The State PWD which was maintaining the land and building has handed over the land (1.5 acres) to HUDA in 1980 for developing the area. Some land has been handed over to the forest department also for developing the area. However, no landscaping has been done and no saplings have been planted in a planned and systematic manner. Instead, there is a lot of outgrowth all over the hospital which could harbour deadly poisonous reptiles not uncommon to this area. The hospital authorities should requisition the services of a good arboriculturist and get a plan for landscaping and plantation of species suitable to the soil so that all the outgrowths could be removed and a sylvan surrounding could be created in a sequential manner much to the happiness and joy of patients, their relatives, MOs, paramedics and other staff.

There is no proper approach road to the hospital. The narrow approach road leading to the Superintendent’s room and the administrative block is gravelly, full of pot holes which are also full of rain water which could be breeding grounds for mosquitoes. All the pathways within the hospital premises connecting one department/unit to another are full of red morrum soil and muddy. They need to be paved properly to establish better inter departmental physical access to each other.

Outpatient’s department (OPD):

On 20.7.2010 (11 AM) I took a complete round of the OPD along with the Superintendent, Dy. Superintendent, Civil Surgeon, Dy. Civil Surgeon and Resident Medical Officer. The following are the impressions emanating out of the visit to the OPD:-

- The waiting hall for patients and relatives is commodious and can easily accommodate at a time 150 persons. There is a continuous flow of patients to the OPD commencing at 8.30 AM but since patients are being called from time to time for medical examination the seats vacated by them are being taken by other patients and thus there is no congestion or overcrowding in the OPD;

- On the left side of the main entrance of the OPD there is a pre-registration desk where an employee of the hospital is issuing serial numbers to the patients so that they can get themselves registered in an orderly manner. At the time of my visit to the pre registration desk 19 slips for new cases and 47 slips for old cases had been issued;

- There are 3 types of cases coming up for OPD treatment such as new, old and follow up cases. The new cases are visiting the hospital for the first time, the old cases are coming for a review by the psychiatrist and the follow up cases are coming primarily for collecting medicines;

- On the right side of the entrance there is one board consisting of eleven instructions in Telugu meant for the patient's relatives on the care, concern and attention which should be shown by them towards a mentally ill person;

- On the left side of the entrance there is a big board in English about the Citizen's Charter, the hospital timings and the services provided. By the side of the big board there is a small board on the provisions of the Mental Health Act, 1987 and

notably about the admission and discharge procedures which are quite helpful for the public;

- On the right side of the entrance there is a staff nurse who is taking pains to explain to the family members/relatives of the patients accompanying the latter about the contents of the prescription, dosage of the medicines, interval at which the medicines are to be taken, how relapse of mental illness can be prevented through better drug compliance and so on. This is a good practice which comes quite handy for patients and their relatives who are illiterate and who benefit immensely from this counselling;

- There are four staff nurses at the registration counter. At the time of registration of a case, all relevant informations are being simultaneously entered in four separate places i.e. main registration record, patient's case sheet, patient's medicine book and index card. On the basis of this information, the case history of each patient is being prepared and the same gets converted to a file. The same goes to a folder which is kept in a rack. In the registration room visited, there were five such racks. Each rack has about 20 folders and each folder has about 400 files. The relevant files are retrieved in barely a few minutes and sent to the MO to facilitate screening of patients;

Deficiencies in the registration room and process of registration:

- The registration room is too small to allow any movement of more than one person at a time. Unlike other hospitals (Institute of Human Behaviour and Allied Sciences, Shahadara, Delhi, Gwalior Manasik Arogyashala, Ranchi Institute of Neuro

and Allied Sciences etc.) there is no separate queue for elderly persons, physically, orthopaedically and visually handicapped, women with children, other male adults and convicts/ UTPs with mental illness being referred by jail authorities or mentally ill persons for whom reception orders have been issued. All patients are entering through one door to register themselves and going back through the same door which makes the task rather clumsy and arduous. The registration counter should be at a slightly higher level so that patients/relatives of the patient can have easy access to the counter in required number of separate queues, can furnish full particulars about the patient to the clerk at the registration counter and get themselves registered in a short time;

– There is no data entry operator near the registration counter to feed the data about personal history, family history, case history and demographic profile of the patient into the computer. With increase in incidence of mental illness and consequent increase in number of mentally ill persons, it is necessary and desirable that all these data are fed to the computer and a proper computerized data base is created for analysis and for drawing conclusions.

The Superintendent was advised to reorganize the registration process, go in for a larger registration room, arrange the patients/relatives in required number of separate queues and post one data entry operator with immediate effect.

The last five years figures relating to registration and attendance at the OPD is indicated in the table placed below:-

DETAILS SHOWING THE NUMBER OF PATIENTS ATTENDING THE OPD IN THE LAST 5 YEARS

YEAR	NEW REGISTRATION			REVIEW CASES		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
2006	4591	2535	7126	63421	24898	88319
2007	4438	2538	6976	63289	37271	100560
2008	4447	2705	7152	73975	32550	106525
2009	4527	2693	7220	60133	43463	103596
2010 up to 06/2010	2960	1475	4435	24019	22301	46320

OP Pharmacy:

At the time of visit to the OP Pharmacy it was found that the Pharmacist – a lady with the help of four nursing students was dispensing the medicines. She informed me that it takes about one to two minutes to take out the drugs prescribed by the MO concerned before dispensing it to the patients/their relatives. All the medicines have been kept in open racks but have not been labelled.

At the time of visit around 12 Noon we were informed that around 150 patients/relatives (old + new + follow up cases) have received the medicines which indicates a good coverage. Considering the heavy out turn of patients both at the OPD as well as at the drug dispensing unit it was suggested by the Pharmacist incharge of drug dispensing unit that five more posts of pharmacists may be sanctioned and posted at the OPD, main store, sub stores etc. This appears to be a reasonable request. The Superintendent may make out a case on

the basis of job content of a Pharmacist's job and formulate a proposal for creation of additional posts if the job content so warrants.

Interaction with nursing students at the OPD:

A few nursing students undergoing practical training in the OPD and drug dispensing unit were interrogated by me. They have come from private nursing colleges to undergo training in Psychiatry for one month. They stated that they were being immensely benefited by the content and quality of the training as also the quality of communication.

Characteristic features of the OPD patients:

- They were coming from far off places in the Telengana region.
- One patient is being accompanied on an average by two to three persons depending on the condition of the patient (more violent/aggressive the patient will be more the number of attendants) incurring thereby heavy expenditure to travel by bus/rail.
- Majority of the patients are below poverty line.
- The ailments in a few cases were a combination of mental retardation, psychotic and neurotic problems, physical illness and disability. Such a combination brought utter misery to the life of the patients as also their relatives.
- Despite disintegration of the joint family system and emergence of an atomized family structure there were exceptional situations where the wives were being brought by the husbands, husbands by their wives, parents by their children and children by the

parents. Such acts were not on account of any social compulsion but out of genuine humane feelings.

- The MOs were attending the patients with kindness, compassion and consideration. On an average they spend about 15 to 20 minutes per patient (time spent on new patients is more while it is much less in case of old patients) and through friendly and informal conversation were able to bring out the best out of the patients/relatives which will help correct and timely diagnosis and treatment.

- PG students were also playing a key role in the screening, diagnosis and treatment of patients.

- Many psychiatric problems could be traced to complicated delivery of the children. A patient was found to be congenitally deaf at the time of birth. This necessitates urgent and imperative need for counselling of all pregnant women.

Impressions arising out of interaction with OPD patients/ relatives:

In all I interrogated 11 OPD patients/relatives with the help of an interpreter and the impressions arising out of the said interview are as under:-

1. Gouragaih is a 45 year old male patient from Nachanpally Village of Siddipet constituency which is 100 Kms away from Hyderabad. He informed me that he is a daily labourer below poverty line and earns Rs. 50/- per day which is much lower than notified minimum wage. He is required to spend Rs. 200/- towards his travelling expenses to visit the hospital and go back.

He has one son and daughter. Diagnosed as a case of Psychosis he has been undergoing treatment for the last 3 years. Every time he visits the OPD for follow up as an old patient, it takes about half an hour to get himself registered, examined by the Psychiatrist and get medicines. As he and his family members/relatives are illiterate the pharmacist does explain clearly the dosage of the medicines and the interval at which they are to be taken. This is found to be very useful. He feels that his ailment is under control with the help of medication. Even though he is illiterate he is able to take the drugs entirely on his own according to the schedule prescribed by the physician.

2. Lachaiah is a 40 year old male patient from Chenyala Village of Warrangal district. He is married with one child. He used to work as an auto rickshaw driver and earns Rs. 100/- per day while his wife works as a domestic help. Diagnosed as a case of psychosis he is undergoing treatment for the last 3 years. He came to see the first symptoms of his illness through hallucinations and imagination of spirits. Even though illiterate, he is able to identify the drugs colourwise and is able to follow the schedule prescribed by the physician. Though there is a ‘feel good’ factor in medication, due to pains and tremors he cannot drive the auto rickshaw as he used to do earlier and to that extent mental illness has made him non functional.

3. Kanaka Durga is a 36 year old female patient from Jeedimetla area of Hyderabad. This is her first visit to the hospital. She had initial complaints of headache, lack of appetite and sleep and a feeling of remorse. She underwent treatment previously in a

private hospital and spent nearly Rs. 5000/- as she was not aware of the existence of the government mental health hospital at Hyderabad (Erragadda). This reinforces the need for giving massive publicity all over – on the walls of the hospital, at the bus stand, railway station, at all other conspicuous places in the city and in all the 23 district headquarters that (a) there is a government hospital for mental health and care at such location (b) it provides OPD and IPD treatment free (c) there is no need for any patient to go to a private hospital by incurring such heavy and avoidable expenditure which drives them to indebtedness and a lot of misery and suffering.

4. Nagamallama is a 50 year old female patient from Guntakal mandal of Ananthapur district which is 300 kms away from Hyderabad. She has two sons and one daughter. Although she had first symptoms of mental illness for the last 4 years, she is undergoing treatment in the hospital only for a year which reinforces the need to inform all other patients through appropriate IEC materials that (a) the following are mental illness specific symptoms (b) the patient should be brought to the OPD of the hospital as soon as these symptoms are found and (c) no attempt should be made to suppress mental illness under any circumstances whatsoever.

5. Mohammad Nakuddin is a 22 year old male patient who was being examined by the Asstt. Professor, Psychiatry in his room. This seems to be a case of mental retardation with psychosis. He is having the ailment for the last 7 years and has been undergoing treatment for the last 6 years. The patient appears to be dumb, mute and totally withdrawn from the existential

reality of the situation around him. He was taken to the National Institute for the Mentally Handicapped, Secunderabad but did not register any improvement as far as mental retardation is concerned. Currently he is able to sleep with medicines.

6. M. Sreenivas is a 18 year old male patient from Thorrimamidi of Ranga Reddy district which is 100 km away from Hyderabad. His relatives accompanying him informed that they had to incur heavy expenditure of Rs. 200/- for one person (to and fro) towards travel expenses. The redeeming feature of this case is that the patient has been brought to the hospital within 10 days since the first symptoms of mental illness were seen. The symptoms are (a) abusing and beating others (b) talking and smiling to oneself. The patient's monthly income was Rs. 3000/- prior to onset of mental illness but currently he is not able to manage his own affairs and there is total loss of this income.

7. Venkataiah is a 35 year old male patient from Mahaboobnagar which is 120 kms away from Hyderabad. The cost of travel one way is Rs. 100/- which is unaffordable for a daily wage agricultural labourer with a meager earning of Rs. 50/- per day. He has been brought to the hospital for the first time by the family members after the initial symptoms of running away from home, purposeless wandering, muttering to self and abusing others without rhyme or reason were seen a few days back.

8. M. Ramesh Babu is a 33 year old male patient from Bakada Village of Nizamabad district which is 250 kms away from Hyderabad and one way travel by bus involves a fare of Rs. 300/- per person. As a toddy vendor, the patient used to earn

Rs. 4000/- per month before onset of the illness. The first symptoms of illness were seen 10 years back when the patient was treated in a private hospital and the treatment involved an expenditure of Rs. 15000/-. The second episode of illness was seen 4 days back and the patient has been brought to the hospital for the first time but without any loss of time. There was an expression of satisfaction in the minds of the family members who have brought the patient that the entire process involving screening, diagnosis, issue of prescription and collection of medicine at the drug dispensing unit was completed in 2 hours between 9 AM to 11 AM.

9. Omar Ali is a 17 year old male patient whom I met in the room of Dr. Rajasekhar, Asstt. Professor, Psychiatry. The space in the room is limited without any wash basin or attached toilet and 2 chairs in front of the MO. The patient was already seen by the doctors of Osmania General Hospital and they referred the case to the Institute of Mental Health, Hyderabad. The patient has been accompanied by his mother and brother. On the basis of preliminary examination Dr. Rajsekhar diagnosed the case as one of developmental delay. The patient's brother informed that the patient's sister is also a patient with mental illness and is undergoing treatment for the last 3 years as an OPD patient in the hospital. Incidentally the patient's brother is now the only earning member in the family (his average earning being of the order of Rs. 3000/- per month).

10. In the second examination room of Dr. Gangaram, Tutor in Psychiatry I met Shri G. Srinivasulu, farmer from Obulaiapalli Village of Mehaboobnagar district. He had 6 acres of farming

land and had taken a loan from the bank to buy a tractor. As he could not run the tractor profitably due to some reason he sold it to repay the loan to some extent and in the process incurred a heavy loss of Rs. 2 lakh. This was enough reason for loss of appetite, sleep, headache and a feeling of worthlessness. The case was diagnosed by Dr. Gangaram as one of moderate depression caused by indebtedness and inability to repay the bank loan.

11. In the third examination room of Dr. Shailaja, Senior PG student of MD I met Smt. Swaroopa from Ibrahimpatnam of Ranga Reddy district. She had hearing problem since childhood. She is married with one child but has been deserted by her husband. She is undergoing the treatment since 2 years and is responding well to the same without any side effects. When she was normal she used to perform regular household chores. Regretfully, however, she stopped the medicines about 8 months back, there was a relapse and she has started manifesting the symptoms of mental illness for about a week. The visible symptoms are (a) abusing and beating the public without reason (b) hallucinations (c) lack of sleep and (d) repeating the same words again and again. The patient's mother informed that she had delayed milestones in her childhood and did not perform well in the school. She studied upto 5th standard and got married at a young age of 18 years. She was born deaf and her mother informed that it was a case of home delivery with all the associated risks and complications.

This case indicates the following contributory factors to mental illness:-

- home delivery with all the risks and complications vis-à-vis institutional delivery which is safe judged by the normal standards;
- disturbed/neglected childhood;
- early marriage;
- educational deprivation;
- discontinuation of psychotic drugs.

Visit to IPD and impressions emanating out of interaction with male and female patients:

The Institute of Mental Health, Hyderabad has the following wards in the IPD:-

- Closed wards;
- Open wards;
- Criminal ward;
- Deaddiction ward;
- Family ward.

Due to constraints of time I concentrated on the male and female open ward, met and interacted with the following patients/relatives staying with them and the overall picture emanating out of the said interaction is as under:-

1. Malla Reddy, A/0149069, Saroor Nagar, Ranga Reddy district:

He was admitted to the hospital on 19.7.2010 with a complaint of hearing voices. Patient's wife – Smt. Yadavva was present in

the ward along with the patient. Their house is barely 20 kms away from the hospital and the food for the attendant is being brought from outside by their nephew. She informed that she is sleeping on the cots provided for the patient's attendant. It appears that these cots under the main bed are made of steel with adequate storage facility. All the patient's beds have been provided with these cots and the attendants are using them. These cots have been donated by the Organizing Committee of the Indian Psychiatric Society South Zone Annual Conference (IPSOCON – 2007).

2. Satyanarayana Reddy, a 55 year old male patient has been undergoing treatment for Schizophrenia for the last 11 years and has been repeatedly admitted seven times.

   The patient's wife reported that they are taking medicines regularly and there is no discontinuation of drugs even once in the last 11 years. Even though the patient has shown signs of recovery, he remains by and large withdrawn, does not interact with the people and does not respond to queries. They have their own house in Hyderabad city where her daughter lives with her in-laws and brother-in-law. Since she has to stay with her husband in the hospital, she is not able to look after the child as well as she would have liked to do. She herself is not able to stay all the time with her husband as she is working as an Aya in a play school. She goes for work in the morning and returns to her husband in the hospital after the school hours. She is cooking her own food in the open area of the male open ward and sleeps on the attendant's cot provided by the hospital.

3. Maruthi is a male patient of Parbani district of Maharashtra State. He has been accompanied to the Institute of Mental Health by his mother, incurring in the process an expenditure of Rs 800/- towards the cost of travel alone. Before admission the patient was suffering from headache with complaints of pelting stones, physically abusing and beating people without reason. Within a few days of admission he has shown signs of improvement and is now fast on the road to recovery.

4. Chand Pasha is a 60 year old male patient from Gulbarga district of Karnataka State. The patient was brought to the Institute by the attendants who had to hire a vehicle for this purpose, incurring in the process heavy expenditure and incurring some loan. The patient who has been suffering for the last 4 years had complaints of wandering purposelessly, shouting, abusing, pelting stones before he was brought to the hospital. He has 2 boys and 1 girl and all of them are woodcutters by profession. The children are young and are going to school.

5. Anil Kumar is a 26 year old male patient from Mehaboobnagar. He is functionally literate and highly educated (he has studied MCA). His younger brother identified the problem and brought him to the hospital. As reported by him in course of interaction the patient could not marry a girl he loved and their relationship broke down about two and half years ago resulting in depression of the patient. Currently, the patient continues to remain suspicious and has been beating the family members out of suspicion.

6. Santosh, a twenty four year old male patient who developed mental illness due to financial problems had to discontinue his education in engineering. Since then he has been remaining morose and withdrawn. His has been diagnosed as a case of mania. The family is passing through a period of acute economic distress due to the following reasons:-

   – the patient's mother is with him in the open ward and has to be supported;

   – his father has undergone oncological surgery which has entailed heavy expenditure;

   – every visit to the hospital entails an expenditure of Rs. 400/-.

7. Syed Majaharuddin is a 34 year old male patient from the Charminar area of Hyderabad. He is a marketing executive by profession. He is an old patient with a history of discontinuation of drugs and relapse. The mother of the patient who was present with him at the time of visit informed that she brought him to the hospital with complaints of purposeless wandering, seeing hallucinations etc.

8. Venkatswamy is a 30 year old male patient admitted a week ago with complaints of lack of appetite, sleep and loose wandering. He has responded well to the line of treatment and is eating well but not having any sleep.

9. Sreenu is a 18 year old patient who has been admitted to the hospital only 3 days back. He has studied upto intermediate.

He was brought to the hospital by his mother with complaints of indulging in loose, irrelevant and excessive talks and causing damage to household articles. His has been diagnosed as a case of mood disorder.

10. Parasuram is a 45 year old male patient and a mason by profession. He has fully recovered from the mental illness for which he was admitted and is now ready for discharge.

11. Venkatesh was admitted 9 days ago with an irritable temperament. He was also indulging in physical abuse and beating his father who had accompanied him to the hospital. As reported by his father he has improved by 25% with medication and is now able to sleep with medicines.

12. Naveen is a 15 year old patient who has been recently admitted to the mental hospital and kept in the same ward where elderly people are undergoing treatment. The Superintendent was advised to shift him to a child psychiatric ward, if any and if not, remove him to the National Institute of Mental Health, Secunderabad.

Female Open Ward:

This ward has been constructed between the male open ward and male closed ward. Like the male open ward, it has adequate space, lighting and ventilation. I interacted with the following female patients and their family members/relatives and the overall picture which emanated out of this interaction is stated as under:-

1. Mahadevamma is a 22 year old patient admitted with mental illness which could be attributed to marital problems. She was

married 6 months ago but using mental illness as an allibii the husband deserted her. The patient's husband and in laws never came to the hospital to meet the patient.

Interaction with the patient revealed that she developed illness after marriage and at her in law's place. Although she stated that she is feeling better after admission on the surface it appeared that she is still maintaining a gloomy appearance.

2. Padma is a 26 year old patient from Bhongir area of Nalgonda district who has been admitted to the open ward barely a week ago. She delivered a child 8 months back and developed the second episode of illness 1 month back. She had a history of post partum depression after her first delivery 5 years ago. The gap between the 2 children is 4 years. The patient continues to remain morose, depressed, withdrawn and suspicious. She is all the while muttering to herself – a symptom she had shown in the previous episode too. The patient is accompanied by her mother. Since advent of the second episode she has been virtually abandoned by her husband and in-laws who have not found time to come and look her up even once.

   The patient's mother is cooking food for herself and taking care of the patient's 2 children – one son (4 ½ years) and a daughter (8 months). Breast feeding was stopped on the advice of the treating physician ostensibly due to the side effects of injectable psychiatric drugs being used by the patient.

3. Swapna is a 21 year old patient from Ramannagudem area of Ranga Reddy district. She was admitted to the open ward 10 days back with the complaint of abusing and beating others. The

patient has been accompanied by her mother. She is married and unlike serial No. 2 her husband and in-laws are coming to the hospital to see the patient.

4. Shabana is a 24 year old patient from Patancheru area of Medak district. She was admitted to the open ward nine days back with symptoms of hysterical convulsion disorder. The patient has responded well to the treatment and is feeling better.

5. Narayanamma is a 30 year old patient from Prakasam district. She was admitted to the open ward 2 weeks back along with her father as an attendant. She is married but has been deserted by her husband as she could not bear to him any child. Her father, the attendant stated that they have to spend on an average for each trip to Hyderabad a sum of Rs. 1000/- towards travel expenses. She has a younger brother who is a daily wage labour. Her father further stated that the patient's condition is showing signs of improvement due to medication and care in the hospital.

6. Prameela is a 40 year old patient admitted to the open ward about a week ago. She hails from Banswada of Nizamabad district. She is a widow with 2 children (1 son and 1 daughter). Her husband committed suicide due to being laden with debts 9 years ago. The patient has been accompanied by her mother. The patient is reported to have developed an account of the medication about 10%.

In course of the round to the IPD, I was given to understand by the Superintendent that there are instances of the family members of the patient deserting the patient on the day of admission to the open

ward itself or 2-3 days after the admission. In such cases the patients are immediately shifted from the open ward to the closed ward and after recovery they are shifted to their homes along with the hospital escorting them. This, however, could lead to a catch 22 situation for such patients. Will they be accepted/entertained by the same family members who have already deserted them?

A summary of impressions from visit to male and female open wards:

Backdrop of open wards:

Open wards were recommended by Prof. Channabasavanna Committee in 1998-99 for the ostensible reason that they will (a) remove social isolation (b) hasten the pace of recovery of patients. The objective has been fulfilled to some extent. There are redeeming features as well as grey areas in the entire experiment.

Redeeming features:

- When a patient is admitted to the open ward, staff nurses will go to the patient and enquire about the place he/she has come from, profession, personal history, family and other details with a view to making him/her feel completely at home.

- Every patient is examined within 24 hours of admission. A separate register is opened for each patient where all body vitals are recorded on the basis of such examination.

- Nursing staff duty hours are spread over in three shifts. In the morning shift 2 staff nurses and 1 head nurse is posted to each ward. Four rounds are performed daily – two in the morning shift,

one in the afternoon shift and one in the night shift. Regular supervisory rounds are also performed in short intervals.

- The toilet patient ratio is 1:6. Cleaning of toilets is being done by an Agency on outsourcing basis. All the toilets are fitted with Indian commodes which, I was given to understand, is the acceptable pattern as most of the patients come from rural background and are not used to Western commodes.

Low Height Steel Cots:

- Cots with storage facility have been provided for family members/attendants. These have been donated by the organizing Committee of the IPS South Zone Annual Conference.

- The average duration of stay is 2-3 weeks for 80-90 PC of the patients. Food is served to the patients in the ward itself (more about right to wholesome, sumptuous and nutritious food at the appropriate place).

- The open ward system has established to some extent the sacrosanctity of joint family system in as much as in a number of cases wives are giving emotional support to their husbands (although the same is not true in case of husbands to wives), brothers are giving support to brothers, mothers are giving support to sons and so on. This demonstrates that the joint family system has not disappeared altogether.

Grey areas:

- Women patients in both closed and open wards are the worst victims of deprivation and neglect. The problems with women

occur soon after marriage. There is an unbridled craze on the part of the husband and the parents of the husband (in laws of the bride) for male offsprings. If women fail to fulfil this craze they fall from grace. Cruelty, neglect and ill treatment at the in-law's place result in the woman being dropped at the parent's place or deserted by the husband or both. The situation takes a turn for the worse when the husband dies. The woman is then treated by the callous and insensitive in laws as a witch or a mankiller with utter disdain. The woman who was already traumatized is driven to desperation and is forced to leave her husband's place. In that state of desperation and depression she is brought to the mental health hospital by her parents.

- Most of the women I interacted with in the open ward (female) appeared to be morose, grief stricken and traumatized for this reason. They were unable to articulate their concerns.

- Children of such patients turn out to be worst victims of deprivation, neglect, malnutrition, misery and suffering.

- Prohibitive cost of travel from far off districts to Hyderabad turns out to be a major financial liability for most of the BPL families which also drives them to indebtedness.

- In the female closed ward the women were not so morose but had put up a brave front even though their husbands and family members were not turning up resulting in prolonged stay of these women going up from five to ten years and beyond.

- In sharp contrast, men in both open and closed wards were healthy and strong, did not have the problems which women faced. Infact, when men were placed in such situations as patients women were with them, feeding them, clothing them and providing the elixir of life by remaining as the men's constant companions. A mild dysfunctionality of a male member of a family is tolerated in the society but not tolerated for women.

A few redeeming features about closed wards:

- The closed wards are large halls with adequate space between 2 beds. There are no cells.

- Every admitted patient is examined within 24 hours of admission. A separate register is opened for each patient where all the body vitals are recorded. No major abnormalcies (loss of body weight, low haemoglobin count etc.) were found in course of examination of the registers.

- During daily rounds, duty medical officers and staff nurses do enquire about the medical condition of patients by spending adequate time with each patient.

- The closed ward sanitation and personal hygiene is maintained by the hospital staff. Adequate number of sweepers have been engaged to clean the wards.

- Recreational activities like television, FM radio, music, indoor games have been provided. Newspapers in all languages (Telugu, English) are being supplied.

Grey areas:

- A few wards are without beds and only mattresses have been provided (orders for 150 cuts have been placed with Central Jail, Cherlapalli and they were expected to be received within one week).

- The patient toilet ratio in both male and female closed wards is 8:1 as against 5:1. More toilets need to be constructed in both the wards.

- In the female ward, there are 21 patients who are fit for discharge but none is turning up to take these patients home. Special mention may be made of 2 female patients namely Ms. Latha and Ms. Janaki who are staying in the hospital for the last 5 and 30 years respectively. Ms. Latha has been declared fit for discharge by the discharge Committee of the hospital but could not be discharged as none from her family is willing to come and take her home. Ironically enough, her father happens to be a Dy. Collector. In case of Ms. Janaki her relatives/family members could not be located so far.

- There are no separate occupational therapy units for male and female patients for their skill training, behavioural therapy and economic rehabilitation.

- There are no psychiatric social workers for undertaking home visits, for imparting family counselling and for providing correct feedback to the hospital authorities on the current status of patients who have been treated, recovered, discharged and sent back home.

- IEC materials (symptoms of mental illness, line of treatment and dos and do nots) are conspicuous by their absence. These could be source of good education and awareness for the relatives/family members of the patients and for the patients themselves.

- There is no worthwhile activity for imparting functional literacy for those patients who are functionally illiterate, who have substantially recovered and who are in a position to imbibe and assimilate the gains of functional literacy. Similarly patients who are literate and who can read out and explain the contents of newspapers and which could benefit patients who need access to such information are not doing so. There is neither any thinking, planning and action in this direction.

Drug Deaddiction Ward:

This is a 10 bedded ward in which 6 patients have been admitted (60% occupancy rate). The details of the cases are:-

1. Shri M. Nagarathnam S/o Mogulaiah is a 55 year old patient admitted on 20.7.2010. He has been admitted with alcohol dependence syndrome. He is currently in the first week of detoxification and is showing withdrawal symptoms.

2. Shri B. Raju is a patient admitted on 29.6.2010 with alcohol dependence syndrome. Withdrawal symptoms are yet to be seen. The patient is currently having liver abnormalities.

3. Shri Ganga Prasad is a patient admitted on 19.7.2010 with alcohol dependence syndrome. He is in the first week of detoxification and showing withdrawal symptoms.

4. Shri G. Sampath is a patient admitted on 19.7.10 with alcohol dependence syndrome. He is in the first week of detoxification and showing withdrawal symptoms.

5. Shri K. Yadagiri has been admitted to the deaddiction ward on 13.7.10 and has completed the first week of detoxification. Since he has developed some psychotic features he was put on anti-psychotic drugs.

6. Shri Malla Reddy has been admitted on 15.7.2010 with alcohol dependence syndrome, has completed the first week of detoxification and is showing withdrawal symptoms.

When asked as to how they got addicted to alcohol, it was reported that they were introduced to alcohol at social gatherings and over a period of time they got addicted to it.

Right to Food:

Right to Food has the following implications:-

I. Location of the central kitchen and its proximity to the wards where food will be transported by trolleys after being cooked in a clean and hygienic environment.

II. Installation of a chimney, required number of exhaust fans, tiling on the wall upto a height of one metre, platforms for washing, cutting and storing vegetables before being cooked, adequate lighting and ventilation, flyproof wiremesh all around, flyproof

automatic closing doors, floors made of an impermeable material, adequate number of taps inside the kitchen, LPG and hotplate, containers made of stainless steel to keep the cooked food hot prior to being served etc.

III. Arrangement for scientific storage of food grains (rice, wheat, atta, flour, besan, suji, idli, rawa, sugar, edible oil, condiments/spices, fruits and vegetables with arrangement for adequate lighting and ventilation and pest control.

IV. Arrangement for medical examination of cooks once in 6 months.

V. Arrangement for change of apron for the cooks.

VI. Arrangement for storage of LPG cylinders.

VII. Transportation of food by trolley to respective wards in a neat and orderly manner.

VIII. Existence of dining hall with dining table for each ward.

IX. Washing of hand and feet of patients before they settle down to food to ensure personal hygiene.

X. Serving of food with a human touch – to ensure that while old, infirm and disabled patients are assisted to take food, there is no wastage of food.

XI. Timings for breakfast, lunch and dinner are such that there is no large gap between them which could cause gastric problems.

XII. Food which is served for breakfast, lunch and dinner is a balanced combination of carbohydrate, protein, oil/fat, trace minerals and vitamins.

XIII. The nutritive value of food should be around 3000 kilo calorie for men and 2500 kilo calorie for women.

XIV. The per capita allocation for food in monetary terms conforms to the above nutritive value.

Redeeming features in observance of the right to food in the Institute of Mental Health, Hyderabad:

- There is a dietician who oversees the process of cooking and serving food.
- Diet Indent book and diet distribution registers are maintained.
- The kitchen block and dining hall (one which was inspected) are fairly commodious in size with adequate lighting.
- Food is being transported from the kitchen to the inmate's block/wards by food trolleys and is being served soon after preparation.
- According to the assessment made by the dietician the nutritive value of food which is being served is 3339.3 kilo calorie per patient per day against an allocation of Rs. 28/- per day.

Grey areas:

- The kitchen does not have an ideal location which could be central to the wards where food will be transported.
- There is no chimney, only 2 exhaust fans, no flyproof wiremesh all around, no flyproof automatic closing doors. Vegetables are cut on tables only (in the absence of properly installed platforms fitted with water taps for washing vegetables).

- The arrangement for storage of food grains (rice, wheat, atta, flour, besan, suji, idli, rawa etc.), sugar, edible oil, condiments/spices, fruits and vegetables is neither adequate nor scientific. The central store room is small and storage of too many items partly on the platforms and partly on the floor makes it rather congested. Storing food grains on the floor would make them vulnerable to pest attack.

- There are a lot of holes present in the kitchen walls. The kitchen floor is damaged at a number of points with water being splashed on the floor (it should be neat, dry and tidy). Similarly some windows have also been shattered and these are not being repaired/replaced.

- There are no benches in the dining hall and patients are taking their food sitting on the floor which contributes to an untidy environment in the dining hall.

- There is leakage of water in the roof of the dining hall.

- While attendants of the open ward patients who came to collect the food generally expressed their satisfaction over the quantity and quality of food one of the patients complained that rice is over cooked and tea should be served in cups instead of pouring tea in the plates.

- The timings for serving breakfast, lunch and dinner are:-

  Breakfast - 7 AM to 8 AM
  Lunch - 12 Noon to 1 PM
  Dinner - 6 PM to 7 PM

This leaves a gap of 12 hours between dinner and breakfast. Such a huge time gap is likely to cause gastric problems. The dietician should, therefore, consult the Head of the Deptt. of Gastroenterology of the Osmania Medical College and Hospital and redesign the time table for breakfast, lunch and dinner.

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

- The hospital is not getting rice and other essential commodities from the PDS under the Food and Civil Supplies Deptt. Since (a) the hospital does not have any agricultural estate like RINPAS, Ranchi (b) the cost of foodgrains and other articles procured from the open market is high and is constantly on the increase and (c) the allocation at Rs. 28/- has limited purchasing power, it would improve matters if Principal Secretary, Health takes up the matter with Principal Secretary, Food and Civil Supplies Deptt. to get the foodgrains at the normal controlled prices from PDS instead of procuring them from the open market at high rates (which eat into the limited outlay on account of food).

Right to Potable Water:

This has the following implications:-

I. The source must not be contaminated.

II. According to the existing established norms 135 litres of water are required per head for drinking, cleaning, washing, cooking, bathing, flushing the toilet. Calculated according to this requirement adequate quantity of water must be stored in the overhead tank.

III. The overhead tank must be linked to all the wards (both closed, open, drug de-addiction, convicts ward etc.) through pipes and a subtank installed for each ward.

IV. The overhead tanks should be cleaned by using the state-of-the-art technology with mechanized dewatering sludge removal, high pressure cleaning, vaccum cleaning, antibacterial spray and ultraviolet radiation.

V. Samples of water should be collected and sent to PH Laboratories to test and certify the following:-

- Water is free from chemical and bacteriological impurities;
- It is free from excess of iron, calcium, sodium, sulphur, magnesium and floride;
- It has no colour, no hardness, no turbidity and alkalinity.

In the Institute of Mental Health, Hyderabad 24 hours supply of potable water to the wards is being ensured through a direct line from the Hyderabad Metro Water Supply and Sewerage Deptt. I was given to understand that the Institute has made available the required extent of land to HMWS&S Deptt. for construction of their reservoir and in lieu

thereof HMWS&S Deptt. has ensured supply of potable water for 24 hours to the hospital.

Samples of water are being regularly drawn at appropriate intervals and sent to the Institute of Preventive Medicine, Hyderabad for testing and certification. On the basis of tests of the said samples conducted no adverse remarks have been received by the Institute so far.

Geysers have been provided in the wards to ensure supply of hot water for bath of inmates in winter. Water coolers have also been provided in some parts of the hospital to ensure supply of cool potable water in summer months.

Right to personal hygiene:

This has the following implications:-

- arrangement for cleaning and pressing of clothings;
- arrangement for supply of hot water for bath of inmates in winter;
- arrangement for haircut;
- supply of hair oil/shampoo/soap in adequate quantity to inmates;
- change of bedsheet, pillow cover, linen at appropriate intervals;
- arrangement for cleaning and disinfection of floors, pantry, dining hall, dining tables and toilets.

The position as it stands in the Institute of Mental Health is as under:-

- The hospital is equipped with an automated laundry with 2 sets of washing machines, hydro extractors, dryers and pressing equipment. The laundry staff collect the patient's clothings at around 8 AM and deliver them after 2-3 days. It was suggested that it may be desirable in the interest of personal hygiene of inmates if the clothings of inmates could be delivered to them on the same day.

- Five pairs of uniforms have been provided to each patient. All patients have been provided with cot, mattress and pillow. The linens are being changed on every alternate day.

- Since there are a lot of outgrowths and uneven grounds with stagnant water accumulating during rainy reason these will provide breeding grounds for mosquitoes and insects. There is an urgent and imperative need for anti-lice, anti-bug and anti-malaria measures.

- Separate barbers are reported to have been appointed for male and female patients who are reported to be taking care of the shaving, haircut, cutting of nails etc. of the patients.

- In response to the questionnaire prepared by me it has been stated by the hospital administration that 'all the wards are kept clean and tidy'. This does not appear to be the ground level reality for the following reasons:-

    – The entire landscape on which the hospital has been constructed, appears to be uneven i.e. having different levels without care being taken to provide an outlet for

discharge of rain water. Consequently water has accumulated at a number of points;

- The whole area has not been paved; wherever the area remains unpaved, it becomes muddy during rains;

- MOs and staff nurses who are taking rounds of the wards will be treading these muddy tracks and will be bringing the dirt to the wards making them untidy.

The Superintendent of the Institute should discuss the problem arising out of uneven landscape (high and low) on which the hospital building has been constructed, with the State PWD, take measures to get the entire area properly paved and provide the required number of outlets so that accumulated rainwater gets a passage for discharge. This together with removal of all the outgrowths and a proper landscaping will create a neat, tidy, dry and healthy physical environment within the hospital premises.

Right to communication:

Communication facility within the hospital and with the outside world:

There are occasions when family members/relatives of patients from outlying stations do make enquiries on the phone about the condition of patients who have been admitted to the Institute of Mental Health as IPD patients. An attender/security guard should be detailed to receive such phone calls. He in turn should be made responsible to pass on the message to the MO incharge. The MO incharge should send for the staff nurse along with the file to apprise himself/herself about the condition of the patient. He/she may make a return call to

pass on the information about the condition of the patient to the family members/relatives who had made the call. The entire process may take about 10-15 minutes.

Similarly within the hospital premises we need intercom facility between MOs, MOs and staff nurses, technicians and other supervisory staff, between MOs and the library and intercom connections with the Central Store, Central Kitchen, Emergency Services, Automated Laundry Services, OPD, IPD, OT etc.

The telephone system in the Institute is 12 years old and as on date it is totally non functional. All formalities for installation of a new telephone system (BSNL centrex) have been completed, payments made and the new system is expected to be installed shortly.

Right to specialized treatment:

It may so happen that mentally ill persons have associated complications such as appendicitis, cancer, cardio vascular complications, infections in the respiratory track, immunological disorders, complications centering round eye, ear, nose and throat etc. These are required to be referred to general or other hospitals having facilities for specialized treatment of these ailments. It is also necessary for the mental health hospital to maintain a close and continuous liaison and coordination with these hospitals offering the specialized treatment so that the patients whose cases are referred are well entertained without preconditions, are looked after and are returned safe and sound to the mental health hospital after the specialized treatment.

In IMH, Hyderabad cases of all mentally ill persons associated with physical ailments are being referred to Osmania General Hospital, Hyderabad. Patients staying in the openward of the hospital are being sent with their attendants to the General Hospital. For the patients of the closed ward, the ward boys of the hospital are accompanying the patient in shifts during their entire stay and treatment in the General Hospital.

Drug Management:

Drug Management has the following implications:-

- The Superintendent makes a correct assessment of the genuine requirement of drugs for the OPD, IPD, drug deaddiction centre, half way home, if any, community satellite clinics, central jail, NGOs who are running homes for the mentally ill etc.;

- The Superintendent indents the requirement formally to the Head of the Deptt. i.e. DME/Deptt. of Health and Family Welfare, as the case may be;

- The indented drugs are centrally procured and made available to the Superintendent or the Superintendent is authorized to procure them within the ambit of his delegated powers;

- After the drugs are procured they are entered in the stock register and kept under proper hygienic conditions in the Central Store;

- Drugs are issued from the Central Store to the Sub Stores for issue to OPD, IPD and other patients;

In IMH, Hyderabad drugs are being procured by the Government for the whole State through A.P. Health and Medical Housing and Infrastructure Development Corporation. While 80% of the requirement of drugs of IMH is met through the Central Procuring Agency, 20% of the requirement is procured by the Superintendent through issue of open and competitive tenders. Unlike other mental health hospitals where drugs are issued for atleast 30 days drugs for OPD patients in IMH are issued for a period of 15 days. Drugs may be issued for 2 more weeks, if necessary when patients come for review after 2 weeks. This practice has the following limitations:-

- patients come from far off places. In the absence of any public policy to recommend their case for concessional travel by rail/bus, they have to incur heavy expenditure to travel all the way to Hyderabad;

- such drugs are not easily available either at the district or sub divisional hospitals or at the PHC;

- the patient concerned has to leave for the hospital at least 2 to 3 days before the drugs get exhausted and collect the drugs after the review; if he/she is unable to make the trip due to economic reasons this would result in relapse.

The hospital management in consideration of these limitations may take a decision to issue drugs for a minimum period of 30 days, to start with and may extend the period of medication when the patient comes for review/follow up. Simultaneously, and as an integral part of

drug counselling, the concerned treating physician/MO may advise the patient to come to IMH, Hyderabad atleast 2 to 3 days before the drugs prescribed in the first lot get exhausted.

Occupational Therapy:

The basic objective of OT is to impart training in a few rudimentary skills/trades which are market relevant and which may enhance functionality and employability of the inmates to a certain extent and which may act as a useful tool for rehabilitation of the patients after they have been effectively treated, have recovered and sent back to their respective homes. Additionally, such skill training also promotes gregariousness, builds up the unity and solidarity of the inmates who receive the training and makes them think, plan and act together with self restraint and discipline.

The OT unit in IMH, Hyderabad is equipped to impart trades/skills in carpentry, cover making, candle making and weaving but is currently not functional for the following reasons:-

- there is no post of instructor sanctioned as yet;
- there is no arrangement for procurement of raw materials;
- there is no arrangement for sale of finished products;
- there is correspondingly no arrangement for payment of wages or some remuneration to the inmates.

Even though Prof. Channabasavanna Committee had recommended way back in 1998-99 that ‘rehabilitation services have to be improved’ and more than 12 years have lapsed since then there is no sign of revival of the OT Unit as a tool of rehabilitation. A brief mention was made in the book captioned, ‘Mental Health Care and

Human Rights' brought out by NIMHANS in 2008 to the following effect:-

> 'As part of rehabilitation services the hospital has started male and female quarter way homes. As proposed by the MS the A.P. State Mental Health Authority has decided to start rehabilitation services for the mentally ill with NGO collaboration'.

On the ground, however, there is no sign of any rehabilitation services either through halfway or quarter way home or through OT or through NGO collaboration. No reasons are forthcoming for this uncertainty.

Library Service:

A modern library service on the model of what obtains at RINPAS, Ranchi would imply the following:-

- there should be 2 libraries – one for the members of the teaching and treating faculty and another for the patients in both closed and open wards;
- the first should have books in the field of philosophy, psychology, religion, social work, mental health, pure science, applied science, medicine, neurology, art, literature, history, geography, modern psychiatry, child psychiatry etc.; the journals and periodicals may primarily be in the area of psychiatry and neuro sciences;
- the second should primarily cater to preferences and interests of patients and should comprise of both books (primarily story books which are for light reading) and magazines;

- there should be a reading room fully furnished and equipped in the first where research scholars/students pursuing courses in M.D. Psychiatry, M.Phil, Clinical Psychology, M.Phil, Psychiatric Social Work could spend time in going through books, thesis, journals/periodicals, data stored in the computers etc.;

- there should be a separate reading room for the patients/their relatives/family members where they can read books (light reading), magazines, cartoons of their choice;

- e-connectivity should be established between the library and the various departments of the Institute so that the faculty members of the departments could have easy access to books/journals of reference value;

- library should remain open from 9 AM to 6 PM and the Superintendent should encourage the faculty members to spend as much time as possible outside the teaching and treatment hours;

- views of faculty members should be constantly elicited on purchase of new books and journals as also for strengthening library services.

The IMH, Hyderabad has 2 libraries – one for the faculty members and another for patients. The first has books under the following heads:-

Subject	No. of books
Psychology	423
Medicine	61

Neurology	127
Modern Psychiatry	689
Child Psychiatry	100
N. Therapy	120
Research Thesis	132

The details of journals and periodicals in Psychiatry, Clinical Psychology and Psychiatric Social Work have not been furnished even though this was specifically asked for in the questionnaire.

In regard to e-connectivity between the library and various departments (Psychiatry, Clinical Psychology and Psychiatric Social Work) it was stated that this will be completed shortly with the Centre for Excellence funds.

Admissions and discharge of patients:

The number of patients admitted and discharged in the last 5 years is given in a tabular statement placed below:-

DETAILS SHOWING THE ADMISSION AND DISCHARGES IN THE LAST 5 YEARS

YEAR	Admissions			Discharges		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
2006	2193	858	3051	1986	819	2805
2007	2139	921	3060	2116	909	3025
2008	1986	905	2891	1983	938	2921
2009	2259	956	3215	2148	909	3057
2010 up to 06/2010	1085	587	1672	956	653	1609

The following are the basic principles and striking features governing admission and discharge of patients:-

- all admissions are made by strict observance of the provisions of Mental Health Act, 1987 and Rules framed thereunder;
- only persons who are 17 years of age and above are eligible for such admission;
- all decisions relating to admission and discharge are taken by a small group of medical officers;
- majority of the patients are admitted as voluntary boarders; over the years the PC of voluntary admissions is on the increase;
- the occupancy rate (of beds) during the last 2 years ranges between 45 to 49 PC;
- due to advancement in Psychotic and neurotic drugs patients are getting discharged after recovery within a short span of time and the overall bed occupancy rate is quite low;
- the average duration of stay for both female and female patients is 2 to 3 weeks;
- all admitted patients are being examined medically within 24 hours of admission;
- as already stated in course of visit to female open ward female patients are not welcome back in the fold of the family even after they have recovered and have been discharged;

- absence of psychiatric social workers is a major handicap in organizing home visits, contact with family members and effective follow up of rehabilitation and reintegration of female patients into the family setup.

The following 3 cases which were brought to my notice in course of review highlights the aberrations and peculiar mindsets suffered by members of the civil society which upsets all the rational and scientific thinking of the medical fraternity on matters associated with admission and discharge:-

I. Mr. Chennur Shabudaiah (Registration No. A/0138737) was discharged by the discharge committee of the hospital. When the hospital staff tried to drop the patient at home the patient's father threatened the hospital staff that he will commit suicide if they drop the patient at home.

II. Ms. Latha (Registration No. A/0109823) was admitted to the hospital through a reception order from the Court. The patient was treated and got cured of her illness and discharged by the Discharge Committee of the hospital. When she was sent home, her father did not agree to take her even though the discharge was with the approval of the Court. The patient's father happens to be a Dy. Collector.

III. Ms. Hemalatha (Registration No. A/050745) was admitted to the hospital on the strength of a reception order issued by a Court. The patient was a victim of mental retardation. The reception order issued by the Magistrate stated that the patient should remain in the hospital as long as she has not been fully cured of

her illness. The Medico Social Worker of the hospital visited the patient's house and tried to explain and convince the parents for taking back the patient who has been effectively treated and who has substantially recovered but did not succeed.

Death audit:

The tabular statement placed below gives the mortality figures over a period of 5 years i.e. 2005 to 2010, the date of death, factors which contributed to death. Most of the deaths are natural ones except one which is a case of suicide by hanging:-

S.No.	Year	Name of the patient	Date of death	Causes/contributory factors	Remarks
1.	2005	Unknown	03.01.05	Cardio-respiratory failure	Natural death
2.	2005	Akhitar Sultana	28.2.05	Respiratory failure	Natural death
3.	2005	B. Bikshapathy	25.3.05	Cardio-respiratory arrest	Natural
4.	2005	J. Chandra Sekhar	13.5.05	Cardio-respiratory arrest	Natural
5.	2005	Ratnam Pushpa Latha	29.5.05	Suicide by hanging	Unnatural
6.	2005	M. Ananthaih	17.11.05	-	Natural
7.	2005	Lurd Mary	6.12.05	Cardio pulmonary arrest.	Natural
1.	2006	G. Kailasham	22.5.06	Cardiac arrest	Natural
2.	2006	T. Krishnamurthy	15.12.06	Cardio respiratory arrest	
1.	2007	R. Lakshmi	17.3.07	Cardio pulmonary arrest	Natural
2.	2007	Epitta Babu	23.3.07	Cardio pulmonary arrest.	Natural
3.	2007	Kavali Pentaiah	12.6.07	Cardio respiratory arrest.	
4.	2007	Girish Kumar	5.6.07	Cardio respiratory arrest	Natural

5.	2007	Kondalaiah	19.10.07	Cardio pulmonary arrest.	Natural
1.	2008	Abdullah	6.2.08	Cardio pulmonary arrest	Natural
2.	2008	Yanadamma	18.3.08	Cardio respiratory arrest due to hypertension	Natural
3.	2008	Muneerunnisa	29.5.08	Cardio respiratory arrest	Natural
4.	2008	Md. Parvez	30.12.08	Cardio respiratory arrest due to hypertension with intracranial bleeding.	Natural
5.	2008	K. Krishna	23.12.08	Cardio respiratory arrest secondary to unknown lung pathology	Natural
1.	2009	Umera Begum	3.2.09	Cardio pulmonary arrest, secondary to shock, secondary to pyrexia.	Natural
1.	2010	Krishaveni	8.2.10	Sudden cardiac arrest	Natural
2.	2010	J. Somamma	18.7.10	Cardio respiratory failure	Natural

Discussion with Shri J. Satyanarayana, Special Chief Secretary and Principal Secretary, Health and Family Welfare:

20.7.2010 3 PM to 4 PM

This was a wrap up meeting in course of which I shared with the Principal Secretary, some of my ideas and suggestions in the larger interest of bringing about a qualitative change and improvement in the overall management and functioning of the hospital.

I. Considering the fact that large number of families are below poverty line in the State and they find it difficult to commute a long distance from their native place to IMH, Hyderabad, there is

urgent and imperative need for developing an appropriate State Policy under which genuine and deserving cases which are also BPL cases can be recommended by the IMH authorities for concessional bus and rail travel.

II. Prof. Channabasavanna Committee had recommended in 1998-99 that the Medical Superintendent should be given more administrative and financial powers. It had further recommended that Medical Superintendent must be given power to accept donations in cash and kind to improve the hospital.

Twelve years later all that the Medical Superintendent has or has been given is a financial power for giving administrative sanction upto Rs. 10,000/-. This is a pittance (considering the sharp spiraling of prices of all commodities, the rapid decline in the purchasing power of the rupee and the problems which have emerged due to lack of post sales maintenance) which needs to be enhanced to atleast Rs. 20,000/- with which the Superintendent can purchase drugs, tools and equipments, food items on a day to day basis.

III. At the time of Prof. Channabasavanna Committee's Visit (1998-99) the budget for IMH was approximately Rs. 200/- per lakh. It went upto Rs. 317 lakh in 2004-05. Currently the budget is of the order of Rs. 70826766 or Rs. 7.08 Crores. Considering the fact that a number of new structures has been raised (open wards, a 10 bedded casualty–cum-emergency service, separate acute admission ward, drug-deaddiction ward, modern kitchen etc.) more funds would be needed for their proper repair and maintenance. Besides, landscaping of the hospital, new

structures like geriatric ward, child guidance unit, half way home, day care centre will have to be put up. Keeping the genuine need for such future expansion and growth, the budgetary outlay will also require to be substantially augmented. The Deptt. of Health and Family Welfare of the State Government should adopt a proactive approach in making liberal provisions for such future expansion and growth.

A tabular statement giving the breakup of budgetary allocations received and amount spent is placed below:-

BUDGET DETAILS

FINANCIAL YEAR	RECURRING BUDGET		NON RECURRING BUDGET RELEASED
	received	Expenditure	
2005-2006	51459482	50822961	NIL
2006 - 2007	46423164	45729954	NIL
2007 - 2008	60531978	60247860	NIL
2008 – 2009	68583328	66941966	NIL
2009 - 2010	70826766	70728191	NIL

IV. The hospital premises are full of outgrowths which could provide shelter to reptiles which would adversely affect the safety of inmates. Many of these outgrowths being very close to the wards the reptiles could sneak into the wards and might cause accidents. The State Horticulture Deptt. may be requested to engage the services of an arboriculturist to prepare a proper layout plan for (a) removal of these outgrowths (b) provide a proper landscaping along with a good drainage system for discharge of water and (c) develop mini parks for the benefit of

the patients and their family members who can come out in the afternoon and relax a few hours in these mini parks.

If the State Government has budgetary constraints the cost of the project can be met by Reddy Laboratories or any other Corporate House based in Hyderabad under the scheme of Corporate Social responsibility.

V. As against a total number of 305 sanctioned posts 239 posts have regular incumbents and 3 are working on contract, leaving 63 vacancies (20 PC of the sanctioned posts). The vacancies are far too many and hamper smooth management of the hospital on a day to day basis. All these vacancies should be filled up without delay. Administrative powers may be delegated to the Superintendent so that he can fill up Group 'C' and 'D' category posts within the ambit of his delegated powers.

VI. Additional budget provision may be made for construction of staff quarters, nurse's hostel, PG student's hostel, geriatric ward, child guidance clinic and a small guest house within the premises of the hospital for accommodating officers and dignitaries coming from outside for inspection of the hospital.

VII. The practice of outsourcing jobs and activities, offloading regular posts and filling up the same by contractual appointments should be thoroughly discouraged as there is no accountability associated with this practice.

VIII. There should be timeliness in release of funds. Unilateral and arbitrary cuts should not be taken recourse to at the level of DHS or at the level of State Government as the same would

prejudicially affect day to day smooth and uninterrupted management of the hospital.

IX. The Centre of Excellence Proposal has 3 components such as:-

- Physical infrastructure;
- Recurring expenses associated with purchase of tools, equipments and other store items;
- Recruitment of quality human resource.

As far as the first is concerned a good building and construction agency should be selected which has an eye for (a) architectural elegance (b) structural safety and (c) functional utility.

Similarly in purchase of all store items total openness and transparency should be observed. The tools and equipments should be procured from agencies of standing and repute without being unduly bothered about the estimates of cost.

Human resources of quality and competence should be recruited without fear or favour so that these resources can contribute their very best to the upgradation, strengthening and growth of IMH.

Interaction with Superintendent, Dy. Superintendent, other faculty members and PG students:

In course of the said interaction on 21.7.10 (forenoon) the following suggestions were made:-

I. Staff nurses of the hospital need to be trained as Psychiatric nurses by organizing inhouse training programme with the help

of resource persons from the Osmania Medical College and Hospital.

II. Teaching, training, treatment and research go together and this has also been emphasized by the apex Court. In IMH, Hyderabad, however, in regard to teaching, Ph.D. and M.Phil programmes need to be started. For this the physical infrastructure in the library both in terms of creation of extra space, procurement of more books and journals related to Psychiatry, Clinical Psychology and Psychiatric Social Work, better facilities in the reading room, e-connectivity between the library and the departments needs to be strengthened.

III. The Superintendent needs to be delegated with adequate administrative and financial powers and the present limit of Rs. 10,000/- for incoming expenditure needs to be augmented substantially.

IV. A census needs to be organized to ascertain the preferences of patients (who have undergone treatment and who are fast on the way to recovery) and their relatives who are literate for particular books, periodicals and other reading materials. The patient's library needs to be strengthened on the basis of the findings from this Census.

V. Yoga, meditation, pranayam, prayer etc. need to be organized in a better organized and systematic manner.

VI. Soft and subdued music has a stabilizing effect on human mind in general and on the mentally ill persons in particular. A good experiment in this has been launched at GMA, Gwalior. The

Superintendent may like to learn from that experiment and make a beginning in IMH, Hyderabad.

VII. Landscaping should be taken up by engaging the services of an experienced arboriculturist. After landscaping has been done, a few mini parks may be created where patients of the open wards may be able to sit with their relatives in the evening hours.

VIII. To promote personal hygiene of the inmates the functioning of the automatic laundry should be monitored to ensure that clothings of the inmates collected in the morning should be delivered in the evening.

IX. Separate occupational therapy units for male and female patients should be planned. The following should be the components of that plan:-

- a market survey should be conducted to ascertain the skills/trades which need to be imparted which are market relevant;

- the survey should be followed by listing the tools, equipments and raw materials which are needed to start a vocational skill training programme;

- posts of two separate instructors (one for male and another for female) should be sanctioned and such human resources should be selected who have the aptitude for training mentally ill persons under specific situations and conditions;

- after the Instructors are in place a brief orientation needs to be given to them on (a) how to deal with mentally ill persons (b) how to manage the OT unit with optimal efficiency (c) how some of the genuine needs of the hospital can be met and how the hospital can be made self sufficient (beds, envelopes, file covers etc.) along with rehabilitation of the patients through OT;

- the pace and progress of learning the vocational skills/trades by the patients should be closely monitored and their reaction to the entire process of skill training should be recorded on a day to day basis;

- constant liaison and coordination should be maintained with the concerned department of the State Government so that the skills learnt in OT could be sustained in later part of life after the patient has been treated and discharged. RINPAS, Ranchi model of management of OT could be studied and adopted to the advantage of IMH, Hyderabad.

X. The patient's record room needs to be reorganized on par with the record room of Dharwad Mental Hospital. The following basic facts need to be kept in view while proceeding to reorganize the record room:-

- the record room should be located in a very large hall (50'x40') with the required number of sky lights, with arrangement for ensuring adequate lighting and ventilation

and protecting the room from outbreak of fire, pests, heavy rain etc.;

- adequate number of good quality tall steel racks (each 10’ height and 3’ width) with required number of compartments should be procured for the record room;

- for every patient (both old and new) a new file is to be opened;

- the name of every patient should be alphabetically categorized;

- the file should be in a bound volume and papers inside should be properly stitched so that they are not torn or mixed up or misplaced/lost (as is usually the case with all government offices/institutions);

- the file should be maintained yearwise; each file should be allotted one hospital serial number;

- all new cases registered should be entered into the computer by the data entry operator (the post to be created afresh).

Each file should contain the following:-

- personal data (name, age, sex, address and occupation etc.);
- name of the informant;
- gist of the complaint/illness;
- past history of psychiatric illness;
- past history of other associated complications;

- personal history (marriage, divorce etc.);
- family history (was the form of mental illness genetically loaded);
- premorbid personality (how was the personality before illness).

X. Psychiatric Social Workers have a very useful role to play in matters of (a) behavioural and drug related counselling (b) home visits (c) counselling family members (d) providing feedback to the hospital authorities about the current status of the patient who has been discharged and sent home. A.P. is a large State and there are only two State managed mental health hospitals at Hyderabad and Visakhapatnam. Rule 22 of State Mental Health Rules, 1990 requires one psychiatric social worker for 100 beds. Since IMH has 600 beds there should be atleast 6 PSWs in position to do justice to the responsibilities enumerated for such PSWs as above. The requirement would, however, be much more if the norms laid down by ICMR and as quoted by Dr. S.P. Agarwal, former DGHS, Government of India in his compilation captioned 'Mental Health – an Indian Perspective 1946-2003' of 2004. According to this norm there should be 2 PSWs for every 1,00,000 population. According to the same publication A.P. has a total of 45,23,650 (75,7275 major and 37,66,375 minor mental disorders) mentally ill population and according to this norm there should be (45x2) 90 Psychiatric Social Workers for all the mental health hospitals (both public and private). As against this massive requirement IMH, Hyderabad does not have a single Psychiatric Social Workers. A beginning, therefore, has to be made and considering the urgency and importance of this

proposition this needs to receive serious attention and consideration of the State Government.

XI. The urgency and importance of developing a set of well visualized and well illustrated IEC materials hardly needs to be over emphasized. IMH, Hyderabad appears to be quite weak in this respect. The Institute of Psychiatry, Jaipur has developed exemplary materials in this area and is considered to be a model which will be worthy of being emulated. IEC is a multi dimensional concept and in the context of mental health, the IEC materials which need to be developed are:-

- disease/form of mental illness related;
- patient related;
- family member/relative of the patient related;
- medical officer related;
- staff nurse related;
- attender related;
- civil society related.

Basically IEC materials should encompass as to what these categories of persons need to know, understand and internalize in dealing with various facets of mental health and how they are to harness what they know through print medium of communication on the ground. The totality of such knowledge and internalization is also what we call the therapeutic dimension of mental health. Developing IEC materials require a lot of imagination and insight and it may be necessary to organize an inhouse workshop of professionals where the exemplar IEC materials can be developed, field tested and eventually validated before adoption.

XII. New areas to be developed by way of futuristic projection:

- considering the increase in elderly population and increase in the incidence of mental illness among the elderly (anxiety, depression, dementia, alzhiemers etc.) geriatric wards exclusively for use of the mentally ill persons need to be developed. The Institute of Psychiatry, Jaipur has taken a lead in this and this example needs to be seen, studied and replicated, if suitable to A.P.

- incidence of mental illness among the children (autism, cerebral palsy/spastics, other forms of mental illness like Schizophrenia) is also on the increase and we need an exclusive child guidance clinic like Sishu Bhavan, Cuttack (has come up with external funding).

Both the new geriatric ward and child guidance clinic need to be seriously considered and started as new initiatives under the Centre of Excellence proposal.

Additionally the following ideas also emanated as a part of the exercise for churning of critical consciousness from both the medical and para medical staff:-

Manpower related:

I. One Addl. Director should be appointed in the State Directorate of Health to look after exclusively the area of mental health.

II. The main draw back in mental health is lack of manpower in the field of Clinical Psychology. In a 600 bed mental health hospital

2 Clinical Psychologists are found to be grossly inadequate (as against 6 units of Psychiatry).

III. The hospital is grossly understaffed in all categories for which the faculty is facing serious problems.

IV. One general physician needs to be appointed to manage the physical health problems of mentally ill persons.

V. The Biochem Lab should function round the clock with a full time qualified technician appointed on a regular basis.

VI. Occupational Therapists (2) should be in position – one for male and another for female.

VII. Various other categories of staff should be sanctioned and be in position strictly as per the norms laid down in the Mental Health Act, 1987 and the Rules framed thereunder.

VIII. Thirty more staff nurses should be sanctioned and be in position and a proposal to this effect should be sent to Government.

Treatment related:

I. The patients who require tertiary care only should be sent to the mental health hospitals. The primary and secondary cases should be sent to the district headquarters hospitals where a psychiatrist needs to be posted to look into all such primary and secondary cases.

II. Rehabilitation services should be improved.

III. Both psychotic and neurotic drugs should be issued for a period of one month as against 15 days as now.

IV. Outdoor activities for the inmates (basket ball, volley ball etc.) should be organized.

V. Community kitchens may be started for the patient's attendants.

VI. RO (Reverse Osmosis) plant should be set up to ensure provision of pure water to the patients.

Human Resource Development related:

I. Orientation programmes should be started for both police and magistracy for their thorough familiarization with the provisions of MHA, 1987.

II. Psychological orientation needs to be developed throughout the country.

III. Hospital management should subscribe to adequate number of journals in Clinical Psychology for the library.

IV. Latest software related to clinical psychology needs to be procured.

Hospital staff welfare oriented:

I. Accommodation should be provided to all PG students of the Institute.

II. Library timings should be extended to 8 PM. Round the clock reading room facility needs to be started.

III. Salary and allowances of contract staff need review and revision.

IV. The uniform allowances for staff nurses are quite low. Besides, only one set of uniforms is currently being provided. Every staff nurse needs a minimum of 3 sets of such uniforms. As one set of uniform costs Rs. 2000/- the uniform allowance should also be raised to Rs. 6000/- per annum. The current washing allowance @ Rs. 60/- per month is quite low. This needs to be raised to Rs. 150/- per month. All the nursing staff should be provided with residential accommodation.

V. There should be separate inservice quota for the staff nurses of the IMH in the admission for psychiatric nursing courses to be started in the hospital.

In course of interaction with technicians, other Class III and Class IV staff they ventilated the following grievances which need to be redressed at the earliest by the hospital management:-

I. The posts of biochemist and laboratory technician are lying vacant for the last 10 years which is detrimental to public interest and cannot be easily overlooked for a 600 bed hospital. Although the posts are being advertised from time to time no suitable candidates could be found as (a) the posts are on contract basis and (b) the salary offered against the post is quite meager to provide any attraction or incentive for an interested and willing candidate.

II. There is one weaving mistress – Forhath Sulthana who single handed is imparting training to 20 women daily in chair caning, weaving and candle making. She is soon going to retire after attaining the age of superannuation. This will make matters extremely difficult for day to day management of the OT Unit as

the 2 posts of occupational therapists are already lying vacant. Neither the products which come out of the OT Unit are being marketed nor any wages are being paid to the trainees.

III. The pharmacists represented that the supply from the Central Store is irregular and is not fully meeting the requirement of the sub store. To illustrate, it was stated that the following drugs are not available for the last 2 months:-

- Trihexiphenydie;
- Lithium carbonate;
- Diazepam and sodium valproate tablets;
- Olanzepine tablets;
- Halopendol injections

It was represented that for a hospital of the size of IMH, Hyderabad 2 more posts of pharmacists need to be created. Appropriate software needs to be developed which can reduce the workload of pharmacists like stock entry, maintenance of a number of registers, verification of balance medicines left in the central store, verification of expiry date etc. The workload of the existing pharmacists becomes heavy as they are required to participate in community health programmes as well.

IV. There is one electrician to look after the basic needs of carrying out necessary repairs in the event of break down of power in a 600 bed hospital spread over an area of 45 acres. Apart from the arduous task of maintaining continuous vigilance and surveillance movement in a large spread over area for one person becomes extremely difficult. There is a vacant post of electrician Gr. II which needs to be filled up urgently. A few

supporting hands of electricians also need to be created to provide relief to the existing incumbent. There is no power back up at present. To meet such back up a dedicated DG set needs to be installed.

V. The radiographer represented that the post of Dark Room Assistant is lying vacant for the last 10 years and is not being filled up as there is a ban imposed by the State Government. The existing incumbent is looking after the duties of the Radiographer and Dark Room Assistant.

VI. The Medical Record Clerk represented that (a) the volume of correspondence with Courts, jails, other State Government offices has considerably gone up (b) there is no typist in A & D Section and (c) it becomes increasingly difficult to manage the workload single handedly. He further represented that training in medical record keeping is available only in JIPMER, New Delhi but unless special leave is sanctioned it is not possible for the Medical Record Clerk to undergo the said training.

VII. The lone telephone operator represented that as against 3 sanctioned posts of telephone operators 2 have fallen vacant and the telephone lines have become dysfunctional.

VIII. The drivers represented that they are facing serious problems in getting the 3 ambulance vans repaired as due to procedural formalities it takes long time to carry out the repairs through the State Health Transport Organization. The repair work can be promptly attended to and completed in time if such repairs could be carried out with the help of the authorized dealer of the vans.

IX. The lone lady tailor represented that of the 3 sanctioned posts, 2 are lying vacant as the incumbents have retired and the posts have not been filled up. The existing incumbent being physically challenged is not able to attend to the repair work of sewing machines. She is currently working in the space given in the female ward but as there is no toilet facility nearby she requested that the tailoring room may be shifted to the OT unit.

X. The following grievances were ventilated from Class IV staff:-

- the number of female nursing orderlies is much less and the existing FNOs are finding it difficult to manage the workload;

- it becomes all the more difficult when the patients in the IPD are violent and aggressive and start physically assaulting the ward staff;

- the vacant Class IV posts need to be filled up urgently;

- there are no staff quarters for Class IV staff; a few staff quarters may be constructed for them;

- in the event of patients escaping from the male closed ward, a punishment of withholding 3 increments to the staff of the closed ward was awarded which is heavy and unwarranted as the gaps in the boundary wall facilitate such escapes and these gaps have not been filled up;

- when a mentally ill person has associated physical illness complications and is referred to a general hospital for specialized treatment, a male nursing orderly accompanies

the patient as attendant and he is required to remain with the patient for all the 3 shifts. This is a humanly impossible task. It was represented that 3 Class IV staff should be posted in 3 shifts instead of asking one Class IV staff to manage all the 3 shifts;

- it was represented that the risk allowance of Rs. 15/- for Class IV staff (male and female nursing orderlies) is too meager and needs to be suitably enhanced keeping in view the difficult conditions at present;

- it was represented that 3 pairs of uniforms along with stitching and washing allowance for Class IV staff should be provided as the uniforms get torn/damaged by mentally ill persons when they tend to be violent.

The Superintendent was requested to address these grievances in a proper spirit and redress them to the extent possible within the ambit of his delegated powers. In case they cannot be addressed and redressed within the ambit of his delegated powers, a case should be made out and issues referred to Government for redressal. On no account grievances should be allowed to accumulate as they may explode and give rise to a very difficult situation.

Conclusion:

Prof. S.M. Channabasavanna team had visited IMH, Hyderabad and reviewed its activities/performance in 1998-99 and had brought out several deficiencies in their report presented to the Commission. Nearly a decade later NIMHANS in its publication, ‘Mental Health Care and Human Rights’ brought out in 2008 did not note any significant

improvement except in a few areas (construction of open wards, 10 bedded casualty-cum-emergency service, 24 hours water supply, provision of geysers and solar heaters etc.). The present review was planned keeping the above 2 reports and their findings in view. To make the review participative and meaningful a questionnaire was circulated in advance and the thrust areas in the questionnaire i.e. human rights dimension of mental health were explained at length orally on the telephone to both the Superintendent and Dy. Superintendent prior to undertaking the visit and review. The visit to the hospital covered Registration Counter, OPD, IPD, laundry, kitchen, store, dining hall, interaction with patients both in the OPD and IPD as also at the dining room, interaction with MOs and para medical staff, Class III and Class IV staff etc. The findings in course of visit and interaction were shared with the Superintendent, Dy. Superintendent, Principal Secretary to Government in Health and Family Welfare Deptt. The impressions observations and recommendations made in the review report are a honest and transparent reflection of these rounds and interactions. Since this is a large hospital (600 beds) with a large area (45 acres) a number of deficiencies have been persisting for years and a smooth and efficient management of this Premier Public Service institution warrants that these deficiencies be addressed with urgency and seriousness of concern, a few suggestions are being made as under which need to be addressed on priority basis:-

I. Dispute over ownership of hospital land which is currently subjudice which is causing many a sleepless night to the hospital management needs to be addressed by the State Government with the highest priority. The Advocate General should be engaged to contest these land disputes on behalf of IMH. The endeavour should be in the direction of not causing any

dislocation to the functioning of the hospital without, however, ignoring the rightful claims of the claimants over the hospital land. If necessary, the best legal brains of the country should be consulted to arrive at a just and fair solution which should be in the larger public interest.

II. The hospital has 45 acres of land but there is no landscaping and presents not a very endearing look due to a lot of wild outgrowth, unlevelled high and low lying areas providing scope for accumulation of water and an unclean and unhygienic surrounding, want of properly paved roads and units/sub units of the hospital scattered all over. The services of a qualified and experienced arboriculturist need to be requisitioned for landscaping, planting species in a neat and orderly manner which can thrive in the particular soil and climate and carving out a number of lush green mini parks where the patients can sit with their relatives and spend the evening hours.

III. Quality construction of new structures and quality repair and maintenance of the existing structures should receive priority attention. For this purpose, the State Government and hospital authorities should select an agency (not necessarily confined to PWD or CPWD) known for its impeccable track record of quality construction, controlled gestation period, controlled cost escalation and timely delivery.

IV. The Centre of Excellence Proposal of IMH which has been approved by the Ministry of Health and Family Welfare, Government of India has a civil works component of Rs. 18 Crores, staff component of Rs. 3 Crores and the remaining

amount (Rs. 9 Crores) is meant for tools, equipments, library books, development of software etc. In order that the amount is spent productively and with optimal efficiency which makes expenditure result oriented the planning process, execution of works and procurement of tools and equipments should be overseen by a high level committee under the Chairmanship of Special Chief Secretary-cum-Principal Secretary, Health and Family Welfare with involvement of eminent mental health experts like Dr. M. Gowri Devi, Dr. P. Rahurami Reddy and Dr. T. Nilakantaray Yadav (ex Superintendents of IMH for several years).

V. In the pattern of IMHH, Agra, GMA, Gwalior and RINPAS, Ranchi the State Government should take a decision to make IMH, Hyderabad and Government Hospital for Mental care, Vizag fully autonomous, issue orders for constitution of a Managing Committee and a number of Sub Committees (personnel, HRD/HRM, Civil works, drug procurement, food, therapeutic management of patients) and issue simultaneous orders for delegation of administrative and financial powers in favour of the MC and Sub Committees as also the Superintendent. This will (a) reduce paper work (b) bring down helpless dependence of the Superintendent on the State Government on each and every issue and (c) enhance the power, authority and image of the Superintendent which is essential for promoting and sustaining discipline in the organization. The State Government should give a serious thought to such autonomy proposal for IMH.

VI. The budget for the hospital (both recurring and non recurring) should reflect the genuine needs of the institution. Such needs should be correctly identified in time, got approved by the MC (when constituted) and sent to Government through the Head of the Deptt. for incorporation in BE and RE, as the case may be. Since the estimates are based on the genuine requirements of the institution, no unilateral and arbitrary acts should be effected by the Head of the Deptt./Government as such cuts are likely to cause avoidable dislocation in the management of the hospital.

VII. Science of industrial engineering entails job study, job description, job classification and job analysis. Every job should be quantified and on the strength of such quantification manpower needs of the organization – both present and future should be determined. The number of posts determined on the strength of job requirement should be sanctioned by the competent authority. This is not being done and posts, if any, are sanctioned on adhoc basis and ban is being imposed after sometime. This defeats the very objective of industrial engineering.

VIII. Once the number of posts have been determined on the basis of a scientific job study and sanctioned they should be filled up on a regular basis with a time scale of pay. Apart from the fact that outsourcing certain key jobs (like jobs of the biochemist and lab technician) demotivates and demoralizes and there are a few takers for such contractual assignments, there are serious problems of accountability as well. These positions may not be filled up for years for the poor scale of pay and contractual nature of the job as has happened in IMH.

IX. Posts sanctioned must be filled up in time and through a totally open and transparent mechanism where merit is recognized and rewarded and sloppiness is discouraged. Currently against 305 sanctioned posts (both permanent and temporary) only 239 are in position and 63 posts are lying vacant. This is more than 20% of the total number of sanctioned posts. Such a large number of vacancies persisting for a long time is bound to adversely affect the optimal productive efficiency of the hospital. The Superintendent is helpless as he is without any powers to create or sanction a new post.

X. Training is an essential input of human resource development. Training is both induction and recurrent. Training is relevant and vital for all categories of personnel and can be in house and out house. Both the avenues of training should be harnessed and a detailed calendar of training should be in place after the first time joining of an incumbent. In the entire schedule of training for personnel of all categories. Psychiatric training of all staff nurses assumes utmost significance. Similarly all male and female nursing orderlies or attenders are in need of behavioral training which will make them more civil, kind, compassionate and considerate towards all patients and their family members/relatives.

XI. Right to food, which should be sumptuous, wholesome and nutritious, right to potable water for cleaning, washing, cooking, bathing, drinking, right to personal hygiene, right to environmental sanitation, right to leisure and recreation, right to occupational therapy and rehabilitation, right to be treated with dignity, decency and freedom from discrimination are inalienable

rights and conditions must be created for realization of these rights for all patients through information, education and communication through orientation and sensitization, through behavioural and drug counselling and so on.

Right to life implies that conditions must be created for a decent and dignified existence of all patients – male and female alike. Such conditions are as much relevant at the hospital as they are outside and at home in particular. Psychiatric social workers are needed for home visits and home counselling and the need for creation of adequate number of PSWs and filling them up with human resources who are good, kind, compassionate and considerate to others cannot be dispensed with or wished away.

Death audit must be conducted at appropriate levels not only to investigate into the causes of death but also to ensure that all possible efforts have been made to save human life in all contingencies – natural and unnatural, normal and abnormal.

Last but no the least, while good examples or success stories obtaining elsewhere should be emulated, gaps, omissions and deficiencies or human failings should be acknowledged and timely efforts be made to correct human failings and aberrations instead of allowing them to drift.

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