I visited Gwalior for the fourth time (the first three visits having taken place on 6.1.2007, 11th and 12th February, 2008 and 2nd to 4th February, 2009) for an indepth review of its activities and performance as mandated by the Hon'ble Supreme Court of India to NHRC from 21st to 24th February, 2010. In addition to the Director, Dr. Dwivedi a senior functionary of the Health Deptt., Government of M.P. was deputed by Secretary, Health – Smt. Vijaya Srivastav who participated in the 3 day review throughout. This is a 135 year old mental health hospital located at the outskirts of the city in a total land area of 59104 sq. metres. Except the OPD Block and canteen building which were added on the suggestion of NHRC most of the structures are fairly old, made of lime and mortar. The hospital has a sanctioned bed strength of 212, one closed ward (male), one closed ward (female), one open ward (male), one open ward (female), one modified ECT Centre along with a recovery room, one emergency room, one EEG and ECG room, one Pathological Laboratory, one recreation room-cum-library for male and another for female patients, one hospital kitchen and a central store, one halfway home with 11 inmates and one OT for female patients.

The incumbency chart maintained from the Year 2004-05 onwards is conspicuous in 2 respects namely (a) the GMA has been manned mostly by part time Directors drawn from Gajara Raja Medical College (b) there has been no continuity in the tenure of these functionaries, the average tenure ranging between one to three years. This regretfully has been the reality notwithstanding the importance of continuity of tenure for the head of a mental health hospital being emphasized by the Hon'ble Supreme Court of India and NHRC from time to time for better management.

Dr. (Mrs.) Amrita Mehrotra has taken over the charge of Director, GMA w.e.f. 6.8.2009. Substantively she is the Professor and Head of the Department of Anaesthesiology in G.R. Medical College, Gwalior. This arrangement is a repetition of the earlier ones like Dr. (Mrs.) Jyoti Bindal from 14.9.2007 to 14.1.2009 being Director incharge of GMA in addition to being Professor, Gynaecology and Obstetrics, G.R. Medical

College and Dr. (Mrs.) Shaila Sapre from 22.7.2004 to 13.6.2005 in addition to being Dean, G.R. Medical College.

A mental health hospital like GMA has its own peculiarities and complexities. Unlike general hospitals it houses mentally ill persons who are unable to fend for themselves and, therefore, are in need of constant care and attention of hospital authorities. Besides, there are a number of management functions such as food management, water management, management of personal hygiene, environmental sanitation, recreation, rehabilitation and specialized treatment of illness associated with mental illness in other hospitals outside the mental health hospital etc. All these involve very close coordination with a number of agencies and institutions. There is also an imperative need for liaison and coordination with the Judicial authorities, those of the Central/district jail (which house a number of mentally ill persons), officers of district administration (executive), NGOs and other sections of the civil society. These call for meticulous management of time which becomes extremely difficult with a part time arrangement in which the incumbent is saddled with a number of simultaneous functions, duties and responsibilities.

I was given to understand that the primary reason for this part time arrangement is that sufficient number of candidates are not responding to the advertisement issued for filling up the post of Director, GMA possibly on account of the unattractive scale of pay attached to the post on the one hand and those who are responding are not otherwise found suitable for appointment as Director. Rule 20 of State Mental Health Rules, 1990 framed under the Mental Health Act, 1987 lays down the prescribed qualification for the post of Chief Executive of a Mental Health Hospital.

To quote:

'Rule 20: <u>Manner and conditions of maintaining a psychiatric hospital or Psychiatric Nursing Homes:-</u>

Every psychiatric hospital or nursing home shall be maintained subject to the condition that –

‘A’ Such hospital or nursing home is located only in an area approved by the local authority.

‘B’ Such hospital or nursing home is located in a building constructed with the approval of the local authority.

‘C’ The building where such hospital or nursing home is situated has sufficient ventilation and is free from any pollution which may be detrimental to the patients admitted in such hospital or nursing home;

‘D’ Such hospital or nursing home has enough beds to accommodate the patients.

‘E’ The nurses and other staff employed in such hospital or nursing home are duly qualified and competent to handle the work assigned to them.

‘F’ The supervising officer incharge of such hospital or nursing home is a person duly qualified having a post graduate qualification in Psychiatry recognized by the Medical Council of India.

It appears that Dr. Tushar Jagawat who earlier officiated as Director, GMA from 12.11.2003 to 21.7.2004 had applied in response to the advertisement for the post of full time Director, GMA but did not conform to the prescribed qualification and hence could not be selected.

On being asked as to how she is coordinating between the pressure of work in the present department as Professor and Head of the Anaesthesiology Department and that of Director incharge, GMA she explained as under:-

She stays at her own ancestral home in Gwalior city which is located at a distance of 10 kms from the GMA. She starts her routine from GMA at 9 AM to take rounds in OPD, IPD (both closed and open wards of GMA) and finishes them by 10.30 AM

when she goes back to the parent department. She is back to GMA once again at 3 PM and spends about 3 hours till 6 PM. If there is any emergency she makes herself always available on the telephone and gives directions to the emergency Medical Officer on duty. There is a Director's bunglow located within the premises of GMA but since Dr. (Mrs.) Mehrotra has her own residential premises the Director's bunglow is being occupied by Dr. Ranjit Kumar, Asstt. Professor, Clinical Psychology.

Location and Physical infrastructure

GMA is located in the outskirts of Gwalior city without any proper approach road. The hospital may be divided into 2 parts. On one side of the road coming from the VIP Circuit House and main market are located (a) OPD with a registration counter, record room, rooms for examination of patients, drug dispensing unit and a makeshift arrangement for a library (b) a canteen which is now lying closed (c) a staff quarter and on the other side is the male and female ward (closed) and male and female ward (open), kitchen, store, dining hall, rooms for recreation and patient's library (with a reading room and room for indoor games), Pathological Laboratory, modified ECT Centre, EEG, ECG etc. There are 2 kutcha drains without any cover and without any embankment on both sides of the road which are in a very bad shape. These are within the municipal corporation limits and it is the responsibility of the Municipal Corporation of Gwalior to repair and maintain them. This, however, has been a sad story of utter callousness and negligence. The waste water flowing in the open in the drains is a source of pollution and a breeding ground for flies and mosquitoes. Besides, the approach to the OPD is so fragile that there is a possibility of mentally ill persons crossing the drain while going to the OPD falling inside the drain. This has been brought to the notice of the Divisional Commissioner- Shri S.P. Singh and Chairman of the Managing Committee who has assumed charge recently wit a request that he in turn take up the matter with the Commissioner, Municipal Corporation for (a) not leaving public works in an incomplete

form for a long time which is risky to human life and limb (b) for providing a proper approach to the OPD for patients and their relatives.

The kutcha drain providing approach to the other and major half of the hospital continues to be in the same deplorable state as in January, 2007 when I visited GMA for the first time. In coursse of my subsequent visits to GMA I have pointed it out in my review reports and brought it to the notice of the concerned authorities for remedial action. I was given to understand that a sum of Rs. 10 lakhs has also been placed at the disposal of the State PWD for converging the kutcha drain into a pucca one. Regrettably there has been no change in the situation and the sorry state of affairs continues.

GMA is as much a legacy of colonial history as IMHH, Agra and RINPAS, Ranchi. Unlike IMHH, Agra and RINPAs, Ranchi, however, which have a sizeable area each (in case of IMHH Agra it is 172 acres while in case of RINPAS, Ranchi it is 645.96 acres) out of which 347.71 acres are being used in agricultural farm, hospital and staff quarters (remaining area is under unauthorized occupation by Biramunda Agriculture University), GMA has a total area of 59,104 sq. metres. While this may be barely enough for the current requirement, it is not at all sufficient for future expansion and growth. This is particularly relevant in the context of the emphasis of the apex Court on bringing about an integration between teaching, training, treatment and research. The future expansion and growth may comprise of the following:-

- A new teaching block to take up teaching MD Psychiatry, M.Phil Clinical Psychology, DPN, Ph.D. in Psychiatric Social Work etc.;

- A 20 bedded geriatric ward;
- A 20 bedded child guidance clinic;
- A 20 bedded drug deaddiction centre;
- A day care centre;
- A long stay home;

- Construction of residential quarters for faculty and staff (as against 146 faculty members and staff there are only 12 staff quarters within the premises of GMA).

For such future expansion and growth, a minimum of 5 acres of land is required on a very modest scale. The need for this was highlighted in course of earlier visits before the Divisional Commissioner and Collector/DM, Gwalior. Originally, the district administration had offered to GMA such an area measuring 5 acres at Sada which is located 25 kms away from the location of the present hospital and, therefore, unsuitable. Besides, GMA was asked to deposit a sum of Rs. 8 Crore for this purpose. On account of change of incumbency of the Chief Executive of GMA, this issue which should have been subsequently agitated before the district administration could not be followed up. In course of my meeting with the Divisional Commissioner – Shri S.P. Singh on 23rd and 24th February, 2010 I impressed on him the urgency with which a decision to allot 5 acres of government land with a token premium but substantially free of cost needs to be taken. For this, the following procedure needs to be adopted:-

- identification of a suitable plot of land measuring 5 acres in the vicinity of GMA;
- preparation of a land plan and land schedule;
- allotment of the plot and issue of the allotment order;
- handing over physical possession of the plot of land to the Director incharge of GMA.

I also impressed on the Divisional Commissioner to involve the Director incharge, GMA fully with the process. The Divisional Commissioner who was fully tied up with India South Africa Cricket match at Sardar Yallabhbhai Patel Stadium on 24.2.2010 asked the Director incharge, GMA to meet him after Holi (after 1.3.2010) along with copies of all previous communications on the subject so that a final decision could be taken.

Construction of a new female ward:

The construction work at an estimated cost of Rs. 77 lakh was taken up in May, 2008. The need for the work was felt with a view to reducing congestion in the old female ward which was fairly old, damaged at multiple points and incapable of being renovated. At the time of my visit to GMA in February, 2009 the need for and urgency in completion of the work were impressed on the PWD and they were requested to complete the work in all respects (civil, electrical and PH) and hand over physical possession within one year. The EE, PWD had also assured me that it should be possible to hand over physical possession of the new female ward complete in all respects by May, 2009. At the time of my fourth visit to GMA in February, 2010 it was observed that the following items of work were yet to be completed:-

- electrical wiring;
- installation of fans;
- fixing of bar lights;
- drinking water supply;
- installation of toilets (both Indian and Western commode).

The building has the following redeeming features:-

- the wards were large ('x') spacious, airy and lighted;
- the quality of plaster and paint work was good;
- the toilets were of standard size;
- there was a small hall (square in shape) in a corner which would provide space for patients to sit and relax in spare hours.

However, the following deficiencies were also noticed in course of going round the building:-

- the window panes are made of glass. This poses a safety hazard for the inmates;

- since the old female ward which is old, damaged and unsafe is required to be demolished and this would generate a lot of dust (at the time of demolition) the paint work should have been taken up only after the demolition work was complete;

- there was a solar power heater which had been installed on the top of the old female ward which was required to be shifted to and installed in the new female ward. The PWD had shown their unwillingness and inability to do so on the ground that they had no expertise for the same and that the M.P. Urja Nigam alone was the competent agency for the same. Dismantling of the old female ward building and removal of the solar power heater could have been simultaneous operations and could have been undertaken as a joint responsibility of State PWD and M.P. Urja Nigam. The PWD did not bother to contact the Urja Nigam but left it as a responsibility on the shoulders of GMA. This is one of the worst example of departmentalism or departmental exclusiveness which is not a good reflection of the otherwise poor image of PWD;

- building materials, debris, broken bricks, stones were lying accumulated and scattered all over.

Suggestions:-

- The dispute about shifting of the solar power heater from the old female ward to the new one should be resolved at the earliest. The Director incharge of GMA should write to the MD Urja Nigam, requesting the organization to depute a professional who could visit GMA, work in unison with the PWD and complete the process of shifting at the earliest.

- The process of demolition of the old female ward should be carried out sufficiently in advance before the new ward was occupied on account of the following reasons:-

- The process of demolition would generate a lot of dust and noise which would adversely affect the health, peace and safety of the inmates;

- This would block the passage to the new ward apart from generating a very unhealthy environment.

- The building materials, debris, broken bricks, stones etc. should be cleaned as early as possible.

- No concreting in the open space should be carried out; this should be left for being developed into mini parks (essentially for recreation of the patients) where appropriate species could be planted; this would add to the greenery of the environment.

- A new dining hall which exists in front of the new female ward (close to the recreation ward) should be used as the dining hall for the new female ward.

At the time of last visit in February, 2009 a new overhead tank with a capacity of 3 lakh litres at an estimated cost of Rs. 17 lakh was observed to be under construction. This work has since been completed and it will be handed over to GMA only after installation of a submersible pump by the Public Health Engineering Department.

Relatives of patients accompany the patients over long distances and most of them hailing from BPL families can ill afford the luxury of hiring any accommodation during their stay at GMA. They need to be provided accommodation within GMA premises itself as has been done in mental health hospital, Thrissur or at a place which is proximate to GMA. With this end in view it was proposed by me to the Divisional Commissioner in course of my earlier visits to make the space available in a Dharmashala which is lying close to GMA for use by relatives of patients. Thereafter, there has been protracted correspondence with the office of the Commissioner, Municipal Corporation. The latter has eventually extended permission to GMA to occupy the Dharmashala on

lease on payment of lease money of Re. 1/-. While according such permission it has been mentioned that a private medical store and PHE Department office would also continue to occupy a portion of the Dharmashala building as before. On the face of it, such a conditional offer does not appear to be acceptable as this may pose a threat to the security of the relatives of the patient apart from affecting their right to privacy and posing other administrative problems. A view has to be taken by the Director, GMA as to whether we should insist on getting the space occupied by the medical store and the PHED vacated from the premises of Dharmashala before taking possession thereof.

Needs of the institution vis-à-vis budgetary allocations:

GMA as a State managed institution dedicated to public service has a few genuine needs. These are related to (a) infrastructure development (b) manpower – selection, appointment and placement (c) human resource development through training (d) furniture, tools, equipments and chemicals for laboratories, clinical examination of patients (EEG, ECG, x-ray, dental, ophthalmology etc.) (e) raw materials for OTs (f) diet (g) drugs (h) personal hygiene and (i) environmental sanitation needs of patients. These may be broadly divided into 2 heads namely recurring and non recurring. The financial implications of these needs are required to be precisely worked out, reflected in the budget estimates (both BE and RE) and should be presented through the Managing Committee (MC) to the State Government for incorporation in the Appropriation Bill and approval. After the Appropriation Bill has been approved by the State Legislature the approved budget should be communicated in the beginning of the year commencing from 1st April of a particular year so that the Chief Executive incharge of management of the institution is not handicapped in any manner whatsoever in ensuring its smooth management.

In case of GMA it was observed that there is a considerable gap between the budgetary requirement of the institution (Rs. 3.86 Crores) and the allocations which have been communicated in the past as also

for the year 2009-10. This gap would be evident from the following table:-

Financial Year	**Budgetary grant duly approved by MC (Rs. 500/- per day per patient)**	**Grant received from the State (DME)**	**Difference**	**Actual Expenditure**
2005-06	3,86,90,000	2,25,00,000	1,61,90,000	3,28,31,000
2006-07	3,86,90,000	3,10,00,000	76,90,000	3,27,17,000
2007-08	3,86,90,000	3,13,27,000	73,63,000	4,21,18,000
2008-09	3,86,90,000	2,72,00,000	1,14,90,000	3,39,02,000
2009-10 (upto January 10)	3,86,90,000	1,89,50,000	1,97,40,000	3,63,20,000

This gap which is not easily explainable was brought to the notice of the Divisional Commissioner in course of my 2 rounds of discussion with him and he was urged to (a) hold one special meeting of the Finance Sub Committee and Managing Committee to approve the RE for 2009-10 and BE for 2010-11 as proposed by GMA (c) follow up with Secretary to Government, Medical Education and Principal Secretary, Health Department to ensure that no gap persists year after year between the genuine needs of the institution and actual budgetary allocations.

The percapita allocation in case of GMA continues to be in the scale of Rs. 250/- per patient per day. This was the position at the time of earlier visits in January, 2007, February, 2008 and February, 2009. The scale is grossly inadequate; it is outdated too. It is not related to the genuine needs of the institution. The scale was Rs. 500/- in case of IMHH, Agra and RINPAS, Ranchi. As a matter of fact, the Managing Committee, RINPAS has in consideration of the inadequacy of the existing scale, recommended to increase it to Rs. 900/- This is on account of the fact that the rates of all consumables i.e. drug, food items, dress items (linen, bedsheet, pillow cover, fabrics for dress of inmates), raw materials for the OT, films for x-ray, chemicals for the pathological laboratory, fuel and lubricants etc. has considerably increased and it is

next to impossible to ensure smooth and scientific management of an institution like GMA with a per capita allocation of Rs. 250/- per day without diluting the quality of services. This also deserves consideration of MC on top priority.

Human Resource
Human Resource Development
Human Resource Management

There are certain basic principles which need to be kept in view while dealing with the above. The first principle is that there must be a fairly accurate assessment of manpower requirement in different grades in an institution conforming to different functions (teaching, training, treatment, household management, research). This will be possible by (a) every job needs to be described and analysed and a conclusion reached whether the job is temporary or permanent, contract/casual or regular and (b) jobs must be classified under different heads. The second principle is to lay down the qualification, experience, emoluments for each job. The third principle is to ensure that the right people are selected for the right jobs in a right manner which is one of total openness and transparency. The concomitant principle to this is that all vacancies must be filled up in time. The fourth principle is to refine and sharpen the human resource so selected through both induction and refresher training as a tool of human resource development. The fifth principle is continuous objective and dispassionate assessment or evaluation of the work, conduct and performance of the individual task holder on the strength of which measures can be taken for confirmation, career advancement through promotion, issue of indictment/warning in the event of non performance and disciplinary action for acts of omission and commission. The sixth and the last principle is non discrimination i.e. other things remaining equal every individual should be judged on the basis of worth and not on any other extraneous consideration (birth, social origin, caste, creed, colour, gender, faith, ideology etc.). All human resources selected to work for the institution must receive constant encouragement and support in discharge of their functions.

During my last review I had made a thorough assessment of the manpower position. I had observed that apart from a large number of vacancies (70) in various grades (A, B, C and D), the contractual nature of appointment on a consolidated wage was a major disincentive for people to respond to advertisements and reluctance to join even if selected after the interview for the same reason. It was also observed that due care and attention had not been paid to the cost of living (which is very high and which is going up higher and higher due to inflation in general (which is around 10% at present) and food inflation in particular(which is around 18% at present) in a city like Gwalior while fixing the consolidated wage (Rs. 18000/-) for Psychiatrists, Clinical Psychologists and Psychiatric Social workers.

I was happy to note in course of the current review that new appointments are no more on contractual basis. As a matter of fact, according to the revised policy of the State Government conveyed through order No. 5061/2007/1 dated 10th July, 2008, contractual appointments were not to be made in all State managed institutions from 2007 and after but GMA had not been included in the purview of the policy. Now GMA has been included which means that all appointments are to be made on regular basis except certain jobs which are outsourced.

At the time of the last review against 213 posts sanctioned, 143 had been filled up and 70 were lying vacant in various groups (A,B,C and D). The vacancy in Class IV was 20. The Director reported that after 9 days of intensive drive the process of selection to 18 Class IV Posts has been completed, letters of appointment issued and all the selected candidates have joined on 15.2.2010. This has made provision of additional support to the care and attention of patients possible.

The current position in regard to number of posts sanctioned against different groups (A,B,C and D), posts filled up and vacant posts is indicated below:-

Group	Total Number of posts sanctioned	No. of Posts filled	Vacant Posts
A	11	02	09
B	22	13	09
C	95	52	43
D	85	79	06
Total	**213**	**146**	**67**

The following redeeming features and deficiencies were observed in GMA in terms of manpower planning:-

Redeeming features:

- Male nurses (8) which were filled earlier on contractual basis have been regularized after an interregnum of 2 years in a time scale of pay of Rs. 4000 – 6000/-.

- There has been perceptible improvement in regard to filling up of vacancies (18) in Group 'D'.

- Total openness and transparency have been observed in filling up posts in various groups.

Deficiencies:

- The norms on the basis of which posts in all groups are to be sanctioned have been laid down in Rule 22 of State Mental Health Rules, 1990. These are (for 100 beds):-

    - one full time qualified Psychiatrist;
    - one Asstt. Clinical Psychologist;
    - one Psychiatric Social Worker;
    - staff nurses in Nurse Patient ratio 1:10;
    - attenders in the attendant patient ratio 1:5;
    - Medical Officers having recognized MBBS degree: Patient ratio 1:50.

- Judged by this norm, GMA is entitled to sanction of the following number of posts of professionals:-

1. Psychiatrists - 3
2. Clinical Psychologists - 3
3. Psychiatric Social Worker - 3
4. Staff Nurses - 20

Every Psychiatric hospital runs for 3 shifts and the requirement as indicated prepage will have to be multiplied by three to arrive at the correct manpower required for all the 3 shifts. Judged by this norm there are gaps between the manpower needed, manpower sanctioned and manpower in position in GMA. The current status obtaining in GMA is as under:-

- A proposal for sanction of 82 additional posts is pending with Government of M.P. in Health and Medical Education Department.

- The Pathological Laboratory was manned by a Pathologist – Dr. Sharma who passed away a few days back. The post of laboratory technician is also lying vacant. In other words, the pathological laboratory is non functional.

- This has been compounded further by vacancies in the posts of Radiographer (1), compounders (3) (now redesignated as Pharmacist Gr. II) and occupational therapist (male) (1).

- It is not understood as to why these vacancies in Gr. C are not being filled up when the same can be filled up with the approval of the Appointments Committee.

  Even now there is no change in the current status of –

  - Asstt. Professor, Psychiatry – 1
  - Assistant Professor, Clinical Psychology – 1
  - Psychiatric Social Worker – 1
  - Clinical Psychologist – 1

  They continue with their contractual status.

Human Resource Development:
Library:

We need to have 2 libraries namely one for faculty and staff members and another for patients. The first should comprise of books, journals and periodicals in Psychiatry, Clinical Psychology and Psychiatric Social Work as also history, geography, sociology, psychology, art, literature, fiction, humour, yoga etc. while the second should comprise of books, journals and periodicals which are meant for light reading to generate curiosity, excitement and joy on the part of patients who have been effectively treated and who are fast on the road to recovery. There should be a separate budget for purchase of these books, journals and periodicals and the purchase should be made with the approval of the Purchase Committee. For purchasing books, journals and periodicals for the patients it will be useful if their preferences are ascertained through consultation and purchases made accordingly. The journals and periodicals for patients should be well visualized and well illustrated.

At the time of last review it was observed that (a) the number of books in the library was very small in the realm of psychiatry, clinical psychology, psychiatric social work, psychiatric nursing, pathology, ophthalmology, dentistry etc. It was further observed that even though the power of sanction for purchase of new books, journals and periodicals (both indigenous and foreign) has been delegated to the MC, this power is yet to be used. The reasons are threefold. No planned and coordinated exercise seems to have been carried out to select the books, journals and periodicals which are of interest and relevance to faculty and staff members and place the same before the MC. The latter has not issued any direction to the Director, GMA to this effect. In any case, the meetings of the MC have been few and far between. Besides, such purchases can be made only in conformity with the Government of MP Purchase Rules and there is a stipulation in the said Purchase Rule that no purchases can be made after 31st January of a financial year.

Suggestion:

- The Director incharge should consult the faculty and staff members for purchase of books, journals and periodicals (both indigenous and foreign) for the financial year 2010-11, should place the proposal before MC and should invite tenders for purchase of the same with the approval of the MC.

- Similar exercise for purchase of books, journals and periodicals for the patients should be carried out in consultation with the patients.

- There should be a continuous interaction and exchange of books/research papers between the faculty of IMHH, Agra, RINPAS, Ranchi and GMA, Gwalior. A number of useful publications have been brought out by IMHH, Agra and RINPAS, Ranchi on the following:-

  - common mental health problems;
  - mental health of school children – a handbook for teachers and parents;
  - manual for mental health workers in disasters, dementia, HIV/AIDs etc.

- Director, GMA should write to her counterparts in Agra and Ranchi to share with her details of all their publications in Psychiatry, Clinical Psychology and Psychiatric Social Work.

- Proceedings of seminars, papers contributed in seminars and published thereafter, souvenirs published after national and international workshops/conferences should be disseminated among the libraries of these three premier hospitals.

- If there is any other publication in Psychiatry, Clinical Psychology and Psychiatric Social work worthy of being procured for the

library of GMA, Director. GMA should write to the Head of the concerned institution and have them procured.

Human Resource Development through training:

Training is an important input of human resource development. Training imparts information. It equips the trainee with certain skills namely life skills, communication skills, survival skills, vocational skills, attitudinal and behavioural skills, entrepreneurial and managerial skills. It removes doubts and uncertainties and places issues in a proper and holistic perspective. Properly conducted it could be an effective tool of sensitization of the insensitive. Viewed in this perspective training is essential for personnel in an organization/institution and it is necessary at the end of each training session to evaluate the content, quality and impact of training.

Training can be inhouse or outside depending on the infrastructure and expertise available at a particular point.

Judged by these norms GMA appears to be extremely in an extremely weak wicket. It is particularly weak in regard to psychiatric training of all staff nurses. Since many of them are reluctant to go to NIMHANS, Bangalore which is best equipped with such facilities, care should have been taken to plan and organize such a training programme in RINPAS, Ranchi or IMHH, Agra who are imparting such training.

GMA is also extremely weak in terms of building up an electronic data base on training covering the number of personnel in various categories, number of personnel who have been deputed for training, where and at what intervals, whether the content, quality and impact of training has ever been evaluated and if so, the outcome thereof.

Treatment of patients:
OPD:

Between 9 AM to 11 AM on 23.2.2010 i.e. second day of my visit I went round the OPD and interacted with fifteen patients and their

relatives who after registration were waiting in the OPD hall to be called for examination by the MO concerned. I also spoke to the MOs examining the patients. The following are my observations at the end of my visit to the OPD:-

- There is a registration counter for registering women, men and senior citizens but is being manned by only one person unlike RINPAS, Ranchi where it is manned by atleast three persons.

- Between 8 AM and 10 AM (when I was taking the round) 33 patients had registered themselves while 30 patients had deposited the slips collected from the registration counter with the record room in charge.

- It takes about a minute for the clerk in charge of the record room to take out the relevant file of the patient (in an old case) and have it sent it to the MO concerned.

- In all there are 2 record rooms, 6 almirahs and 12 racks. In each rack there are 5 compartments. Patient's files have been maintained monthwise and yearwise in each compartment. Twenty files have been kept in each compartment. Patients' records from 2006-09 have been kept.

- The patients hail form Bhind, Morena, Chitrkoot, Chattarpur, Sagar, Vidisha, Banda, Jhansi and Dabra traveling long distances either by bus or by rail.

- On an average a patient is being accompanied by one to two persons (relatives or family members).

- Most of them hail from the families of small and marginal farmers which are also BPL families.

- There is always some time span between the first day of observation of mental illness and the date when the patient is actually brought to the hospital.

- This violates the principle that timely diagnosis is key to timely cure.

- On account of the high cost of travel, loss of employment and wages, relatives of the patients are not able to come to the OPD for follow up as also for collecting drugs (after drugs issued for one month have been exhausted).

- The track record of drug compliance is poor which results in relapse.

- The patients who are from BPL families have brought with them their photographs and BPL certificates and made a plea for issue of a letter of recommendation with which they can avail of concessional tickets by rail/bus.

- On account of the long distance and cost of travel a request was made if the drugs could be issued for about 2 months at a stretch.

- The room sizes of MOs is fairly small (except the room of Dr. Gautam Anand). There is not enough space for accommodating all the relatives of the patient.

- The sitting arrangement for patients in the OPD is good. Chairs have been provided for patients and relatives. All facilities and amenities (drinking water, conservancy etc.) have been provided.

- A couple of IEC materials (Boards) have been procured from the Institute of Psychiatry, Jaipur depicting the following:-
  - Name of the ailment;
  - Characteristics/symptoms;
  - Line of treatment;

- Dos and donots for the patients and relatives.

- A couple of good IEC materials have also been prepared by a patient called Ms. Rekha Sharma who is literate is full of imagination and insight and who, given the opportunity and encouragement can do a lot more.

- The time taken for collecting medicines at the drug dispensing unit is barely 5 minutes.

- Adequate quantity of drugs have been issued by the central drug store to the drug dispensing unit which is a sub store. There is no scarcity of drugs.

A couple of suggestions:

- A board should be displayed to indicate that genuine and deserving cases (BPL families included) would be recommended for issue of tickets for concessional fare travel by train/bus. All that the patients/their relatives are required to do is to bring with them (when they come to the OPD) 2 copies of their passport size photographs and copies of the BPL certificate issued by the revenue authorities.

- Considering daily average outturn of patients at the OPD (ranging between 100 to 125) the registration counter should be manned by atleast 3 persons (as against one at present).

- A data entry operator needs to be in position for recording personal history, family history, case history and all the demographic profiles of the patient. Such computerized database about the patients would stand the hospital authorities as well as the patients in good stead.

- A newspaper stand with local newspapers and a TV set should be installed in the OPD for facilitating access to information and recreation of patients and their relatives.

- A number of observations were made by me in February, 2009 at the time of visit to the canteen which was opened for the benefit of patients and the relatives accompanying them during the incumbency of Dr. (Mrs.) Jyoti Bindal and entirely on account of her initiative. Not to speak of compliance with these observations, it was observed that the canteen is not functional. The Indian Red Cross Society which was managing the canteen found it uneconomical as patients/relatives started demanding snacks to be served at very low rates which are not economical. The matter was placed before the Managing Committee on 12th January, 2010 which decided that the canteen should be restarted with the help of Central Jail, Gwalior. The Jail Superintendent, Gwalior has been requested on 10.2.2010 to restart the canteen. Till a decision is taken by the Jail Superintendent, the canteen stands closed.

The same observations which were made at the time of the earlier visit hold good even today. To reiterate:-

- a chart indicating the items supplied and the rates thereof should be displayed at a conspicuous point;

- sufficient number of chairs and tables should be put in the dining hall of the canteen to enable patients and their relatives to sit and take food;

- the canteen staff should be got trained by a local food craft institute to be civil, courteous and considerate to patients and their relatives while serving them food with a human touch;

- food in the canteen always be served hot, wholesome and nutritious.

A few other disquieting observations:

- The overall situation which was observed at the OPD is one of ignorance, illiteracy, dependence on others and utter helplessness.

- Many families are below poverty line but do not have a BPL card. They have no clue as to where and how they can get a BPL card. This is a sad reflection on the working of the Panchayatiraj System or the system which rests on the principle of democratic decentralization.

- In quite a few cases it was observed that the treatment is going on for quite sometime but there was no visible improvement in the condition of the patient. This would result in long stay of the admitted patients necessitating permission of the CJM in each and every case where the stay exceeds 90 days (proviso to Section 19 of Mental Health Act, 1987).

- In all such cases where prolonged medication prescribed by the MO at the OPD did not produce the desired results the patients have to come to GMA from long distances again and again.

- The patient does not know at what interval and with what dosage the drug is required to be taken. This calls for a lot of vigilance, care and attention on the part of the family members. I, however, came across a situation where the husband is not prepared to administer drugs to his wife leaving her entirely to her fate.

- There are extremely difficult situations where both the husband and wife are undergoing treatment. They have children but they have allowed them to study (son is doing MBA while daughter is doing first year of the three year degree course) and, therefore, are not available to either accompany the parents and take care of them while they are attending the OPD. This shows that mental

illness has indirectly been responsible for children remaining away from mentally ill parents.

- Substance abuse was found to be taking a heavy toll of life of the younger generation. The tragedy of the whole situation is that when children start taking charas or smack they do so in seclusion and parents are totally unaware of it. There is no social communication between them. There is no way by which unsuspecting parents can forewarn their children about the deleterious consequences of addiction to drugs. In a report by Kounteya Sinha published in Times of India dated 22.2.2010 India's gaping generation gap has come out clearly and convincingly. To quote from the report:-

  > 'Fathers appear to be worse off when it comes to communicating with their children. Only 7% boys and 4% girls aged 15-24 discuss growing up issues with their fathers. Mothers were equally bad when it comes to their sons with only 6% boys confiding and discussing life with them'.

- Substance abuse brings about utter economic ruination to lower middle class families apart from contributing to mental illness. Since there is no Drug Deaddiction Centre in GMA it is extremely difficult to treat these patients who are victims of substance abuse and who need hospitalization in an exclusive drug deaddiction ward for about 3 to 4 weeks.

Visit to open ward:
Impressions and Observations:

- The environment inside the wards was neat and tidy.
- The gap between 2 beds was sufficiently wide to make room for lockers where personal belongings of relatives can be kept.

- Many patients on account of anaemia and malnutrition looked half their age. Reduced appetite and sleep on account of mental illness was a common feature with most of the patients.

- Several of these cases are instances of delayed admission. They have initially gone to private medical practitioners and have come back to GMA only after discovering that going to private practitioners was an exercise in futility.

- There are instances where relatives get the patient admitted in the open ward and go away leaving the patient in wilderness even though open wards are meant for relatives to stay with the patients. The staff and the attendant have, however, maintained a close watch over the patients on account of which occurrence of any mishap has been preempted.

- Different patients react differently to the same line of treatment. Some respond well while others do not. Those who do not respond and do not get expected results out of the treatment have to come to GMA again and again. This further adds to growing economic liability and attendant frustration.

- There are, however, a number of cases where non compliance with drugs has resulted in relapse necessitating return to GMA again and again.

A few suggestions:

- Counselling – both drug related and behaviour related has to be very effective. With effective counselling drug compliance will improve and with better drug compliance the possibility of relapse will be minimal.

- Regular check up of health of all inmates – male and female is a must, is being done and the outcome of the check up is being reflected in a register. However, there are a few patients who are

of low haemolgobin and also of low weight and who are in need of special care and attention by way of special diet. They should be subjected to more frequent observation.

Food Management:

Visit to Kitchen and dining hall:

- A good quality food management involves the following:-
  - procurement of food grains of standard quality either from PDS or open market, as the case may be;
  - storage of food grains, fruits, eggs, vegetables in a clean environment; preferably on platforms and not on the floor;
  - prescribing a scale of diet which is consistent with cost of food articles and food inflation as also conforming to the special status of patients, if any (low weight, low haemoglobin count) etc.;
  - preparation of food in the kitchen in an environment of total hygiene and cleanliness, free from dust, fume, pest etc.;
  - storing food hot in stainless steel containers;
  - serving food on a dining table in a room which is airy and well lighted with a human touch;
  - ensuring personal hygiene of all patients (through cleaning of their hands and feet) before they settle down to their meal;
  - assisting physically and orthopaedically handicapped patients, patients who are victims of rheumatoid arthritis, whose connective tissues have been damaged and who are incapable of taking food entirely on their own; this will ensure prevention of wastage of food;

- playing soft and subdued music through a music channel so that a joyous environment is created where the patients can take their food with freedom and spontaneity; to the extent space permits, making the hospital self sufficient by developing an agricultural farm/kitchen garden, making the patients who are comparatively strong and skilled to work in the farm/garden to raise crops, fruits, vegetables etc. (which will promote dignity of labour) and minimizing thereby dependence on market (where adulteration of foodgrains, milk etc. is the order of the day).

Keeping the above in view, a number of suggestions were made keeping the kitchen in IMHH, Agra as a model such as:-

- a modern chimney regardless of the type of fuel used;
- sufficient number of exhaust fans;
- fly proof wire mesh all around;
- fly proof automatic closing doors;
- floors made of an impermeable material;
- a platform for washing vegetables daily with potash permanganate and for cutting before cooking;
- an electric kneader for preparing a paste out of atta prior to making chapattis;
- chapatti making machines, mixers and grinders;
- adequate number of taps inside the kitchen;
- LPG and hotplate;
- cooking and serving utensils to be made of stainless steel.

In course of my round of visit to the kitchen and dining hall an interaction with patients taking their food (12 Noon at 23.2.2010) I would like to record the following impressions and observations:-

- There has not been any change in the design of the kitchen; there is no outlet for smoke to go out (in the absence of a chimney);

- Vegetables, fruits, eggs were found to have been kept in containers on the floor and not on any rack or platform; they cannot be free from pest attack;

- Atta and sugar bags have also been kept on the floor; there is no orderliness in storage;

- There is no electric kneader nor any chapatti making machine.

- Chapattis are being made manually on low height plates;

- As the tawa on which chapattis are being baked is not of good quality there is too much jwalan or burning of chapattis.

- Food trolleys are yet to be procured even though clear recommendations have been made to this effect in the past.

- The food items (wheat, rice and pulses), fruits (banana, apple, guava, mousambi, orange etc.) and vegetables (carrot, radish, spinach, maithee, potato, peas, tomato, green leafy vegetables), milk and egg are being served on alternate dates in appropriate quantities (there was no restriction on the quantity of food being served).

- The patients taking food in the dining hall appeared to be by and large satisfied with both quality and quantity of the foodstuff served to them on different dates according to the approved menu.

- There is no sanctioned post of dietician in GMA. Even GR Medical College and Hospital does not have the sanctioned post of a dietician. The quantity and quality of foodgrains which are being procured from the open market are being certified by the MOs.

- The scale of diet per patient per day comes to Rs. 34/-. In my last review report I had suggested that if a proper link is established with PDS the primary food articles (wheat, rice) could be obtained at a much lower price (lower than Rs. 28/- for 1 kg of rice and Rs. 15/- for 1 kg of atta at which these food articles are being currently procured from open market) and the saving could be utilized in increasing other components of food, improving the nutritive value and overall quality.

Since then efforts have been made in this direction but the PDS authorities showed their inability to provide wheat and rice as per the requirements of GMA). GMA, therefore, continues to buy these 2 primary food articles from the open market at 450 PC higher than the PDS price.

The timings for breakfast (8.30 AM), Lunch (1 PM) and dinner (6.30 PM) are in order.

Suggestions:

- It may be desirable to go in for planning and construction of a modern kitchen block like IMHH, Agra which should comprise the following:-

  - waiting lobby with a platform towards left and dispensing space for food on the right – about 11 metres;
  - vegetable storage platforms – about 12 metres;
  - preparation of food area – about 20 metres (washing and cutting vegetables);
  - cooking area – about 120 metres;
  - washing area (for cleaning utensils) – about 20 metres;
  - food storage area – about 30 metres;
  - pantry area – about 16 metres;

- changing room – about 10 metres (for cooks changing their apron);

- entrance – about 10 metres;
- toilet block – about 10 metres;
- gas bank – about 10 metres;
- verandah – about 10 metres.

Like IMHH, Agra the following need to be installed in the Kitchen block of GMA:-

- chimneys (3);
- exhaust fans (8);
- aircooled pipeline duct (1);
- gas pipeline (6 outlets);
- chullah with grills (5);
- chullah with tawa (2);
- steel pipe trolleys for transportation of food to the dispensing window.

The financial implications of the new kitchen block may be worked out, incorporated in the BE for 2010-11, approval of the MC may obtained and the proposal for enhanced allocations sent to Government for approval.

It may, however, be appropriate to depute the officer who is incharge of kitchen – Dr. P.K. Singhal to pay a visit to IMHH Agra, study the planning and architecture of the new kitchen block and replicate it in GMA with modifications, if any, to suit local conditions. Prior to taking up the exercise of preparation of estimates for construction of a new kitchen block.

Water Management:

Right to water, according to the apex Court, is as fundamental a right as right to food, both being integral part of right to life (Art. 21).

Water is required for absorption of food as also for cleaning, washing, gardening, bathing, cooking, flushing the toilets etc. Approximately 130 litres of water per head would be needed for all these purposes combined. At the current bed occupancy rate of 92.16% about 25000 litres of water would be needed per day for about 200 patients. At the time of last visit a new overhead tank with a capacity of 3 lakh litres was under construction at an estimated cost of Rs. 17 lakhs. It was reported that civil works of this OT tank has since been completed. The MC has given sanction for installation of water pumps to fill the OH tank and it was expected that it would start functioning soon.

Management of environmental sanitation:

At 1:3.75 GMA has an ideal toilet patient ratio with sufficient number of toilets and bathrooms. In response to the suggestion made in the last review report 3 WCs have been fitted in the male and 4 WCs in the new female ward.

Suggestion:

Physically and orthopaedically challenged persons, persons who are victims of rheumatoid arthritis, austeo-arthritis and austeoporosis with low density of bones and damaged connective tissues need to be given orientation and encouraged to use and maintain WCs in a neat and tidy environment.

Management of recreation:

There is no park inside the hospital where inmates can sit with their relatives and relax in the evening hours. All open spaces inside the hospital premises have been paved leaving little or no scope for their conversion into mini parks. There is minimal greenery or sylvan setting in GMA. The only way by which the hospital management could give a push to greenery is to utilize the open spaces around the new female ward for conversion of the same into mini parks. These open spaces on no account should be paved.

Wherever mini parks are created small RCC benches could be installed so that patients with relatives could use them to relax in the evening hours.

Apart from there being a Vachanalay which is stuffed with newspapers, books and journals as also facilities for indoor games and music there are a few human resources amongst the patients like Sewa Ram and Ms. Rekha Sharma who are literate, skilled, creative and imaginative persons and are capable of recording feelings and impression of others, effectively communicating to others as also capable of organizing activities which would bring happiness and joy to them. There is yet another human resource in GMA who though a treated patient is an asset to the other patients as also to the institution. He is one Sanjay Saxena who at one point of time had made an unsuccessful attempt to commit suicide in a state of severe desperation which led to his present state. Initially he was treated by Dr. Sahu at Bhopal (currently Secretary of the State Mental Health Authority) and later brought to GMA. He knows typing, he can read out prescription to patients, can distribute medicines, can check and record BP, assists patients to take bath, looks after them in many other ways and informs the Director if any wrong is being committed by anyone anywhere anytime.

All the 3 of them i.e. Sewa Ram, Ms. Rekha Sharma and Sanjay Saxena and a few others like Shri Partha Sarathi (who is a graduate), Vijay Nair and Balendu Dubey (who are literate) can start literacy classes to make non literate and non numerate inmates functionally literate. This will be a useful and worthwhile activity which can be organized with the support of Bharatiya Grameen Mahila Sangh based at Indore which is the State Resource Centre for MP. The latter can provide academic and technical resource support to this activity.

Management of Occupational Therapy (OT):

In the last review report a number of deficiencies in the management of OT were pointed out such as;-

- there are no 2 separate OT units for male and female patients; the existing OT is meant only for female patients;

- there is no appreciable engagement or involvement of inmates in the OT;

- products made by the inmates neither indicated their names nor the period when they were made;

- the skills/trades were mostly traditional and a very few of them were market relevant;

- there was no significant addition of new skills/trades between the 3 reviews (January, 2007, February, 2008 and February, 2009);

- the space available in the OT is insufficient.

Accordingly a number of suggestions were made to remove these deficiencies and to bring about a qualitative change. At the time of the fourth visit it was found that most of these deficiencies remained uncorrected except the following:-

- every product which was made by an inmate is bearing her name;

- the following skills/trades have been added to the list of existing skills/trades:-
    - durry making;
    - photo framing;
    - doll making;
    - sofa cover;
    - door mats;
    - typing;
    - board painting.

Occupational therapy is not meant merely as a short term activity for imparting a few skills/trades; it should be seen as a tool or instrument of rehabilitation of patients who have been treated in the mental health hospital and who are fast on the way to recovery. To make this possible, the following short term and long term strategy needs to be adopted:-

- a market survey should be launched to identify such skills/trades which are market relevant;

- a manual should be prepared to incorporate (a) raw materials needed for imparting a particular skill/trade (b) tools/equipments/ machines needed (c) costs thereof (d) training of instructors with the help of master trainers (e) duration of imparting a particular skill/trade (f) evaluation (g) marketing of products (h) payment of remuneration to the inmates for making specified products;

- there should be two separate OTs – one for male and another for female inmates;

- two or more separate instructors should be appointed for imparting skills/trades to the inmates;

- the skills/trades to be imparted should be market relevant;

- every OT has recurring and non-recurring financial implications; these should be carefully worked out and incorporated into the budget estimates;

- OT through skill training apart from being a tool of rehabilitation should be viewed as a source of excitement and joy of creation, as a way of promoting dignity of labour, work culture and work ethics, discipline and group solidarity;

- OT should not be viewed as a one time activity. There should be a continuum in this in as much skill formation and skill upgradation should continue as activities even after the patients have been treated, after they have recovered, discharged and

sent home. This will be possible only with the involvement of the following agencies:-

- District Industries Centre (DIC);
- Small Industries Service Institute (SISI);
- Small Industries Development Bank of India (SIDBI).

– The State Government must adopt OT through skill training as an integral pat of its rehabilitation policy and should coordinate this activity through the DIC at the district level.

Drug Management:

Drug Management in its totality envisages the following:-

– A fairly accurate and authentic forecast of requirement of specific drugs for a particular year in relation to different forms of mental illness on the basis of trends observed in the previous year;

– A fairly accurate forecast of requirement of funds for procurement of those specific drugs for that year;

– Incorporation of the same in the budget estimate for the year;

– Recourse to the procedure approved by Government for procurement of drugs;

– Storage of drugs so indented and procured and distributed from the Central Store to Sub Stores;

– Issue of drugs to patients at the OPD, IPD, halfway home and community satellite clinics for a specified period (15 days, 30 days, 60 days and so on);

– Compliance with drugs through counseling;

– Follow up at appropriate intervals.

As far as GMA is concerned, till the time of the second review conducted by me in February, 2008 drugs were being procured through a Central Procuring agency i.e. M.P. Laghu Udyog Nigam. Besides, under the Government Purchase Rules in vogue then GMA could not indent drugs for more than 3 months. Besides, no purchases (except food materials) were to be made after 31st January even if budget provision for the same existed.

At the time of conducting the third review in February, 2009 there was a limited change in the exiting procedure in as much as instead of routing the requirement for drugs through M.P. Laghu Udyog Nigam, the Director, GMA could procure drugs through open tender system.

The other restrictions of (a) not being able to indent drugs for more than 3 months (b) no expenditure can be incurred and no orders can be placed with any supplying agency for purchase of drugs, tools, equipments and furniture after 31st January of a year continue unchanged.

Despite these limitations I was given to understand by the Director incharge that she has been able to manage the procurement of drugs as per requirement as would be evident form the following table :-

Expenditure on medicine (1.4.2009 to 31.1.2010):

S.No.	OPD	IPD (both closed and open wards)	Halfway Home	DMHP Shivpuri	Total
1.	Rs. 78,78,470	Rs. 1,85,974	Rs. 21,688	Rs. 61,718	Rs. 81,47,850

Therapeutic dimension of mental health:
Ward Management:

It has long since been established beyond doubt on the basis of empirical research that the behaviour of every patient in the hospital including the pace and progress of his prognosis is largely a function of the environment. This means that mentally ill persons are to be treated

as not just ordinary victims of molecular or chemical derangement. If they are treated as guests in a family environment with kindness and compassion they would act and react in a positive manner which is the key to their recovery.

In concrete terms, therapeutic dimension of mental health implies the following :-

- Number of ward rounds taken by the Director, other Psychiatrists, Clinical Psychologists, Psychiatric Social Workers, MOs, Matron and staff nurses;
- Formation of ward groups;
- Ward group meetings;
- Developing informal means of communication in a ward as in a family for dissemination of information;
- Continuously instilling hope, faith and confidence in the minds of the patients both at the OPD and in the IPD that (a) all is not lost (b) life can be started afresh (c) mental illness is not a fatality, not irreversible but fully preventable and correctable.

Ward Community meetings can have a behaviour control function and the patients may benefit by attending such ward group meetings. They may imbibe and assimilate new ways of reacting to problems and behaving.

It has been observed that most of the mentally ill persons have problems of social interaction. If ward groups are formed and periodic meetings of the ward groups are organized and such meetings facilitate informal communication, the patient may overcome his or her difficulty in social communication.

Humane interaction has a tremendous effect on torn minds. A medical officer with high morale, motivation and positive emotional interaction can instil hope and confidence and accelerate the healing process.

A few specimens of such humane interaction are listed as under:-

For Senior MOs:

- Do you feel free to work, to take decisions and, in particular, to take care of the patients with a sense of discretion and independence?
- Do you feel free in clinical management of your patients?
- Are you attending to patients, in emergency, in casualty in OPD and IPD with the urgency and seriousness of concern which the patients deserve?
- Are you under compulsion for referring cases of psychiatric patients outside for extraneous consideration?
- Do you have any suggestion for improving the ward environment?

For Junior MOs:

- Do you participate in clinical work?
- Are you punctual in coming to the ward?
- How many rounds do you take?
- What type of questions do you ask?
- What type of responses do you elicit?
- Are you allowed to involve yourself wholeheartedly in treatment of patients?
- Do you participate in academic and seminar activities?
- Do you have any suggestion to improve the ward environment?

For Staff nurses:

- Have you been provided with residential accommodation within the premises of the hospital?
- If not, how do you commute the distance from your residence, how much time is consumed, does it cause any exhaustion?
- Does it affect punctuality of your attendance? How do you respond to emergency calls?
- How many rounds do you take in the wards everyday?
- How much time do you spend with the patients in each round?
- What type of questions do you ask the patients and their relatives?
- What type of responses do you get?
- Do you document them for the purpose of analysis and for taking certain decisions?
- Do you think, feel and believe that by your rounds, interaction and dealing with the patients, you have been able to create the right type of ward environment which is conducive to recovery?
- Do you have any specific suggestions for improving the ward environment?

For Class IV staff – warder/ward attendants:

- How do you generally find the patients – calm, quiet, subdued, not opening up or violent, aggressive and loud mouthed?
- How do you handle various categories of patients?
- Do you ever take recourse to violence to counter violence to control those patients who are otherwise unruly?

- Have you come across instances of unethical practices like patients paying money at the time of admission?

- Do you think that the situation in which a mentally ill person has been placed is not his/her own creation; this could happen to any one of us?

- Do you identify yourself with weal and woe, the joy and sorrow of the patients with total empathy and sensitivity?

- Do you have any specific suggestions for improving the ward environment?

Relatives of patients:

- Do you face any financial difficulty or otherwise in bringing the patient to the hospital?

- Are you required to pay any bribe to anyone for securing admission of the patients?

- Are you satisfied with the quality of the drugs which are dispensed through the drug dispensing unit of the hospital and the time taken in the process?

- How do you find the behaviour of the MOs, paramedics (including staff nurses) and ward attendants towards the patients?

- Do you think that the ward environment on the whole is homely, humane, fraternal and, therefore, conducive to recovery of patients?

- Have you come across instances of any middleman, anti-social element or any other ward attendant creating a situation of extortion, unruly behaviour, persecution and torture either of the patients or their relatives?

- Do you think that in the family ward where you are staying with the patient, the arrangements for your stay, safe upkeep of your personal belongings etc. are satisfying? If not do you have any suggestions for improvement?

- Do you have any specific suggestions for bringing about improvement in the ward environment?

Patients:

- How do you feel here? Do you feel quite at home?
- Do you have any problem in day to day living?
- Has any one treated you in a manner which you think has affected your dignity?
- If so, what is the nature of that treatment?
- Has any medical officer, staff nurse, PG student or ward attendant come to meet you?
- If so, how much time did he/she spend with you?
- Do you recall their names?
- Whom do you remember to have appealed to you most? If so, for what reason?
- Do you feel that you are receiving due attention and care here?
- What else do you need?

Such interaction particularly with the patients and their relatives would yield valuable results such as:-

– It will enable patients to open up; such opening up is useful for their recovery;

– It will help in unearthing what is going on in the wards;

- It will promote group solidarity;
- It will help in effectively dealing with crisis situations, if any, with the intelligence collected through interaction;
- It will establish a rare emotive bond between the MOs, staff nurses, warders/ward attenders and patients/their relatives resting on rapport and bonhomie.

The experiment of formation of ward groups and holding ward group meetings is yet to take a definite shape in GMA. The Director incharge could make a modest beginning in that direction and see the good results flowing in a very short time.

Table-I

This deals with the outturn of OPD patients from the Year 2005 till date. This indicates an increasing trend in terms of more patients coming to the OPD for treatment over the years:

Year	New Patients			Old Patients			Grant Total	Average	
								Per Day	Per Month
	M	F	Total	M	F	Total			
2005	5494	3520	9014	10961	3125	14086	23100	63.28	19.25
2006	5397	3340	8737	10925	3012	13937	22674	62.12	18.89
2007	7125	3243	10368	9232	3257	12489	22857	62.62	19.04
2008	4252	2008	6260	15131	6803	21934	28194	77.24	23.49
2009	3930	1829	5759	16182	7134	23316	29075	79.65	24.22
Up to Jan. 10	220	140	360	1235	650	1885	2245	72.41	-

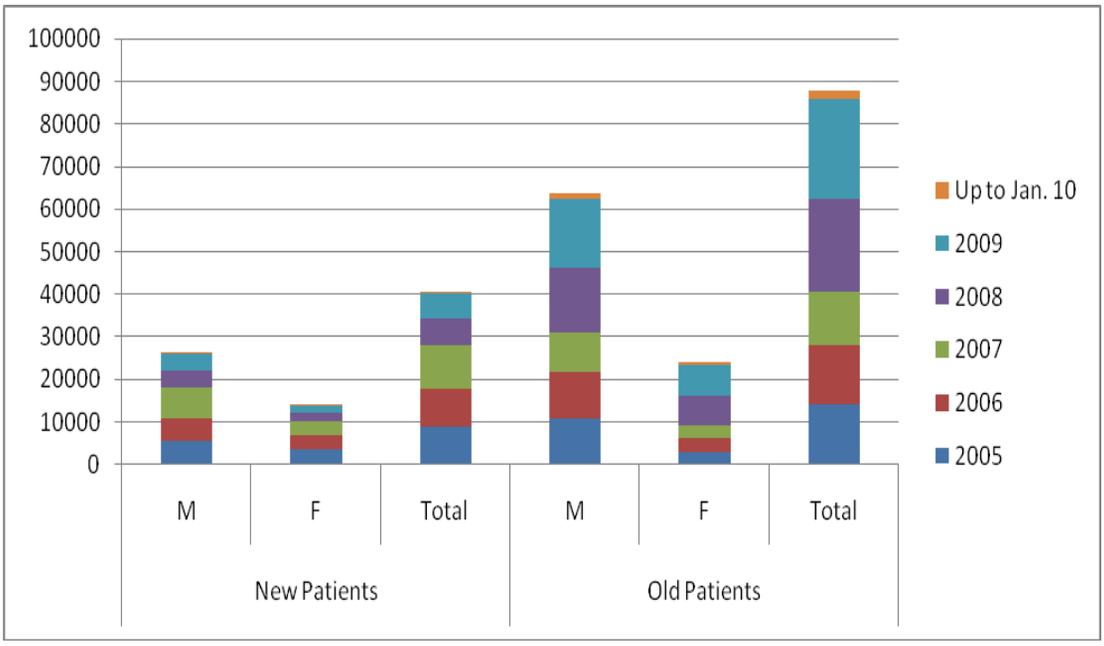


Table-II

This gives a break up of new and old patients in OPD:

Year	New Patients	Old Patients	Total	Average	
				Per Day	Per Month
2008	176	254	430	1.17	35.83
2009	75	407	482	1.32	40.16
Up to Jan. 10	-	09	09		

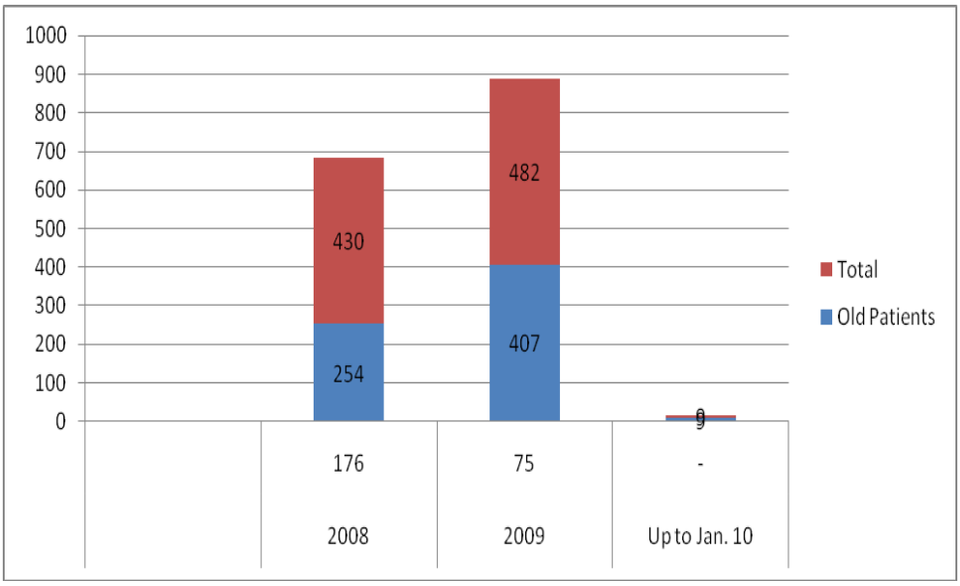


Table-III

This depicts patients coming to OPD clinic at the Satellite Clinic:

YEARS	MEDICAL COLLEGE (MADHAV DISPENSORY) O.P.D.	CIVIL HOSPITAL Morar's O.P.D.	D.M.H.P.-SHIVPURI O.P.D.	HEALTH CAMPS AND MELA'S	Central Jail Gwalior
2005	890	1200	3144	420	55
2006	-	1350	1749	-	50
2007	-	-	1891	-	205
2008	-	-	997 (Up to Sept. 08. Restarted since dated 27/01/2009)	5	103
2009	-	-	2029		110
Up to Jan. 10	-	-	137		

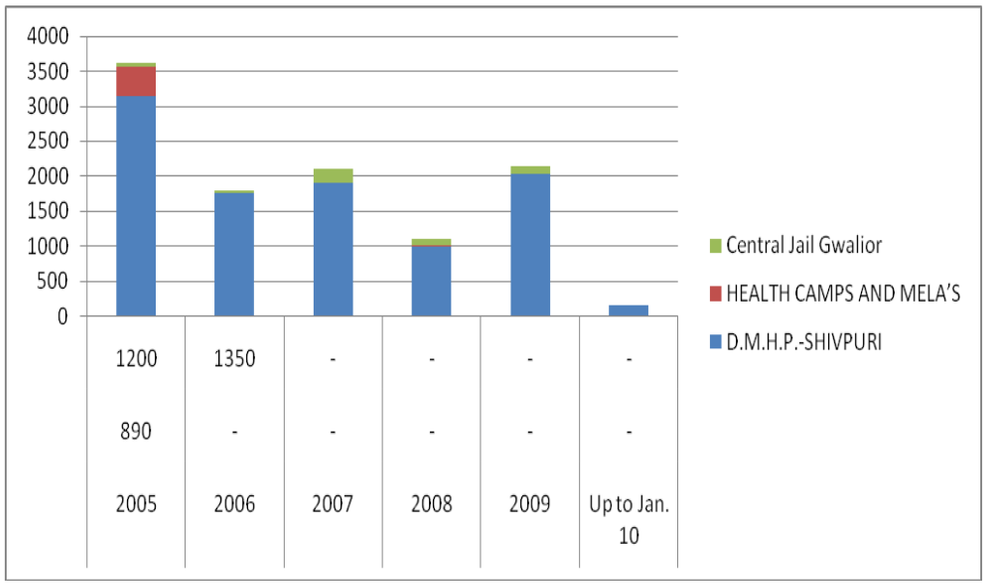
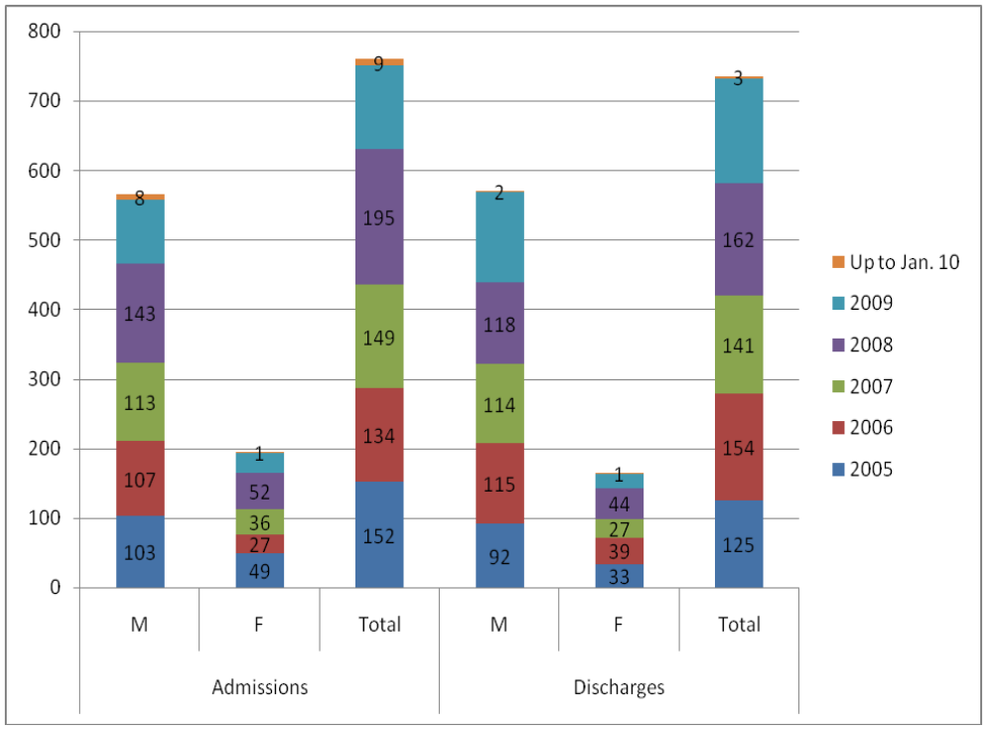


Table – IV

This deals with admission and discharge figures in the closed ward :

Year	Admissions			Discharges		
	M	F	Total	M	F	Total
2005	103	49	152	92	33	125
2006	107	27	134	115	39	154
2007	113	36	149	114	27	141
2008	143	52	195	118	44	162
2009	91	30	121	129	21	150
Up to Jan. 10	8	1	9	2	1	3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114
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92
1
44
27
39
33
3
162
141
154
125
M
F
Total
M
F
Total
Admissions
Discharges
Up to Jan. 10
2009
2008
2007
2006
2005

Table - V

This deals with admission and discharge figures in the Open Ward:

Year	Admissions			Discharges.		
	M	F	Total	M	F	Total
2005	1091	564	1655	995	524	1519
2006	1105	651	1756	942	653	1595
2007	1239	608	1847	1183	605	1788
2008	1285	625	1910	1298	664	1962
2009	1238	595	1833	1133	572	1705
Up to Jan. 10	92	37	129	89	38	127

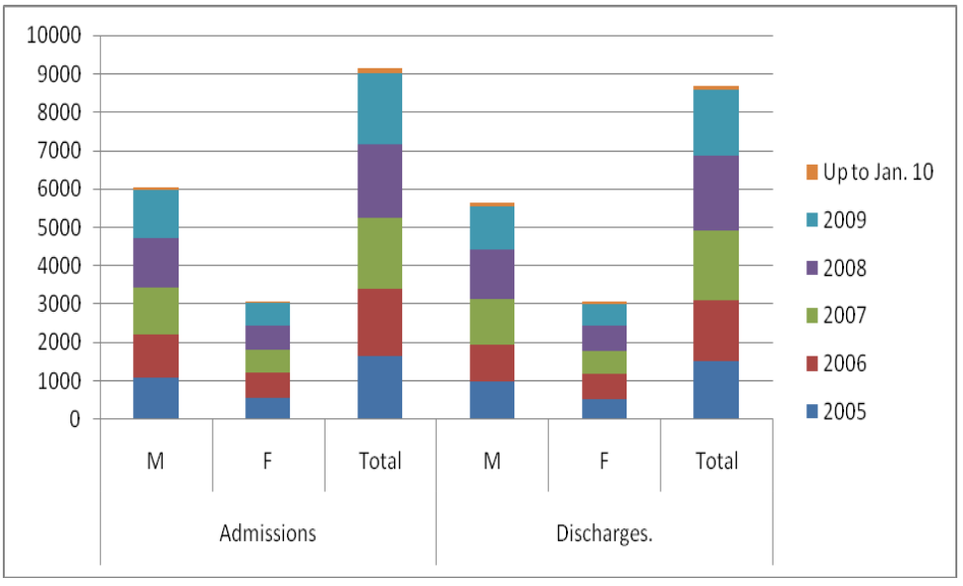
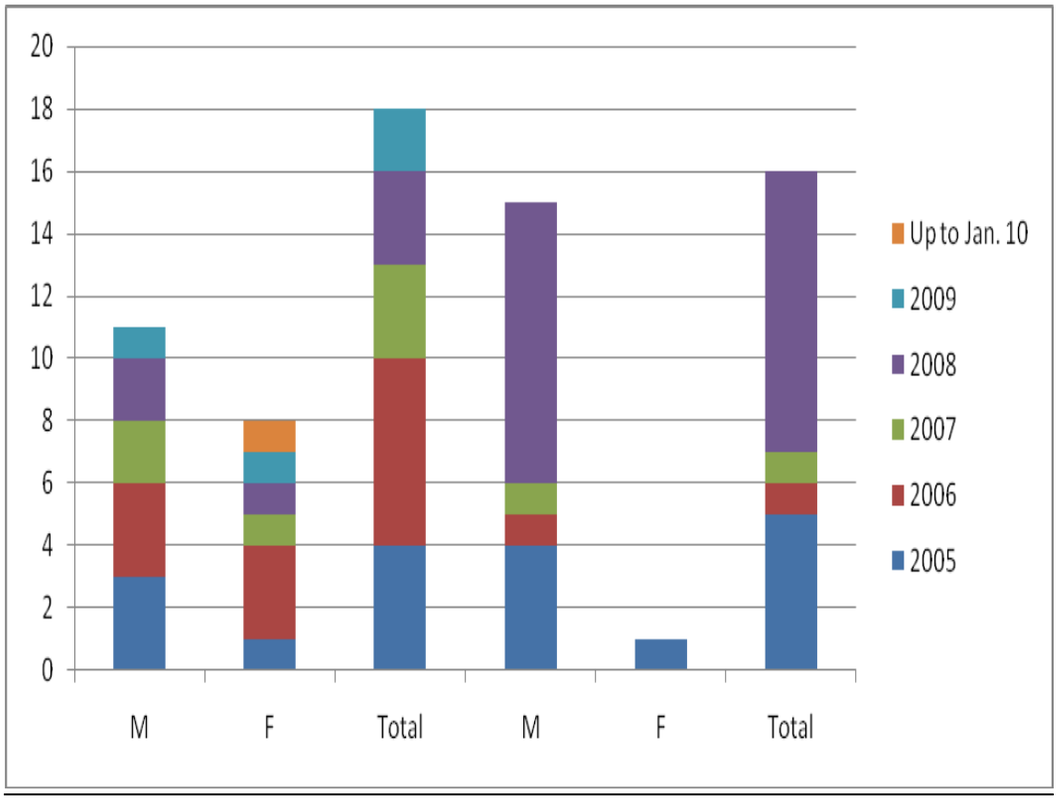


Table VI

This deals with death and abscond figures of the Closed Ward:

Year	Death			Abscond		
	M	F	Total	M	F	Total
2005	3	1	4	4	1	5
2006	3	3	6	1	X	1
2007	2	1	3	1	X	1
2008	2	1	3	9	X	9
2009	1	1	2	X	X	X
Up to Jan. 10	X	1	X	X	X	X

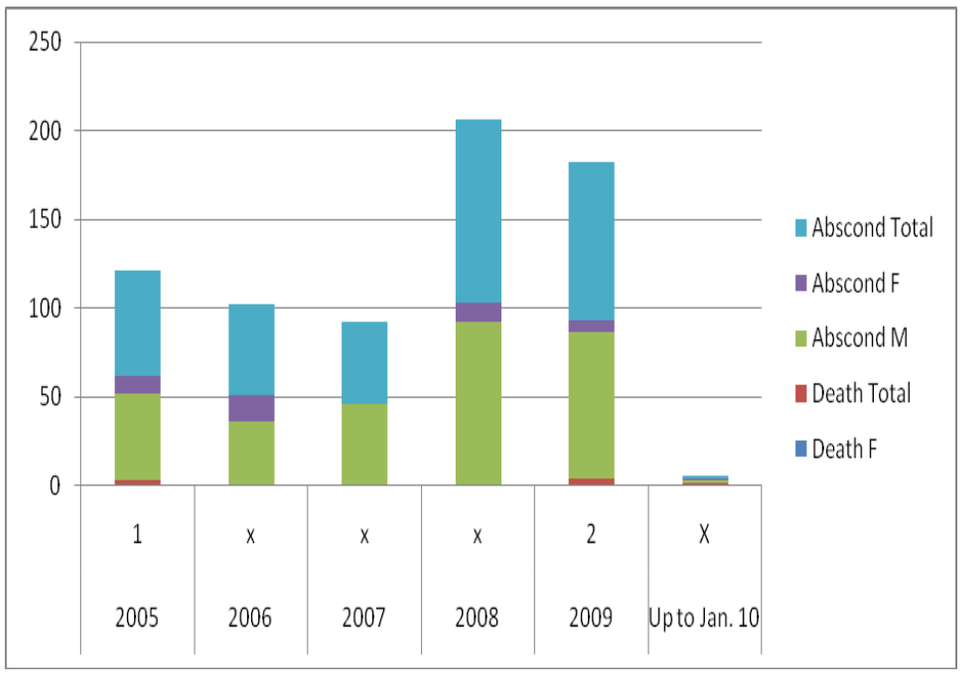


N.B: Unlike an openward, a closed ward is subjected to greater vigilance and tighter supervision. Despite this 9 patients are reported to have absconded in 2008. Reasons for this should be analysed and corrective measures taken to preempt repetition of this phenomenon in future.

Table VII

This deals with death and abscond figures in the Open Ward:

Year	Death			Abscond		
	M	F	Total	M	F	Total
2005	1	1	2	49	10	59
2006	X	X	X	36	15	51
2007	X	X	X	46	X	46
2008	X	X	X	92	11	103
2009	2	1	3	83	6	89
Up to Jan. 10	X	1	1	1	1	2



N.B: The reasons for abscond of unusually large number of patients from the open ward in 2008 (103) and 2009 (89) should be analysed and measures taken to prevent this regrettable phenomenon.

Table VIII

This deals with long stay psychiatric patients in the closed ward from 2005 onwards:

Years	2005		2006		2007		2008		2009	
	M	F	M	F	M	F	M	F	M	F
More then 15 years	7	4	7	4	7	4	7	4	5	4
More then 10 years	3	5	2	5	2	5	-	4	-	4
More then 05 years	8	23	7	22	7	18	6	4	14	12
More then 02 years	20	19	19	18	19	18	18	11	17	14

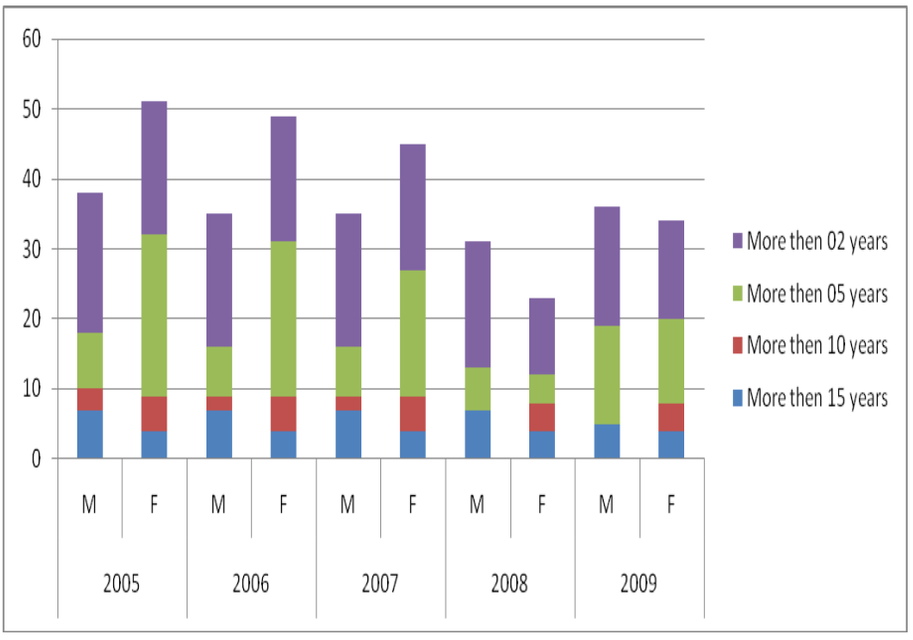


Table IX

This deals with training of nursing students from 2005 onwards:

Years	Category	Batches	No. of student
2005	Nursing Students	12	413
2006	Nursing Students	13	535
2007	Nursing Students	14	747
2008	Nursing Students	18	761
2009	Nursing Students	22	750
Up to Jan. 10	-	-	-

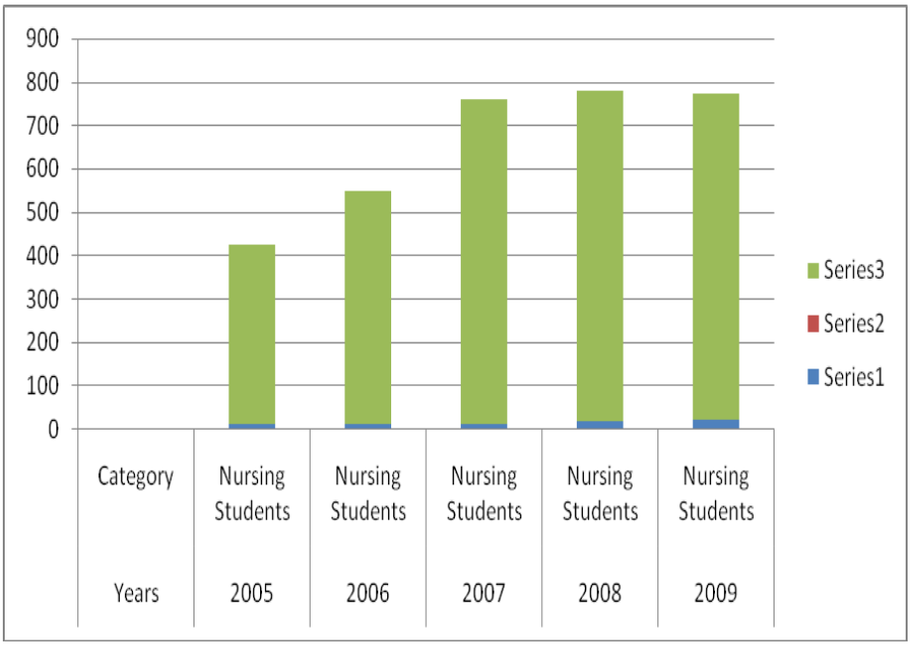


Table - X

This deals with total number of OPD and IPD patients who have been administered modified ECT from 2005 onwards:

Years	Outdoor Patients			Indoor Patients			Grand Total
	Male	Female	Total	Male	Female	Total	
2005	27	5	32	1376	641	2017	2049
2006	18	X	18	1291	548	1839	1857
2007	6	3	9	1309	434	1743	1752
2008	20	7	27	1367	657	2024	2051
2009	12	2	14	879	419	1298	1312
Up to Jan. 10	X	4	4	74	39	113	117

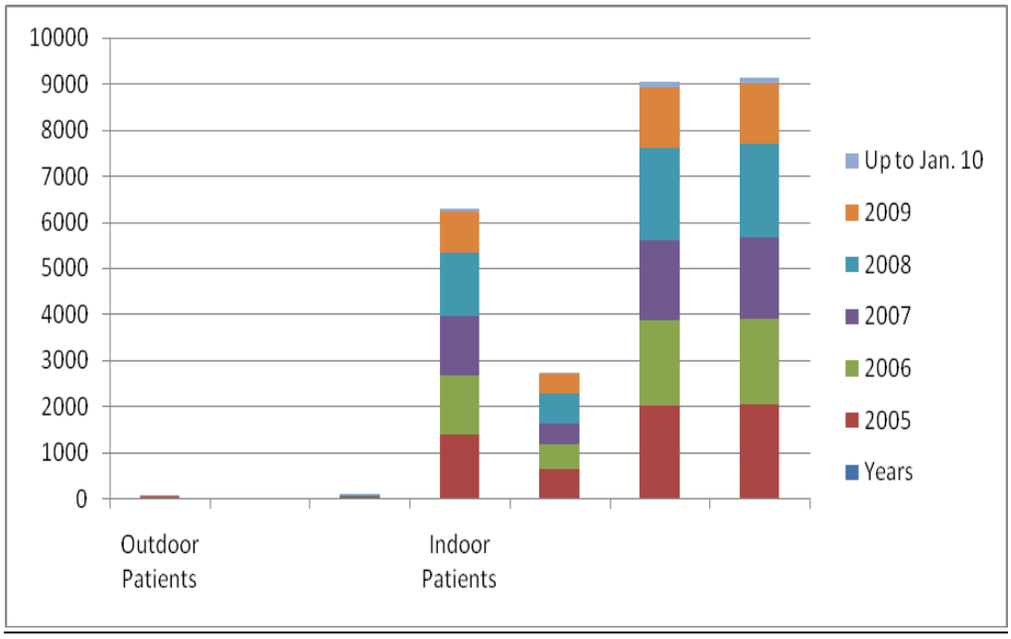


Table XI

This gives a break up of number of cases of ECG since 2005:

YEARS	MALE	FEMALE	TOTAL
2005	2	09	11
2006	45	57	102
2007	4	9	13
2008	123	38	161
2009	110	48	158
Up to Jan. 10	16	3	19

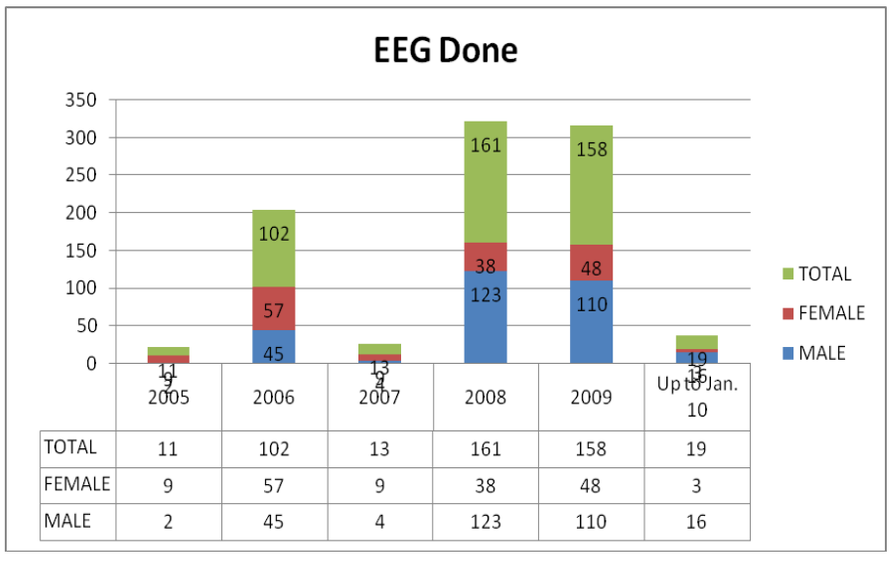
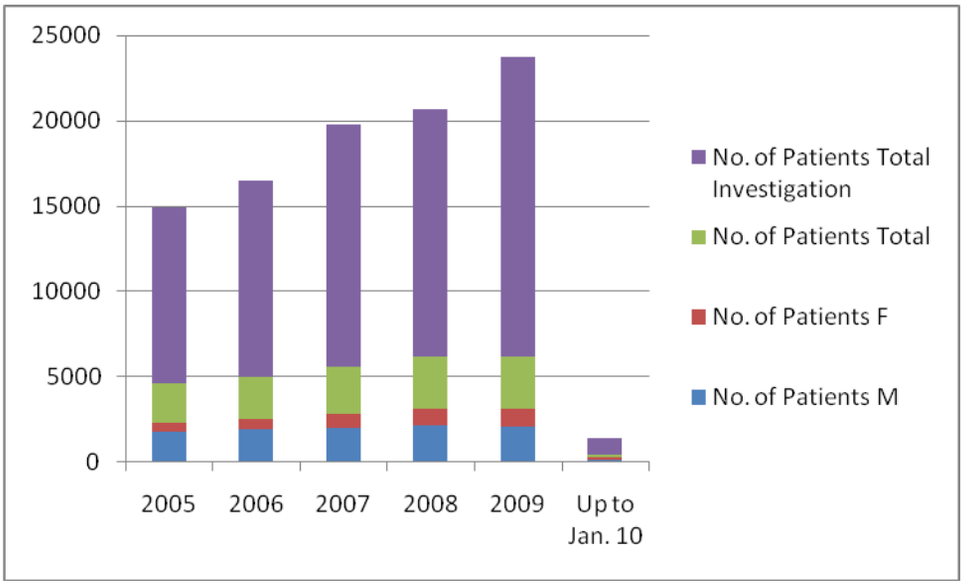


Table XII

This gives a break up total number of patients and total number of pathological investigations carried out since 2005:

YEARS	No. of Patients			Total Investigation
	M	F	Total	
2005	1688	589	2277	10342
2006	1843	612	2455	11583
2007	1981	789	2740	14274
2008	2101	985	3086	14522
2009	1984	1089	3073	17560
Up to Jan. 10	101	96	197	925



N.B.: The current trend is encouraging. To maintain the trend the vacancy in the post of Pathologist caused by the death of Dr. Sharma should be filled up at the earliest.

Table - XIII

This gives a break up of the number of X-ray cases since 2005:

YEARS	M	F	TOTAL
2005	203	195	398
2006	118	177	395
2007	144	149	393
2008	640	320	960
2009	545	317	862
Up to Jan. 10	40	22	62

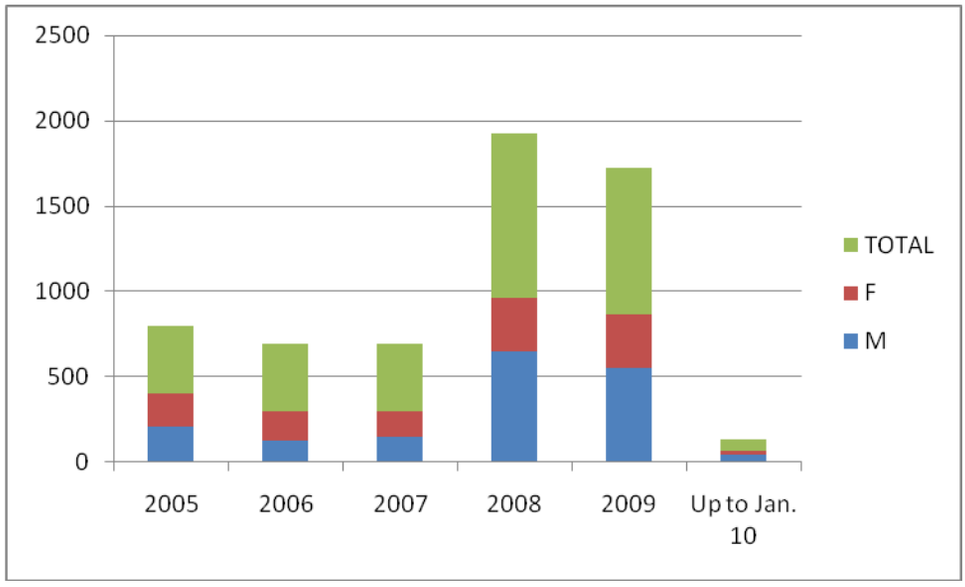


Table – XIV

Male Half Way Home Report :

Year	Male patients shifted to Halfway Home	Male patients shifted from Halfway Home to GMA.	Number of male patients rehabilitated	Present Situation
27-09-1999 to 02-05-2005	131	38	91	
2006	09	&	1	Continue
2007	45	27	13	15
2008	36	14	16	15
2009	13	24	04	Closed from 19.6.2009

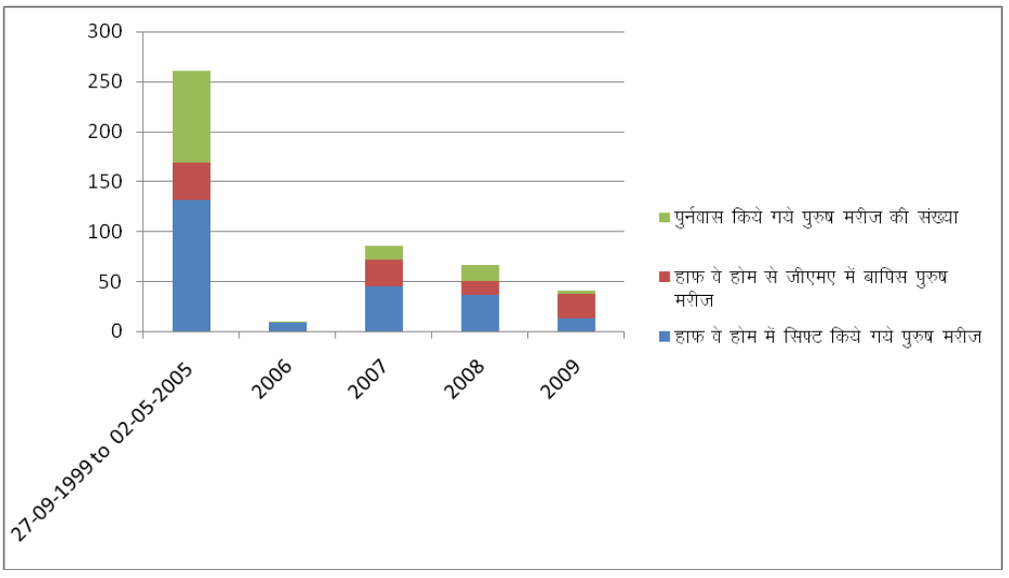


Table- XV

This gives a breakup of the number of inmates entertained in the female Halfway Home:

Year	Patients shifted to Halfway Home	Female patients gone back from Halfway Home to GMA	No. of female patients rehabilitated	Current situation
17-05-2001 to 31-12-2005	150	91	45	20
2005	33	29	4	14
2006	28	23	2	16
2007	26	23	6	12
2008	12	5	6	13
2009	15	11	4	14
Up to Jan. 10	1	-	-	14

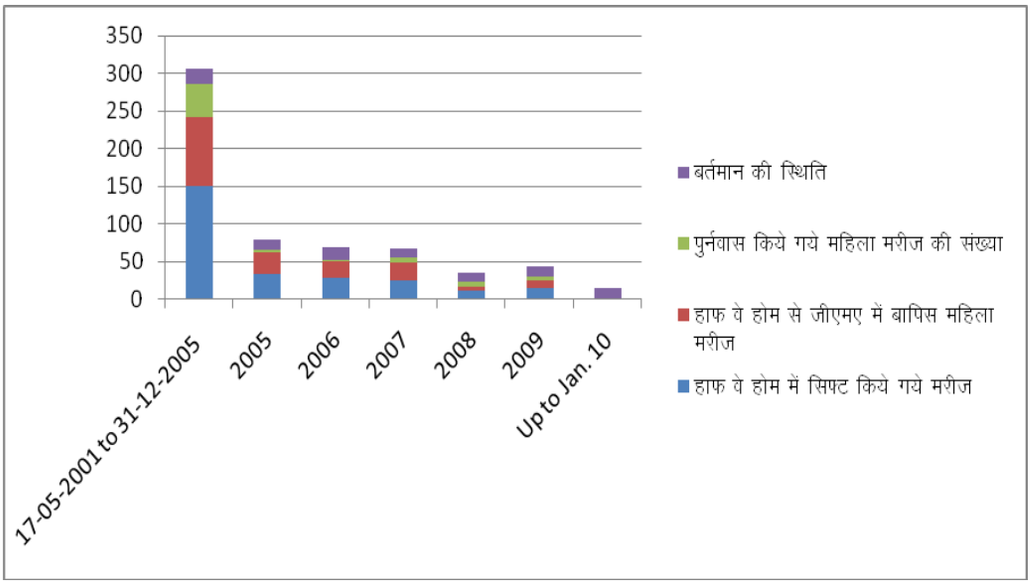


Table – XVI

This gives a description of activities in the female ward

Average Daily patients	32
Total No. Of Activities	11
Main Activities: ➢ Yoga ➢ Dance ➢ Singing; Crafting ➢ Envelope Making ➢ Knitting ➢ Embroidery ➢ Stitching ➢ Origami ➢ Indoor Games ➢ Outdoor Games.	

Table XVII

This gives an outline of activities in the Male ward

Average Daily patients	28
Total No. Of Activities	11
Main Activities: ➢ Gardening ➢ Yoga ➢ Envelope Making	

- Prayers
- Singing
- Gardening
- Indoor and Out door games.

Table XVIII

This gives an outline of expenditure on diet and expenditure per patient:

Year	Expenses On Diet (In Lakhs)	Rs.Per day/Patient
2001-02	18.50	27/-
2002-03	18.93	27/-
2003-04	17.60	30/-
2004-05	18.88	30/-
2005-06	19.61	30/-
2006-07	19.88	30/-
2007-08	23.68	30/-
2008-09	125.79	34.76
Up to Jan. 10	25.24	

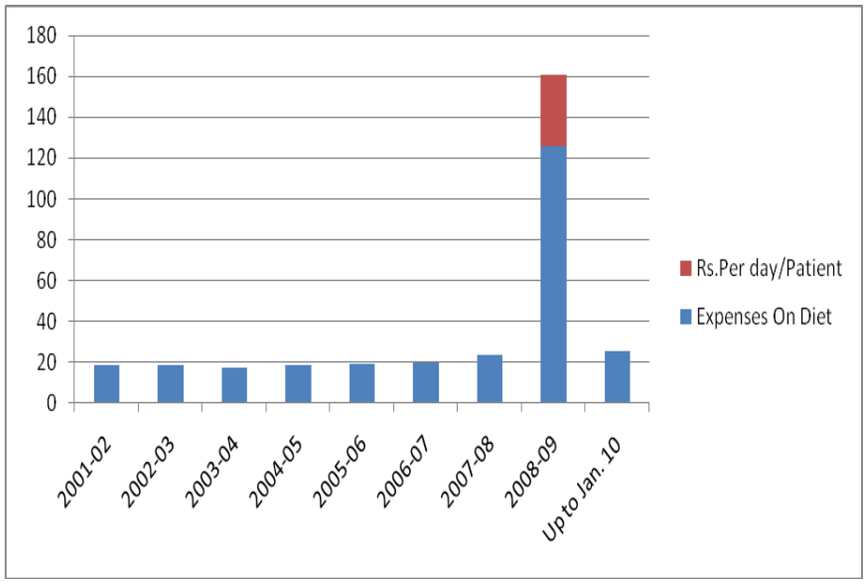


Table –XIX

This gives a broad outline of the diet chart:

S. No.	Food Item	Quantity (Gram)	Calorie (Gram)	Protein (Gram)	Carbohydrate (Gram)	Fat (Gram)	Rate per Kilo	Price
1	2	3	4	5	6	7	8	9
1	Wheat	350	1041	30-2	213-6	4-5	15.80	5.53
2	Rice	150	347	6-9	79	0-4	28.50	4.27
3	Dal	90	315	18	50-9	1-1	61.37	5.52
4	Breakfast	65	225	7-8	46-2	0-9	42.57	2.76
5	Sugar	30	120		30		31.40	0.96
6	Tea	2					260.00	0.54
7	Haldi	2					156.00	0.31
8	Chilly	3					170.00	0.51
9	Coriander	4					160.00	0.64
10	Salt	20					11.90	0.24
11	Oil	35	315			35	72.00	2.52
12	Milk	250	292-5	12-9	12-7	22	22.20	5.55

13	Heeng	-					1100.00	0.10
14	Garam Masala	1/2					320.00	0.16
15	Jeera	2					170.00	0.34
16	Gas	-					355.00	2.40
17	Vegetable	300	100		10		21.26	6.37
18	Fruits	100	50				28.75	2.87
	Total -		2805-5	81-8	524-2	63-9		41-55

Special Diet – On special occasion festivals.

– Eggs are provided to non vegetarians in winter season.

Table – XX

This presents a financial statement of receipt and expenditure from 1999-2000 till date:

(Figure in Lakhs)

No.	Particulars	Year										
		99-2000	2000-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10 (Up to 18-02-10)
1.	Opening Balance	113.94	146.48	330.85	111.94	299.10	261.20	175.95	72.64	55.47	-	-
2.	Received From Govt.	258.00	348.00	Nil	540.00	219.20	233.33	225.00	310.00	313.27	272.00	189.50
3.	Expenditure	225.46	163.63	218.91	352.84	257.10	318.58	328.31	327.17	421.18	339.02	363.20
4.	Balance	146.48	330.85	111.94	299.10	261.20	175.95	72.64	55.47	-	-	-

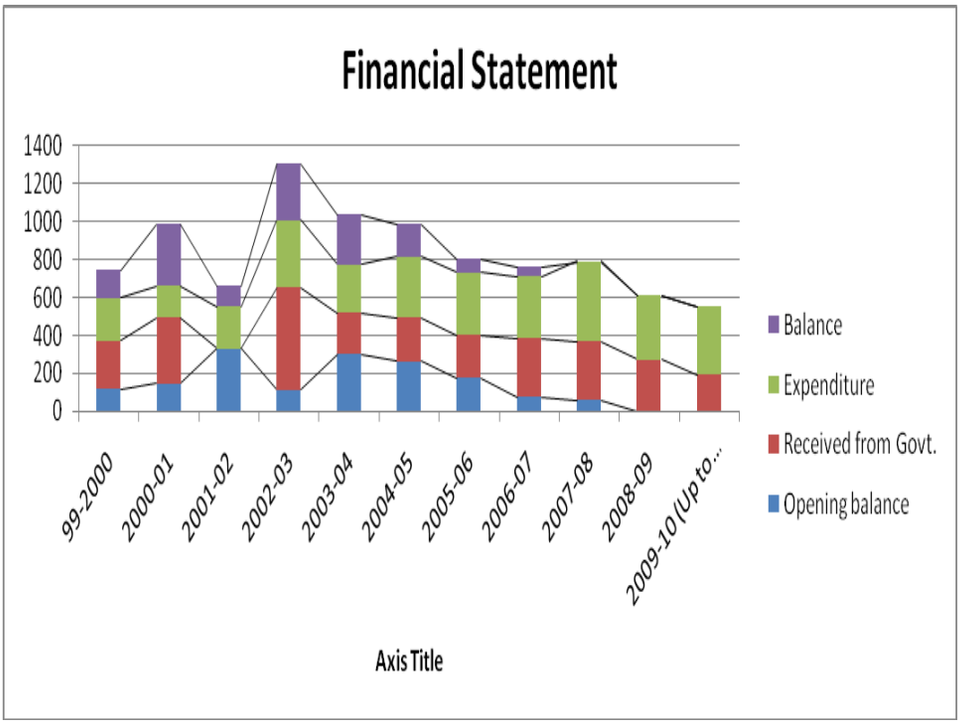
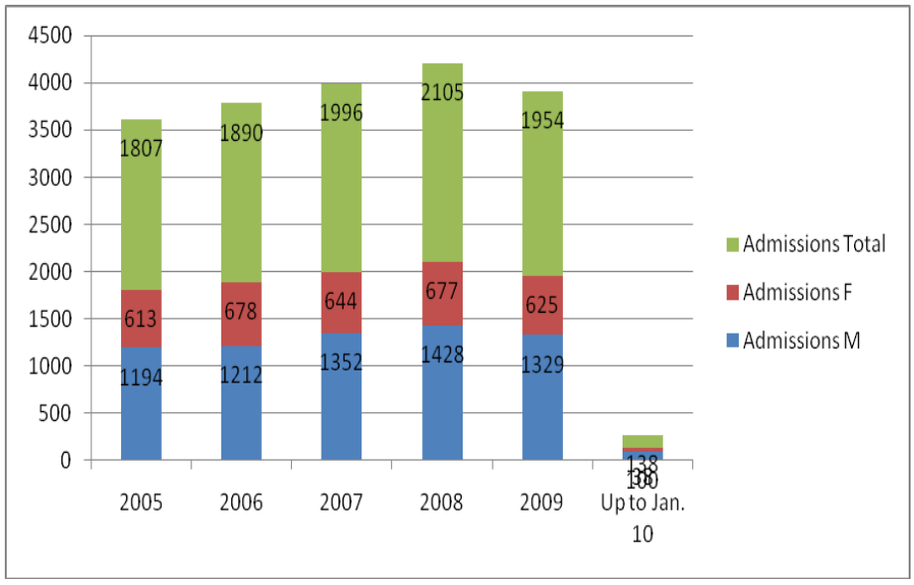


Table – XXI

This gives a complete picture of total admissions:

Year	Admissions		
	M	F	Total
2005	1194	613	1807
2006	1212	678	1890
2007	1352	644	1996
2008	1428	677	2105
2009	1329	625	1954
Up to Jan. 10	100	38	138



Meeting with Director-incharge and other faculty members: (23.2.2010 2.30 PM to 5.30 PM)

I met the Director-in-charge and all faculty members in a friendly and informal manner to share ideas and experiences. The following ideas and suggestions came from the meeting:-

- Adhocism in appointments or contractual appointments should be fully dispensed with as such appointments are demoralizing and demotivating; they do not promote quality human resources and do not contribute to image building of the institution.

- According to the recommendations of the Sixth Pay Commission there should be 4 levels in a time scale of pay for officers in the medical cadre. Such a scale of pay has been implemented in medical colleges and hospitals all over MP but GMA has been left out. This omission should be made good.

- Per capita expenditure per patient in GMA continues to be Rs. 250/- which is pretty low and grossly inadequate considering the rise in expenses at all levels. This should be revised to Rs. 500/- in the minimum as in IMHH, Agra and RINPAS, Ranchi without further delay as it gives rise to an unmanageable

situation. It should be reviewed year after year and further upscaled depending on increase in food inflation and rise in prices of other commodities.

- Progressively and over the last 10 years the outturn of patients in the OPD has registered increase. The total number of patients treated at the OPD at the end of 2008-09 had gone upto 57000. More and more old patients are coming for follow up. This makes an encouraging reading about the caliber of MOs and quality of services provided by them to OPD patients. This notwithstanding, GMA has not received the type of attention that it deserved and there are a number of outstanding issues awaiting solution. If these issues are resolved the stature of GMA would rise to great heights. Some of these issues are:-

  - A Drug Deaddiction Centre should be established within the premises of GMA considering rapid increase in the incidence of substance abuse. It appears that the Ministry of Health and Family Welfare had sanctioned the required amount for this purpose but since no land was available, the amount was diverted for other purposes with the approval of MC;

  - The number of books in the library must be progressively raised from 200 to an appreciable number to meet the full requirement of the faculty members and to enable them to keep pace with the changing times;

  - The post of a Librarian should be sanctioned; this is the irreducible barest minimum need of a library;

  - Full powers for purchase of books and journals which are required for academic, research, treatment and training purpose should be delegated to the Director-in-charge;

- All operations in the library should be computerized eventually ending up with e-connectivity between the library and other faculties;

- Posts of a pathologist, anaesthetist, radiologist and occupational therapist should be sanctioned without any hitch.

- In regard to creation of additional physical infrastructure for GMA the following suggestions were made:-

  - Conforming to the direction of the apex Court a beginning should be made to plan and open a teaching block at the earliest; the teaching activity could be introduced in the following:-
    - M.D. Psychiatry;
    - DPN;
    - M.Phil in Clinical Psychology;
    - M.Phil in Psychiatric Social Work.

  - Currently 25 to 30 patients are attending yoga classes in the open in the absence of a full fledged yoga centre; there was, therefore, urgent and imperative need for starting a full fledged permanent yoga centre;

  - In addition to a half way home for female patients, GMA may plan to start a long stay home for patients to be managed by an NGO.

- Giving a concrete shape to all these proposals would necessitate mobilization of enormous resources. A drive for fund raising should be launched and GMA should be permitted to do so by Government of M.P. on the analogy of similar fund raising campaign for institutions elsewhere (Kadavam in Bangalore and Dr. Rahiya's Clinic at NOIDA).

- With a view to giving a push to decentralization of mental health it was suggested that District Mental Health Programme should be launched in the following new districts:-
  - Morena;
  - Bhind;
  - Datia.

- It was emphasized that if more and more districts are progressively brought within the purview of District Mental Health Programme it would (a) spare BPL families the unaffordable cost of travelling long distances to GMA (b) carry mental health care to the door steps of patients and (c) more and more disability certificates can be issued.

- Like RINPAS patients are coming from Chattisgarh, U.P. and Rajasthan for treatment in GMA. This depended on a number of factors such as (a) geographical distance (b) personal and family convenience and (c) reputation of the medical officer concerned. It was suggested that Government of M.P. in consultation with those States should fix a minimum charge per patient and the total contribution by the State concerned would be decided on the basis of average number of patients visiting GMA in a year.

- It was heartening to note that despite the poor State of the library and difficulty in access to relevant books, journals and periodicals some of the faculty members have been relentlessly pursuing their academic interests which resulted in a good number of research publications. The details of these publications are as under:-

Contribution of faculty/M.O. members

1. Attitude of ward attendants towards mental illness- comparison and predictors. Vibha Pandey, Saddichha Sahoo and Ranjeet Kumar, International Journal of Social Psychiatry volume, 54, 469-478 (2008).

2. Diagnostic efficiency of new Rorschach depression Index (DEPI) Lissy George and Ranjeet Kumar, Journal of projective Psychology and Mental Health. Volume 15, 118-127 (2008).

3. Rorsach Thought disorder in various clinical conditions by Deepti Mishra, Ranjeet Kumar and Jai Prakash. Journal of projective Psychology and Mental Health volume 16, 8-12 (2009).

4. SIS imagery in depression with somatisation: therapeutic intervention. A case study. Ranjeet Kumar and Deepti Mishra. Journal of Projective Psychology and Mental Health volume 17, 69.72 (2010).

5. Profile of Mania Patients on Rorschach. Deepti Mishra and Ranjeet Kumar. Journal of projective Psychology and Mental Health. Volume, 18 (In press) 2010.

6. Relationship between academic achievements, self esteem and inter personal competence among School going adolescents. Ranjeet Kumar and M. Thomas Kishore. Indian Journal of Social Psychiatry volume, 24 51-53 (2008).

Visit to Halfway Home:

Akhil Bharatiya Samajik Swasthya Sangh (M.P. Branch) a registered NGO of standing has been running a halfway home for female inmates within the premises of the GMA since 17.5.2001 for psychosocial rehabilitation of treated and controlled mentally ill persons. GMA has made available necessary accommodation for this purpose; GMA has also been bearing the cost of food, drugs and dress of the inmates. According to the information made available a number of mentally ill persons with the help of the NGO managing the Halfway Home have attained the status of Psychosocial rehabilitation and have been sent to their respective homes. The figures for such rehabilitated persons yearwise are indicated as under:-

2005-06	-	6
2006-07	-	8
2007-08	-	7
2008-09	-	4

As of date there are eleven inmates in the Home. Protracted correspondence is taking place with their families, husbands, brothers and sisters but despite best efforts the NGO has not succeeded in sending them back to their respective homes for the following reasons:-

- Family members and relatives have visited the patients and have promised to take them back but have gone back on the promises.

- The postal address of home furnished by the patients did not turn out to be correct. None was found at the concerned destination.

- There are patients who have lost their parents and are left only with sisters; the latter are disinterested in rehabilitation of the patients.

- There are patients who have none left in this world.

- A patient has 3 daughters and all are married. The sons have sold the ancestral home, have been charged with some offence and police cases and have absconded.

- A patient's father is alive but with poor economic status and has shown reluctance to keep the patient with him. Correspondence is still going on with him and efforts continue to persuade him but without any success so far. The matter has been brought to the notice of CJM as well.

- Family whereabouts are not known.

- Son is dead and daughter is married and none is left in the family to take care of the patient.

- Family disputes are subjudice. While husband has filed a divorce suit, father has lodged a dowry case against the son-in-law. GMA has provided the services of a lawyer to contest the case against the husband. GMA's Counsellor made efforts to bring the estranged husband and wife together but the husband refused to cooperate.

- With the efforts of the NGO two children of a patient have been admitted to SOS, Bhopal. The patient has a brother at Bhopal and his whereabouts have been traced but the patient could not be sent to him as yet.

Activities like management of a Halfway Home by an NGO are funded by the Ministry of Social Justice and Empowerment, Government of India. It appears that since inception of this activity by Akhil Bharatiya Swasthya Sangh (MP branch) protracted correspondence is going on with the Ministry of Social Justice and Empowerment but except one solitary grant of Rs. 1.86 lakh received in the year 2006-07 no other grant-in-aid has so far been received from that Ministry. From a letter dated 11.4.2008 received from the National Institute for the Mentally Handicapped under the Ministry of Social Justice and Empowerment addressed to the Secretary, Akhil Bharatiya Samajik Swasthya Singh it appears that one Dr. R.K. Hora, Officer-in-charge, NIMH, Regional Centre, New Delhi was deputed for inspection of the Project. He came and inspected the Halfway Home and must have submitted his report by now but it is not known what action was taken on the said report. The NGO has been kept on the tenter hooks since then.

Subsequently and in pursuance of the guidelines issued by the Ministry of Social Justice and Empowerment the NGO concerned has sent applications for sanction of grant-in-aid to that Ministry through the Panchayat and Social Justice Department, Government of M.P. on 13.2.2010 with all relevant accompanying documents. It is too early to know the outcome of the same but nevertheless this could be followed up by the GMA with the Government of M.P.

In course of my visit to Halfway Home I had specifically enquired about the condition of Dr. Anuradha Moga. In my earlier review report of February, 2009 I had recorded in detail the circumstances under which she was removed from the Halfway Home by one of her family friends – Miss C.H. Angre, the humiliation and torture to which she was subjected, the severe relapse that she suffered and how she was brought back by the same family friend and left in GMA in a pathetic condition. Later I met Dr. Anuradha Moga myself and had an interaction with her. She told me that even though she is a gynaecologist (and a gold medalist too) and was capable of conducting deliveries the severe relapse of schizophrenia had left her with debilitated fingers and she was not in a position to contribute anything worthwhile to the society. This indicates how mental illness like Schizophrenia can work havoc with the life and psyche of a patient.

In course of visit to the Halfway Home a question was posed by the Director-in-charge of GMA as to whether the management of the Halfway Home should continue to remain with the existing NGO or offers should be invited from other prospective NGOs in conformity with the decision of the Managing Committee? Mentally ill persons who have been effectively treated, who have been substantially recovered and who are in need of rehabilitation need a halfway home as a transit Home. They need to be attended to with care and affection. This cannot be a commercial proposition to be settled through advertisements. Issue of an advertisement is, therefore, uncalled for.

What is needed, however, is that the track record of performance of the NGO managing the halfway home should be objectively and dispassionately evaluated on the strength of the following norms:-

- have the inmates been treated with kindness and compassion?

- have their basic needs of food, water, dress, check up of health, personal hygiene, environmental sanitation etc. has been addressed properly and in time?

- are they safe and secure?

- what skills/trades have been imparted to them to make them self sufficient in life after they have been discharged from the hospital?

- what special efforts have been made to engage them in continuous social interaction, has it produced the desired results?

If the NGO meets the norms it may be considered eligible for management of the halfway home and statusquo ante may be allowed to continue. In other words, nothing should be done in haste which will cause dislocation in the process of rehabilitation of the inmates (11).

Interaction with other NGOs:

Shri R.B. Singh Kushwah, President, Online Service Association, Gwalior met me at GMA and drew my attention to the following issues affecting the life of mentally ill persons:-

- There are a number of mentally ill persons who are wandering in the streets. They are otherwise not violent or aggressive but when asked to go with someone (from an NGO) to go to the CJM or go to GMA with a reception order from the CJM they turn violent. It takes approximately one day to get a reception order from the Court and it is a formidable problem for the NGO to keep the mentally ill person for that period. Even transporting the mentally ill person to GMA with the reception order of CJM takes 3 to 4 hours and services of a minimum number of three persons are needed to take care of the mentally ill person during the period of transition.

- After the patient has been effectively treated and is fit for discharge, GMA writes to the NGO which brought the patient to the hospital with the reception order but the patient is unable to furnish the home address which makes such discharge extremely difficult.

Against the above limitations in admission and discharge of mentally ill persons, the following suggestions were made:-

- Whenever a wandering suspected mentally ill person is found on the Streets he/she should be immediately brought either by organized ambulance service No. 108 or police or online service and got admitted in the nearest Psychiatric hospital.

- He/she should be subjected to a preliminary check up of his health to arrive at the conclusion as to whether he/she is mentally ill or not and whether he/she is in need of hospitalization or not.

- On the basis of the preliminary check up of health and the conclusion reached the case file should be prepared and the online service staff could approach the Court of CJM on the strength of these dossiers and obtain the reception order accordingly.

- Till such time no arrangements have been made for rehabilitation of the patients, existing schemes like preparation of a card, Deendayal health scheme, BPL card, ration card, social security should be availed of to facilitate rehabilitation.

Executive Summary of impressions, observations and recommendations:

- Review is a form of monitoring which is conducted to assess the status of compliance with certain observations and recommendations which have been made in the past and which are considered useful in the larger interest of the institution and larger public interest.

- If there is no compliance or compliance is tardy the same negatives the basic purpose of a review and the same gives rise to a lot of frustration.

- In the previous review reports it was observed as under:-

  - The Director does not have full autonomy in filling up posts in Group ‘B’, ‘C’ and ‘D’;

  - The Director does not have full autonomy in procurement of essential store items like medicines (except food);

  - He/she does not have powers to purchase books and journals for the library;

  - Purchase of drugs has been centralized;

  - All other purchases (tools, equipments etc.) are couched with and circumscribed by a number of restrictions (like no purchases can be made after 31st January of a year);

  - There is a huge gap between the number of posts which are required to be sanctioned on the basis of a prescribed norm and posts which are actually sanctioned; this makes the task of management extremely difficult;

  - The gap between the number of posts sanctioned and number of posts which have been filled up is equally large;
  - The vacancies persist for a long time;

  - Several positions (MOs and para medical staff) are on adhoc and contractual basis with a consolidated wage;

  - It is for this reason that when posts are advertised they do not elicit good response primarily for the reason that contractual nature of appointment is a major disincentive;

  - It is demoralizing and demotivating;

- The Director does not have powers to outsource certain activities like appointment of electrician, plumber, gardener, barber, dhobi etc., where the existing manpower is inadequate and it is not possible to sanction and fill up posts on a permanent basis;

- The position of residential accommodation is most unsatisfactory. Against 146 persons in position staff quarters are available only for 12 persons;

- The average expenditure per patient per day has been of the order of Rs. 350/- while the actual expenditure is over Rs. 500/-. Government of M.P. has, however, been rigid in fixing a norm of Rs. 250/- per capita expenditure per day. In IMHH, Agra and RINPAS, Ranchi the norm has since been revised to Rs. 500/-.

- To cap it all there is a huge gap between requirement of funds related to the genuine needs of the institution i.e. GMA and the actual flow of funds.

- There is no timeliness in flow of funds.

- Since the last visit there have been only 2 welcome changes namely:-

  - Purchase of drugs has been decentralized from M.P. Laghu Udyog Nigam. Powers for such purchase rest with the Director and she has been purchasing the required quantity of drugs through the open tender procedure.

  - Government of M.P. have issued a GO No. 5061/2007/1 dated 10.7.2008 to go in for regular appointments in all categories as against adhoc and contractual appointment.

- There has not been any change in any other gaps, omissions, deficiencies pointed out in the earlier review reports.

- To make matters worse, no recruitment rules for the post of Director, GMA have been finalized as yet.

- The same adhocism in appointment of Director, GMA continues as on the earlier 3 occasions.

- There is no continuity in the tenure of the Director incharge either.

- Undoubtedly individuals (including the present incumbent) who have held the position of Director-in-charge since September, 2007 have been women of exceptional ability, dedication and commitment to serve the institution but they have been appointed as Director-in-charge purely as an adhoc arrangement in addition to their own duties in Gajraja Medical College (Professor, Dean and Head of the Department).

- An institution like GMA deserves total energy and attention of a full time professional; a part time arrangement made with best of intentions and in the exigencies of a given situation does not produce the desired results. Time management is a part time arrangement becomes extremely difficult.

- Besides, none of the part time Director-in-charge was given a fixed tenure of atleast 3 years to plan, think, reflect, analyse and implement.

- Time has come to put an end to such adhocism.

- Recruitment Rules for the post of Director should be finalized at the earliest and a professional (preferably a psychiatrist) with a track record of impeccable integrity and competence and experience in hospital management should be appointed to the post.

- Once appointed as Director, he/she should be given a minimum fixed tenure of 5 years so that he/she can plan and translate his/her plans and dreams in relation to genuine needs of the institution to concrete action.

- The scale of pay of the Director, GMA should be the same as that already obtaining in RINPAS, Ranchi i.e. equivalent to a Secretary to Government of India/Chief Secretary of the State Government.

- Once the incumbent to the post of Director is in saddle a thorough and scientific job study, job description, job analysis should be undertaken on the basis of which (a) jobs required to perform vital functions in an organization can be sanctioned (b) women/men fulfilling the norms and qualifications attached to the post could be selected on a regular basis, given induction and refresher training and confirmed on the basis of work, conduct and performance.

- Staff quarters for all officers and staff members should be constructed within the premises of GMA on the basis of a survey and after ascertaining incumbents who are willing to stay with GMA premises.
- The Director must be delegated full administrative and financial powers. He/she should have full powers to –

    - fill up posts in 'B', 'C' and 'D' categories;
    - sanction their leave, increment, PF, reimbursement of medical expenses etc.;
    - purchase all items of recurring and non-recurring expenditure (tools, equipments, furniture, drugs, books, journals, food and all other consumables).

- The Director or Chief Executive should not be made to look upto Government for each and everything. He/she should be able to

function and incur expenditure related to genuine needs of the institution and according to approved scales.

- GMA is a 135 year old institution. The old building was made of lime and mortar. Its safety and suitability should be thoroughly assessed and steps taken to progressively dismantle the old structures and raise new ones in their place. The norms and requirements of adequate lighting, ventilation, personal safety, security of all inmates, sufficient number of beds in wards at a gap of 1 metre each, provision of lockers for use of relatives, provision of bedsheets, linen, sufficient number of WCs for use by physically or orthopaedically handicapped persons should be made.

- Right to wholesome and nutritious food, right to clean potable drinking water, right to personal hygiene through use of mechanized laundry, right to environmental sanitation, right to leisure and recreation, right to occupational therapy are human rights – inalienable and non-negotiable. Appropriate scales have been laid down by WHO, ICMR etc. and endeavour should be made to adhere to these scales to the maximum possible extent possible.
- Human Resource Development and Human Resource Management are inseparable in as much as teaching, training, treatment and research one. These should be strengthened on the strength of suggestions and recommendations made in the report.

- Like RINPAS, Ranchi a beginning should be made to construct a teaching block. For this, however, there is no space available within the existing premises of GMA. Request for making available 5 acres of land proximate to the location of GMA is still pending with the Divisional Commissioner and the Collector. The Director-in-charge with the help of local Tahasildar should go round, locate a suitable site measuring approximately 5 acres,

prepare the land plan and land schedule and place the same before the Collector with a formal request for land alienation. Once the area has been identified, land allotted and physical possession of land handed over formal proposals for putting the following in place should be placed before the MC and sent to Health Department, Government of M.P. with the approval of MC:-

- Drug Deaddiction Centre;
- Long Stay Home;
- Male Halfway Home;
- Teaching Block;
- A Modern Kitchen;
- A Geriatric Ward;
- A Child Guidance Clinic;
- 90 bedded New Male Ward;
- A Modern Hostel for stay of relatives of patients.

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